HEALTH AND ADULT CARE SCRUTINY SUB-COMMITTEE

MINUTES of the Health and Adult Care Scrutiny Sub-Committee held on Wednesday 17 March 2010 at 7.00 pm at Town Hall, Peckham Road, London SE5 8UB

PRESENT: Councillor Lorraine Zuleta (Chair)
Councillor Jonathan Mitchell
Councillor Caroline Pidgeon

OTHERS PRESENT: Phil Boorman, Stakeholder Relations Manager, KCH
Ann-Marie Connolly, Director of Public Health, SPCT
Jane Fryer, Medical Director, SPCT
Malcolm Hines, Dep Chief Executive & Finance Dir, SPCT
Sally Lingard, Head of Corporate Communications, KCH
Patricia Moberly, Trust Board Chair, GSTT
Sean Morgan, Dir of Performance & Corporate Affairs, SPCT
Michael Parker, Trust Board Chair, KCH
Michael Marrinan, Medical Director, KCH

Rachael Knight, Scrutiny Project Manager

1. APOLOGIES

Apologies for absence were received from Councillors Dixon-Fyle, Holford and Lauder.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

Councillor Mitchell declared a personal, non-prejudicial interest – that he is chair of the local campaign group 'Keep Dulwich Hospital'.

4. EFFECTIVENESS OF FOUNDATION TRUSTS

4.1 The chair explained that this item had been discussed throughout the year and that the discussion this evening was an opportunity to consider further information related to the local Foundation Trusts' (FTs) performance targets, as overseen by Monitor.

4.2 Patricia Moberly, Trust Board chair, Guy's and St Thomas' (GSTT), explained that the performance of Foundation Trusts is assessed against mandatory targets. This includes an element of self-certification based on performance indicators. Risk ratings are then awarded in line with the performance data.

4.3 Michael Parker, Trust Board chair, King's College Hospital (KCH), added that, whereas trust's capital funds came from the state under the former system, FTs are now expected to create an operating surplus and can also borrow funds on the open financial market to fund major capital projects.

4.4 Members queried what impact a new government could have on FTs. The GSTT Trust Board chair responded that the key impact will be determined by what PCTs choose to commission from the acute trusts. The KCH Trust Board chair commented that treatment prices are set by the government; and that for emergency admissions the FTs will be paid according to the activity levels of 2008/09, and will therefore have to subsidise the increased levels of treatment themselves, as output increases year on year. He added that the establishment of the Academic Health Sciences Centre (AHSC) allows for a number of back office costs to be reduced; as work is realigned across the AHSC members.

4.5 Malcolm Hines, finance director, NHS Southwark, reported that the financial settlement to the PCT for 2010/11 of 5% growth may appear to be very positive, but this is not the case in real terms, as the money is already committed and will not cover the span of local joint initiatives that the PCT is wanting to take forward. He added that the current economic outlook is bleak; that the whole health system will be contracting significantly through the next year and to an even greater extent in 2011. He also referred to the 5 year health strategy and financial strategy for Southwark and explained that this would be considered by the PCT Board the following week.

4.6 A member queried what the FTs are doing regarding community engagement. The chair commented that the sub-committee's most recent report relates to aspects of the local FTs' community engagement. She explained that aspects of the local trusts' public consultations over the past year have caused concern and that the sub-committee therefore decided to put in writing what lessons might be learned. She added that copies would be sent to the key trust partners in the following week.

4.7 The chair also commented that it would be useful for the local health trusts to involve local communities when trying to identify new ways to provide current services when needing to attain budget efficiencies.

4.8 The GSTT Trust Board chair stated that the 2008 Health and Social Care Act binds all trusts to consult and engage with their communities and that GSTT takes this duty very seriously. She referred to the letter from the GSTT chief executive, Ron Kerr, (see agenda pp. 24 – 26) and added that in view of the scale of efficiencies to be achieved, GSTT has established a new board and is taking a long hard look at new ways to deliver services. She emphasised that the financial stringency will not affect the need to attain the same performance targets, and that any proposed changes will be rigorously tested.

