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, 28 November 2014.

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

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Mr P D Wickenden (Democratic Services Manager (Members))

UNRESTRICTED ITEMS

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

(1) Cllr Michael Lyons declared an interest as a Governor of East Kent Hospitals University NHS Foundation Trust.

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

79. Minutes
(Item 3)

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

(a) Minute Number 43 - Community Care Review: NHS Ashford CCG & NHS Canterbury & Coastal CCG. The CCGs were asked to provide an update on the design of the community hubs. An update paper on the Community Care Review was circulated to Members on 4 November 2014.

(b) Minute Number 67 – NHS England: General Practice and the development of services. A meeting has been arranged for the working group to meet with Professor Tavabie (Interim Dean Director, Health Education Kent, Surrey & Sussex) in February 2015.

(c) Minute Number 71 – Child and Adolescent Mental Health Services (CAMHS) – Tiers 1, 2 & 3. On 31 January 2014 HOSC requested that NHS West Kent CCG to identify an outstanding trust to assess improvements that could be made in the way in which the Sussex

Partnership Trust was carrying out the Kent and Medway CAMHS contract and to report back to the Committee.

Oxford Health NHS Foundation Trust was commissioned to carry out a high level review of Kent and Medway CAMHS (provided by Sussex Partnership NHS Foundation Trust) and to make recommendations about how the clinical service could continue to improve in line with the service recovery plan. The report was circulated to Members on 14 November 2014. The Committee will consider the report at a formal meeting on 10 April 2015.

The CAMHS papers submitted to HOSC for 10 October meeting were circulated to the Corporate Parenting Panel on 27 October.

(2) RESOLVED that the Minutes of the Meeting held on 10 October 2014 are correctly recorded and that they be signed by the Chairman.

80. Dates of 2015 Committee Meetings
(Item 4)

(1) The Committee noted the following dates for meetings in 2015:

Friday 30 January
Friday 6 March
Friday 10 April
Friday 5 June
Friday 17 July
Friday 4 September
Friday 9 October
Friday 27 November

81. Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy and Stroke Services
(Item 5)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), Dr Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Douglas began by giving an update on the clinical strategy. The strategy was being finalised and written. The Trust was required to produce a clinical strategy for the NHS Trust Development Authority (TDA) as part of their assurance process for clinical quality and sustainability. He stated that the Trust believed that they had a viable future.

(2) Initial findings of the strategy had found that the Trust should focus on establishing a strategic hub for emergency care; improving productivity; serving a larger population base and developing patient pathways and community focus. There was an opportunity for the Trust to develop a Keogh Centre for emergency care at Tunbridge Wells Hospital to serve West Kent

and parts of East Sussex. The Trust had already made £22.4 million of savings on the 2014/15 budget of £400 million; it was acknowledged further savings could be made through improving productivity and serving a larger population base including Medway and East Sussex. The Trust was also looking to carry out more elective surgery and outpatient services or expanding their emergency. It was stated that the Trust did not need to merge with the Conquest Hospital, Hastings or Medway Maritime Hospital to become a financially viable organisation.

(3) Four key enablers had been identified to achieve the strategy: improving capability; promoting innovation to reduce costs; seizing opportunities for development and growth such as proactive care management; and being able to compete in tender processes. The Strategy will be taken to the Trust's Board in December for approval. Mr Douglas stated that the strategy would be a dynamic document which would be regularly refreshed. An implementation plan, including a comprehensive stakeholder engagement plan, was being developed in addition to a review of the Trust's governance structure.

(4) Dr Sigston gave an update on the Trust's plans for stroke service improvement as part of the clinical strategy. He explained that stroke was a major focus and concern for the Trust's Board. A Stroke Improvement Board, Stroke Clinical Steering Group and Engagement Group had been established. He stated that the Trust was conscious of the need to meet the Government's four tests for service reconfiguration. The Trust had undertaken early engagement with stroke patients and survivors, staff, GPs and MPs.

(5) The Trust found that patients thought the service was good but the Trust had identified improvements. A clinical case for change had been developed. Both hospital sites did not meet stroke standards as measured by Sentinel Stroke National Audit Programme (SSNAP) data; improvements had been made during the last nine months with both sites moving from the lowest rating 'E' to 'D'. The Trust had identified significant delivery options to improve their SNNAP performance to the highest rating 'A'. The Trust was also required to meet the stroke specification issued by the South East Coast Clinical Network. The specification included a hyper acute service, similar to London, and a seven day rapid access to transient ischaemic attack (TIA) service which was currently lacking.

(6) It was explained that the Stroke Clinical Steering Group had developed a long list of options for delivery. Early patient and public engagement would help inform a shortlist of options before public consultation on the options in May 2015. He noted the importance of taking time to engage with the public in order to reach a consensus.

(7) Mr Ayres stated that NHS West Kent CCG, as lead commissioner of the Trust, welcomed the development of the strategy. He explained that there had been a joint CCG and Trust appointment to develop the strategy. He stated that the CCG believed that the Trust had a sustainable long term future without the need to merge and were keen for the Trust to develop a Centre of Excellence. He noted that the CCG would lead on the public consultation and that the clinical strategy would need to return to HOSC prior to public consultation in May 2015.

