HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 14th May, 2010

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 14th May, 2010, 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

Conservative (10):	Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr K A Ferrin, MBE, Mr J A Kite, Mr R L H Long, TD, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Cllr Mrs A Blackmore, Cllr C Kirby, Cllr M Lyons, and Cllr Mrs M Peters
LINk Representatives (2):	Mr M J Fittock and Mr R Kendall

UNRESTRICTED ITEMS

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

Item		Timings
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes (Pages 1 - 6)	
4.	The Future of PCT Provider Services and the Use of Community Hospitals (Pages 7 - 54)	10:10 – 12:25

This item will be examined in two sections as follows:-

a) The Future of PCT Provider Services 10:10 – 11.15

BREAK

b) The Use of Community Hospitals 11:25 – 12:25

5. CQC Registration Update (Pages 55 - 70) 12:25 – 12:30

6. Forward Work Programme (Pages 71 - 76) 12:30 – 12:40

7. Committee Topic Discussion (Pages 77 - 78) 12:40 – 12:50

8. Date of next programmed meeting – Friday 11 June 2010 @ 10:00 am

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

6 May 2010

Please note that any background documents referred to in the accompanying papers maybe 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, 26 March 2010.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr C P Smith, Mr R Tolputt, Mrs J Whittle, Mr A Willicombe, Cllr Ms A Blackmore, Cllr R Davison (Substitute for Cllr Mrs M Peters), Cllr M Lyons, Mr R Kendall and Mr M J Fittock

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

UNRESTRICTED ITEMS

3. Minutes of the meetings held on 5 February and 19 February 2010
(Item 3)

RESOLVED that the Minutes of the meetings are correctly recorded subject to the amendment of the typographical errors contained within the Minutes referred to by the Overview, Scrutiny and Localism Manager and the signed set of Minutes by the Chairman reflect these changes as a correct record.

4. Dentistry
(Item 4)

Ms Maureen Hall (Dental Contracts Manager, NHS West Kent), Dr Tim Hogan (Chairman, Kent Local Dental Committee), Mr Stephen Ingram (Director of Primary Care, NHS West Kent), Mr David Meikle (Acting Chief Executive, NHS Eastern and Coastal Kent), Mr Bill Millar (Head of Primary, Community and Elective Care, NHS Eastern and Coastal Kent), Dr Allan Pau (Dental Public Health Registrar), Ms Paula Smith (Lead Commissioner for Max Fax, Orthodontics & Dental, NHS Eastern and Coastal Kent), were present for this item.

(1) One of the recurring themes in discussions on the work programme for the Health Overview and Scrutiny Committee was the issue of Dentistry.

(2) The focus of the Committee's attention was to ask the following:-

Public Question

How can I access NHS dentistry and be certain I will receive quality treatment?

Scrutiny Questions

a) Are the Primary Care Trusts commissioning sufficient dental provision to meet the needs of the resident populations?

b) Is the care being provided of an appropriate quality?

c) What can be done to improve dental service provision in Kent?

(3) The Committee had before them a briefing paper prepared by the Research Officer to the Committee, supplementary briefing material provided by the Primary Care Trusts in West Kent and Eastern & Coastal Kent and a report from the Local Involvement Network (LINk).

(4) The Chairman invited Dr Pau to inform the Committee of the services that are provided by dentists.

(5) Dr Pau responded that the services that dentistry now provides including prevention of gum and tooth disease. He spoke primarily about the prevention services.

(6) The Committee noted the allocation of monies to the Primary Care Trusts for provision of dentistry and in particular the current underspend that was occurring in NHS West Kent which was due to slippage on the new procurement of dentists.

(7) Of particular concern to a number of Members of the Committee was dentistry provision for children, i.e. NHS dentists that were not taking on children.

(8) The LINk work had identified a range of issues including the disappearance of the routine six monthly checkups, the high price of dental care deterring people from going to the dentist, out of hours care, the inability to obtain lists of NHS dentists and poor dental care of those with other medical needs, such as those who are pregnant and those with cardiac problems.

(9) In response Mr Meikle said that it was a mixed economy, it was incumbent upon the Primary Care Trust to understand the difference between general medical services with a registration based service and dentistry which has moved towards a needs assessment system. It was important to identify needs and to identify the dentist activity.

(10) Dr Pau informed the Committee that they were not allowed not to take on children.

(11) The Committee noted the emergency services which were provided across the authority and across the county with the out of hours services provided by Dentaline in Medway. For out of hours services in Eastern & Coastal Kent these were provided at the Queen Elizabeth the Queen Mother (QEQM) and Kent & Canterbury Hospitals.

