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 Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 13 February 2013.

PRESENT: Mr C P Smith (Chairman), Wendy Purdy (Vice-Chairman), Mr R E Brookbank, Mr D S Daley, Mr K A Ferrin, MBE, Sylvia Griffin, Teresa Murray, Mr L B Ridings, MBE, David Royle, Mr K Smith and Mr A T Willicombe

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)

The Vice-Chairman in the Chair opened the meeting and on behalf of Medway Members, expressed their condolences at the sad passing of Mr Michael Snelling, Chairman on the Kent and Medway NHS Joint Overview and Scrutiny Committee.

2. Substitutes
(Item 2)

3. Election of Chairman
(Item 3)

Cllr W Purdy proposed and Mr A Willicombe seconded that Mr C Smith be elected Chairman.

Carried Unanimously.

4. Declarations of Interest by Members in items on the Agenda for this meeting
(Item 4)

5. Minutes
(Item 5)

RESOLVED that the Minutes of the meeting held on 3 July 2012 are correctly recorded and that they be signed by the Chairman.

6. Adult Mental Health Inpatient Services Review
(Item 6)

David Tamsitt (Director Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Lauretta Kavanagh (Kent and Medway Director of Commissioning for Mental Health and Substance Abuse, NHS Kent and Medway), Rosarii Harte

(Assistant Medical Director – Acute Services, Kent and Medway NHS and Social Care Partnership Trust), Dr Peter Green (Chief Clinical Officer, Medway Clinical Commissioning Group), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Patricia Davies (Accountable Officer (designate), Swale CCG), Sara Warner (Assistant Director Citizen Engagement, NHS Kent and Medway), and Dr Pete Sudbury (National Clinical Advisory Team) were in attendance for this item.

(a) The Chairman introduced the item and welcomed the Committee's guests. He then drew attention to an additional paper from Medway Members of the Committee which had been circulated just prior to the meeting. It contained additional information along with concerns and questions to be raised. The question was asked why the paper had only been made available prior to the meeting. It was explained that information required to produce the paper had only been received the week before and it had taken until the morning of the meeting to produce the report. Due to the lack of time available to read the paper and properly evaluate its contents, the Chairman determined that it could not be considered at the meeting.

(b) NHS representatives were invited to introduce the item. It was explained to Members that the NHS representatives present at the meeting would endeavour to explain how the four tests the Secretary of State for Health had laid down for service reconfigurations had been met. This was also evidenced in the information supplied in advance and present in the Agenda. These tests were: ensuring appropriate patient choice; support of GP commissioners; adequate patient and public engagement; and a good clinical evidence base. It was also explained that the proposals for change outlined in the Agenda would be presented to the NHS Kent and Medway board meeting on 20 February and at the board meeting of Kent and Medway NHS and Social Care Partnership Trust (KMPT) shortly after that.

(c) Dr Pete Sudbury was also introduced. He was not part of the team who developed the proposals and was one of the external scrutineers who had commented on them. It was explained that he would be able to provide an independent perspective.

(d) An overview of the case for change was presented. NHS representatives explained that it had been developed over a long period of time with ongoing engagement. The core issue was that the NHS could not guarantee effective treatment and the quality of care at Medway A-block. The excellent work which KMPT staff did was recognised, but it was not sustainable to continue with the service as it was. Medway A-block saw a much higher proportion of serious incidents than comparable facilities and there had recently been a rise in incidents of aggression. It was commented that the ongoing uncertainty about the future shape of services was an additional factor in this. In addition, there was a need to address the imbalance between east and west Kent in terms of the psychiatric intensive care support available. The inequity of service itself caused anxiety amongst service users.

(e) On the question of choice, it was explained that in the context of mental health services this needed to be appropriate choice. For those patients detained

under the Mental Health Act, there was a limitation of choice, but there was still a need to ensure patients were treated with dignity and respect.

(f) There was a lot of discussion about the engagement process. Some Members expressed concerns that the consultation may not have involved many service users. It was explained that the engagement exercise involved a number of public meetings as well as an open invitation to go out to groups. Invitations went out to 700 groups and information was sent to all KMPT Foundation Trust members. It was also featured in the local press. Over 50% of the respondents were services users or their carers. The results showed a high level of support for the ambitions of the strategy but also showed travel and transport were major concerns, particularly for carers. There was a clear mandate given through a 62% preference for Option A, and this is the option that would be taken to the Board meetings. This was a consistent preference across all catchment areas, including Swale. The Agenda papers contained an independent analysis of the consultation produced by the University of Greenwich. One Member commented that this did demonstrate support, but only within the narrow confines of the consultation.