(8) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about engagement with GPs and implementation of the strategy. Dr Sigston explained that GPs were engaged with the strategy through NHS West Kent CCG, NHS High Weald Lewes Havens CCG and the Stroke Clinical Steering Group. Mr Douglas acknowledged that there was a long timescale for implementation. The Trust had hoped to consult sooner but was restricted by the 2015 General Election. He explained that the Trust was carrying out extensive pre-consultation engagement prior to the election and would go out to public consultation as soon as practical after the election. Once the public consultation had concluded, the implementation process would begin. He stated that in the interim, the Trust would continue to make improvements to the stroke service.

(9) In response to a specific question on the hyper acute service in London, Mr Ayres explained that 30 local hospitals in London, which had previously received stroke patients, were reduced to eight hyper acute stroke units. Once stabilised the patient was transferred to a Stroke Unit in the same hospital or closer to home. Dr Sigston stated that this may involve a longer ambulance journey, passing several hospitals, but enabled patients to be assessed by a specialist, have access to CT scan and receive thrombolysis. This acute stroke care model had improved outcomes for patients in London. A similar model for cardiac patients had been developed in East Kent. Mr Douglas confirmed that there was no hyper acute stroke unit in Kent based on the London model. He stated the Trust's intention to develop a hyper acute stroke unit on either of its sites with improved rehabilitation and community services for stroke patients.

(10) A Member asked for clarification on mergers. Mr Douglas explained that the Trust was financially viable without the need for mergers and acquisitions. He noted that there were issues in Hastings and Medway and the Trust had been drawn into relationships with these Trusts. The Trust had recently opened up outpatient appointments to Swale residents via the Choose and Book system. There had also been an increasing number of referrals and births at Tunbridge Wells Hospital following a reconfiguration at Conquest Hospital, Hastings. He acknowledged that the Trust may be required to merge with other Trusts in the future but the Trust would be able to merge on their own terms. He stated that there was more synergy with Medway than East Sussex. Mr Ayres stated that the Trust was a standalone trust and that there was no reason for it to merge at this time.

(11) A number of comments were made about advanced warning of strokes, the use of technology and private sector equipment. Dr Sigston explained that GPs were aware of patients with co-morbidities who would be prone to stroke. He stated that it was difficult to know in advance when an arterial bleed or clot would occur. A transient ischaemic attack (TIA) was a warning sign that unless urgent preventative action was taken, a major stroke could occur. He noted that the Trust was moving towards a new IT system which would be implemented within the next 18 months. Dr Sigston explained that a seven day access carotid Doppler imaging machine was required as part of the South East Coast Clinical Network's Stroke Specification. Private hospitals such as the Kent Institute of Medicine and Surgery (KIMS) were not able to provide this facility as their staff worked for other Trusts which would prevent seven day access.

(12) There was discussion about a return visit by the Trust to the Committee before purdah. Mr Wickenden advised that the purdah period typically began six weeks before the scheduled election; an informal briefing to the Committee could be organised during purdah if required. Mr Douglas suggested a return visit to the Committee on 6 March 2015 with a shortlist of options for stroke services. A Member requested additional information on rehabilitation and community services for stroke patients to be brought to the March meeting.

(13) RESOLVED that:

(a) there be ongoing engagement with HOSC as the Trust's five year clinical strategy and strategy for stroke is develop.

(b) the Trust return to the Committee in March 2015 with a shortlist of options for stroke services and additional information on rehabilitation and community services for stroke patients.

82. Patient Transport Services
(Item 6)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and James Graydon (Account Director, Kent Care Services, NSL) were in attendance for this item.

(1) Mr Ayres began by giving an update on the latest performance figures. He noted that there had been little improvement. Whilst 'Discharges/Transfers booked "On the Day" collected within 2 hours – 80%' performance had improved, this had a negative effect on the other key performance indicators. He noted that there was a peak of discharges daily at 14.00 hours. He explained that Trusts were not booking discharges ahead of time; the majority of discharges were booked on the day as the Trusts struggled to clear beds for emergency admissions.

(2) Mr Ayres commended NSL for their support in helping Medway Maritime Hospital discharge patients. He noted improvements in the service since the appointment of James Graydon in July who provided local operational leadership. He stated that a discrete ring-fenced renal service would be introduced and tested in East Kent.

(3) Mr Ayres confirmed that CCGs in Kent and Medway, in discussions with providers, had agreed to re-procure at the end of the existing three year contract. A working group of CCGs and providers had been developing the project plan for re-procurement and the service specification. The group was aiming to complete the final draft service specification by the end of January 2015 in order to commence procurement from April 2015. He stated that there was no intention to change the eligibility criteria but there were discussions about options for the future delivery of the service – a Kent and Medway wide service or an individual service for each Trust.