(12) Councillor Blackmore was concerned at the statistics relating to the number of children who did not have a dentist and what proportion of the population that was who were not being seen either by private or NHS dental provision. In addition the Chairman asked how screening of school children was now undertaken since it had ceased in schools.

(13) Dr Pau responded that 85% of children do not have any sign of decay and 75-80% have a dentist. However, he did say that there were a sizeable proportion of children who do not go to the dentist.

(14) The key was the preventative community programme. He added that evidence undertaken in Manchester that screening for the prevention of disease in dentistry does not promote greater attendance at dentists. He added that there was no statutory requirement to screen children.

(15) Mrs Blackmore was also keen to understand how imaginative and innovative the Primary Care Trusts were in reaching groups of the population who were hard to engage. She referred specifically to the target set out in the papers received from NHS Eastern & Coastal Kent and asked what the position was for NHS West Kent. Mr Daley added that it was not clear from the papers where the money set aside for dentistry was and how it was spent.

(16) Mr Meikle responded on behalf of the Eastern & Coastal Kent Primary Care Trust indicating that the target they set within the financial resources they had available to achieve the maximum leverage. He explained how the Trust monitored dental activity.

(17) NHS West Kent colleagues responded that they will show an underspend. This was due to slippage and delay on the negotiation of a new contract. Various questions were raised by Members of the Committee relating to the contract for dentistry.

(18) The Committee were informed that there was a national programme of new contracts for dentistry. What the PCTs needed to be mindful of was monitoring underperformance of these contracts. A range of questions were asked relating to the fees charged for dentistry activity and why that resulted in a shortage of money.

(19) Mrs Whittle asked for details of the number of dentists particularly in West Kent who had opted out from the NHS contract in the last ten years.

(20) The response from PCT colleagues was maintaining sustainability between the old and new contracts presented a challenge they would very much welcome an increase in the allocation of funding.

(21) Several Members raised concerns with issue of access to services particularly for those on low income who lived in areas of high deprivation.

(22) The PCTs responded that these members of the population were very much those targeted by the Primary Care Trusts. Members mentioned the possibility of having a mobile dentistry unit to overcome these issues of access for people that could not afford to travel etc for a dentist.

(23) Reference was made to a mobile dentistry unit in the London Borough of Tower Hamlets.

(24) One Member also raised the issue of emergency care and where that was located across the county. He asked what percentage of people presented to the emergency services at hospital because of the distance to find the emergency dental care service.

(25) In response the Committee were informed that Dentaline were the emergency care provider. The Dentaline contract was currently being reviewed. However the payment structure was the same.

(26) The Primary Care Trusts recognised that providing more information about the availability of the emergency service was necessary. Several Members particularly from West Kent referred PCT colleagues to the lack of dentistry provision in towns such as Tunbridge Wells, Sevenoaks and the Tonbridge and Malling Borough Council area. They asked what the overall generic provision for dentistry should be across the county and referred to the debate that was being undertaken nationally on the needs assessment. It was clear to several of the Members that members of the public could not afford NHS dentistry treatment.

(27) Mr Meikle from the Eastern & Coastal Kent PCT informed the Committee of the efforts that the PCT were taking to reduce their management costs. NHS West Kent referred to the activity that they were undertaking to improve access to NHS dentists and increase the number of patients' access dentists across the PCT area. They indicated that there had already been a 17% reduction in management costs across NHS West Kent. In West Kent 12 new practices had opened in the last six months, one of which was in the area specified by the Members, i.e. Chestfield. The Committee was then joined by Dr Tim Hogan and he referred to the activity that he undertook as a dentist. He said that people did not feel that they needed to go to a dentist and would only go when they really needed to go.

(28) He spoke of the contract which had been renewed in 2006 which in his view had destroyed the structure of the contract and dis-incentivised dentists to look at those with the greatest of need. He said the costs of dental services were huge and even within his practice 90% of his income was from private patients.

(29) He referred to the new Care Quality Commission requirements whereby in 2011 every dentist had to be registered to have the ability to practice.

(30) RESOLVED that colleagues be thanked for their attendance at the meeting on the important issue of dentistry provision across the county which the Health Overview and Scrutiny Committee will wish to monitor and return to on a periodic basis.

5. Forward Work Programme

(Item 5)

(1) The Overview, Scrutiny and Localism Manager submitted a report setting out the revised work programme for the meetings in May, June and July. He also sought the Committee's suggestions for inclusion in the work programme for the meetings in September, October and November.

(2) Attached to the report were some briefing notes relating to the items to be considered over the next three months' meetings and he sought Members' views on further questions that they would like to see added to those already covered so that these could be sent to those whom the Committee wished to invite to attend the meeting to answer their questions in advance. The ideal was to have a work programme for a year or even more set out in advance.

