



AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 17th October 2008 at 10.00 am
Council Chamber, Sessions House, County
Hall, Maidstone

Ask for: Paul Wickenden
Telephone (01622) 694486

Tea/Coffee will be available from 9:45 am

Membership (21)

Conservative (12): Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood,
Mrs S V Hohler, Mr G A Horne MBE, Mr M J Northey, Mr R J Parry,
Ms B J Simpson, Dr T R Robinson, Mr R Tolputt and
Mrs E M Tweed

Labour (4): Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and
Mrs E D Rowbotham

Liberal Democrat (1): Mr D S Daley

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item No		Timings
1.	Membership To note that the Borough and District Councils have now agreed to their four voting members on the Committee. The Members are as follows:- Councillor Marilyn Peters, Dartford Borough Council Councillor Annabelle Blackmore, Maidstone Borough Council Councillor Jackie Perkins, Canterbury City Council Councillor Michael Lyons, Shepway District Council Colleagues from West Kent have a pool of substitutes should Councillors Peters or Blackmore be unable to attend. The pool of Members are:- Councillor Janet Sergison, Tonbridge and Malling Borough Council Councillor John Cunningham, Tunbridge Wells Borough Council Councillor Diane Marsh and Councillor Leslie Hills, Gravesham Borough Council Councillor Richard Davison, Sevenoaks District Council	10:00 - 10:15 am
2.	Substitutes	

3. Election of Chairman
4. Declarations of Interests by Members in items on the Agenda for this meeting.
5. Minutes - 5 September 2008 (Pages 1 - 24)
6. Update on various issues (Pages 25 - 28) 10:15 - 10:20 am
7. Delayed Transfers of Care from Acute Hospital Trusts (Pages 29 - 52) 10:20 - 11:20 am
Steve Phoenix, Chief Executive and Sharon Jones, Director of Community Services, West Kent Primary Care Trust; Nikki Luffingham, Chief Operating Officer, Maidstone & Tunbridge Wells NHS Trust; Jessica Scott, Head of Clinical Site and Operational Safety, Medway Foundation Trust; Sarah Andrews, Director of Nursing, Simon Perks, Deputy Director of Commissioning and Sue Baldwin, Assistant Director, Intermediate Care Services, Eastern & Coastal Kent Primary Care Trust; Andy Schofield, Head of Nursing for Medicine and Lesley White, Acute and Emergency Services Manager, East Kent Hospitals Trust; Steve Leidecker, Director of Operations, KASS and Anne Tidmarsh, Head of Adult Services, East Kent and Janice Duff, District Manager, East Kent, KASS will be in attendance for this item.

Break

8. Delayed Transfers of Care from Acute Hospital Trusts (continued) 11:35 am - 12:50 pm
9. Date of next programmed meeting – Friday 28 November 2008 at 10:00 am 12:50 - 1:00 pm

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
 Head of Democratic Services and Local Leadership
 (01622) 694002

9 October 2008

Please note that any background documents referred to in the accompanying papers may be inspected by arrangement with the officer responsible for preparing the relevant report.

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, 5 September 2008.

PRESENT: Mrs C Angell, Mr M J Angell (substitute for Mr R J Parry), Ms S J Carey (substitute for Mrs S V Hohler), Mr A R Chell, Mr A D Crowther, Mrs V J Dagger (substitute for Dr T R Robinson), Mr D S Daley, Mr C G Findlay (substitute for Ms B J Simpson), Ms A Harrison, Mr C Hibberd (substitute for Mr R J Parry), Mr G A Horne MBE, Mr W V Newman, DL (substitute for Mr M J Fittock), Mr M J Northey (substitute for Mr B R Cope), Mrs E D Rowbotham, Mr R Tolputt and Mrs E M Tweed.

ALSO PRESENT: Mr R A Marsh, Cabinet Member for Public Health and a range of press, public and former Patient and Public Involvement Forum Members.

IN ATTENDANCE: Mr P D Wickenden, Overview, Scrutiny and Localism Manager and Mr T Godfrey, Research Officer to Health Overview Scrutiny Committee.

UNRESTRICTED ITEMS**35. Membership**

(Item 1)

The Overview, Scrutiny and Localism Manager informed the Committee that Mr M J Northey had filled the vacancy created by the death of Lord Bruce-Lockhart and Mrs B J Simpson had replaced Mr R A Marsh on the Committee.

36. Election of Chairman

(Item 3)

(1) The Overview Scrutiny and Localism Manager informed the Committee that following the death of Lord Bruce-Lockhart Mr B Cope had been identified as the Chairman designate for the Committee. Unfortunately, Mr Cope was currently unwell and unable to attend the meeting. Mr Fittock, the Vice-Chairman, was unable to attend the meeting.

(2) It was therefore proposed that a Chairman should be elected for the meeting. Mr Tolputt proposed, Mr Northey seconded that Mr G A Horne, MBE be elected Chairman for the meeting.

Carried without a vote

(Mr G A Horne, MBE presiding)

37. Lord Bruce-Lockhart

The Committee stood in silence as a mark of respect for the late Lord Bruce-Lockhart, Chairman of the Health Overview and Scrutiny Committee.

38. Minutes - 18 July 2008

(Item 5)

RESOLVED that subject to Mr Tolputt being recorded as having been present at the meeting, the Minutes of the meeting held on 18 July 2008 are correctly recorded and that they be signed by the Chairman.

39. Application for Foundation Trust Status

(Item 6)

RESOLVED that the Committee endorse the letter of support which had been sent to the East Kent Hospital's Trust by the Overview, Scrutiny and Localism Manager following consultation with the Chairman, Vice Chairman and Liberal Democrat Spokesman.

40. Dates of meetings in 2009

(Item 7)

The Committee agreed to its meeting dates in 2009 as follows:-

Friday, 9 January
Friday, 6 February
Friday, 20 March
Friday, 1 May
Friday, 17 July
Friday, 4 September
Friday, 16 October
Friday, 27 November

All meetings to start at 10.00 am.

41. Dover Healthcare

(Item 8)

(Ms A Sutton, Chief Executive, Dr Sandro Limentani, Director of Public Health, Ms Sheila Pitt, Director of Practice-based Commissioning, Mrs Lynne Selman, Director of Citizen Engagement and Communications, of the Eastern & Coastal Kent Primary Care Trust, Mr S Bain, Chief Executive, Ms Liz Shutler, Director of Strategic Development and Service Improvement, of the East Kent Hospitals Trust, Mrs L Sencicle and Mr R Hansell, former Patient and Public Involvement Forum representatives, Councillor P Heath, Cabinet Member for Health, Well Being and Public Protection, Councillor J Hood and Mr N Aziz, Chief Executive, of Dover District Council, Mr G Prosser, Member for Parliament for Dover, Kenneth Cobb, Transport Integration Manager, and Martyn Ayre, Senior Policy Manager, from Kent County Council, were in attendance for this item)

(1) Further to Minute 19 of 2008 the Committee returned to the issue of Dover Healthcare following the resolution approved by the Committee on 9 May:-

“That the Health Overview and Scrutiny Committee of Kent County Council strongly recommend and support East Kent Hospital’s Trust working closely with the Eastern and Coastal Kent Primary Care Trust and Dover District Council to locate a central site in Dover for the Community Hospital Services for the population of Dover and the surrounding areas. This proposal to be delivered to the East Kent Hospital’s Trust by the end of August 2008. This third option to be considered and evaluated alongside options 1 and 2 concerning the Buckland Hospital site.”

(2) The Committee had before them a background briefing paper prepared by the Committee’s Research Officer.

(3) The Committee also had a briefing paper received from the Eastern and Coastal Kent Primary Care Trust which set out from the Trust’s perspective:-

- (a) a summary of actions taken since the 9 May 2008 meeting of the Health Overview and Scrutiny Committee;
- (b) the practice-based commissioning intentions/opportunities to bring back services to Dover before the new hospital is developed;
- (c) the process for arriving at a hospital site recommendation and criteria for selection;
- (d) other relevant information including on-going stakeholder/public engagement; and
- (e) some operational next steps dependent upon the Health Overview and Scrutiny Committee’s decision/recommendation.

(4) Attached to the briefing note was:-

- (a) a diary of events/public engagement undertaken;
- (b) some frequently asked questions with the answers;
- (c) Dover District Council Overview and Scrutiny Committee recommendations;
- (d) the Health Equity Audit;
- (e) the criteria for selecting sites;
- (f) the long list of site options; and
- (g) the practice-based commission intentions.

(5) The Committee also had before them:-

- (a) a statement from Mrs L Sencicle, a member of the former Eastern and Coastal Kent Primary Care Trust Patient and Public Involvement Forum. Mrs Sencicle had referred the issue of Dover Healthcare to the Health Overview and Scrutiny Committee prior to the dissolution of the Patient and Public Involvement Forum at the end of March 2008;
- (b) a statement from Mr R Hansell;
- (c) a letter from the Chairman and Clinical Lead for Dover and Aylesham Practice-Based Commissioning Consortium, Dr S Chaudhuri; and
- (d) a short statement from Mr C Elphicke, a Prospective Parliamentary Candidate for Dover.

(6) Ms A Sutton, Chief Executive of the Eastern and Coastal Kent Primary Care Trust made a short presentation, attached as Appendix 1.

(7) The Primary Care Trust and other partners had taken into account fully the recommendation of the Health Overview and Scrutiny Committee.

(8) Ms Sutton's presentation concentrated on the work that had been undertaken to identify a potential central site in Dover. This work had been undertaken against the background of the outcomes of the Independent Reconfiguration Panel which had determined where the acute hospital sites should be for East Kent, namely, Ashford, Canterbury, and Margate, to provide sustainable working services. The full implementation of the acute services changes had come into being in March 2006.

(9) The Committee noted that in June 2008, clinical GP leaders in Dover had excluded in-patient and acute services from their commissioning intentions for reasons of safety and clinical effectiveness.