(4) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about extreme waits for discharge. Mr Ayres explained that extreme waits were reducing slowly, since August there had been a focus on discharges. On an average day, there

would be 30 – 40 booked discharges for Medway Maritime Hospital; recently there had been 100 discharges booked on one day as the Trust struggled to clear beds for emergency admissions. He commented that PTS was an enabler of quality within a Trust; if PTS worked well, it enabled the hospital to perform better but if PTS did not work well, it put pressure on the rest of the hospital.

(5) A number of comments were made about planned discharge. Mr Ayres explained that all Trusts estimated an approximate discharge date for each patient when admitted. He stated that it was much easier for NSL to plan if they were given the approximate discharge date in advance, even if it was later cancelled and rescheduled, than being booked on the day of discharge. He noted that the new specification would require a discharge protocol to be agreed between the PTS provider and each Trust. Mr Graydon highlighted that NSL was engaging and reviewing the discharge policy with each acute trust to improve the booking of discharges. It was difficult for NSL to plan without advance booking due to the geographical spread of the seven acute sites in Kent and Medway. However Mr Ayres stated that the target to collect 98% of patients discharged from hospital within two hours was found to be reasonable when benchmarked against other providers.

(6) A Member highlighted the work of the Integrated Discharge Team at Dartford and Gravesham NHS Trust. The Member enquired if there was a cut off time for returning patients home at night. Mr Ayres explained that patients should be returned home with support in place by 21.00. He acknowledged that patients who lived closer to the hospital, who had support in place, could be returned home by 22.00. In addition, he stated that patients should be readmitted to the hospital, if they are unable to be transported at a sensible time. He noted that some residential homes did not accept admissions beyond 17.00; NHS West Kent CCG was in discussions with KCC contracted residential homes to extend the admission time.

(7) A Member noted the deterioration in performance for renal patients. Mr Graydon explained that if a patient arrived more than 30 minutes before their appointment, NSL would fail their Key Performance Indicator. He noted that 90% of renal patients arrived within 20 minutes of their appointment. He highlighted that from the week commencing 1 December 2014, PTS for renal patients was being ring-fenced. This would mean that renal patients would be given their own transportation which could not be knocked out by a discharge or transfer.

(8) A Member enquired about the culture at NSL. Mr Ayres explained that within NSL there were two groups: front line staff and the leadership. In his view, the front line staff did a great job; they had been through a period of significant change when they were TUPEd across from other Trusts to NSL. Mr Ayres expressed his concerns about the quality of local leadership, prior to Mr Graydon's appointment, as demonstrated by the poor performance.

(9) In response to a specific question about terminating the contract, Mr Ayres explained that there was a no fault clause in the contract which allowed a 12 month early termination. Under procurement law, the CCG would have to then advertise the contract in the European Journal for 15 – 18 months which would result in a termination six months early and would require a new provider to

take over the service during the middle of winter. If the CCG terminated the contract on a faults basis, there was a risk of legal action by NSL. He confirmed that lessons learnt from the previous procurement would be incorporated into the re-procurement. If a contract variation was required prior to re-procurement, this would be negotiated between NHS West Kent CCG and NSL.

(10) A number of comments were made about voluntary transport services and patients who were not eligible for PTS. Mr Graydon confirmed that NSL used 35 voluntary car service drivers. Mr Ayres stated that NSL had a responsibility to signpost patients, who were not eligible for PTS, to non-NHS funded voluntary sector transport. Funding for PTS was restricted to patients who were eligible.

(11) A Member requested that the Chairman should write to all Trusts, on behalf of the Committee, about the importance of pre-booking discharges in advance with NSL. Mr Ayres suggested that he return to the Committee in March 2015 with the service specification, a more detailed performance summary and focused analysis of discharges by each Trust. He noted that there was good practice and a Trust by Trust analysis would identify specific Trusts who needed to make improvements. The Member agreed to this proposal.

(12) RESOLVED that the report be noted and that CCG colleagues be invited to attend the March 2015 meeting of the Committee.

83. Medway NHS Foundation Trust (Written Update)
(Item 7)

(1) A Member noted and welcomed the update report which was produced in advance of the latest CQC inspection report published on 26 November 2014. The Member requested that the Trust be asked to produce an update on the patient journey through the Emergency Department, leadership stability and the use of technology when the Trust returns to the Committee.

(2) RESOLVED that Medway NHS Foundation Trust and NHS Swale CCG be invited to attend the January meeting of the Committee to provide an update on actions taken to support Medway's Emergency Department.

84. Date of next programmed meeting – Friday 30 January 2015
(Item 8)

(1) Since Agenda publication on 20 November, with the Chairman's agreement, a number of the proposed agenda items had changed:

- South Kent Coast CCG: Integrated Care Organisation
- Medway NHS Foundation Trust and NHS Swale CCG - Medway Emergency
- SECAmb - Future of Emergency Operation Centres (Written Update)
- Kent Community Health NHS Trust: Community Dental Clinics (Written Update)
- Faversham MIU (Written Update)