(3) RESOLVED that the Committee:-

a) endorse the proposed work programme for the forthcoming meetings; and

b) were invited to submit any suggestions and questions they would like asked as part of the discussion on the scheduled topics and items for inclusion in future meetings of the agenda to the Overview, Scrutiny and Localism Manager.

6. Update on Referral to the Secretary of State for Health
(Item 6)

(1) Included in the papers for the Committee to note was the letter setting out the reasons for the referral of the Committee following the unanimous decision on 19 February 2010 to refer the issue of Women and Children's Services at Maidstone & Tunbridge Wells NHS Trust to the Secretary of State for Health.

(2) The Committee also noted the response from the Department of Health and the further response letter on behalf of the Committee dated 18 March 2010. Since the papers were published a further letter had been received by the Chairman dated 24 March 2010 from the Secretary of State indicating that he had asked the Independent Reconfiguration Panel to undertake an initial review on the Committee's referral. Should that review by the Independent Reconfiguration Panel advise that a full review is necessary then the Committee would have the chance to present their case to the Independent Reconfiguration Panel in full.

(3) The Secretary of State had indicated that he had asked the Independent Reconfiguration Panel to report to him by not later than 7 May 2010.

(4) RESOLVED that the report be noted.

This page is intentionally left blank

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 14 May 2010

Subject: Item 4. Intended Outcomes: the Future of PCT Provider Services and the Use of Community Hospitals

---

1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.

(2) This paper is intended to be a way to progress towards achieving these twin aims. Two sets of questions are set out below, both of which the meeting will look to having answered by the end of the meeting: the strategic, overarching questions, and the more detailed questions. These have been sent to the attendees in advance of the meeting.

2. Hierarchy of Questions

(1). Strategic Questions

1) What decisions have been made about the future direction of community services in Kent?
2) What is the timeline of key organisational and service changes?
3) What are the plans for the use and development of community hospitals in the future?

(2). Detailed Questions

4) Do you have plans for any public consultations as a result of changes to community services community hospitals?
5) Can you outline the differences between the commissioner and the provider functions of your organisation?
6) What services does your PCT Provider Service (PCTPS) provide?
7) How many staff are employed by your PCTPS, and what staff groups does this include?
8) Specifically, what role do health visitors play within community services, how many are currently employed, and how many have been employed in each of the last five years?
9) How many properties, including the community hospitals, does your PCTPS own or manage?
10) What are the governance arrangements of your PCTPS and how does this connect with the commissioning side of the PCT?
11) How much is spent on community services each year?

12) How are community services commissioned and funded?
13) What may be the impact of the current financial situation?
14) What role have other organisations played in the development of your proposals – for example the Kent LINk, other PCTs, other provider Trusts in Kent and Medway, NHS South East Coast?
15) What is the definition of a 'community hospital'?
16) What is the difference between the community hospitals you are responsible for and hospitals like the Royal Victoria Hospital in Folkestone run by an Acute Trust?
17) Can you provide a list of what services you currently provide at each community hospital?
18) Are there any plans to add to or remove any of these services in the future?
19) Where are Minor Injury Units (MIUs) provided and how do the services delivered here differ from those provided in acute settings such as Accident and Emergency Departments and Emergency Care Centres?
20) Have you any plans to develop/change MIU provision?
21) Are there any inpatient beds at your community hospitals?
22) If there are, how many are there and what is the average length of stay?
23) How do community hospitals work with other Trusts and Social Services (such as receiving patients discharged from Acute Trusts)?

3. Recommendations

(a) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

Background Note.

By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 14 May 2010

Subject: Item 4. The Future of PCT Provider Services and the Use of Community Hospitals.

---

1. The Future of PCT Provider Services

(a) Community health services cover a range of services provided by a variety of organisations and staff groups including community nurses, health visitors, community dentistry, physiotherapy, and community rehabilitation. Since their establishment, the vast majority of Primary Care Trusts (PCTs) have in the past both *commissioned* and *provided* these services.

(b) The policy direction over the last few years has been towards the increasing separation of the commissioner and provider functions of PCTs[1]. The development of the options for the provider arms is often referred to as Transforming Community Services (TCS).

(c) A wide range of options for the future organisational form of provider arms was set down in *Transforming Community Services: Enabling new patterns of provision*, published in January 2009[2]. In a subsequent document published in February 2010, the "the most likely options" were given as integration with an NHS acute or mental health provider; integration with another community-based provider; or a Social Enterprise. Among the other options, "not expected to be the norm"[3] were Community Foundation Trust; continued PCT direct provision; and Care Trust which includes provision.