(g) Transport, and the potential cost of it, was a particular issue for carers, friends and relatives, it was explained, as patients would be transported by the NHS. On the issue of transport, one Member mentioned the 'Deal Deal' where he had said he would support the proposals if he could be assured that transport arrangements from Deal, as the furthest point from any centre, would be sufficient. It was explained that these details could not be shared as they involved case studies which would identify individuals. The Member explained that he had been reassured. The same Member also raised the issue of the number of visits received by mental health inpatients was surprisingly low. This was confirmed by NHS representatives and it was also explained that the number of service users who received inpatient treatment in any year was also comparatively low. Visits could aid recovery, but the patient's wishes needed to be respected and this might involve the request not to receive visitors.

(h) The need to have a comprehensive transport plan was emphasised by a number of Members. The Committee was assured that producing a plan formed part of the implementation programme contained in Appendix 3 of the Agenda. Mr Tamsitt explained that he was leading on this work and two committee meetings on it had already been held, the most recent in the previous week. An extension of the volunteer driver scheme was being costed and a business case being worked up. The model operating in Maidstone was given as a good working example. Improving the information available about travel and opening times was another area being looked at. Signage was also being studied and work would be undertaken with Dartford Borough Council on clearer directions to Little Brook Hospital being put in place. Data was given that across the 9 acute wards, there had been 265 visits in the last 2 weeks. This equated to 25 visits for each ward. Of these 81% travelled in their own transport or were conveyed by a friend. 6% used public transport. 13% did not say when surveyed. Other Members felt that although the numbers were small, the issue of transport was exceptionally important to those affected by changes.

(i) A series of points and questions were raised about the adequacy of community mental health services and the availability of crisis resolution home treatment teams (CRHTs). The view was expressed, including the views expressed by a Member who stated his wife was a GP in the Medway area, was that services across the board were not adequate. A variety of examples were given by Members, some revolved around concerns about how to ensure people took the appropriate medication at the right time. This was a barrier to agreeing a change in acute provision.

(j) These concerns were recognised by NHS representatives. In response it was explained that the specialist community health services provided by KMPT received 28-29,000 referrals each year and would be supporting 10,000 at any one time. This compared to the 160 acute mental health inpatient beds available. Since the publication of the National Service Framework for Mental Health, there was more involvement with complementary services provided by local authority social services. Discharges from acute mental health inpatient units were often delayed due to social issues rather than medical. The Kent HOSC had in the past considered the developments in community mental health services across the County.

(k) Proceeding to discuss the CRHTs, it was explained that the workforce for these was being expanded by 24. In addition peer support workers were being recruited and developed. These had proved effective elsewhere, and would be useful to ensure people continued to take their medication. It was explained the developments of this service needed to be seen against the background of wider changes to acute services, namely treating more people at home with home treatment. In response to one particular concern, it was explained that sufferers of mental health illness were more likely to be victims of crime than to commit a crime.

(l) It was also acknowledged by NHS representatives that concerns had been expressed nationally about the quality of inpatient services, both for physical and mental health illness. Recent reports on Medway NHS Foundation Trust were mentioned. It had been recognised nationally that concentration of certain services in specialist centres delivered better outcomes.

(m) The issue of the location of services was raised and in response to a question the reports in the Agenda about other locations in Medway which had been considered were indicated. A Member asked about whether the wards which were being closed at Maidstone Hospital and Sittingbourne Hospital had been considered. In response it was explained that due to the high service standards which needed to be delivered, it was not possible necessarily to simply convert an existing acute ward. These would often not be sustainable environments. In response to a question from a Member, it was explained that the pooling of staff which centralisation allowed also brought benefits. The example of a recent consolidation of services in East Kent was given, centred in Canterbury. This was now the first centre of excellence in effect. There were now 6 consultants on site and this allowed consultant cover at all times. There was also an increase in the number of junior doctors available as well as allied health professionals, such as occupational therapists, who were very important in effecting reintegration with everyday living.

