Better health and care in West Kent

Listening event

NHS West Kent Clinical Commissioning Group

Wednesday 15 March 2017

Hadlow Manor Hotel, near Tonbridge

Questions and Answers – Local Care Dr Bob Bowes

Q1. Respite care costs £2000 a week. KCC will only pay £700 – and that only if you have less than £23,000 a year in savings. How do you plug the gap?

A1. I don't know. You're right. It is a serious problem.

Q2. The word care is very confusing. When you leave hospital after expensive treatment and extensive help, you come out to really nothing. Vast sums of money are spent in hospital on treatment and diagnosis. Out in the community, there is very very little in the aftermath of serious operations - meals cooked for you and so on. It is very important to make the value of all that expensive care mean something.

A2. Yes, there's a need for adequate step down care for people coming out of hospital.

Q3. History shows that transformation costs a lot of money upfront and any savings come way down the line if they come at all. You're doing it for less money. All 44 STP leads in the country should be shouting from the rooftops for more money.

A3. I'd agree with you that the transformation will cost money and that needs to be identified. We are a statutory organisation and we are legally required to live within funds given to us. We are not a lobbying organisation but we are part of the NHS Confederation which lobbies the Government on our behalf.

Q4. Everybody is onboard with what you're talking about. But economically, it is never ever going to happen. You wrote off £12billion on a computer system in 2007. What guarantees have you got?

A4. There are no guarantees. But there is this difference from the past. Then each individual organisation (commissioning and provider) had a statutory duty to live within its means. Now that's not the case. If the CCG meets its budget but its providers are in difficulty, the CCG will be deemed to have failed. It's no longer a question of just looking after your own organisation, each organisation has a commitment to the system. It is a conscious way to make professionals within the

system act like one system. At the moment, we have a system which is fragmented. Every time your care is passed from one organisation to another, there's a transaction cost. If we can make this work, and I agree there's many a slip, it wil improve productivity a lot.

Q5. What is being done to train more staff?

A5. We are changing the roles of staff such as pharmacists and healthcare assistants. Where we have a surplus of staff in particular roles, we can make better use of their skills. We also have to somehow improve the ambition of people to make their way into health professions.

Q6. I absolutely agree about the importance of care in the home but really I don't believe people who have had a serious operation should be sent straight home. I would have thought there's a lot to be said for making better use of convalescent care at Tonbridge Cottage Hospital. I was in hospital for four days after a hip operation and was discharged straight home. A farmer I know in France had two weeks of physio and hydrotherapy at a convalescent home and was back on his tractor within two months.

A6. The need for rehab after hospital stays is well known.

Q7. I work for a voluntary organisation and we have had positive conversations with West Kent CCG. We are now providing convalescent care but we have been told this is a short term solution. Is there any willingness from the CCG to continue to work with the independent and voluntary sector to fill this gap?

A7. In theory yes, but decisions about spending follow a rigorous process to assess benefit for patients.

Q8. It sounds like we need to work smarter. What degree of buy-in are you getting from other organisations and wider?

A8. The coming of the STP is a big change at the highest level and it is going to shine a spotlight on organisations that don't get involved or play ball. That is going to make a difference.

Q9. A lot of the passion and drive is from the NHS. Is it matched by the other stakeholders?

A9. I think it is. The local authorities' budgetary is even tighter than ours but there is no hint from the districts or boroughs or county that they don't want to get involved.

Q10. Services in the community have been cut year after year. Specialist nurses in hospitals aren't allowed to go out to the community. Re-admission rates for people aged 75 plus are very high when they come out of hospital and haven't got services at home. The NHS need to be talking to providers and a strategy needs to be pulled together for both step down beds and keeping people out of hospital.

A10. (Answered by Dr Peter Maskell, Medical Director of Maidstone and Tunbridge Wells NHS Trust, who is a consultant geriatrician, specialising in the care of older people.) If you walk into hospital with a mobile aid and a care package, you are likely to become stranded in hospital. We need to identify those patients and start planning for their discharge on admission, and identify those patients at high risk of re-admission and plan for them. So we need to have step up and step down care, to support patients out of hospital wherever possible.