(d) A deadline of 31 March 2010 was set for PCTs to have "agreed with SHAs proposals for the future organisational structure of all current PCT-provided community services."[4] A further deadline of 31 March 2011 was set for the "Implementation of any new provider form … or very substantial progress to have been made towards the new organisational form, meeting

---

[1] Department of Health, *NHS Next Stage Review: Our Vision for Primary and Community Care*, 3 July 2008, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085947.pdf

[2] Department of Health, 13 January 2009, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197

[3] Department of Health, 5 February 2010, *Transforming Community Services: The assurance and approvals process for PCT-provided community services*, p.4 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112146.pdf

[4] Department of Health, 16 December 2009, The NHS Operating Framework for England for 2010/11, p.42, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_110159.pdf

the milestones agreed on approval with the SHA towards final implementation."[5]

(e) Historically, the funding of community services in the NHS has largely been through block contracting arrangements which have impacted the ability of commissioners "to identify what services are being delivered and pay for them appropriately."[6] A number of documents have been produced setting out options for developing local currencies and pricing[7].

(f) For reference, the description of a Community Foundation Trust in *Transforming Community Services* is as follows[8]:

Table 1

Example	Description	Separate Legal Entity	Legal Route	Governance
Community Foundation Trust	A Public Benefit Corporation consisting of members who may be in constituencies of the public, patients and staff. There is a Board or Council of Governors and a Board of Directors.	Yes. An FT is a corporate body known as a public benefit corporation (s.30 of NHA Act 2006).	An NHS Trust may apply for authorisation as an FT (s.33 of the 2006 Act). … Applications considered and authorisation given by Monitor (s.35). for a PCT provider arm an NHS Trust is created to take on the provider arm and apply for FT status under s.33.	FT is governed by its board of directors. Board is partly accountable to, and appointed by, board of governors. Board of governors are elected by the members' constituencies. FT reports to and is regulated by Monitor.

[5] Department of Health, 5 February 2010, *Transforming Community Services: The assurance and approvals process for PCT-provided community services*, p.3, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112146.pdf

[6] Department of Health, *Currency and pricing options for community services*, http://www.dh.gov.uk/en/Healthcare/Primarycare/TCS/Currencyandpricingoptionsforcommunityservices/index.htm

[7] Ibid.

[8] Department of Health, 13 January 2009, *Transforming Community Services: Enabling new patterns of provision*, p.44, extract, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093196.pdf

2. Community Hospitals

(a) The Department of Health have provided the following definition of a community hospital:

> (1) "A modern community hospital service aims to provide an integrated health and social care resource for the local population to which it belongs. These local facilities develop as a result of agreements between local people, service providers and the NHS. Community hospitals are an effective extension to primary care with medical support provided largely by GPs. The health and social care provided may include medical care, rehabilitation, palliative care, intermediate care, mental health care, maternity care, surgical care and emergency care. Community hospital care is characterised by care pathways that make the most of local sources of support. The community hospital provides a focus for local community networks."[9]

(b) Eastern and Coastal Kent Community Services are responsible for the services at Faversham Cottage Hospital, Queen Victoria Memorial Hospital (Herne Bay), Sheppey Community Hospital (Minster), Sittingbourne Memorial Hospital, Victoria Hospital (Deal) and Whitstable and Tankerton Hospital.

(c) West Kent Community Health is responsible for the services at Edenbridge and District Memorial Hospital, Gravesham Community Hospital (Gravesend), Hawkhurst Community Hospital, Livingstone Hospital (Dartford), Sevenoaks Hospital, and Tonbridge Cottage Hospital.

(d) In many areas, community hospitals are part of the PCT estate and will remain with the commissioner. The following is the relevant extract from *Transforming Community Services:-*

> (1) "Therefore, In order to maintain the maximum freedom of choice, commissioners should plan on the basis that they will retain direction over estate and that providers should be tenants, not owner-occupiers."[10]

(e) NHS Medway (the provider arm of NHS Medway) is responsible for St. Bart's Hospital in Rochester, Wisdom Hospice in Rochester and three Healthy Living Centres across Medway.

(f) The Royal Victoria Hospital at Folkestone and Buckland Hospital at Dover are part of East Kent Hospitals University NHS Foundation Trust.

---

[9] E-mail from Department of Health Customer Service Centre, 18 November 2008, DH Ref: DE00000363761.

[10] Department of Health, 13 January 2009, *Transforming Community Services: Enabling new patterns of provision*, p.72, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093196.pdf

Appendix - Select Glossary

Commissioning The full set of activities that local authorities and Primary Care Trusts (PCTs) undertake to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively.

Practice-based commissioning (PBC) PBC gives GPs direct responsibility for achieving best value within the funds that the Primary Care Trust (PCT) has to pay for hospital and other care for their practice's population.

Provider A generic term for an organisation that delivers a healthcare or care service.

Primary Care Trusts (PCTs) Freestanding statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions.

