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, 11 October 2013.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mr L Burgess, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr A J King, MBE, Mr R A Latchford, OBE, Mr G Lymer, Cllr M Lyons, Cllr Chris Woodward, Mr P J Homewood, Mr R A Marsh and Mr M J Northey

ALSO PRESENT: Cllr Mrs A Blackmore and Cllr R Davison

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting

(Item 1)

2. Declarations of Interest

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) The Vice-Chairman reported to the Committee that following a meeting with the relevant Cabinet Member, January was proposed as the date for the Committee to consider Child and Adolescent Mental Health Services (CAMHS).

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

4. Meeting Dates 2014

(Item 5)

AGREED that the meeting dates for 2014 be noted.

5. East Kent Outpatients Consultation: Written Update

(Item 6)

(a) The Chairman introduced the item and explained that it was a written follow-up to the discussion the Committee had on the East Kent Hospitals University NHS Foundation Trust's clinical strategy in June and that the intention was for the issue to return to HOSC following the public consultation.

(b) Comments were invited from Members. Several comments were made as to the importance of including information about travel to the 6 sites where services would be provided. One Member used the analogy of supermarkets, with the need for services to be where the demand was. On the topic of the number of sites, one Member referred to the discussion in June when NHS representatives mooted the possibility of a 7th site on Sheppey and hoped there would be clarification as to whether this was still the case.

(c) On the plans for public meetings, the report in front of Members stated that there were plans to hold one in either Hythe or Dymchurch. One Member requested a meeting be held in both towns.

(d) The Chairman drew attention to the part of the NHS report where a request was made for volunteers from HOSC to read and comment on the draft consultation document. The following Members of the Committee volunteered:

- Dr M Eddy
- Mr R Latchford, OBE
- Councillor Michael Lyons

(e) The Chairman proposed the following recommendation:

- That the Committee note the report, ask the NHS to take on board the comments and questions raised by the Committee and that a small group be formed to liaise with the NHS on the draft consultation document.

(f) AGREED that the Committee note the report, ask the NHS to take on board the comments and questions raised by the Committee and that a small group be formed to liaise with the NHS on the draft consultation document.

6. Patient Transport Services
(Item 7)

Ian Ayres (Chief Officer, NHS West Kent CCG), Helen Medlock (Associate Partner, KMCS), Deborah Tobin (Senior Associate, KMCS), Alastair Cooper (Managing Director, NSL Care Services), Paul Costello (Client Account Manager, NSL Care Services), Felicity Cox (Kent and Medway Area Director, NHS England), and Dr John Allingham (Medical Secretary, Kent LMC) were in attendance for this item.

(a) The Chairman introduced the item and asked the Committee's guest to explain the background and the current situation.

(b) It was explained that NSL Care Services took over the provision of Patient Transport Services (PTS) on 1 July 2013. This came at the end of a two year process. Previously there had been a patchwork of five providers, of which four were major providers. A decision had been reached by the old Primary Care Trust Board that a single provider was preferable. It was still the consensus now that one provider was preferable. The bid from NSL scored the best on value for money and quality.

(c) The transfer to the new provider was very complex given the number of different providers previously with different shift patterns, fleets, operating procedures, organisational cultures and so on. 100 staff needed to be transferred under TUPE to the new provider. It was openly admitted that the transfer had not gone to plan. It was explained that there were two parts to the service. The first part, that of whether appointments were able to be booked, was going to plan. However, the second part, that of whether patients were being picked up and taken to their appointments at the appropriate time, was not. NSL were currently achieving 60-65% regarding timeliness.

(d) Both the commissioner and provider apologised for this. It was explained that there was a recovery plan in place and things were improving. There were a number of performance indicators in the contract and Mr Ayres stated that he received updates on the 5-6 key ones daily, the top 8-9 ones weekly and the rest monthly. Performance data was being shared with the Acute Trusts and an independent expert was being brought in to review the measures being taken to improve the situation and this would report before the winter. NHS England was supportive of this approach.

