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, 5 September 2014.

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

ALSO PRESENT: Cllr J Burden, Mr A H T Bowles, Mr T Gates, Mr S Inett, Dr J Allingham and Dr M Parks

IN ATTENDANCE: Mr T Godfrey (Policy Manager (Health)), Miss L Adam (Scrutiny Research Officer), Mr A Scott-Clark (Interim Director of Public Health) and Ms D Fitch (Democratic Services Manager (Council))

UNRESTRICTED ITEMS

60. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 2)

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

(2) Cllr Michael Lyons declared an 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.

61. Minutes
(Item 3)

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

(a) Minute Number 43 - Community Care Review: NHS Ashford CCG & NHS Canterbury & Coastal CCG. The CCGs had been asked to provide an update on the design of the community hubs. An update email was circulated to Members on 20 August. A paper was being drafted and would be circulated to Members after public events in September.

(b) Minute Number 49 - Child and Adolescent Mental Health Services (Written Update). Michael Ridgwell (NHS England (Kent and Medway Area Team)) had co-ordinated a joint response and update on performance across the four CAMHS tiers in Kent. The response was circulated to Members on 24 July.

(c) Minute Number 53 - Kent Health & Wellbeing Board: Update and Strategy. In response to a question about statistical variances in the report and the utilisation of libraries and gateways, Mr Gough stated that he would need to check the differences in the statistics and would provide additional information on the utilisation of libraries and gateways. Responses were circulated to Members on 1 and 3 September.

(d) Item 58 - Future of Services at Dover Medical Practice. A Member asked for clarification regarding the status of Dover Medical Practice as one of 13 practices in Dover and Folkestone to pilot extended and more flexible access to GP services as part of the Prime Minister's Challenge Fund. Responses from NHS England (Kent and Medway Area Team) were circulated to Members on 24 July and 15 August.

(2) The Scrutiny Research Officer requested that the following sentence be added to Minute 53: Mr Roger Gough (Cabinet Member for Education and Health Reform, Kent County Council) and Mr Tristan Godfrey (Policy Manager (Health), Kent County Council) were in attendance for this item.

(3) Mr Hoare requested that the following sentence be added to Minute 53: A Member made a comment about the number of people in Kent who could be potentially affected by the Assisted Dying Bill. Mr Gough stated that he was unable to provide a definitive answer as the Bill was going through its parliamentary passage.

(4) RESOLVED that, subject to the amendment in paragraph (2) and (3) above, the Minutes of the Meeting held on 18 July 2014 are correctly recorded and that they be signed by the Chairman.

62. Medway NHS Foundation Trust: Update
(Item 4)

Dr Phillip Barnes (Acting Chief Executive, Medway NHS Foundation Trust), Patricia Davies (Accountable Officer, NHS Swale CCG), Fiona Armstrong (Clinical Chair, NHS Swale CCG) and Gillian Wells (Governing Body Independent Lay Member, NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Barnes began by giving an overview of the last 15 months. As a Trust investigated by the Keogh Mortality Review, the Trust was inspected in June 2013. A Quality Improvement Plan (QIP) was developed in response to the inspection report and had been worked through by the Trust and external stakeholders. A re-inspection took place in April 2014 and the inspection report was published on 8 July. The Trust was rated as inadequate with particular concerns about emergency and surgical services.

(2) Dr Barnes highlighted a number of themes from the report including leadership instability; over the last 18 months there had been 32 different board members. It was announced that the Council of Governors had appointed Shena Winning as the new Chairman of the Trust on Thursday 4 September. Interviews for a substantive Chief Executive would take place at the end of October. A new management structure will be introduced which would include

a Chief Operating Officer. The Trust was receiving best practice guidance and support from University Hospitals Birmingham NHS Foundation Trust with its management and governance structure. The Trust had produced a very detailed action plan in response to the CQC inspection report. The action plan detailed proposals to improve staff engagement and ownership; and surgical leadership with seven day working for consultants.

(3) It was reported that a further unannounced inspection of the emergency department by the CQC took place in August. In response to the inspection, the Trust had implemented a support team to challenge and hold the emergency department to account; changed the front of house assessment process; and made improvements to discharge as part of seven day working. The Trust had also received advice and guidance from Homerton University Hospital NHS Foundation Trust in Hackney.