Service level agreement (SLA) This is a formal written agreement made between a provider and the commissioner of a service. It specifies in detail how and what services will be provided, including the quality standards that the service should maintain.

Strategic Health Authority (SHA) The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans and for ensuring that Primary Care Trusts (PCTs) are performing well. They are the link between the Department of Health and the NHS.[11]

[11] All of these definitions taken from: Department of Health, 13 July 2006, *Health reform in England - update and commissioning framework: annex - the commissioning framework*, pp.73-77, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4137230.pdf

KENT ADULT SOCIAL SERVICES

Written Submission to the Health Overview and Scrutiny Committee Meeting 14 May 2010

THE FUTURE OF PCT PROVIDER SERVICES AND THE USE OF COMMUNITY HOSPITALS

Summary

- **Opportunity for joint cost reductions**
- **Personalisation and Choice**
- **Early Intervention and Prevention**
- **Provision of Care Closer to Home**
- **Integrated working**
- **System of incentives**

INTRODUCTION

1. Kent Adult Social Services (KASS) welcomes the opportunity to submit this evidence to the Health Overview and Scrutiny Committee (HOSC) in its consideration of aspects of the *Transforming Community Services*.

2. The views of KASS expressed in this submission are against the background of long standing partnership arrangements with NHS organisations in Kent that cover older people, mental health and learning disabilities services, from the strategic multi-agency team and the case management levels.

3. The need to work together to improve the lives of the people of Kent, at a time when we face the twin challenges of rising demand (due to the impact of demographical changes) and reducing public funding is compelling.

4. Equally compelling, is the need to ensure improved user experience brought about through locally integrated services that deliver better health outcomes which are derived from flexible and responsive approaches whilst, enabling people to exercise more choice and control. This will result in people being able to stay at home for as long as possible and with fewer unplanned admissions to hospital and long term residential care.

EVIDENCE

Opportunity for joint cost reductions

5. The *Total Place* national reports provide evidence of the benefits that may be realised by public services which are prepared to seize the opportunity to redesign how facilities and other assets are used. These could be combined to deliver improved services and thereby secure financial and non-financial efficiencies.

KASS is of the view that is an area that HOSC may wish to pursue and test the extent to which the NHS community service organisations in Kent are willing to explore the potential opportunities.

6. At one end of the spectrum, it is possible to envisage arrangements where shared systems and approaches can lead to shared cost reductions. Although this will be challenging, partly as a result of the need to overcome organisational, cultural and professional barriers, we are confident there is collective will to put strategy in place to overcome them.

Personalisation and Choice

7. KASS observes that the transformation changes taking place across adult social care has its equivalent programme in the NHS. The foundation of this is captured in the Next Stage Review by Lord Darzi *(Department of Health, 2008).*

8. KASS supports any move that leads to people being offered choice and control over how they are supported. This position underlies why KASS is supporting NHS East Kent's Personal Health Budget pilot. We believe that we can work together by influencing the market and encourage improved choice for people through commissioning personalised service, which individuals can choose through their personal budgets.

Early Intervention and Prevention

9. KASS is aware of the growing evidence base of the efficacy of early intervention and preventative services that we know can prevent or delay older people from needing more expensive support services. The headline report of the *Partnerships for Older People Projects* show that the reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every extra £1 spent on the *Partnerships for Older People Projects* (POPPs) services, there had been approximately a £1.20 additional benefit in savings on emergency bed days.

10. Furthermore, through the implementation of pro-active case coordination services visits to A+E departments fell by 60%, hospital overnight stays were reduced by 48%, phone calls to GP's fell by 28%, visits to practice nurses reduced by 25% and GP appointments reduced by 10% (*National Evaluation of the Partnerships for Older People Projects: final report, January 2010).*

11. The place of preventative services should therefore form part of the consideration of changes to community services. This should not be limited to services delivered that are delivered from fixed locations. In addition, we place a high value on the NHS making use of 'out-reach' models of care as part of these changes.

Provision of Care Closer to Home

12. We strongly believe that this is the chance for making 'Care Closer to Home' a reality. The changes under consideration must include investment in different forms of NHS rehabilitation services for the most vulnerable people in the community whose need for non-acute care may be as a result of stroke, dementia, falls or end- of- life.

13. We believe that the provision of 'assessment/step down beds' which allow patients to be assessed away from the acute site is essential. Not only would this help improve the quality of assessment but also lead to better patient experience. Moreover, it would free-up acute beds at a quicker rate, and reduce the number of delayed transfers of care.

14. We would advocate that the provision of 'emergency nursing respite' should be in place so that those eligible for nursing care can be looked after if their carers become ill, or if their carers require respite. The contribution of carers nationally is estimated at between £67bn and 87bn *(Carers UK, 2007).* It is essential that the proposed changes should be taken forward in a way that positively address better support for carers

15. The KASS position in regards to the use of community hospitals is that their role within the health care system should be reviewed and re-defined, to incorporate a mixture of the above services.