(10) The presentation set out the site selection criteria which had been prepared following a consultation of views from public and partner organisations. These included:-

- Supporting the delivery of commissioning intentions;
- Transport and car parking;
- Accessibility – % of households in Dover District within 30 minutes of each site by public transport or on foot;
- Future proofing – potential for expansion, ability to adapt to changes in need/service;
- Deliverability – time scale, site availability;
- Value for money;
- Adjacencies with other health services, e.g. GPs, dentists, clinics etc; and
- Wider considerations – regeneration, depreciation, attracting staff.

(11) The Committee noted that a number of sites were excluded on the basis that they were:-

- (a) not currently available;

- (b) no better than the shortlisted options; and
- (c) could not support the Commissioning Intentions.

(12) The selection criteria had been applied to all options and the following three options had been shortlisted:-

- (a) Mid Town Development;
- (b) Whitfield (White Cliffs); and
- (c) Rebuild on Buckland Hospital site.

(13) Ms Sutton's presentation then dealt with the advantages and disadvantages of each of the three shortlisted options.

(14) Ms Sutton made it clear to the Committee that services to be provided in a new hospital when available would be an enhancement of the services currently available in Dover. The proposal was not a "polyclinic". Ms Sutton concluded that as a new Community Hospital is developed the Primary Care Trust did wish to explore whether more intermediate care beds were needed.

(15) The Chairman then invited Mrs Lorraine Sencicle, who as a former Patient and Public Involvement Forum Member for the Eastern & Coastal Kent Primary Care Trust had referred the issue of Dover Healthcare to the Health Overview and Scrutiny Committee, to address the Committee. Mrs Sencicle then read to the Committee a statement that she had prepared which expressed her concerns about possible bias in the local media which she felt was not supportive of the Community Hospital.

(16) Mrs Sencicle informed the Committee that a site was available at Whitfield. She acknowledged that there was £20 million available now which would enable a Community Hospital to be available, up and running in two years time. She said this had to be the priority. She added that the benefits of a Community Hospital were that it would become a major local employer and those health workers that currently commute would be able to work closer to home. It was important that the service included more diagnostic services in Dover to cut down on the patients who currently have to travel to other parts of Kent.

(17) Mrs Sencicle then read a list of services that she would like to see in the Community Hospital.

(18) Mrs Sencicle concluded that a Community Hospital was needed now somewhere in Dover.

(19) Colleagues from Dover District Council including Councillor Mr P Heath, Cabinet Member for Health, Well Being and Public Protection, Councillor Mr J Hood, Chairman of the District Council's Scrutiny (Community and Regeneration) Committee and Mr N Aziz, Chief Executive were present at the meeting and addressed the Committee. Mr Heath said that consideration of the future of the Buckland Hospital had provided an opportunity to review health services in the area. He said that there were five very depressed wards with health needs which required better facilities than those currently available at the Buckland Hospital.

(20) He added that the District Council had a good working relationship with the Health Trusts in taking the healthcare needs of Dover residents forward and he was content with the Primary Care Trust's proposals. He considered that a midtown site was the most appropriate proposal. Councillor Hood referred to the work of the Dover District Council's Scrutiny Committee which had been looking at the issue of Dover healthcare. They had concluded that a town centre site was the most appropriate. Councillor Hood added that he had found the dialogue with the Primary Care Trust and the Acute Hospital Trust to be open and honest.

(21) He concluded that the regeneration was also important and that provision of a Community Hospital in the town centre would act as a catalyst for this regeneration. Mr Aziz added that the health inequalities and health needs of Dover were blindingly obvious, the need for health improvements in the town were long overdue and it was important to look now at what health improvements were required and what was deliverable.

(22) Mr Aziz added that the debate about a full general hospital was a damaging distraction. He did not anticipate seeing a full acute hospital, although it would be nice, in his lifetime. He said that the Whitfield site which was being suggested would have to be purchased at a commercial rate and there would be significant planning challenges. In addition, the health inequalities in the area favoured a town centre site.

(23) Mr R Hansell read the statement included in the papers for the Committee's meeting to the Committee. In summary Mr Hansell said that the Dover population rated low in the health rankings.

(24) It was important that the facility to be provided had the room to expand. He said that the Queen Elizabeth, the Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) at Ashford were already operating at full capacity. With Operation Stack and 14,000 new homes to be built in the area he said that parking in the town centre option would be impossible.

(25) He said that he was pleased that Dover District Council were working seriously on the concept of a new general hospital at Whitfield. He concluded that 30,000 members of the Dover population supported a new general hospital and he encouraged the Health Overview and Scrutiny Committee to make site visits to the sites proposed.

(26) The Committee then invited Mr G Prosser, Member of Parliament for Dover, to address the Committee. Mr Prosser made it clear that initially he had wanted the Buckland Hospital or the Buckland car park options to be taken forward. He also initially had various doubts about the viability of the town centre option. He had been campaigning to save the Buckland Hospital for some 20 years. However, the town centre site issues had now largely been resolved and £20 million capital funding had been found.

(27) He therefore asked that the Committee confirm its resolution of 9 May 2008 so that a town centre site could be developed.

(28) Mr Prosser added that the proposal for a new hospital at a site in Whitfield had too many practical problems. It was important that a practical solution, one that was deliverable and deliverable without delay, was found and the town centre option best meets requirements. However, he added that there were issues with the town centre site where assurances would be required including future proofing, car parking, intermediate care, ability to expand the site and all these issues needed to remain live on the agenda and could be monitored as things moved forward. He now wished to see the resolution of the Committee taken forward by the Eastern & Coastal Kent Primary Care Trust, East Kent Hospitals Trust and other partners.

(29) Members of the Committee then asked a range of questions of those officers of the County Council, Dover District Council, the Eastern & Coastal Kent Primary Care Trust and East Kent Hospitals Trust who had been asked to attend the meeting for this item. Questions raised included:-

- (a) future proofing, car parking, accessibility of the town centre site;
- (b) whether the size of the hospital was fit for purpose in planning terms and regional capacity;
- (c) further details of the petition which had been presented to 10 Downing Street;
- (d) how the needs of residents from surrounding areas such as St Margaret's were taken into account; and
- (e) how much impact the cruise ship terminal and port expansion would have on the provision of health services in the Dover area.

(30) The Committee noted the responses to the various questions. These included the fact that the town centre site was adjacent to a health centre which was an old building which would probably need replacing.

(31) Access to the site needed to be looked at in the context of sustainable transport.

(32) It was understood that the petition presented to 10 Downing Street was for a general hospital.

(33) Regarding the questions relating to cruise ship issues these were currently dealt with by the ambulances as at present. There had been no public health issues or outbreaks of illness on cruise ships in the past.

(34) One Member of the Committee who represented several parish councils indicated that government funded improvements to rural bus services had made it easier for those from the rural areas in the parishes she represents to access the site proposed in the town centre. It was important that there was equitable healthcare provision for the deprived areas. Dover District Council Park & Ride scheme needed to be linked into any proposal and it was important that the new health facility employed local people.

(35) Ms Sutton informed the Committee that health needs assessments had been carried out and the issue of access to jobs and good housing were extremely important for the health and wellbeing of local residents. In answer to some questions around public consultation the Committee's attention was drawn to the documents within the papers.

(36) A further series of questions were asked relating to the catchment area for a new Community Hospital and whether those areas outside Dover town centre which were deprived would fall within it; the relationship between the town centre population and the growth planned for Whitfield; how the County Council had recently failed in getting a depot built at Whitfield and what challenges this presented for the Whitfield option; and concerns which had not been heard before relating to flooding as an issue for the town centre option.

(37) Mr Bain, Chief Executive of the East Kent Hospitals Trust, said that he had experience of building on constrained sites. In response to the issue relating to flood risk assurance the representative of Dover District Council responded that that part of Dover town centre was considered safe and the likely incidents of flooding was a 1 in a 100 year event.

(38) In answer to a question relating to intermediate care beds and the expansion of these beds in community health teams locally Ms Sutton responded by explaining where the current allocation of beds was and referred the Committee to the excellent model at Westview, Tenterden of integrating health and social care.

(39) The Committee also noted that the Eastern & Coastal Kent Primary Care Trust together with partner organisations were working with children's commissioners on intermediate beds for children.

(40) In response to further questions relating to transport and ownership of the site the response was that the County Council and the two PCTs were working on the whole transport issue. The site in the Dover town centre area was partly owned by the Primary Care Trust and partly by Dover District Council.

(41) Responding to questions relating to whether the Community Hospital being proposed would have all the aspects on the list which Mrs Sencicle had alluded to, questions around parking, and the consultation process the response was that practice-based commissioners were not asking for acute hospital beds. The intermediate care beds would be provided in other settings other than the Community Hospital and end of life care would be based in hospices.

(42) The Committee also noted that the building of a new Dover hospital would cut down on transport/parking at other sites.

(43) The Eastern & Coastal Kent Primary Care Trust acknowledged that there had been no formal consultation but there had been an ongoing engagement process. One Member commented that the Dover Project consultation had been an exemplar recognised by the Health Overview and Scrutiny Committee which should be repeated elsewhere. This Member also praised the partnership working and hoped that there would be some devolution of powers from the Health Overview and Scrutiny Committee so that the ongoing work in this project could be monitored locally not only by the Council but also local councillors.

(44) In conclusion Ms Sutton made it clear that what was being considered was definitely not a polyclinic but was a Community Hospital.