(e) It was further explained that the PTS eligibility criteria had not changed from the previous arrangement and that the criteria in Kent and Medway was more generous than elsewhere. They had been applied inconsistently in the past. It was reported that press stories about people being refused transport were cases where someone was not eligible for PTS or had not requested the service. A request was made for the eligibility criteria to be made available to the Committee.

(f) One Member commented that subsequent to a recent news story, he had been contacted with a number of further examples. It was accepted that there was a problem around public confidence with the service.

(g) Representatives from NSL explained that they had underestimated the challenge of setting up the new service. One challenge was the shift system. Some staff were on 9-5 contracts but the service requires a 24/7 shift system. A consultation was underway with staff to enable this to be changed. This consultation ended soon and a new shift system would be able to be brought in on 4 November. The role of supervisors was seen as key. At pinch points were demand could not be met, sub-contractors were used. The activity was also different to that anticipated, with a greater need of the use of stretchers. It was explained that when further activity data was available, NSL might acquire further vehicles capable of accommodating stretchers.

(h) Members asked a series of questions and raised a number of points aiming at probing deeper into the reasons behind the problems with the transfer to a new provider. On being asked directly, the commissioners gave the judgment that the service was not as good as it was before the change, but that it would be better. The provider admitted to being surprised by the complexity of the challenge, but the point was also made that NSL successfully ran PTS contracts in other areas of the country and had a recent successful takeover of a contract in the South West of England. A Member made the counter point that this was not much comfort to patients in Kent.

(i) In terms of the commissioning, the Committee was informed that the specification for the contract was drawn up based on information collected in the past. One Member drew attention to the statistics presented on page 30 of the Agenda. This indicated that there were more stretcher patients than planned and the number of wheelchair patients was higher than planned but then went below. The question was posed as to whether the levels would settle down to that expected. However, the numbers of high dependency patients were negligible compared to the planned numbers. It was explained that while there was good information about the bills relating to PTS in the past, the details around the number and type of journeys was less reliable. The numbers in East Kent could be out by 30-40% either way. On high dependency patients, these journeys were undertaken by a sub-contractor but the type of journey was not recorded. The uncertainty about the accuracy of the figures extended to the period between the awarding of the contract and NSL taking it over. In hindsight, it was acknowledged that a shadow period where accurate information could be gathered would have been a sensible approach. Commissioners had looked to the market for a solution of the problem but had not explained fully what was required of the service. Lessons had been learnt and would be applied to future procurements. The priority now was to ensure a sustainable service was being delivered and then a full review of the process would be able to be carried out. A request was made for the findings of any internal review undertaken to be shared with the Committee. The point that Kent County Council (KCC) had a good track record on procurement was well taken and it was explained that there were a number of areas where KCC and the NHS could learn from each other and procurement was one area where the NHS could learn from KCC.

(j) The financial implications of the problems faced by the service were also explored by the Committee. It was explained that it was an activity based contract and even though NSL had been required to hire more staff and use sub-contractors, the commissioners would not be providing any more money. Only in cases where the activity was significantly above or below that specified in the contract would there need to be a conversation between commissioner and provider about the cost of the contract. There were clear performance indicators in the contract and it was possible that penalties would be imposed. Against this, the point was made that penalties were not enough on their own where there was an issue with the culture of a service or organisation.

(k) On the subject of the key performance indicators, it was explained that these were reviewed by a programme board consisting of NHS organisations and patient representatives. However, it was accepted that a point made by a Member of the Committee was valid and that some thought would be given to an appropriate place to receive these reports where they would be more openly available, such as possibly the NHS West Kent CCG Board.

(l) Of the 40% who did not undertake their journeys at the booked time, some were at their destinations much too early and some were late, but the exact figures for how many of each there were not available at the meeting. The Acute Trusts were being very supportive of the service and while the commissioners could ask for data on how many patients needed to have their appointments rescheduled, it was felt this would add an extra burden to the hospitals.