(4) The Chairman invited Ms Davies to speak. Ms Davies explained that NHS Swale CCG's concerns were with the speed and pace of delivery at the Trust. The CCG was working very closely with the Trust, Monitor, CQC, NHS England, NHS Medway CCG and wider CCGs to make improvements and reduce pressure on the Trust. NHS Swale CCG had released additional funds to extend the Integrated Discharge Team, provided nursing and quality support and expanded psychiatric liaison. She stated that NHS Swale CCG was using its commissioner levers to engender change; Monitor the regulator for NHS Foundation Trusts had the jurisdiction to enforce regulatory measures.

(5) The Chairman invited Mr Bowles, a local Member, to speak. He thanked Dr Barnes for his openness at the meeting with HOSC and at a briefing with Swale Borough Council.

(6) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A question was asked about the completion of actions in the Trust's Improvement Plan which had been marked as commenced. It was explained that any actions which had not been completed were incorporated into the CQC Action Plan. One of the areas which had been commenced was the development of an estates strategy for the Medway site. This would include the construction of buildings fit for purpose and efficient working which would require a minimum of two years to acquire loan funding. Dr Barnes provided an update on serious incident training; a central team of investigators had been embedded within each of the clinical directorates.

(7) Concerns were expressed about the Trust's ability to make a change. Dr Barnes acknowledged that the Trust had previously lacked calibration and had not worked with outside partners sufficiently. He stated that the Trust had moved from a culture of denial; whilst the Trust had a world class neonatal unit, there were many areas which required improvements. The CQC rated the Trust good for caring which gave assurance to patients and staff.

(8) A number of comments were made about the monitoring of lower levels of the action plan; jeopardy of the Trust and board members; and staff morale. Dr Barnes stated that the Trust's most recent submission to the CQC contained both Trust level actions and detailed actions for each clinical divisions which

would be adjusted accordingly if not delivered. It was explained that jeopardy would be dependent on the level of failure. If there was ultimate failure, every staff member would be at risk of losing their job. The Trust's use of Schwarz Rounds was highlighted as a method to boost morale. Sessions for staff from all disciplines were available to discuss difficult emotional and social issues arising from patient care.

(9) In response to a specific question about the Listening into Action methodology, it was explained that it had been discontinued by the Trust as it had not been effective. The methodology brought together a group of staff who would be given a local problem and work towards an outcome for the Trust to implement. For a number of Trusts who had pioneered the methodology, it had been an effective way of engaging staff.

(10) A number of Members raised concerns about the CQC and the new acute regulatory model. Mr Angell stated that he had attended the Quality Summit and was impressed with Trust's response to CQC inspection report at the Summit.

(11) RESOLVED that guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and that they be invited to attend a meeting of the Committee in six months and submit a two monthly report to the Committee.

63. CQC Inspection Report - East Kent Hospitals University NHS Foundation Trust (Written Update)
(Item 5)

Stuart Bain (Chief Executive, East Kent Hospitals University NHS Foundation Trust), Julia Bournes (Head of Outpatients, East Kent Hospitals University NHS Foundation Trust) and Mary Tunbridge (Divisional Director for Clinical Support Services, East Kent Hospitals University NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Bain began by expressing his disappointment with the CQC inspection report. He recognised that a number of improvements were required and were being addressed including engagement with staff, capacity, outpatient services and the quality of estate. He highlighted the caring nature of staff which was praised in the inspection report; in addition to the excellent mortality rates and clinical outcomes delivered by the Trust. Mr Bain welcomed the opportunity to share and discuss the action plan with the Committee on 10 October.

(2) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member welcomed the opportunity to discuss the Trust's action plan at the October meeting. He stated that he was not surprised with the CQC's findings from the anecdotal experiences of his constituents. He had concerns about the number of qualified staff but recognised their caring and compassionate nature.

(3) A Member enquired if the Trust would receive any additional money as a result of being placed into special measures. It was explained that the Trust would not receive any additional money. Monitor would appoint an external Improvement Director and buddy Trust who would provide guidance and

support in areas of weakness by the end of September. The Trust would be subject to enhanced monitoring each month to check the progress of the action plan.

(4) Cllr Lyons, a Governor of East Kent Hospitals University NHS Foundation Trust, informed the Committee that the Governors of the Trust had written a report to Monitor and the Health Service Journal with their concerns about the CQC inspection report. He stated that the Governors were united and supportive of the Trust.