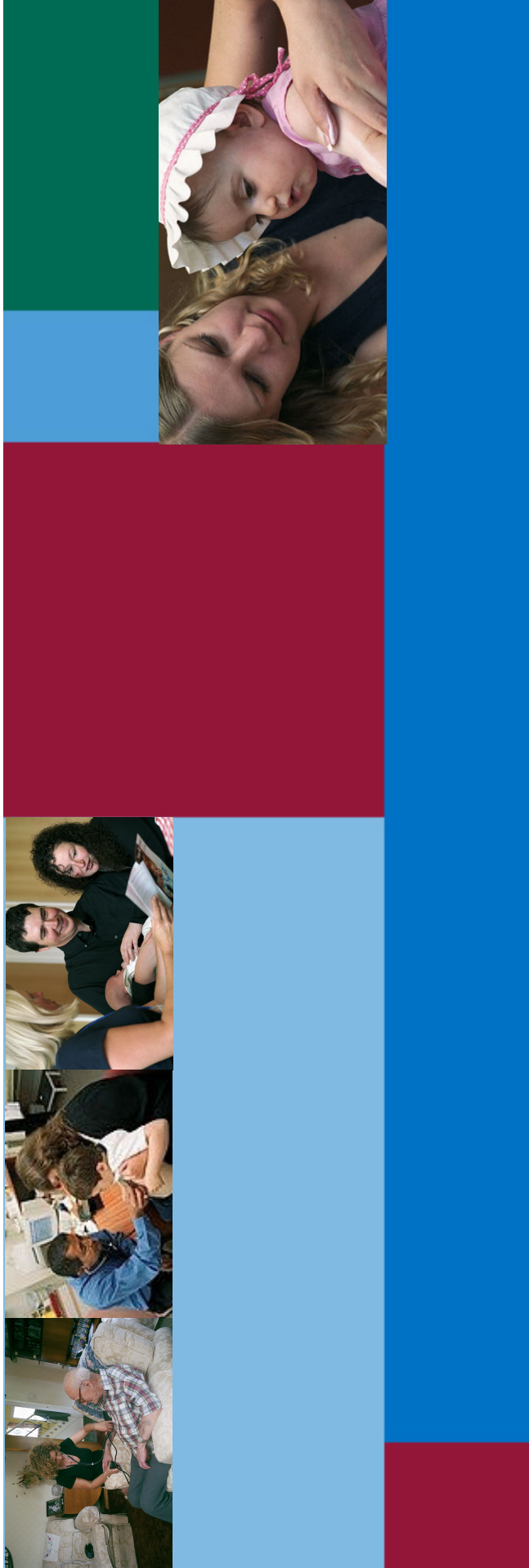
(45) Mr R Tolputt moved, and Mr D Daley seconded:-

“that the Kent County Council’s Health Overview and Scrutiny Committee strongly recommends, supports and endorses Eastern and Coastal Kent Primary Care Trust working closely with East Kent Hospitals Trust, Kent County Council, Dover District Council and the Consortium of Local General Practitioners (CLGP) to develop a central site for Dover for a modern Community Hospital for the population of Dover and the surrounding area by 2011”.

Carried:- 14 votes for, 0 against, 1 abstention

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Dover Healthcare



HOSC Recommendation made on the 9th May 2008

- The Health Overview and Scrutiny Committee of KCC strongly recommend and support East Kent Hospitals Trust working closely with the ECK PCT and Dover District Council to locate a central site in Dover for the Community Hospital Services for the population of Dover and the surrounding areas
- This proposal to be delivered to the EKHT by the end of August 2008. This third option to be considered and evaluated alongside options 1 and 2 concerning the Buckland Hospital site

Identifying a potential central site:

Investigation of site options:

- Talked to Dover District Council
- Undertook a land search
- Members of the public given the opportunity to propose sites

Developed criteria and priorities for site selection:

- 11th June – commissioning plans for Dover discussed to raise awareness of the services to be provided (78 people)
- 22nd July – Development and prioritisation of the criteria for site selection (32 people)
- Worked with other partners (PBC, DDC, EKHT and others) to prioritise their criteria for site selection

Other views considered:

- Dover District Council OSC – presentation on 17th June *endorsed the proposal to locate a central and accessible site in Dover for community hospital services for the population of Dover and the surrounding areas*
- Petition submitted July – for the provision of a general hospital in Dover
- Dover and Aylesham PBC Consortium commissioning intentions supported by PCT Board in July 2008
- 14th August – current preferred site discussed with members of the public (52 people)

Background

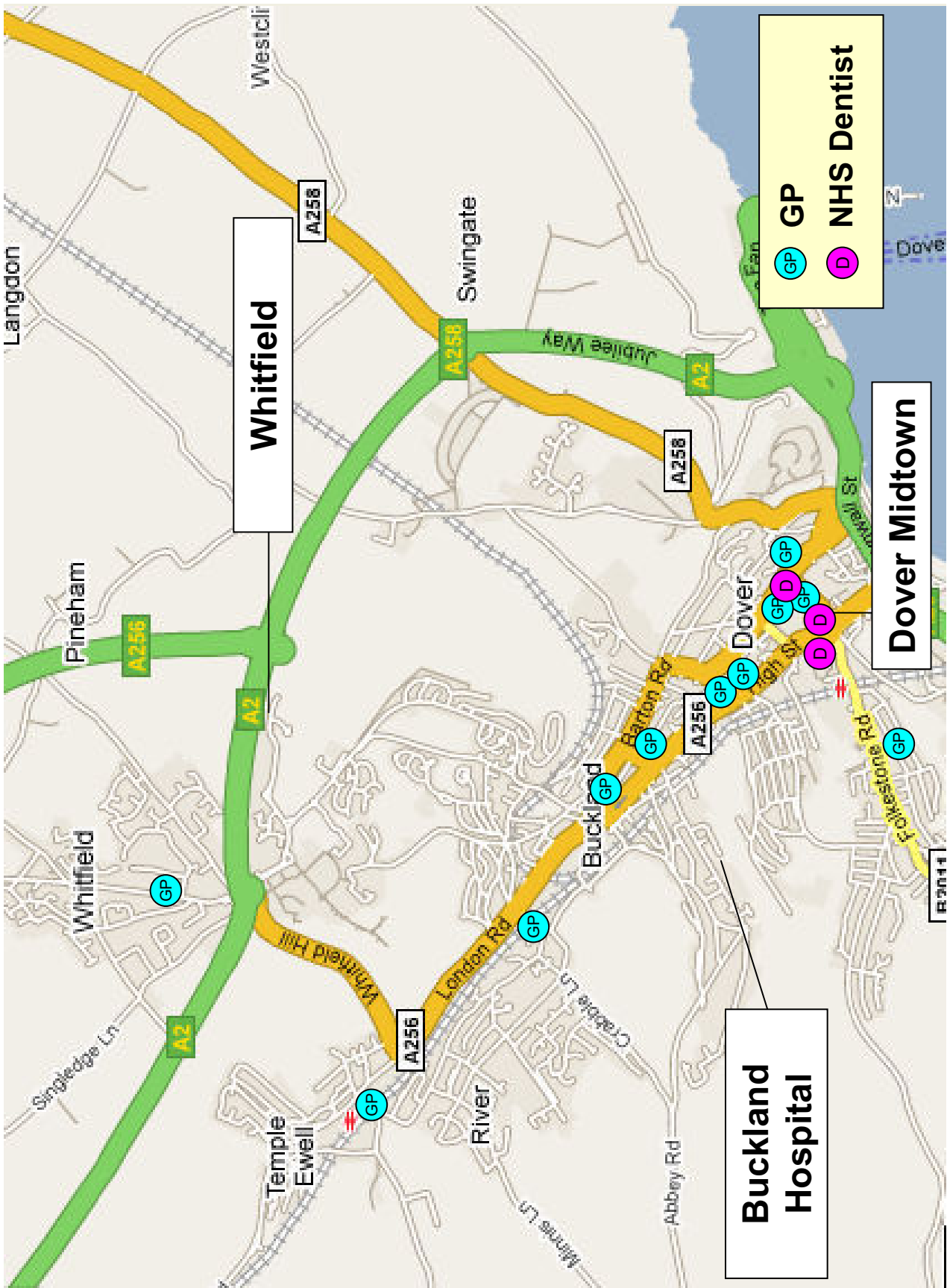
- June 2003 Independent Reconfiguration panel determines acute sites in Ashford, Canterbury and Margate working together to provide sustainable acute services
- October 2003 future location of acute services agreed by local PCTs
- March 2006 Full implementation of acute service changes by EKHT
- June 2008 Clinical GP leaders in Dover exclude inpatient and other acute services from their commissioning intentions for reasons of safety and clinical effectiveness

Site Selection Criteria – combination of views from public and partner organisations

- Supports the delivery of commissioning intentions
- Transport and car parking
- Accessibility - % of households in Dover District within 30 minutes of site by public transport or on foot
- Future Proofing – potential for expansion, able to adapt to changes in need/service
- Deliverability – time scale, site availability
- Value for Money
- Adjacencies with other health services e.g. GPs, dentists, clinics
- Wider considerations – regeneration, deprivation, attracting staff

Site Selection

- A number of sites were excluded on the basis that they were:
 - Not currently available
 - No better than short listed options
 - Couldn't support the commissioning intentions
- All selection criteria applied to the three shortlisted sites.
- Each site has advantages and risks/disadvantages
- Three short-listed options
 - Mid Town Development
 - Whitfield (White Cliffs)
 - Rebuild on Buckland Hospital site



Whitfield White Cliffs:

Advantages: Car parking,
Potential for future expansion
Supports delivery of commissioning intentions

Disadvantages: Cost of site purchase at commercial rates
Deliverability – requires site acquisition on open market, change of planning use, public transport realigned, setting up of road/ utilities infrastructure
Outside areas of deprivation
Moves services and resources away from centre of regeneration
Accessibility – 30.7% of households within 30 minutes
Not adjacent to other health services

Buckland New Build:

Advantages:

- Car parking**
- Potential for future expansion**
- Supports delivery of commissioning intentions**
- Deliverability – site in EKHT ownership, site designated for health use**
- Good access from St Radigund's ward**
- No site purchase cost**

Disadvantages:

- Poor access from other disadvantaged wards**
- No positive impact on regeneration**
- Accessibility – 34.3% of households within 30 minutes**
- Not adjacent to other health services**

Mid Town:

- Advantages:**
- Car parking,
 - Potential for future expansion
 - Supports delivery of commissioning intentions
 - Deliverability – site in DDC/PCT ownership,
 - Good access from all deprived wards
 - Site purchase costs within public sector partnership
 - Accessibility – 56.2% of households within 30 minutes
 - Positive impact on regeneration
 - Adjacent to other health services
- Disadvantage:**
- Awaiting assurance re costs to mitigate any flood risk

Next Steps

- Views of HOSC – 5th September 2008
- PCT Board paper issued to Dover Community from 10th September
- PCT Board meeting in public 17th September 2008, The Ark, Dover
 - single topic debate 9.00 – 1030 am to make decision on preferred option
- EKHUT – will consider response to preferred option

Service Improvements – Work going on now

- Further improvement and investment in intermediate care
- Look at extending the MIU opening Hours
- Investigate “Hospice at Home”
- More outpatients in Buckland
Trauma, orthopaedic, diagnostics, ear, nose and throat, ophthalmology, gynaecology
- Introduce children's centre in the Dover area for pre school children
- More NHS Dentists

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By: Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 17 October 2008

Subject: Update on various health issues on which the Committee has expressed an interest

Classification: Unrestricted

Summary: To update Members of the Health Overview and Scrutiny Committee on a number of issues in which the Committee has previously shown interest.