(m) A number of questions were asked about the fleet. It was explained that there was a disinfectant/cleaning regime and that this did mean vehicles were out of action during cleaning. Additional vehicles were sourced to cover these times. In Kent a standard business fleet was used, with the exact type of vehicle depending on the availability of servicing in the area. Members gave examples of places where pods where used, enabling a wider range of vehicle types to be made available as the chassis would be interchangeable between them. This was something which would be looked at. In response to a specific question, it was explained that while tacographs were not used, a similar system was and data suitable for analysis was gained this way. It was accepted that while there were significant differences between patients and parcels, there could be lessons to learn from the logistics industry.

(n) A series of specific questions were asked and responses received. It was accepted that better signposting to the service in GP surgeries would be appropriate. Volunteer drivers were used and they all had to undergo DBS checks. The service had six bases and these were at Dartford, Tonbridge, Larkfield, Ashford, Aylesham and Margate.

(o) Questions were also asked about regular users of the service. On this issue it was explained that renal patients made up around a third of all journeys and these were programmed ahead of time. There was a full-time person whose role it was to contact each of the renal units four times each day to ensure the service was delivering at an acceptable level. Although only 50-60% of renal patients were delivered within the 30 minute window required, feedback suggested the current levels of service were acceptable. Lessons were being learnt from this and would inform the oncology service when it was rolled out.

(p) There was a discussion on the recommendation and the Chairman, along with a number of Members, commenting positively on the honesty of both commissioner and provider.

(q) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their attendance and contributions today along with their answers to the Committee's questions, and asks for a written update report within 3 months and a return visit in 6 months.

(r) AGREED that the Committee thanks its guests for their attendance and contributions today along with their answers to the Committee's questions, and asks for a written update report within 3 months and a return visit in 6 months.

7. Health and Wellbeing Board: Update
(Item 8)

Roger Gough (Cabinet Member for Education and Health Reform), Felicity Cox (Kent and Medway Area Director, NHS England), and Dr John Allingham (Medical Secretary, Kent LMC) were in attendance for this item.

(a) The Chairman welcomed the Cabinet Member for Education and Health Reform and invited him to present an overview to the Committee. A copy of the PowerPoint is appended to these Minutes.

(b) It was explained that the creation of Health and Wellbeing Boards (HWBs) formed part of the Health and Social Care Act 2012. They have become one of the most accepted parts of what was, in other aspects, a strongly contested piece of legislation. They are viewed as part of the architecture that works. The Health Select Committee at the House of Commons was originally sceptical of HWBs but is now a strong supporter of them.

(c) Much of the membership of the Kent HWB follows the statutory requirement, but there are additions. There is more than one KCC Member on the Board and there are three representatives from the Borough/City/District Councils across Kent. It follows the principle that no group should have a majority and has a strong emphasis on consensus. There has not been a vote required thus far and it would in a sense be a failure if one was required.

(d) In terms of its role, it took over responsibility for the Joint Strategic Needs Assessment (JSNA). It is responsible for the production of the Pharmaceutical Needs Assessment. This is a technical document and work on it is due to begin at the next HWB meeting. The third document, the Joint Health and Wellbeing Strategy (JHWS) takes centre stage as it sets out the vision for health and social care across the county. Health and social care commissioning plans need to be aligned to it. During the passage of the Health and Social Care Act, the role of the HWB in promoting integration was strengthened and this is now a key part of its role.

(e) The Health and Wellbeing Board took on its statutory role on 1 April 2013 and its meetings have been webcast since this time. Before this, a shadow board was in existence from September 2011. During this time, GPs and local authorities have become increasingly used to working together.

(f) Five priorities were set out in the first iteration of the JHWS earlier this year. These are: young people, prevention of ill health, long term conditions, mental health, and dementia. Thus far, each meeting of the HWB has concentrated on one of these priorities. At the next meeting, the focus will be on mental health.