(n) The analogy was used of recent centralisations of angioplasty services at Ashford. This was not because Ashford had more need than other areas, but so that a quality service could be delivered for everyone in Kent and Medway, even if this involved travelling further to the service. Some Members questioned how far the analogy between physical and mental health could be pursued as the nature of mental health illnesses covered such a range of need. Dr Sudbury expressed the view that the two were more similar than not. The average length of inpatient stays for physical health issues was 8 days. The best practice for mental health inpatients was 13 days, but was more often around 21 days. However, the similarities were that the percentage of people with mental or physical ill health who needed to be admitted to hospital was small. The point was to try and avoid admittance to hospital at all. Physical health inpatients could catch infections and mental health inpatients could be influenced by other inpatient behaviour. He expressed the view that focussing on the small percentage admitted at all risked skewing the debate. He also made the observation that when he scrutinised the Kent and Medway proposals, he was concerned that they proposed 3 centres of excellence, when 2 would perhaps be more sustainable.

(o) The question was posed about where the cut off for admittance would be with the reduction in beds overall that the proposals would involve. The response was made that assessments about admittance were more about assessing the risk than the particular condition, although this was a factor. CRHTs carried assessed referrals before admittance. In connection to answering this question it was explained that anorexia was treated separately through a specialist service and did not form part of general mental health inpatient services.

(p) NHS representatives explained that after the public consultation had concluded, two important reports were published. One was from the Schizophrenia Commission and the other from the charity Mind. The findings of these reports were built into local deliberations. One aspect to come from this was the promotion of Recovery Houses as a very valuable addition to treatment at home or hospital. Dr Sudbury had been involved in a pilot of these Recovery Houses when 3 had been set up in Haringey. He explained that these had proven to be extremely popular and were run by Rethink in Haringey. When patients entered a Recovery House, they were reintroduced to regular everyday activities like shopping after a few days with the aim to re-establish normal life as soon as possible. It was explained that home treatment services reached into Recovery Houses. They demonstrated that people who were seriously ill did not need hospital. Dr Sudbury commented that if a mental health service was being developed from scratch, it may not even involve inpatient services. Local NHS representatives explained that conversations had begun with Medway Council over the introduction of one of these Recovery Houses into Medway.

(q) Several Members commented that there was a reassurance for patients in knowing where their local service was. One Member asked a specific question about what was being done to prepare patients for the move. In response, it was explained that reassurance was being built into the recovery programme for patients. The Liaison Psychiatry service would remain at Medway Hospital and there would be a high profile point of contact for patients presenting with mental health needs at Medway, but this did not mean they would be admitted.

(r) On the subject of the support of GP commissioners, it was explained that all 8 of the Clinical Commissioning Groups (CCGs) across Kent and Medway supported the proposals. On behalf of Swale CCG, Patricia Davies explained that the case for change had been made to the CCG board. The two core issues were the need to centralise tertiary specialised care and more broadly ensure continuity of care. GPs are concerned with the whole continuum of care. The proposals for change specifically relate to specialist care and the CCG recognises that Medway A-block was not fit for purpose and a safe unit is needed. The clinical evidence supported centralisation of these specialised services and it was important to deliver the right care in the right place. This was echoed by Dr Green on behalf of Medway CCG. He shared Members' frustration with the quality of care but said that the proposals to move to more community based care was not for economic reasons but because the evidence showed that outcomes were better if this was done. Similarly, better outcomes were achieved where specialist services were centralised. This outweighed any disadvantages involved in travelling further.

(s) Several Members commented that they acknowledged the case for change but remained to be convinced that the change proposed was the correct one. One Member mentioned there were areas of the country which had reopened wards. Reference was made by NHS colleagues and Members to the emphasis the recent Francis Report had put on putting the patient first and ensuring quality of care. Some Members felt it important to be assured that community health services were in place prior to supporting any changes to inpatient services. Another Member commented it would be useful to see the Business Plan for the proposals. NHS representatives explained that there was an opportunity prior to the formal commencement of the following week's Board meeting for questions and issues to be raised and answered. An invitation to this was extended to Members.

(t) The Committee discussed the best way to proceed with this issue as well as whether to include the paper from Medway with the record of the meeting. Cllr Purdy moved that the written submission by Medway should be included in the record of the meeting. The Chairman ruled this out on the basis that he had made clear at the commencement of the meeting that as the paper had been tabled on the day it did not exist.

(u) The Chairman proposed the following motion, seconded by Mr Dan Daley:

- That the Committee convene another meeting in the near future to receive responses to the questions raised by Members.

(v) This was agreed by the Committee, with Mr Kit Smith requesting that his opposition to the motion be noted.

(w) It was also decided it would be appropriate to hold the next meeting at Medway.

(x) RESOLVED that the Committee convene another meeting in the near future to receive responses to the questions raised by Members.

7. Date of next programmed meeting

(Item 7)

It was agreed that the date of the next meeting would be determined as soon as possible.