(5) The Chairman invited Mr Bowles, a local Member, to speak. He thanked the Committee for putting this item on the Agenda and the guests for attending at short notice. Mr Bowles enquired if the Monitor appointed Improvement Director would be available to speak with the Committee. Mr Bain explained that the Terms of Reference for the Improvement Director were decided by Monitor; he stated he would feedback the comments to Monitor.

(6) RESOLVED that the report be noted, the Trust take note of the comments made by Members during the meeting and be invited to attend the October meeting of the Committee.

64. East Kent Outpatients Services

(Item 6)

Stuart Bain (Chief Executive, East Kent Hospitals University NHS Foundation Trust), Julia Bournes (Head of Outpatients, East Kent Hospitals University NHS Foundation Trust), Mary Tunbridge (Divisional Director for Clinical Support Services, East Kent Hospitals University NHS Foundation Trust) and Simon Perks (Accountable Officer, NHS Canterbury & Coastal CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Tunbridge began by giving an update on East Kent Outpatients Consultation. The outcome of the consultation was discussed at the East Kent Hospitals University NHS Foundation Trust (EKHUFT) Board in June 2014 and NHS Canterbury & Coastal CCG Governing Body in July 2014. Both the Board and Governing Body agreed to implement the new outpatient strategy at their respective meetings.

(2) Following the decision to implement the strategy, mobilisation of the strategy had commenced. A number of developments were outlined including the opening of the new Dover Hospital in March 2015 and the implementation of extended working days and Saturday clinics. Further engagement would be undertaken through NHS Canterbury & Coastal CCG's proposed community networks.

(3) The Chairman invited Mr Gates and Mr Bowles, local Members, to speak. Mr Gates highlighted a letter circulated to the Committee by Save Faversham Hospitals which asked the Committee to recommend that the decision be deferred until the town Community Networks were in place and local health needs had been identified.

(4) Mr Bowles stated he disagreed with decision to implement the outpatient strategy. He raised concerns about the centralisation of services and the Trust's decision to subsidise public transport.

(5) Mr Bain responded to the comments made by the local Members. He stated that facilities were poor at the 15 outpatients' sites. The delivery of services at six fit for purpose sites would increase capacity with extended opening hours and Saturday clinics. It would also enable patients to receive their assessment, diagnostic tests and treatment plan on the same day at a one stop clinic. He stated that Kent was a challenging area to serve with its rural populations; some patients would face difficulty in reaching services wherever they were located. 80% of patients would access outpatients' services in a car either by driving themselves or being driven by a relative or carer. The Trust had been in detailed negotiations with Stagecoach to subsidise £450,000 of public transport to improve access.

(6) Miss Harrison reminded Members that she had attended the two option appraisals for the North Kent site on behalf of the Committee. She stated that the process was extremely fair with no bias in favour or against a particular site**.**

(7) Dr Eddy enquired about the transfer of outpatient services from Deal Hospital to Buckland Hospital. It was explained that acute services would move after the opening of Buckland Hospital in March 2015. The services would transfer as quickly as possible. The Scrutiny Research Officer agreed to arrange a meeting with Dr Eddy and NHS South Kent Coast CCG to discuss the future of services at Deal Hospital.

(8) RESOLVED that the Trust be thanked for their attendance at the meeting and the update provided on the progress of the Board's plans for Outpatient Services in Kent and that they be invited to submit a progress report to the Committee within six months.

65. SECAmb - Future of Emergency Operation Centres

(Item 7)

Geoff Catling (Programme Director, Estates, SECAmb), Sue Skelton (Deputy Director of Operations, SECAmb), Chris Stamp (Senior Operations Manager (Kent), SECAmb), Janine Compton (Head of Communications, SECAmb) and Patricia Davies (Accountable Officer, NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Catling introduced the item and proceeded to give a presentation which covered the following key areas:

- The future of the Emergency Operations Centres (EOC)
- Drivers for reconfiguration
- Proposals for reconfiguration
- Preferred option – Two Emergency Operations Centres
- Initial Engagement Plan

(2) Ms Davies explained that NHS Swale CCG was the host commissioner of ambulance services on behalf of 22 CCGs and the resident population of 4.6 million people in Kent; Medway; Surrey; East and West Sussex; Brighton and Hove; and North East Hampshire. She stated that the CCG welcomed the SECAmb review of operational arrangements and the engagement that they were undertaking.