(g) In the days before the HWB took on its statutory role, the operating plans of all seven Clinical Commissioning Groups (CCGs) across Kent were considered in terms of how far they shared a common view. The additional point was made that more needed to be done on bringing the plans of social care, NHS England's direct commissioning and public health to share with the HWB, though some work had already been done by public health.

(h) The observation was made that the Health and Social Care Act was drawn up with compact urban councils in mind where a single local authority and one or two CCGs would be able to work together directly. One of the slides in the PowerPoint presented to the Committee contained a map designed to show the numerous overlaps. Across Kent there were three health economies, twelve Borough/City/District Councils, and seven CCGs. Only one of the latter

was coterminous with the boundaries of a Borough/City/District Council. One of the challenges this posed for the HWB was how to effectively drill down into local concerns while retaining the focus of CCGs from other areas of the County. In September 2012 it was decided formally to establish seven sub-committees of the HWB aligned with CCG boundaries. This model built on something Dover and Shepway had worked on before. The HWB, which itself is a Committee of Kent County Council, is there to look at issues wider than one CCG. This includes large scale reconfigurations, data sharing, and performance across the patch. It also picked up on national policies and initiatives and saw they were taken up locally. The CCG level Boards were there to do the 'heavy lifting' in making integration work locally. Members were also informed that due to their local nature, the priority of each CCG level HWB was different. There was also a 'mixed economy' as to who chaired them. Some were chaired by representatives from the Borough/City/District Council, others by a CCG representative. Mr Gough explained that he was Chairman of the Dartford, Gravesham and Swanley CCG level HWB along with being Chairman of the Kent level HWB.

(i) The overall aim of the HWB was to explore new ways of working to ensure the financial sustainability of both the NHS and local authorities. This involved moving care upstream with greater emphasis on prevention, self care, integration between the sectors, and looking to ensure there were no unnecessary admissions into acute or residential care. A slide with numerous examples of the work going on was presented to Members. Amongst these examples were the integrated health and social care teams in Dover and Shepway and work on year of care tariffs which looked to obviate the perverse incentives which currently existed. There was much good work going on and part of the challenge was to consider how it could be scaled up.

(j) Mr Gough drew attention to two national schemes that were of particular interest. The first was the Integration Pioneer Programme. This was launched earlier this year with bids invited for pioneer status to receive Department of Health support related to the work they were doing on integration. The Kent bid has made it past the first stage and it will become known this month whether it has been successful. When the bid was approved by the HWB, it was agreed to continue with the work set out in it regardless of whether the bid was successful or not. Among the areas being looked at as part of this programme is that of workforce planning.

(k) The second policy was the Integration Transformation Fund. This was discussed at the September meeting of the HWB. Overall, it sets a faster pace for integration. Rather than new money, different funding streams are brought together to the sum of £3.8 billion nationally. This is for the creation of a pooled budget where the NHS and local authorities will be equal partners and where the responsibility will rest with the HWB. The ultimate aim is to have a fully integrated system by 2018. £1 billion of this money is at risk in that local systems have to deliver integration or lose the funding. Progress will be assessed in two tranches, one at the beginning of the 2015/16 financial year and the other at the end of the same year. This will necessarily reflect work done in 2014/15, the start of which is not far away. There is a need to progress with plans quickly, and the idea is to take this work forward through the group which had been established to produce the pioneer bid. The ultimate aim is to

move activity currently carried out in the acute sector to the community sector. It was important to work with providers as it was necessary to avoid destabilising them. This could mean reconfiguration of acute services and this could be controversial. It was accepted there was a tension between local plans and Kent-wide ones, but it was hoped this would be a dynamic tension.