Integrated working

16. KASS and the Primary Care Trusts have maintained an effective joint working approach within the new commissioning systems and structure despite the inherent challenges. In addition to addressing the modernisation of existing services and working within a tight resource position, a number of joint funded initiatives and partnership projects have been implemented. Examples are:

    - Dementia Collaborative Pilot (incorporating DementiaWeb and Dementia Helpline
    - POPPS (INVOKE)
    - Whole System Demonstrator Project (WSD)
    - Integrated Care Centres - Westview, Westbrook House, Gravesham Place and Broadmeadow (rehab and recuperation)
    - C4 Project (Canterbury)

17. While these projects have provided an insight into future commissioning practices and services which benefit the public, they have also presented some challenges in terms of joint-working. Provider services, community hospitals and KASS are, in essence, part of one system and aligning the strategies of each so that planning and performance is measured similarly is crucial.

18. A key part of planning and performance management is the evaluation of services and projects. The review of services is not always possible in a joint-working

structure because of the difficulties inherent when combining different systems and agendas. A consistent approach to evaluation and performance management would be welcomed.

System of incentives

19. The implications of the separation of PCT commissioning function and from those of a provider of community services in the NHS need to be further analysed in order to identify the full range of opportunity, both in joint commission and joint provision. This would include understanding the implications of the 'tariff system' in so far as it affects the operations of primary and secondary care services. The HOSC may wish to explore this area to better understand how it may affect future operations.

Conclusion

20. KASS would wish to maintain its collaboration with health as set out in the Eastern and Coastal Kent's *Community Services Commissioning Strategy 2009-2013* and the *NHS West Kent's Best Possible Strategic Commissioning Plan 2010-2015*

21. We are in no doubt that HOSC would wish to explore what each PCT is planning to put together under the proposed arrangement. In particular, to assess what this means in terms of opportunities and benefits in terms of improved outcomes for patients.

22. In conclusion, there are opportunities for the NHS to work with KASS and other partners, focused on bringing together service arrangements that can truly deliver improvements for the people of Kent. Health and social care services in the community can be redesigned in order to provide a more integrated service in the community that lead to better outcomes and long term efficiencies. This would be greatly advanced if assistive and mobile technology use is given a central role.

Oliver Mills
Managing Director
Kent Adult Social Services
5 May 2010

Officer contact details
Michael Thomas-Sam
Michael.thomas-sam@kent.gov.uk
Tel 01622 694843

NHS West Kent NHS Eastern and Coastal Kent

The Future of PCT Provider Services
Overview of NHS Eastern and Coastal Kent and NHS West Kent
Health Overview and Scrutiny Committee - 14th May 2010

1.0 Introduction

1.1 This paper is a joint paper between NHS Eastern and Coastal Kent (NHS ECK) and NHS West Kent (NHS WK). It aims to provide Members of the Committee with an overview of the current position of both organisations with regard to the future of their PCT Provider Services. It aims to answer the questions posed in the letter of the 1st April 2010 from the Committee to our organisations.

1.2 The questions can be broadly grouped into five areas:

- What are Community Services?
- Commissioning Community Services
- Governance of the PCT Provider Services
- Decision Making on the future of PCT Provider Services
- Consultation

1.3 The questions answered in each section of this paper are referenced on the right hand side of the paper.

1.4 However the following questions are answered, as set out below:

1.5 Question 6: Appendix One lists the services provided by NHS Eastern and Coastal Kent Community Services and NHS West Kent Community Health.

1.6 Question 7: Appendix Two highlights the number of staff and their associated staff groups for both NHS Eastern and Coastal Kent Community Services and NHS West Kent Community Health.

1.7 Question 8: Appendix Three focuses on the role of Health Visitors within Community Services and the current and historical establishment figures for NHS Eastern and Coastal Kent Community Services and NHS West Kent Community Health. *(Specifically in answer to Question 8 of your letter).*

2.0 What are Community Services?

2.1 The national Transforming Community Services and World Class Commissioning initiatives have led to the requirement for PCTs to split out

their providing and commissioning functions to avoid conflict of interests and for both functions to concentrate on their core business. This has led to the formation of arms-length community providers being established in each Primary Care Trust.

2.2 Community Services are primarily those health services which are provided outside of acute hospitals and in, or close to, patients homes, delivering care, treatment and support in the following main areas of healthcare:

- Long Term Conditions
- End of Life Care
- Rehabilitation
- Healthy Living and Wellbeing
- Children and Families

2.3 They are also increasingly playing a role in supporting a shift in the delivery of care, from traditional hospital settings to more community settings closer to people's homes where this is appropriate and clinically safe. Community Services are currently predominately delivered by PCT Provider Services but are also delivered by primary care services (GP, Dentistry, Optometry and Pharmacy) as well as some third sector and private providers.