Access to Healthcare (Transport)

1. (1) The Committee will recall that the Committee agreed and it was subsequently incorporated by the Policy Overview Co-ordinating Committee in the work programme for topic reviews that a piece of work should be undertaken by a Select Committee drawn from the Health Overview and Scrutiny Committee, as soon as resources were available, on Accessing Health Care (Transport Issues).

(2) This piece of work is now being picked up by Mr M Ayre, Policy Manager, who has been liaising with the Primary Care Trusts, transport operators and the Transport Section of the Environment and Regeneration Directorate on how best to deliver the piece of work based very much on the terms of reference and scope review which had been prepared by the Research Officer to the Health Overview and Scrutiny Committee.

(3) I understand from Mr Ayre that at a recent meeting between the Chief Executive of the County Council and the two PCTs in Kent, it was agreed to undertake some intensive joint work on health and transport issues of the kind which have featured quite prominently in discussions about both the Maidstone & Tunbridge Wells NHS Hospital Trust's service changes and work to identify the best location for the re-provision of services in Dover as the Buckland Hospital site and facilities have become unsustainable. The questions being tackled in this strategy development are:-

- are current and planned healthcare facilities in the best location with regard to their accessibility for those requiring access to them (i.e. patients, relatives/friends, staff)?
- how can existing transport infrastructure and facilities, planned/commissioned/provided by various agencies, be more effectively deployed?
- what are the examples of best practice we can import and replicate/adapt for Kent?

(4) This work will build on that already underway in East Kent. Partners are pooling resources to support a project approach – that is to say, task-and-finish.

(5) It is intended to report to the Health Overview and Scrutiny Committee as part of the quality-assurance of the project by Spring 2009.

Picture of Health in Outer South East London

2. (1) The Committee will recall that following the attendance of Graham Gibbens, Cabinet Member for Public Health and Paul Wickenden at a meeting of a joint Health Overview and Scrutiny Committee comprising the London Boroughs of Bromley, Bexley, Lambeth, Lewisham, Greenwich and Southwark the County Council's Health Overview and Scrutiny Committee was asked to join the Joint Committee. The Committee appointed Dr T R Robinson to serve on the Committee. Work has been ongoing over a period of time looking at the consultation for this part of South East London.

(2) At its meeting on 10 September 2008 the Joint Health Overview and Scrutiny Committee agreed to refer the reconfiguration proposals to the Secretary of State. Dr Robinson was unable to be present at this meeting and I was also unable to attend.

(3) The referral is on the basis of the following:

- (a) Concerns about the consultation and the lack of an Integrated Impact Assessment;
- (b) Inadequate information regarding the financial modelling;
- (c) The loss of services proposed for Queen Mary's Hospital, Sidcup, for example, Accident and Emergency and Maternity services;
- (d) Issues around travel and accessibility; and
- (e) The lack of and the integrated impact assessment on Southwark and Lambeth.

Recommendation

3. The Committee are asked to note the report.

Paul Wickenden
Overview, Scrutiny and Localism Manager
01622 694486
paul.wickenden@kent.gov.uk

Background Documents: Project brief on improving health access in Kent through transport (attached).

Other Useful Information: None

Project brief on improving health access in Kent through transport

Background statement:

Kent County Council, Kent PCTs & Trusts are launching a project to improve greater accessibility to health facilities in Kent via transportable means. This will cover all geographic areas and demographic groups.

Proposed Terms of Reference:

This piece of work will examine and make recommendations on the following questions:

- Whether the current and planned healthcare facilities in Kent are in the most accessible locations and offer adequate facilities:
 - A. With reference to the *DfT PSA Target 3; Local Transport Plan (LTP) - [Accessibility Strategy for Kent \(ASK\)](#); the [South East Plan: A Clear Vision for the South-East](#) and the [South East England Health Strategy](#) – sustainable transport options, particularly at the new Pembury Hospital;*
 - B. Accessible parking, for those who require it; and
 - C. That all elements are planned with the range of patients in mind.
- Specifically explore if existing transport services i.e. the role of NHS Patient Transport Services might be used to a greater extent to help overcome transport-related problems in accessing healthcare services – including the role of volunteer drivers in facilitating access to healthcare services;
- What examples of good practice are present locally and elsewhere in the UK and Europe, and how these can be replicated in Kent.

Kent County Council will assist the health trusts who have committed resources to develop integrated Travel Plans drawing on good practice present locally and elsewhere in the UK and Europe. The work already undertaken by the East Kent Integrated Transport Working Group (EKITWG) and the outcomes* provides a good starting point for further joint accessibility-planning involving KCC, the NHS, District councils, transport providers, the voluntary sector and other stakeholders.

The key outcomes of the East Kent Integrated Transport Working Group:

- Refresh of 3 'Getting to hospital' leaflets – 35,000 of each distributed to every:
 - GP surgery in EK;
 - Acute medical site;
 - Static and mobile library;
 - Manned railway station;
 - Parish and District council office, including the “Gateways” in Ashford and Thanet;

- Patient contact centre and Patient Advice and Liaison Service of EKHT for distribution with appointment letters;
 - Bus information offices;
 - County Member and the Leader of each of the District councils in East Kent
-
- Creation of a new website drawing together all of the strands of transport (www.eastkenthsgettingthere.nhs.uk)
 - Review of the existing “Health Hopper” service between the 3 EK hospitals, and planning for a new Health Shuttle
 - New out of hours service for patients discharged from A&E
 - Revised procedure for claims of Hospital Travel Costs Scheme
 - Review of transport guidance given by Patient Advice and Liaison Service
 - A fact-finding visit to Stevenage in Hertfordshire to review their health transport projects

Item 8 – Delayed Transfers of Care

As a result of examining the issue during this meeting, the Committee is asked to consider what recommendations to make.

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Briefing Note

Delayed Transfers of Care

Introduction

“Delayed transfers of care” is where a patient remains in hospital waiting to move into a different care environment after an appropriate and agreed upon date. It is quite a wide-ranging term and refers to when a patient moves from one type of NHS care to another (e.g. inpatient surgery to recuperative care); moves from NHS care to have services provided by social services; or moves from NHS services to privately-funded residential or nursing care.

The Community Care (Delayed Discharges etc.) Act 2003

The Community Care (Delayed Discharges etc.) Act 2003 was brought in by the Government in an attempt to deal with the issue of delayed transfers of care.

The first part of the Act sets out the duties of local authorities and the NHS in relation to people in hospital. It also allows for local authorities to be fined either £100 or £120 (depending on geographical location) by the NHS for each day of delay solely attributable to them. In practice, alternatives to paying the fines of this reimbursement regime have been developed.

The potential effects of this reimbursement regime were offset by the introduction of the delayed discharges grant. For each year of the scheme so far, £100 million has been moved from the NHS to local authorities to help them meet the costs of reimbursement or to assist local authorities in dealing with the issue of delayed discharges. The amount received by each authority is based on the older people’s Formula Spending Share. For Kent County Council in 2007/08, this grant totalled £2,477,136.

Kent County Council, in common with many other areas of the country, has come to an arrangement with the NHS locally to invest the delayed discharges grant in improving services and reducing delayed discharges.

The regulations implementing the Act specify that the reimbursements only apply to patients moving out of acute care. Acute care is defined as:

- “intensive medical treatment provided by or under the supervision of a consultant which is for a limited time after which the patient no longer benefits from that treatment.” (The Delayed Discharges (England) Regulations 2003. SI 2277 2003).

The power exists under the Act to extend the regulations to other areas like maternity, mental health, palliative, intermediate and recuperative care but is restricted to acute care at present.

The Delayed Transfer of Care Process

Each hospital has protocols for assessing the needs of patients and for planning the date of discharge. A date will be specified soon after admission, but kept under

constant review. NHS bodies are required by the Act to inform the appropriate local authority of individuals who are likely candidates to need community care upon leaving hospital. They must also give notification of the proposed discharge date. The local authority is allowed a minimum of two days to consult with NHS professionals and draw up a discharge plan determining which services will be provided. Sundays and public holidays are excluded from the minimum period.

In East Kent delayed transfers of care are the responsibility of the Unscheduled Care Action Group (UCAG), which has been in place since December 2005. Its membership is drawn from East Kent Hospitals University Trust, Eastern and Coastal Kent PCT and Kent Adult Social Services. Meetings are held across the week at each of the three acute hospital sites across East Kent, the first being a discussion forum and the second a validation meeting. Issues are then moved on to the weekly UCAG meeting. UCAG also oversees the reimbursement grant relating to delayed transfers of care from EKHUT. Three pilot schemes are underway at each of the main East Kent Hospitals University Trust sites to trial different ways of working.

In West Kent three Whole Systems Groups have recently been established. These are based around the three main acute hospital sites – Kent & Sussex, Maidstone and Darent Valley. Each Whole System Group is responsible for looking at and resolving local transfer of care issues. If an issue cannot be resolved, it goes up to the Urgent Care Board (which is the equivalent of the East Kent Unscheduled Care Action Group). These Groups similarly include representatives from the hospital, social services and PCT. On 1 July 2008, a discharge planning pilot commenced at MTW with the aim of improving the process.