4.9 The GSTT Trust Board chair added that medical care in the 21st century is increasingly shifting to the use of treatments such as laser and keyhole surgery, with the objective to treat more people and at the same time decrease the need for admitting patients to hospital beds.

4.10 The KCH Trust Board chair commented that 10% savings may appear to be a very high percentage, but KCH has had to make significant savings before, and the Academic Health Sciences Centre was established with the objective to increase innovation and pioneering work.

4.11 A member argued that Dulwich Hospital is being closed down, that patients going there now are being redirected to KCH and that local people are seeing a diminution of services. He added that looking to the future, there is an approach to increasingly use out-of-hospital care, which means care in the community and which to some extent must also mean private care. He also observed that as services such as those provided at Marina House are being closed, there is a need to boost GP services; and that as options such as self-referral disappear, patients will not approach a GP with the same problem and will not access treatment.

4.12 Michael Marinnan, medical director, KCH, emphasised that the quality of care provided for King's patients is not negotiable, and challenged any implication that patients were being treated without due care. He added that KCH treats all patients - those who live locally and those from a distance - indiscriminately to the best of its ability and referred to particular services, such as the major trauma centre as providing exemplary care.

4.13 The KCH medical director also commented that he does not share the confidence that achieving 10% savings year after year will be easy. However, he indicated that bringing together services across King's Health Partners ought to allow increased expertise and research opportunities, providing more specialist treatments.

4.14 A member queried why it is necessary for all maternity and all diabetic services to be centralised with King's as an acute hospital, and whether these services could also be dealt with in a smaller setting, such as at the Dulwich hospital.

4.15 Jane Fryer, medical director, Southwark PCT (SPCT), responded that KCH has almost the highest home-birth rate in the country, at approximately 8%, compared with the GSTT rate, which is close to 4%. She added that some work has been undertaken with mothers about improving their choice for maternity care and it is clear from the outcome that parents are wanting midwifery units

alongside acute units, in case of unpredictable complications requiring a full hospital service. She also explained that much of the care for pregnant women already happens within the community, in people's homes and in GP practices and health centres and that another hospital setting is not needed.

4.16 A member queried whether there were any plans to extend the scope of maternity services at KCH. The SPCT medical director responded that birth rates in Southwark are currently increasing to such an extent that there are plans to increase the capacity of all maternity services. The KCH medical director confirmed that there will be an increase and that maternity services are based in the acute hospital because KCH wants to provide services according to mothers' preferences, which show that women who prefer not to use an obstetric unit still prefer to be within close proximity to one. He also emphasised that while KCH is looking to make radical savings, the trust will not compromise the safety of mothers or newborn babies.

4.17 The SPCT medical director remarked that the treatment of diabetes is also a useful example, as it is a very common disease and particularly prevalent in Southwark. She explained that most diabetic health services are not provided in a local hospital because patients need to have diabetes managed well in GP settings and that the majority of diabetic problems are routine type cases in general practice. She added that there is a very small number of diabetes patients who require treatment in a hospital setting, and that the PCT is currently working with KCH and GSTT to have consultants and diabetic nurses working in community settings.

4.18 A member queried whether the KCH Trust Board chair had inferred that he would happily relocate some of the KCH beds and services if there was a suitable facility locally that would have the capacity. The KCH Trust Board chair responded that patients are sent to KCH by the PCT and that King's treats people where appropriate. When asked whether KCH would have services based at Dulwich hospital had it remained a functioning hospital, he added that KCH previously ran services from there and that he would happily work in collaboration with the PCT about the potential and future of the premises. He also commented that it would be difficult to impose on the PCT what it should be doing with its own asset and that the trust's focus is to provide a great service to patients.

4.19 The chair thanked the FTs for their attendance and provision of information throughout the year. She commented that Southwark is privileged to have three local Foundation Trusts, and that it is useful to be informed and so provide reassurance to constituents when they approach councillors with questions.