3.0 Commissioning Community Services

3.1 The table below shows how much was spent on Community Services for 2009/10 in NHS ECK and NHS WK. **Q11**

	Provider	**2008/09 Budget**	**2009/10 Budget**	**2010/11 Budget**	**% of total PCT budget (09/10)**
NHS ECK	NHS ECK Community Services	£116,071m	£119,473m	£121,633m	9.85%
	Other Providers	£2,261m	£1,774m	£1,642m	
NHS WK	NHS West Kent Community Health	£58.725m	£59.921m	£57.408m*	6.16%
	Other Providers in Kent	£99,515.48	£170,288.19	£175,000 Est	0.017%

*For 2010/11, the reduction in spend is attributed to following changes in providers for certain services. The budget has followed the provider.

1. £2m from the Urgent Care Centre Contract
2. £165K from the Rainbow Lodge Contract
3. £261 from the Primary Care Counselling Contract
4. £779K from the GP Out of Hours Contract

3.2

In the last year both NHS ECK and NHS WK have developed and approved community commissioning strategies that detail the five year strategy for community services, as a whole.

3.3 **Q12**

The commissioning and funding of community services, from the perspective of both NHS ECK and NHS WK, is managed in the same way as the commissioning of any other healthcare service including those provided by acute hospitals or in primary care.

3.4

Decisions about healthcare provision are informed by local priorities which are developed by considering the current and future health needs of the population; developing clinical practice and the existing provision of services. NHS ECK and NHS WK as the commissioners engage the public and clinicians in the ongoing development of services which will deliver these local priorities. Each organisation has a five year Strategic Commissioning Plan which sets out the priorities and the actions that will be taken to deliver the improvements in health outcomes for the population they serve.

3.5

Service specifications are developed to ensure the delivery of clinical care pathways which have been tested against national and local best practice. The commissioners use these service specifications to ensure providers deliver services in line with their requirements. The funding for community services is allocated from the overall Primary Care Trust (PCT) budget, in the same way as any other service areas, and again in line with the PCTs five year Strategic Commissioning Plan.

3.6

The delivery of the PCTs Strategic Commissioning Plan which includes community services, are set within the challenging economic climate that faces local NHS and public service organisations in the coming years. Both NHS ECK and NHS WK have undertaken financial forecasting in order to publish their Strategic Commissioning Plan and understand the scale of quality improvements and productivity and efficiency gains needed in the coming years to meet the needs of the population and ensure financial stability in the local health economies. **Q13**

3.7

As part of these plans there is a strong emphasis in both organisations on delivering more efficient community services and enabling a significant shift of services from acute hospitals to community settings. The development of both the NHS ECK and NHS WK Provider Services as providers in their own right is an important part of ensuring that we have a

provider environment capable of delivering a wide range of services in a number of settings as well as high quality care and improved patient experience.

4.0

Governance of the PCT Provider Services

4.1

The commissioner and provider functions of the PCT are distinctly different. The commissioners role is to understand the health needs of their population area, specify services to deliver upon that need and then commission and performance manage providers who deliver those services. The provider function within the PCT manages and operates the services it has been commissioned to deliver, to the highest standard and to agreed quality and performance measures. **Q5**

4.2

To ensure effective and proper governance of the PCT Provider Services and in line with national requirements, both NHS ECK and NHS WK have set up a committee of their respective PCT Board to manage the operations of those services. These committees have evolved at different rates in both organisations. **Q10**

4.3

In the case of NHS ECK much of the strategy and management of the clinical and support services have been delegated through a scheme of delegation from the PCT Board to a board committee called the Community Services Board which meets in public and has an independent Lay Chair.

4.4

The West Kent Community Health Management Board is a formal sub committee of the main PCT Board. Members include our Executive Directors and the Chair of the Staff Partnership Forum. The Board Chair is a non executive member from the PCT Board. The Management Board has delegated responsibility for the strategic leadership of West Kent Community Health. Work will continue over the coming months to increase the independent membership of the Board.

5.0

Decision making on the future of PCT Provider Services

5.1

Health Overview and Scrutiny Committee members were last updated on this specific matter in October 2009. Since then the NHS Operating Framework for 2010/11 has been published, which accelerates the decision making timescales for PCTs to make a decision about their PCT Provider Services. It stated:

5.2

"by 31 March 2010 PCTs have agreed with Strategic Health Authorities (SHAs) proposals for the future organisational structure for all current PCT-provided community services with implementation of the new organisational form or very substantial progress made by March 2011".