(3) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about collaboration with other emergency services. Mr Catling explained that SECAmb had been working closely with Surrey County Council on a project which looked at the collaboration of emergency services. Their research had found that in Surrey, only 0.9% of SECAmb responses were attended by another emergency service and 0.16% with both Fire & Rescue and Police. SECAmb were looking at the benefits of collaboration with Kent Fire & Rescue and Kent Police.

(4) A question was asked about the two options which were not chosen: the retention of three EOCs and the implementation of one large central EOC. Ms Compton explained that it would be expensive to retain three EOCs and they would be unable to expand due to limited space. It was stated that one EOC would not be resilient in the event of system failure. Under the proposed two EOC configuration, Mr Catling confirmed that both sites would be located on different parts of the BT Super Highway and National Grid which would make the EOCs super-resilient. Ms Skelton explained that in the event of system failure at one EOC, the other would be able to respond immediately.

(5) In response to a specific question about establishing a Centre of Excellence, it was explained that the EOC was already a Centre of Excellence. Under the proposals, there would be one Emergency Operations Centre which would operate over two locations in state of the art buildings. Clinical outcomes for patients and training for staff would be the same at each site. It was highlighted that staff at EOCs were highly trained and the Trust wanted to retain as many skilled staff as possible. If the Trust moved to one EOC, it was stated that this could affect some highly skilled staff.

(6) RESOLVED that guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and that they be invited to attend a meeting of the Committee in three months.

66. Patient Transport Services (Written Update)

(Item 8)

(1) The Committee received a report from NHS West Kent CCG which provided an update on the performance of the Patient Transport Services contract held by NSL Kent.

(2) RESOLVED that the report be noted and that CCG colleagues be invited to attend the November meeting of the Committee.

(3) The meeting adjourned until 13.30.

67. NHS England: General Practice and the development of services
(Item 9)

Stephen Ingram (Head of Primary Care, Kent & Medway Area Team, NHS England), Dr Mike Parks (Medical Secretary, Kent LMC) and Dr John Allingham (Medical Secretary, Kent LMC) were in attendance for this item.

(1) The meeting reconvened at 13.30. The Chairman welcomed the guests to the Committee. Members of the Committee then proceeded to ask a number of questions and made a number of comments.

(2) A Member enquired about the challenges of general practice. Mr Ingram explained that the role of the GP had changed with multi factorial challenges which included running a business; maintaining professional accreditation; complying with regulations; involvement with CCGs in addition to providing services to patients.

(3) A question was asked about succession planning. Mr Ingram stated it was extremely difficult to replace GPs on a like-for-like basis. Health Education England had set a target for 50% of all medical students to become GPs but this was not producing GPs as quickly as they were required. Dr Parks stated that the Kent LMC was actively discussing the fragility of the service and the importance of succession planning with practices.

(4) Mr Ingram and Dr Parks stressed the importance of the wider primary care team in managing GP workload. The use of nurse practitioners to deliver care for long term conditions; accreditation for community pharmacists and nurse practitioners to independently prescribe; and the introduction of physician associates, science graduates who complete two years of intense training, to support GPs in the diagnosis and management of patients were discussed.

(5) Dr Parks explained that Health Education Kent, Surrey and Sussex had identified recruitment to primary care as a key issue for the Deanery in particular the shortage of nurses in primary care. Dr Parks acknowledged that nurses in training had little experience of primary care. The Deanery was establishing community networks to provide mentoring and training for nurses in order to make it easier for them to move from acute to community roles.

(6) A number of comments were made about holistic care and GPs directly employed by the NHS. Dr Parks explained that GPs were generalists and closest to providing holistic care. He stated that the average consultation time had increased to 12 minutes. The Royal College of General Practitioners was campaigning for 15 – 20 minutes consultations as patients were attending with multiple problems. As part of a holistic approach, multiple problems could be assessed over a number of consultations with the most important being dealt with first. Mr Ingram stated than in his experience GPs directly employed by the NHS had not worked well.