5. ACUTE TRUSTS' SAVINGS PLANS

5.1 The discussion of this item was included within item 4.

6. PCT / COUNCIL BUDGETS

6.1 Ann-Marie Connolly, director of public health, NHS Southwark, presented additional data on the South East London public health 'heat map' that members had considered with papers submitted to the 18 November 2009 meeting (see Appendix A). She explained that the data for the heat map is derived from various sources, such as mortality data and statistics from GP surgeries; that some of the local area detail is not available. Key findings and issues were highlighted, and members responded with comments and queries as follows:

6.2 Life expectancy in the borough is generally increasing, especially for women, although the gender gap is also narrowing. Regarding the life expectancy for men, however, there is currently a gap of 17 years between the best and worst scoring wards.

6.3 The chair queried how the calculations for life expectancy are made and what they are based on. She commented that Southwark residents born elsewhere may come from places where life expectancy averages are considerably shorter, and that there may be further discrepancies due to people new to the country not having had the consistency of health care services available here. The director of public health responded that the calculation is made by applying the current adjusted death rates to the age profile of the current Southwark population. She added that she would look into some of the statistics used, but explained that if a borough were being considered that had a relatively stable population, it would still be usual to see quite a marked variation between areas of lesser and greater deprivation and that these figures are therefore not likely to be considerably awry.

6.4 The director of public health pointed to the three major causes of premature death in Southwark, namely cancer, chest disease, and circulatory diseases. She commented that the figures for chest and circulatory diseases are improving and approaching the national average.

6.5 Comparative to physical illnesses, less information is available about mental health. Analysis of the effect of mental health problems on quality of life free of disability, however, indicates that a significant number of years of life free from disability are lost through mental disorders.

6.6 The obesity rates of Southwark children in year six were highlighted as the highest in the country – rates that are not getting worse, but are likewise not yet improving. The director of public health commented that children who are obese are not at an immediate health risk, but are at risk in the longer term to serious diseases including heart disease and diabetes.

7. MATTERS ARISING

7.1 Matters arising at the 20 January 2010 meeting – request 1:

A member referred to page 40 (item 4) of the minutes of the sub-committee's 20 January 2010 meeting and noted that Susanna White had agreed to report back early in 2010 on the "outcome of the commissioned cost assessment for

renovation and repair work at Dulwich Hospital, which would allow again the provision of former services such as intermediate care." He stated that there had been no report back to date, excepting the two sentences on page 36 of the agenda papers which do not provide a proper answer nor deal with the outcome of the assessment. He raised the following questions:

a) has the outcome of the commissioned cost assessment for renovation and repair work at Dulwich Hospital enabled intermediate care services to be resumed; and
b) will intermediate care beds be available for patients at Dulwich hospital when the Health and Safety improvement works have been completed this summer?

7.2 Malcolm Hines, director of finance and deputy chief executive, NHS Southwark, accepted that in terms of the work that the PCT is undertaking the answer given is short, and explained that an appraisal of costs related to health and safety issues was completed and that repair work to the approximate value of £1.3 million has commenced. He said that these works are due to be finished in the summer but that it was not yet feasible to outline a more exact timescale or completion date. He added that the renovation will enable departments that were based on the first floor to be considered to be returned to that space. The medical director added that there would then be no building reason for intermediate care not to be located at the hospital, but that a separate process was underway to review the provision of intermediate care across the borough.

7.3 A member contended that the condition of the building had been the only issue that had lead to closure of the intermediate care beds. The medical director explained that the beds for intermediate care had to be closed urgently due to building issues, but there had always been notice of the intention to review the provision of intermediate care. She emphasised that, in view of the review, she could not state whether there would or would not be intermediate care re-located at the hospital, and that this decision was now separate from the building issue.

7.4 A member queried, why, when questions were earlier asked about the closure of intermediate care at Dulwich Hospital, only the building issue was raised. The medical director responded that, as outlined in the Transforming NHS Southwark consultation, officers had been clear about the need to review intermediate care across the borough. The chair commented that she could recall discussing the planned review of intermediate care with the medical director and NHS Southwark chief executive at an earlier meeting, and that the issue of intermediate care had been an area of the Transforming NHS Southwark consultation that the sub-committee thought was insufficiently covered.

7.5 A member queried when the review of intermediate care would be complete. The finance director offered to provide a written response within the next week that would outline the expected timeframe for the review.