Q11. Mental health can affect anybody, young or old, and if problems start when you are young they can continue to late in life. Prevention seems to be missing. With Facebook, social media, cyber bullying – the pressures can lead to depression. We need to go after this and let people be how they are.

A10. This is part of the unfortunate way our society is going. There is a question of how much of that we can influence. We need to do what we can while accepting that a lot of this is just how culture is these days.

Q11. The STP says the lack of new capital will be a significant barrier to change. It's almost saying that the transformation is unlikely to happen. The inference is there's nothing that can be done about it. In the budget, Philip Hammond announced some extra capital funding to get STPs underway. Other areas of the country have applied for it. Why can't we?

A11. A bid for extra capital funding on behalf of Kent and Medway has already gone in.

Questions and Answers – Hospital Care

Q1. Are we allowed to offer as an additional hurdle criterion the question: is there evidence that the change will improve things? Advance care planning for elderly, frail and vulnerable people seems like a wonderful idea but I have no evidence that it has stopped hospital admissions. Why is there so much emphasis on it?

A1. I agree about the principle of wanting evidence. The problem is that there isn't evidence for everything. There is no evidence that certain drugs work but our experience is that they do. There is no evidence for many interventions in older people because the vast majority of clinical trials stop when patients reach the age of 80. By then, people tend to have so many health conditions, that they are unique and you cannot draw conclusions from their individual reactions to interventions. So elderly care tends to be based on common sense and lots of discussions with patients: "If we do things this way, this might happen. If we do things that way, that might happen." Care planning is a holistic way we can get a view of what the patient thinks. The purpose of the hurdle criteria is to knock some options out, but keep some in. But your suggestion is exactly the type of thing we need to take back to the STP Programme Board, and yes, we will look at it.

Q2. Billions of pounds are being spent on putting these care plans together. It feels lovely for the elderly people and for the professionals working on the plans. We can measure if they reduce the number of admissions – and they aren't making a difference.

A2. (A member of the public). My mother having a care plan made a massive massive difference – it meant the team was able to communicate with me. We probably wouldn't have been able to bring her home.

Further response from Dr Maskell: We must do what we feel is right for patients.

Comment: Before Pembury Hospital was built, I was involved in the PPI Forum. We were told Pembury would have fewer beds than Kent and Sussex Hospital because we were going to have this great care in the community. We are now 10 years later and I have still to see evidence of this happening. What you are saying looks good but I'm angry this wasn't started long long ago. Politicians are all to blame and won't turn around and tell us we have to pay for more. Make the County Councillors answer this question! That's what our vote is for.

Q3. Mental health provision: I see this in the Press and I have watched this on the periphery. We have a Centre of Excellence at Dartford but people struggle to travel there. There is an accessibility issue for the family as for the patients. I have seen people put under enormous pressure trying to get to Dartford and back. How do you evaluate that? Do you think it was successful?

A3. I can't tell you whether or not what happened in Dartford was successful. In the STP Clinical Board we look after four workstreams. Mental health is facilitated by the Medical Director of Kent and Medway NHS and Social Care Partnership Trust (KMPT). We are looking at integrating mental health and physical health, having psychiatric liaison services in all physical health acute hospitals which will increase accessibility and having clinics for people with medically unexplained symptoms. In extended primary care teams, mental health workers will be part of the team. We are all clear there must be parity of esteem.

Comment: One of the things to do is to look at what's happening across the rest of the country. If personal care plans are done properly and facilities are there to enable people to be cared for properly, they do work; they do prevent admissions to hospital. We are all responsible for our own health anyway. We can all do an awful lot more to make sure that we stay healthy and our children and grandchildren stay healthy. Personally, I don't want ever to need the NHS. Prevention is better than cure.