(l) Following the presentation, there were a number of areas of questioning and discussion. On the topic of possible future reconfiguration in the acute sector, it was further explained that there was a decades' long debate in the health sector over the need for centres of excellence where medical specialists were able to see sufficient numbers of patients to maintain and improve their skills against the need for patients to be able to access healthcare closer to home. These were arguments that the Committee were familiar with.

(m) There is a separate argument around the shift of resources from the acute sector to the community and primary care sectors and what this means for the acute sector. The NHS West Kent CCG 'Mapping the Future' Programme was part of this discussion around moving activity to community and primary care settings along with enhanced self-care. This was considered by the Committee at its September meeting.

(n) This connected with the 'NHS A Call to Action' and 'Improving General Practice A Call to Action' programmes. In the latter, the future shape of general practice was also under discussion. Connected with this, it was important to know that NHS England commissioned primary care and CCGs could not commission themselves.

(o) With the year of care tariff, the price paid for treatment is separated out so some goes to the community sector. This could be a risk for the acute sector as it reduces their income. However, the costs of acute trusts could be reduced alongside the reduction in income. Acute trusts could also deliver some work in the community. The shift to community care needed to be managed to avoid the risk of destabilising acute trusts, which would be a particular problem in East Kent where there was no obvious alternative.

(p) The point was made that unless there were services in the community and sufficient GPs, people would still go to acute hospitals. Services did need to be in the right place delivering the right care and Professor Chris Bentley had worked with Kent looking at areas of deprivation and whether they were able to access the right services.

(q) Questions were asked about the relationship of KCC with Kent Community Health NHS Trust (KCHT) and Kent and Medway NHS and Social Care Partnership Trust (KMPT). It was explained that there was a continuing and developing partnership with KCHT on joint working, but it was explained that there was a tension for KCC with its dual role of commissioner and provider. Similarly with KMPT, there was lots of joint working and the example of the Live it Well programme was given. It was also pointed out that there were a number of providers of mental health services apart from KMPT.

(r) There were a number of questions about children's services. In response to a specific question about the location of Sheppey children's centre, it was

explained that this was for historical reasons but that there were moves to more closely integrate CCGs and children's centres. On the question of Children's Trusts, it was explained that their work had moved to the HWB and there was currently a discussion about whether it was better to have a sub-committee of the Board focusing on children's issues or to have children's issues as a regular item on the CCG level HWB agendas.

(s) On the broader topic of wellbeing, a couple of Members raised the issue of what measures KCC could take around licensing laws and dealing with the impact of gambling. Mr Gough offered to continue this particular discussion outside the meeting. The observation was made that wellbeing was a broad concept which could mean the HWB could look at so many things it could risk losing focus.

(t) Mr Gough also expressed a willingness to discuss further the report that a CCG level HWB had a rule excluding Councillors who were not on the Board from asking questions as a member of the public. This rule was not part of the Terms of Reference for the HWB.

(u) There was a discussion about the care that KCC delivered in people's homes. It was explained that Kent had always done well on the time allowed for care visits, but there was less information on the quality of care. Kent social services were part of the NHS England hosted Kent Quality Surveillance Group which did a lot of good work looking at quality issues across the County. This was not an area which the HWB had looked closely at, but it could in the future.

(v) There was a discussion on the future relationship between the Committee and the HWB. Mr Gough explained that he had been to the Committee a number of times during the period of the shadow HWB, and was more than happy to attend in the future. It was for the Committee to determine its own work programme, but the integration agenda and JHWS along with others were all areas that the Committee could legitimately consider.

(w) The Chairman proposed the following recommendation:

- That the Committee thank Mr Gough for his attendance and contributions to the meeting and requests that the Committee continue to be informed of the work of the Health and Wellbeing Board.

(x) AGREED that the Committee thank Mr Gough for his attendance and contributions to the meeting and requests that the Committee continue to be informed of the work of the Health and Wellbeing Board.

8. Date of next programmed meeting – Friday 29 November 2013 @ 10:00 am
(Item 9)