At these meetings, a situation report (usually referred to as a “sitrep”) is completed. Sitreps are required by Government and go on to form part of Unify 2 (the Department of Health’s web-based data collection system). As part of the sitrep, one of the following reasons is assigned for any delays to discharge:

- A) Completion of assessment
- B) Public funding
- C) Further non acute NHS care
- Di) Residential Home
- Dii) Nursing Home
- E) Domiciliary Care Package
- F) Community Equipment
- G) Patient or family choice
- H) Disputes
- I) Housing

A note is also made (where applicable) as to whether the delay is attributable to the NHS or social services singly, or both, jointly.

National Performance Indicators

There is a performance indicator related to transfer of care that forms part of the annual performance assessment of social care services carried out by the Commission for Social Care Inspection and the Annual Health Check of Acute and Primary Care Trusts by The Healthcare Commission. These indicators relate specifically to patients moving from acute care.

The delayed transfer of care indicator for the Annual Health Check sets a target of no more than 3.5% of patients in acute beds having a delayed transfer of care for any reason. The figure is derived from dividing the number of patients who occupied an acute hospital bed and had his or her transfer delayed and the total number of patients who occupied an acute hospital bed over the same period.

Latest figures (drawn from relevant Trust Board Papers):

Trust	August 2008	Year to date (i.e. from 1 April 2008)
Dartford and Gravesham NHS Trust	2.8%	3.0%
East Kent Hospital University NHS Trust	3.4%	3.4%
Maidstone and Tunbridge Wells NHS Trust	2.9%	3.1%

This is an improvement on the figures for the Annual Health Check for 2006/07, where only Dartford and Gravesham Hospitals Trust were rated as having “Achieved” this target of 3.5%. All the other Trusts in Kent “Under achieved” meaning a percentage of less than or equal to 5%, but greater than 3.5%.

The Annual Health Check for 2007/08 will be released on 16 October 2008. However, the Healthcare Commission has confirmed that for technical reasons there will be no scored rating for this indicator for 2007/08. An assessment using a different method will be produced separately.

The same data which is used for the Annual Health Check (drawn from the sitrep reports on Unify 2) are also used by the CSCI as part of their annual performance assessment of social care services. Again, the most recent report relates to 2006/07.

Overall, Kent adult social services were given 3 stars (the highest). They were rated “Good” for “Delivering outcomes” and “Excellent” for “Capacity for improvement”. The portion of the summary report most relevant to this issue is as follows:

- “A variety of intermediate care services have been expanded this year, which has supported social care to keep delayed discharges from hospital at a reasonable level. However, delayed discharges from hospital due to health needs are still very high and evidence is available is to explain the position.”

Intermediate Care

The aim of intermediate care is to provide short-term rehabilitation services to avoid unnecessary admission (or readmission) to hospital or facilitate timely discharges enabling a person to return and live independently in their own home. In some cases an individual may require additional assistance from social services.

The second part of The Community Care (Delayed Discharges etc.) Act 2003 relates to intermediate care. It states that intermediate care must be provided free of charge for six weeks, wherever it is provided. It is here that the role of community hospitals is discussed, as they are sometimes used for the purposes of rehabilitation.

Items of community care equipment up to the value of £1000 which a person is assessed as needing to return home must also be provided for free (this includes such things as shower chairs, walking sticks etc.)

The services provided and the organisation responsible depends on the individual needs assessment of the patient.

A Whole Systems Approach

Tackling the issue of delayed transfers of care is often referred to as requiring a 'whole systems approach', meaning any solution will involve more than one organisation. There are many different ways to reducing the numbers who are delayed. In a broad sense, these include:

- Preventative measures – broader public health initiatives and changes to the way health care is delivered to reduce the total numbers of people that enter hospital/need acute care.
- Process – looking at works to improve the way in which patients are assessed and how different bodies work together.
- Capacity – looking at whether the resources and infrastructure exist in the NHS, social services and elsewhere to deal with the needs of people as they leave acute care.

Appendix: Responses from Kent MPs

As part of the background research for this topic, all the MPs in Kent were written to and informed that the issue of delayed transfers of care was being examined. They were also invited to submit any information they had about the number of complaints received from constituents relating to this issue.

Six MPs submitted information on time periods ranging from several months to a year. Only two reported receiving any complaints about delayed transfers of care and they were all related to Medway, as distinct from Kent.

Tristan Godfrey
HOSC Researcher

From: Greg Clark, M.P.



HOUSE OF COMMONS

LONDON SW1A 0AA

17 July 2008

Paul Carter
Leader
Kent County Council
Sessions House
County Hall
Maidstone
Kent ME14 1XQ

Don Paul

Delayed Discharges from Hospital

Over the last year, in meetings with MTW NHS Trust, West Kent PCT, the Strategic Health Authority and, most recently, Kevin Lynes and Oliver Mills from KCC, Sir John Stanley and I have been investigating delayed discharges from local hospitals. This work was prompted by constituent concerns and hospital visits which demonstrated the very difficult situation being faced by clinicians, particularly in A&E, when hospital beds were being used to capacity.

While we appreciate the progress that is being made, particularly by KCC, in addressing this problem, we believe that it would be exceptionally helpful if KCC's Health Overview and Scrutiny Committee were to examine the issue in greater detail. Both Sir John and I would wish to give evidence to the Committee and I would encourage other Kent MPs also to consider this.

Delayed discharges continue to be a significant issue locally and I am convinced a Scrutiny investigation could have a considerable impact in helping to resolve the problem.

Yours sincerely,

Greg
Greg Clark MP

cc Lord Bruce-Lockhart of the Weald
Kevin Lynes, Cabinet Member
Oliver Mills, Strategic Director
Rt Hon Sir John Stanley MP

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DELAYED TRANSFERS OF CARE

Briefing

Health Overview and Scrutiny Committee

17th October 2008

FOR FURTHER INFORMATION PLEASE CONTACT:-

Simon Perks
Deputy Director of Commissioning
Eastern & Coastal Kent PCT
01227 795074

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1. DELAYED TRANSFER OF CARE

1.1 The term “delayed transfer of care” is used to describe a situation that occurs when an individual is ready to transfer from an acute care setting but continues to occupy an acute bed. An individual is ready to transfer when:

- A clinical decision has been made that an individual (described in the acute setting as a patient) is ready to transfer, and
- A multidisciplinary team decision has been made that a patient is ready to transfer, and
- The patient is safe to discharge/transfer.

1.2 Delays sometimes occur for some people once these three criteria have been satisfied. The reasons for the delays are numerous and complex, but may be summarised as:

- Inadequate and/or untimely assessment and planning for transfer
- Ineffective whole system working to enable timely transfer
- Insufficient placements of the right type for onward transfer from acute settings
- Innate expectations of patients and their carers, and
- Inadequate agreement about funding for ongoing care

1.3 Delayed transfers of care are a complex area of activity, given the critical need for health and social services to work very closely together, to ensure the right outcome for the patient, and their carer, where relevant. It can often mean that life-changing decisions have to be taken if people are to be transferred to residential or nursing care.

2. MEASURING DELAYED TRANSFER OF CARE

2.1 The Healthcare Commission sets a standard about delayed transfers of care. The standard includes the requirement that people should receive the right care in the right place at the right time. NHS commissioning organisations, with acute trusts and their community and social service partners must ensure that people move on once they are well enough.

2.2 The Healthcare Commission delayed transfer of care indicator measures the impact of community based care in facilitating timely discharge from hospital, together with the quality of service received in hospital and the mechanisms in place within the hospital to facilitate timely discharge. People should receive the right care in the right place at the right time and PCTs must ensure, with acute trusts and social service partners that people move on from the acute environment once they are safe to transfer.

2.3 The Community Care (Delayed Discharges, etc) Act 2003 facilitates joint working with social services and requires partners to identify the causes delay and the actions required to tackle delays within the local system but also to a safe environment, whether that is in their own home or another setting.

2.4 NHS Eastern and Coastal Kent (“the PCT”), working with Kent Adult Social Services and its major providers of health services, maintained delays in the

transfer of patients within limits set by the Healthcare Commission during 2006/07. Despite this, the placement within national rankings was poor (Eastern Coastal Kent ranking 140 out of 152).

During 2007/8, performance improved and as a result of renewed focus over the past year, with the introduction of new ways of working including a pilot of assessment beds, the percentage of delays reduced from 4.8% to 3.6% (as at August 2008). Nevertheless, intensive and sustained effort is required to bring the number of delays within acceptable limits (the aim is <3% for the year 2008-09) and ultimately to achieve the goal of zero tolerance of delays.

3. ENABLING SAFE TRANSFERS OF CARE

3.1 Delays in transfer for people ready to leave an acute setting may result in loss of independence, mobility, motivation and wellbeing and pose a risk of healthcare acquired infection. Delays also deprive others in need of acute intervention of the treatment they need. For these reasons it is important that people do transfer from an acute setting as soon as they are able to do so.

3.2 NHS Eastern and Coastal Kent (the PCT) invested an additional £1m with KASS in 2007-08 to facilitate effective transfers of care from acute health care settings. The PCT has also established a Group to oversee the governance of safe transfers of care as these affect the population of eastern and coastal Kent. The Group has a full membership from health and social care partners and has made three reports to the NHS Eastern and Coastal Kent Patient Safety and Quality Sub Committee since June 2008. These reports have been able to draw on the significant learning emerging from existing work in progress through the KCC/NHS Urgent Care Programme. This work, described in the Urgent Care Programme Assessment Beds Pilot Final Evaluation Report suggests further key enablers to minimise delays that are:

- The need for full understanding and engagement of individuals and their families and carers in the transfer process.
- The importance of having a single, agreed pathway and process for transferring patients from one setting to another – currently a number of inherited arrangements are in place, and these are being reviewed by the Group.
- The importance of having a shared understanding of the roles and responsibilities of each agency involved in providing care to each person being transferred.
- The importance of effective, multidisciplinary teamwork. Three pilot schemes have been established at each of the East Kent Hospitals University Trust sites to test best ways of working. The learning will be shared with partners including Medway Foundation Trust.
- The need for in depth assessment of each individual's capability and potential for rehabilitation once the need for an acute stay in hospital is past but when immediate return home is not yet possible, (see next section).
- The essential requirement for sufficient numbers of effective support packages for those who need continuing care in their own homes or in a care home setting.