(7) In response to a specific question about sustainability, Mr Ingram explained that the current model of general practice was not sustainable. Proposals for a new model of general practice included the introduction of place based services whereby an integrated team including GPs could provide health and

social care for their local populations. He stated that CCGs were developing community hubs, based around a clustering of GP practices and a local population, which could provide a wide range of services. He explained that there was a move away from single-handed GPs holding contracts as the challenges were more significant than those in a partnership or a company. Mr Ingram expressed concerns about the overinvestment in buildings rather than services. In Kent there were 260 practices which operated out of 400 buildings. The Local Area Team had concerns about the state and condition of 30 – 50 buildings in Kent and Medway.

(8) A question was asked about the attractiveness of being a GP. Dr Parks explained that General Practice was no longer attractive to medical students. A number of reasons were highlighted including long working hours, rising patient expectations, workforce pressures, partnership working, funding and increased regulation. This was leading to stress and burnout of experienced GPs. Dr Allingham added that with the feminisation of the workforce, many female GPs wanted to be salaried and work child friendly hours rather than take on the responsibility of a partnership. The average age for GPs to leave the profession was 35 – 39 for women and 55 – 59 for men, it was explained that many female GPs did not return to work after having children. Dr Allingham stated that he had recently met with 30 – 40 trainee GPs in Kent; only one trainee GP wanted to become a partner, 7 – 8 trainee GPs were leaving general practice and the remainder were going to practice abroad, become a salaried or locum GP. He stressed the importance of highlighting the interesting nature of the job to medical students such as unexpected and challenging problems brought by patients and new developments such as the Prime Minister's Challenge Fund.

(9) In response to a specific question about the difficulties faced by GPs returning to practice after a period of absence, it was explained that GPs had to undertake a refresher examination and scheme in which they worked full time in a training practice under the supervision of a trainer. GPs had to pay for the examination and often had to pay the training practice for supervision. Once a GP had completed the scheme, the trainer can write to NHS England Local Area Team to say the GP can rejoin the local performers' list. A Member requested examples of difficulties faced by GPs returning to practice. Representatives from the Kent LMC stated that they would be able to provide this.

(10) Mr Inett informed the Committee about a project, being undertaken by Healthwatch Kent, to look at patients' experiences of primary care in Kent. He explained that the CCGs had been approached and enquired if NHS England could input into the project. Mr Ingram stated that he would be happy to discuss the project with Healthwatch Kent.

(11) The Chairman asked the Committee for expressions of interest to join a working group, led by Mr Angell, to meet with Professor Tavabie (Interim Dean Director, Health Education Kent, Surrey & Sussex). Dr Eddy and Mr Chard indicated their interest. It was suggested that Mr Ingram, Dr Allingham and Dr Parks be given the option to attend.

(12) A Member thanked Mr Ingram for the paper which gave a national overview of general practice. The Member requested a Kent focused paper when the item returned to the Committee in six months. Mr Ingram stated that he would be happy to provide more detailed information on Kent which could be broken down by CCG area. He suggested that the Committee could look at one or two CCGs in detail and ask CCG representatives to also attend in six months.

(13) Mr Ingram gave an example of a unique feature of Kent; the county had the highest percentage of nationally negotiated General Medical Services (GMS) contracts in the UK. It was explained that the Local Area Team had little power over this type of contract. NHS England's preference for new contracts was Alternative Provider of Medical Services (APMS) contract as it was the only contract which met the requirements of procurement law. Kent LMC representatives stated their preference for nationally negotiated GMS contracts.

(14) RESOLVED that the report be noted and that NHS England (Kent and Medway Area Team) take note of the comments made by Members during the meeting and be invited to attend a meeting of the committee in six months.

68. Date of next programmed meeting – Friday 10 October 2014 at 10:00 am
(Item 10)

(1) The Chairman confirmed that CAMHS Tiers 1, 2 & 3 would return to the Committee on 10 October 2014.

(2) A number of Members raised concerns about the CQC and their inspection regime. A Member enquired if there was a strategic overview of quality issues in Kent. Mr Inett noted that a joint report on quality issues by Healthwatch Kent and Roger Gough would be taken to the Health and Wellbeing Board on Wednesday 17 September. Mr Godfrey confirmed that there was a HOSC section in the report which gave examples of the Committee's consideration of quality issues. It was agreed the Scrutiny Research Officer would circulate the paper to the Committee when the Agenda was published on Tuesday 9 September.