7.6 Matters arising at the 20 January 2010 meeting – Request 2: That officers provide details on the proportion of PCT budgets spent on consultation.

7.7 The chair referred to the figure of £94,700 spent over the last year on consultation of a total Southwark PCT budget of £530 million. She commented that this seemed to be a very small proportion in light of some of the changes introduced. She added that while she understood that the PCT needs to try to manage tight budgets, she expected that there would be some pay back by investing more in consultation, - especially given the multitude of challenges and increasing financial constraints.

7.8 The director of finance stated that the main spend of the £94,700 was on the Transforming NHS Southwark consultation, and explained that there are officer teams reporting to himself and to the medical director that are working on communications on an ongoing basis whose pay costs are not included in the figure. He added that there is a significant level of industry in terms of the volume of consultation promotion work carried out and that there were lessons to be learnt from pan-London NHS consultation work, under which larger sums had been spent on top media companies to produce, for example, television campaigns. He noted that despite the significantly higher spend, the response rates for such consultations had not differed considerably from the PCT's response rates, which indicated that the issue with promotion is not so much the amount spent, rather the methods used for communicating the consultation.

7.9 Matters arising at the 20 January 2010 meeting – Request 3: That an update be provided on the Southwark PCT decision regarding the re-structuring of drug and alcohol treatment.

7.10 A member commented that the sub-committee had been confronted with a fait accompli, as although members were told that there would be a consultation on this issue, the decision had effectively already been taken. Moreover, the consultation was started without officers notifying the sub-committee of the start date. He added that the issue of self-referral had not been fully considered by the sub-committee and that the favoured system appeared to be one that would abolish self-referral and therefore oblige patients to go to a GP, who may or may not have the requisite specialist knowledge.

7.11 Sean Morgan, director of performance and corporate affairs, NHS Southwark, commented that the number of patients who self-refer directly to SLaM is a very small percentage and that the vast majority of patients access treatment via other routes. Moreover, patients still have access to third sector providers and can self-refer to those. GPs decide with patients the best care plan for their condition and circumstances. The changes also correspond with the established strategy for the increased use of primary care services. The objective of the strategy is to enable SLaM's specialist services to be able to focus on clients with the greatest need.

7.12 Regarding the consultation on the changes to services at Marina House, the director of performance and corporate affairs added that officers had attended the sub-committee's 7 October 2009 meeting to discuss the proposed re-structuring; that officers attended other public meetings and were very open to receiving consultation responses. He emphasised that the re-location of the services will not include any reduction in capacity; that specialist services will still be provided on two sites; and that several months are still needed for the

preparatory work to the buildings before the changes will be implemented.

7.13 The chair queried whether patients would still be permitted to self-refer, if they were to turn up at the Blackfriars or Marina House services. Officers responded that patients would not be turned away, but that this is not being publicised, as it is no longer policy to encourage self-referral to specialist services.

7.14 Members raised concerns about patients going to a GP in extreme circumstances, when they may be tending towards violence for example. It was also queried why the criminal justice system could not establish services on both sites, and the current treatment for drug and alcohol use be retained at Marina House at a reduced capacity. This could also allow for the skills of the two types of services to be linked. The medical director explained that patients in extreme circumstances would not go to Marina house; rather they would go to A&E. She added that in the case of a very dangerous patient, the police and an ambulance would be called for, to bring the person to a place of safety. She also reiterated that SLaM has made clear that no one would be turned away in extreme circumstances.

7.15 Regarding the co-location of the criminal justice system and more standard services, the medical director remarked that this could be explored with partner agencies; although the previous planning had focused on the need for one integrated site.

7.16 The chair thanked all officers for their contributions and for attending.

RESOLVED:

That officers look further into the viability of co-locating the provision of the original services for drug and alcohol treatment based at Marina House, and those provided by the criminal justice system, at both the Marina House and Blackfriars sites.

8. MINUTES

RESOLVED:

That the minutes of the Health and Adult Care Scrutiny Sub-Committee meeting held on 20 January 2010 be agreed as a correct record.

The meeting closed at 9.25 pm.