- The importance of having sufficient numbers of effectively trained staff for those requiring continuing care once they leave hospital.
- 3.3 The Patient Safety and Quality Sub Committee will oversee the work programme embarked upon by the Transfer of Care Governance Group that will take account of these enablers.

4. ASSESSMENT BED PILOTS

- 4.1 Some people are not ready to return home when they are ready to leave the acute setting and need an opportunity for:

- More intensive rehabilitation to enable their going home
- More detailed assessment of their needs
- Arrangement of a care package and equipment to enable their transfer home
- Time to take a decision about a different place of long term care.

The provision of assessment beds, both within community hospitals and registered care centres run by Kent Adult Social Services, has been tested in a pilot scheme, and the successful result is informing future commissioning decisions about expanding the availability of assessment bed availability for the whole population of eastern and coastal Kent.

5. FUNDING

- 5.1 Funding arrangements are frequently cited as reasons for delayed transfers of care. A small number of people with complex health needs and those who are nearing the end of life may be eligible for NHS funded continuing health care. Others may be eligible for combined funding from both the NHS and social services, whilst others will fund their own care. NHS Eastern and Coastal Kent (the PCT) is committed to arrangements for funding to be agreed “away from the bedside” and should not delay transfer of individuals. The opportunity presented for expanding the direct payments scheme implemented through the “Kent Card” to health care as a result of forthcoming legislation resulting from the *NHS Next Stage Review (July 2008)* will be explored by the PCT and KASS working together.

6. CONCLUSION

- 6.1 In conclusion the PCT has an aim that is to work with all partners to eliminate all possible delays in transfer from acute care settings for individuals who are assessed as clinically fit to transfer and where it is safe for them to do so. The need is to ensure we build on existing arrangements and innovations, good will and hard work to ensure we have the best possible arrangements in place.
- 6.2 The outcome we seek is a fully integrated system with a single and agreed approach to assessment, care delivery, information management and record keeping; with sufficient capacity in the immediate, short, and longer term. There is a need to concentrate on excellent communication and information and to consolidating professional trust, to ensure effective joint working between health and social services.

- 6.3 People with complex needs, who are most likely to pose difficulty with transfer/discharge should be actively identified prior to admission wherever possible. People at high risk should have a case manager/community matron. Most people who pose challenges about transfer/discharge are well known in the “system” and anticipatory care needs assessment and care planning is a critical “step development” needed. Where this has not happened and the need for such a complex assessment becomes apparent while an individual is in the acute hospital, and especially where a decision is needed about a move to a care home, the individual should be able to transfer to an assessment bed to allow the appropriate arrangements to be set in place in a timely and sensitive manner.
- 6.4 Effective planning (and not fire fighting) is essential, with attention to the small changes that can make a difference. Once declared fit to leave an acute environment individuals should not be “lying in wait” for assessment; public funding for ongoing care; further but different NHS care; residential care; ongoing nursing care; community equipment; domiciliary care; awaiting the exercise of choice or disputes. All this should be undertaken (if not anticipated and in place ahead of time) in the assessment bed facility to a predetermined timescale.

Full details of the pilot scheme for assessment beds are available on request from:-

Anne Tidmarsh anne.tidmarsh@kent.gov.uk

Or

Sue Baldwin sue.baldwin@eastcoastkent.nhs.uk

For further information please contact the lead commissioner:-

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7 October 2008

Briefing Report to Health Overview & Scrutiny Committee

Delayed Transfers of Care

17th October 2008

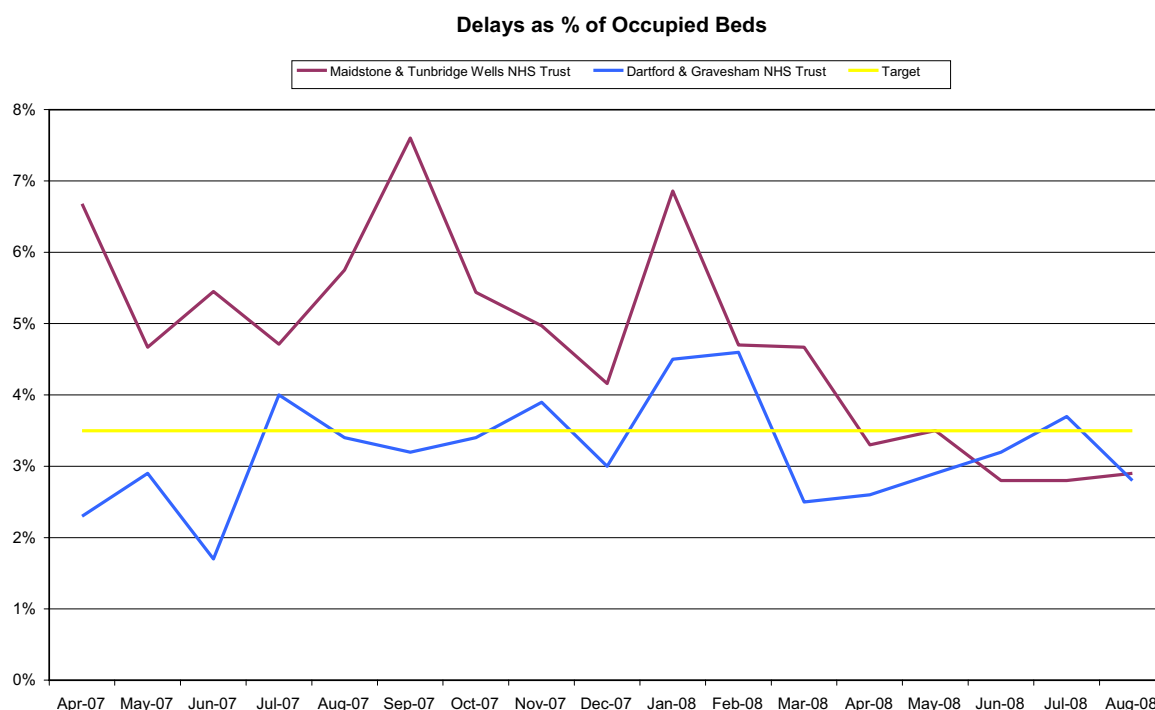
The reduction of delayed transfer of care remains an area of priority concern across the whole health & social care economy.

a) Latest Performance Data

The latest position is of an improving picture, with fewer people in West Kent experiencing a delayed transfer of care when leaving hospital. Both Acute Trusts are reporting delays below 3.5%. Performance for August 2008 was:

Dartford & Gravesham NHS Trust: 2.8% (year to date 3.0%)
 Maidstone & Tunbridge Wells NHS Trust: 2.9% (year to date 3.1%)

This is a significant improvement on last year's performance which reached above 5.5% for Maidstone & Tunbridge Wells NHS Trust and over 3% for Dartford & Gravesham NHS Trust.



The graphs at the end of this document provide a snap shot of the reasons for delays to transfer during the 13-week period 23rd June to 21st September 2008, as reported in the weekly SITREP reports. The data reported includes all delays for West Kent patients only attributed to NHS and social care as reported by Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust and West Kent Primary Care Trust for both acute and non-acute care. In each care type, the data is

displayed in two graphs, firstly by no. of patients, and secondly by no of days. Reimbursable delays which are the delays which are attributable to social services reasons, in Maidstone & Tunbridge Wells Trust remain negligible, with most delays attributable to NHS related issues (continuing health/residential care placements and patient choice).

b) Partnership Working

Local health and social care partners in West Kent continue to work collaboratively to bring about a sustained improvement in delayed transfers of care and to improve further the experience of patients leaving hospital.

At operational level, Whole Systems Groups now meet regularly in the three localities, to discuss and resolve local transfer of care issues. Chaired by PCT locality managers, the Groups consist of representatives from social services, ambulance service, mental health service, private and voluntary sector providers.

Over the past year there have been a number of developments in West Kent aimed at improving collaborative working 'on the front line' in assessing, planning and arranging a patient's transfer of care. These include:

Discharge Planning Pilot: This collaborative project involving the PCT, Maidstone & Tunbridge Wells NHS Trust and Kent Adult Social Services, involved piloting changes to the discharge planning process as recommended by staff, including those on the frontline, from all three organisations who attended a rapid improvement workshop held earlier in the year.

Its aim was to achieve a more co-ordinated/whole-systems approach to managing a patient's discharge, by providing clear dates and key actions for the multi-disciplinary teams to work towards.

The pilot ran during July and August 2008, and involved PCT community teams, KASS care management and MTW teams at both Maidstone Hospital and Kent & Sussex Hospital, across four medical wards, the Acute Assessment Unit and Medical Assessment Unit. The four key proposals being tested were as followed:

- **Patient Streaming** – early categorisation of anticipated length of stay, with patients being categorised as 'red' (complex) or 'green' (simple). All patients admitted through the MAU/AAU during the pilot period were streamed.
- **Robust estimated date of discharge (EDD) process** – based on 'streaming, which would be updated during the patient's episode of care.
- **Consistent multi-disciplinary team (MDT) assessment** – held weekly at ward level to agree discharge plans for complex patients.
- **Efficient transfer of care process** – community services involved earlier, awareness of potential patient end point from an early stage.

An analysis of the pilot has indicated that there is more to do to ensure that new processes are embedded into practice and undertaken in a systematic way. KASS and PCT teams at both sites committed fully to the pilots and attended every MDT

and participated fully in the discharge planning process. The pilot has shown that a multi-agency approach, with strong leadership at ward level, is essential to provide focus and direction when planning a patient's discharge.

Weekly SITREP Meetings: PCT managers now attend the meetings between the acute Trust and Social Services, at each of the acute hospitals to resolve transfer issues for individual patients.

Hospital Care Management Teams: All hospitals have a dedicated Hospital Social Services Team, whose role it is to facilitate discharges through working in partnership with ward and primary care staff. In addition to all the usual services provided by the Local Authority, these teams can access a range of step-down beds provided in nursing homes to assist with discharges, these beds are funded via reimbursement money. Each Hospital Social Services Team has a £52,000 annual fund to be used at the Team Manager discretion to aid specifically with managing hospital avoidance and timely discharge. This can be used to purchase services or placements to assist with timely discharges from acute beds.

Joint Agreement on non-weight-bearing patients: It has been identified that a small number of patients have remained in hospital longer than necessary. Because they are non weight-bearing, usually in plaster, they do not meet the criteria for rehabilitation or intermediate care in a community hospital, nor can they transfer to a residential home. West Kent PCT, Kent CC and Maidstone and Tunbridge Wells NHS Trust have jointly agreed to commission 3 nursing home placements in the Maidstone and Tunbridge Wells areas, for such patients until they are able to weight-bear. Therapy input and case management will be provided by WKPCT Rapid Response Team who will manage the patient's transfer to appropriate care, once fit to do so.

Reimbursement: The Department of Health provides Kent Adult Social Services with funds to help facilitate hospital discharge. In West Kent the total amount is £1.2m. In the MTW area £166,000 is used to purchase six nursing home beds which are solely for the use of Rapid Response Teams. The reimbursement money is used to fund a variety of schemes, all identified as crucial to effective discharge planning. Some of the money has been used to support additional WK PCT nursing and therapist posts. All schemes or posts funded through reimbursement have been commissioned in partnership with the NHS and have been evaluated to ensure that they are contributing to either admission avoidance or timely discharge.

c) Costs associated with delayed transfers of care

It is difficult to provide a single figure to represent the cost of a delayed transfer. It is dependent on several factors. Under 'Payment by Results' arrangements, hospitals receive a sum of money from the PCT for each activity/procedure they carry out. The price or "tariff" is set nationally and varies according to the type of procedure/speciality or Healthcare Resource Group (HRG). Any admission may incur 'excess bed days'. These occur as a result of overstepping a trim point as defined in the National Tariff. There are different trim points associated with different types of treatment e.g. the trim point for a Primary Hip Replacement is 23 days. If a patient were to stay in hospital for 30 days say, this would equate to 7 excess bed days, valued at a unit cost. The unit cost also depends on the type of treatment. An average cost is around £200 per day.

If a patient was discharged before the trim point and received rehab or care from NHS community services, it could therefore be viewed as incurring additional costs to the PCT. The Acute Trust would be able to generate additional income by using that bed for another patient and assist in meeting the 18-week target for referral to treat. However it should be noted that not all delayed discharges will be treated as an excess bed day if they are discharged before the trim point.

d) Services provided for people leaving hospital

A range of services are provided to support people leaving hospital, including:

Community Hospitals: The PCT has increased the available community bed numbers to 132 and has altered its criteria for the use of these beds in order to ensure that this limited resource is used most effectively. They now provide inpatient care for those people needing either a step-up bed to avoid an un-required acute hospital admission or a step-down bed for patient requiring rehabilitation. This step up/step down model has allowed a greater throughput of people who can benefit from intensive therapeutic input. The average length of stay has been reduced from 24.9 days 18 months ago, to less than 18.0 days this year.

Nursing & Residential Care: Increasingly, the PCT have been using local nursing homes to place people who meet the criteria for NHS funded continuing care. Using a community hospital bed for such people would be inappropriate because they would not benefit from the intensive therapeutic input available there, but instead require an environment where they can receive more intensive long term support or end of life care.

Recuperative Care provided by Kent Adult Social Services: The is services provides up to 6 weeks rehabilitation therapies for people over the age of 55, provided in a residential setting. The aim of Recuperative Care is to provide a short period of intensive rehabilitation which will help people to regain the skills and confidence needed to return to living as independently as possible in the community. Provision is located in Dartford, Gravesend and Maidstone but accessible from people reside throughout West Kent.

Intermediate Care Teams including:

Community Liaison Teams appointed by West Kent PCT to provide support, advice and liaison between acute, intermediate, primary health and social care providers, including private sector care homes. Already established in the Dartford & Gravesham area, the PCT is in the process of recruiting further nurses in order to roll out this model to the rest of West Kent. The Teams work both in A&E to prevent unnecessary admission to hospital by identifying patients who could be managed in the community, and also as part of ward-level multi-disciplinary teams (including therapists, discharge nurses and medical staff) to facilitate timely discharge to community services)

Rapid Response Teams: which now provide a 24/7 service, including rehabilitation after hospital admission following surgery or falls. The focus is on promoting independence, risk reduction and promoting a healthier lifestyle.

Other Community Health and Social Care Supporting People Leaving Hospital

Community Nursing Service uses an individualised holistic approach to health assessments, identifying nursing needs and delivering a high standard of care to promote health and well being. Nursing services are also available during twilight/evening/night hours where required.

Community Matrons and Case Managers proactively respond to the needs of patients with complex needs, managing and supporting patients with long term conditions to enable independence and an improved quality of life.

Community Neuro/Rehab/Therapy Teams

Sapphire Wing Inpatient Neurological Rehabilitation Service (12 beds) is a nurse-led multidisciplinary service for adults who are medically stable but require inpatient rehabilitation of a neurological event. It works closely with the Community Neurological Rehab Team, Dartford and Gravesham NHS Trust, GP practices and other community health and social services. Medical advice is covered by a Consultant in Rehabilitation Medicine and dedicated GPs.

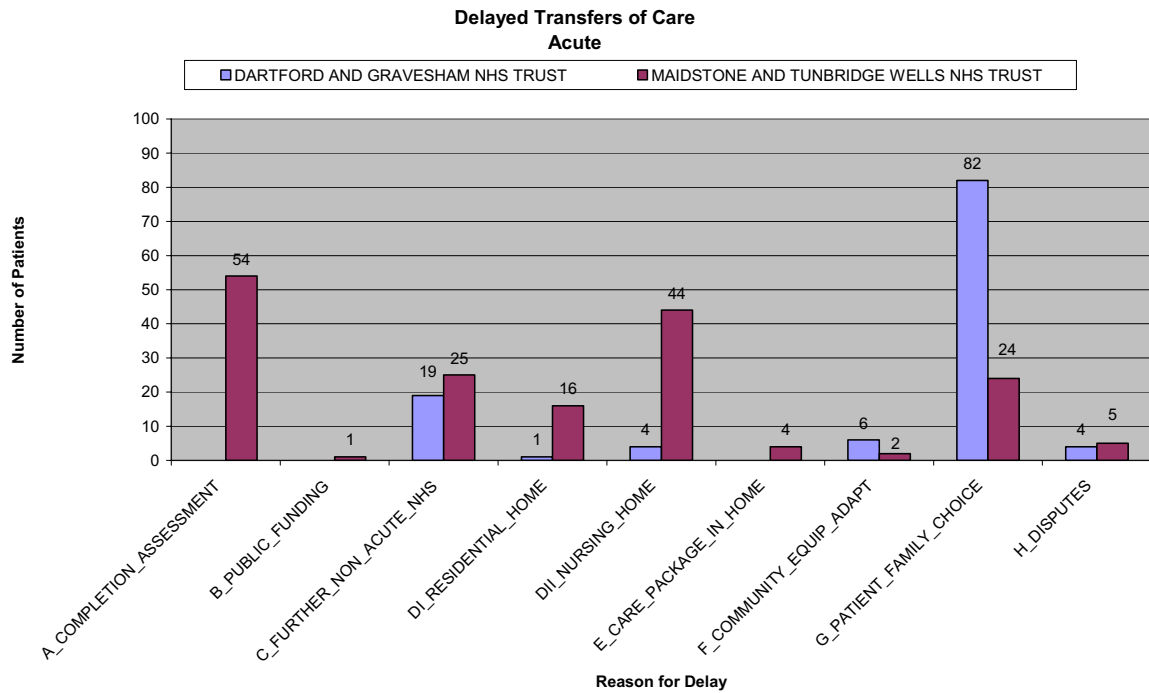
Specialist Nurses (including continence, tissue viability, heart failure, COPD) working with patients with specific conditions to enhance quality of life and to reduce hospital admissions.

Advanced Musculoskeletal Practitioner Service providing an interface between primary and secondary care for patients with musculoskeletal problems requiring physiotherapy extended scope practitioners.

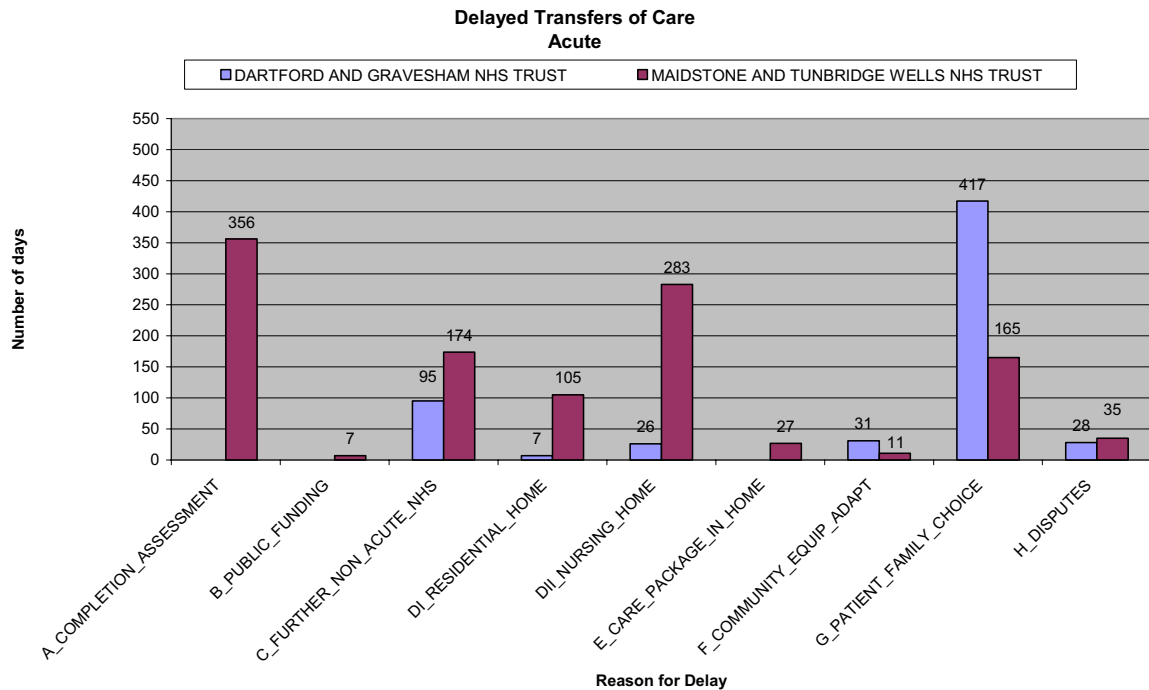
Integrated Community Equipment Service (jointly with Social Services) to enable people to be nursed or remain independent at home.

Active Care – community based service provided by Kent Adult Social Services: This is a short-term service of up to six weeks to enable people in their own homes to improve / maintain their daily living skills following a stay in hospital or some other change in circumstance. Referrals to Active Care will be via a Care Manager. A Home Care Supervisor will work with the individual to draw up their support plan and a team of recuperative domiciliary carers will visit to assist on a daily basis.

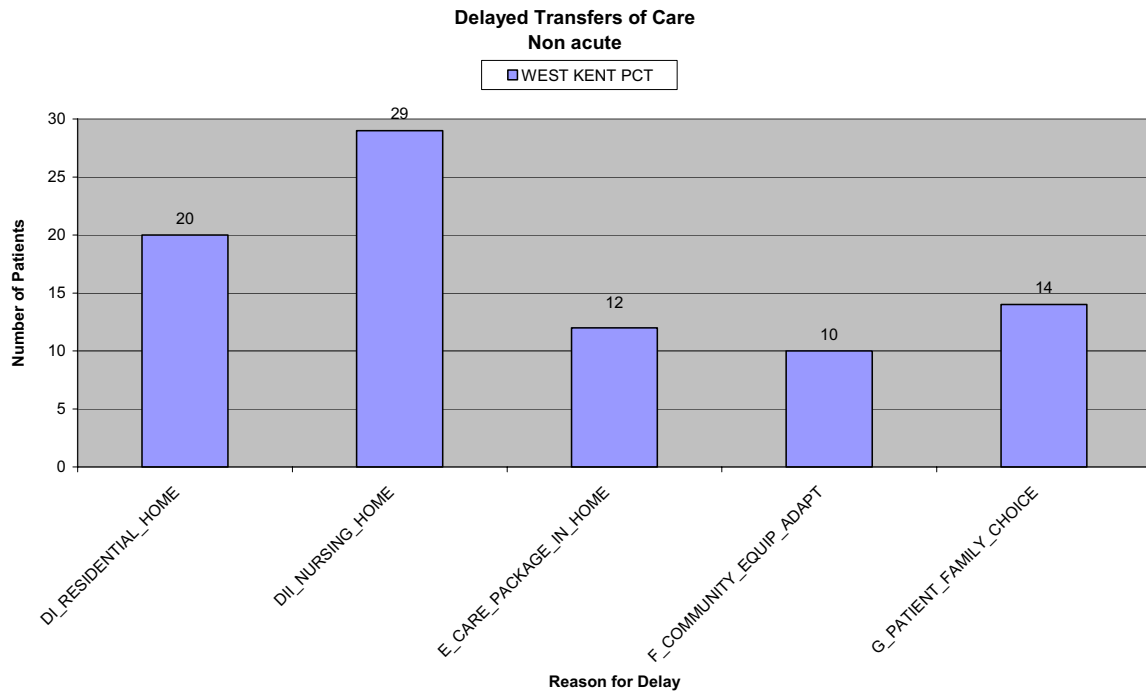
Telecare/Telehealth In partnership with Kent County Council and NHS Eastern & Coastal Kent, NHS West Kent is a national demonstration site for the use of technology in supporting people to keep well at home. The aim of the programme is to provide robust evidence base for the benefits of telehealth and telecare as an integrated element of health and social care services. Within the programme, existing work is being built upon to establish a Single Assessment Process and to pilot IT systems that enable information sharing across health and social care.



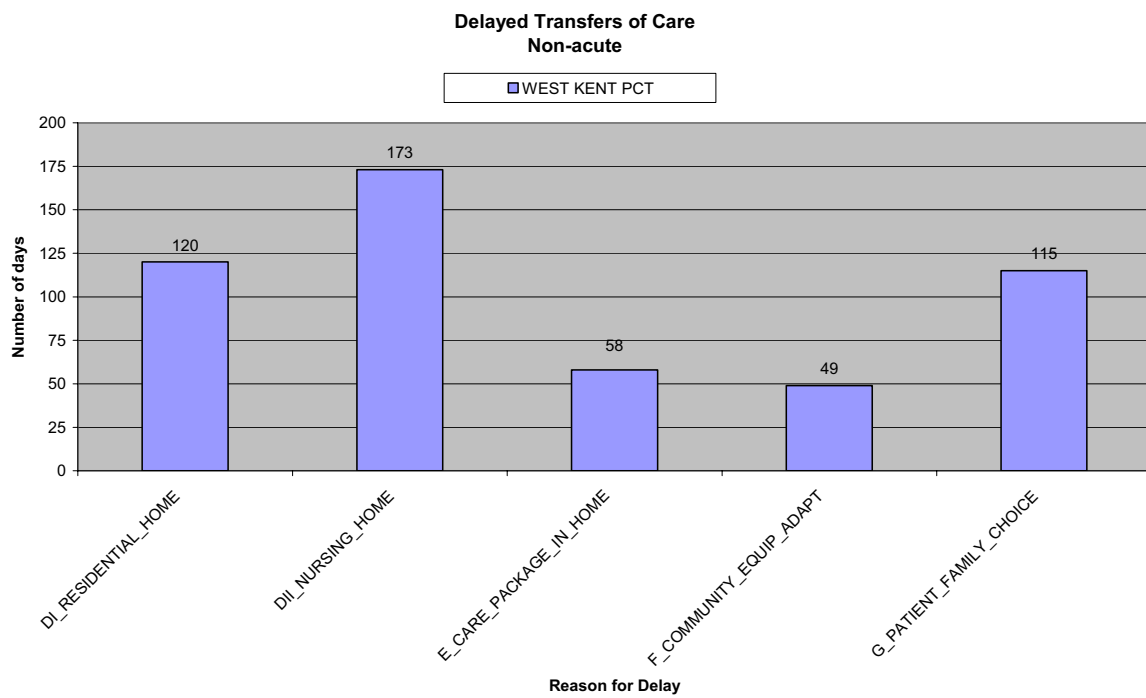
NB This chart relates to West Kent registered patients only. There were an additional 27 patients from outside West Kent who experienced a delayed transfer during this period at Dartford & Gravesham, and 48 at Maidstone & Tunbridge Wells.



NB This chart relates to West Kent registered patients. There was an additional 172 delayed bed days relating to patients from outside West Kent during this period at Dartford & Gravesham, and 219 at Maidstone & Tunbridge Wells.



NB This chart relates to West Kent registered patients.



NB This chart relates to West Kent registered patients.

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PALS Report to Kent County Council

Issues Relating to Delayed Discharges through PALS Oct 07 – Sept 08

Maidstone & Tunbridge Wells NHS Trust's Patient Advice and Liaison Service (PALS) was asked to provide a report to the KCC's Health Overview and Scrutiny Committee regarding concerns about delayed discharges. The KCC explained this was as they were keen to understand the inter-relationship between the Acute Trust, Adult Social Care and the PCT.

PALS looked at all the contacts they had regarding the discharge of patients.

It is noted that PALS also deals with advice, help and information, so not all matters raised related to concerns.

It is also recognised by PALS, that the service has a good relationship with Social Services. When cases are raised as a concern by relatives to PALS about such matters as care packages, Social Services respond quickly to the client or relatives.

Of approximately 3200 contacts to PALS, only 44 related to discharge arrangements.

	Kent & Sussex	Maidstone	Total
Advice	0	4	4
Comment or Suggestion	0	1	1
Help or Support	4	9	13
Complaint Informal	5	19	24
Complaint Formal	0	2	2
Totals	9	35	44

Of the 44 cases, 17 were requests for help or advice e.g. how does one obtain a care package for relative? etc.

The following demonstrates the reasons for the informal complaints:-

Concerns about Care Package and Support	8
Delayed investigations	1
Family does not feel patient is well enough for discharge	4
Delay with move to other hospital	1
Readmission within one month	5
Relatives not informed of discharge	1
Miscellaneous	2
Delayed release of drugs for patient to take away	2

It is noted that PALS figures for delayed transfer relates to what the patient or relative advises PALS in the first instance.

PALS also looked at overall figures of delayed discharges for the Trust for 2008. The Trust has been working on ways to reduce these figures, and this is demonstrated in the following:

Delayed Transfers of Care in Trust (occurrences)

	2008							
	January	February	March	April	May	June	July	August
Kent & Sussex	137	61	52	47	38	29	48	48
Maidstone	68	52	57	36	72	43	38	22
Trust Total	205	113	109	83	110	72	86	70

Delayed Transfers of Care is the number of patients occupying an acute hospital bed whose transfer of care was delayed as at midnight every Thursday, summed across all 52 weeks for the financial year.

Department of Health guidance says delayed transfers of care should be 'kept to a minimum'.

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Maidstone & Tunbridge Wells NHS Trust
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