5.3

It stated that the most likely options for organisational form would be:

- Integration with an NHS acute or mental health provider
- Integration with another community based provider
- Social Enterprise

5.4 It also highlighted three less likely options which were not expected to be the norm:

- Community Foundation Trust
- Continued Direct Provision
- Care Trust which includes provision

5.5 The document also specifically stated that integration means "the single management of services to promote innovation, provide better quality and experience of care for individuals, and improve the efficiency of service delivery."

5.6 In light of this document, and building on the work previously undertaken, both NHS ECK and NHS WK have made recommendations to their Board on the future organisational form for their PCT Provider Services. **Q1**

5.7 NHS ECK confirmed their intention to move their PCT Provider Services towards a Community Foundation Trust model. This model would build on the strong track record of joint working and integration between NHS ECK Provider Services and other agencies and sectors such as KCC Social Services and Primary Care. It will also provide real opportunity to take the work of integration further through the proposed clinical operating model which would ensure joint management arrangements between ECK Provider Services, Social Care and Practice Based Commissioning could be expanded. It would also build on the strong community services commitment to initiatives such as Total Place and Gateways. Further details of this proposed model is available on request.

5.8 In line with this, in January 2010 ECK NHS submitted a Business Case to NHS South East Coast and the Department of Health to become an independent Trust, which would then move to Foundation Trust status. At the end of February 2010 NHS ECK were informed that their Provider Services had been successful in their bid for Trust status, subject to ratification by the DH Transactions Board.

5.9 NHS ECK are still awaiting the final ratification but expect this in mid-May 2010 for a 1st July 2010 establishment date. NHS ECK is now one of eight PCTs / Community Services in England to be successful on this path. This will move the PCT Provider Services for NHS ECK to independent NHS Trust status outside of the PCT. The new Trust would then continue its journey to Foundation Trust status over an 18 month period. Extensive public consultation is a mandatory part of the application for Foundation Trust status.

5.10

NHS WK has agreed that it would welcome an integration of Community Services across Kent with core community services focused around Practice Based Commissioning clusters. NHS WK will also review their specialist services in the coming months to see whether some of these should integrate with local acute hospitals, for example, community paediatric outpatients.

5.11

NHS South East Coast agrees with both NHS ECK and NHS WK that integration of community services across Kent can provide considerable efficiency gains, reduction in management costs and has significant benefits including:

- Supporting the shift from acute to community and so providing patients with greater choice and an alternative to acute services
- Strong alignment with Kent County Council and social care
- Allows strong integration of clinical services with other sectors and agencies at a patient, rather than organisational level
- Economies of scale with a reduction in overheads and an increasing level of productivity and efficiencies
- Supported by staff as NHS Terms and Conditions are retained
- Builds on the momentum already generated and provides a timely and efficient solution across the county
- Best practice can be emulated across Kent
- Enables the delivery of the PCTs Strategic Commissioning Plans
- Strong links with Practice Based Commissioning and GPs
- Opportunity to develop specialist services such as Sexual Health and Specialist Dental and share specialist talent and skill
- Provides a strong community membership model (as a Foundation Trust)

5.12

For integration across Kent to be successful a number of key pieces of due diligence work will need to take place including an assessment of the current alignment of services and business/strategic plans, along with an assessment of the current alignment of commissioning strategies and functions. This would enable any challenges to integration to be clearly identified and addressed.

5.13

This integration will be overseen by NHS South East Coast as the intention

is for NHS ECK Community Services to become a Trust in July with the integration across Kent to take place in the six-nine months to March 2011. The integrated Kent organisation would then proceed to Foundation Trust status during 2011/12 and 2012/13. **Q2**

5.14

When the Trust is established it will not directly own any buildings. The freehold of the buildings owned by the PCT, including the community hospitals, will remain with them when the provider moves out of the PCT. The new Trust will retain a small amount of leases with private landlords for office buildings that are solely occupied by PCT Provider Services staff. **Q9**

6.0

Consultation

6.1

Both NHS ECK and NHS WK have undertaken staff and partner engagement during 2009 and 2010. This has included direct engagement with HOSC in October 2009 and other key stakeholders through various forums during 2009. NHS WK also held a workshop with stakeholders including other NHS Trusts in Kent, in March 2010 to inform their Board decision. **Q4** **Q14**

6.2

The move of NHS ECK to Trust status will not adversely affect or change the delivery of clinical services for patients. As such it is proposed that the move to Trust status does not warrant public consultation under the Local Government and Public Involvement in Health Act 2007. However the move from Trust to Foundation Trust status does mandate a 12 week public consultation period which will be undertaken as per legislative requirements. Both NHS ECK and NHS WK and the new Trust would also undertake formal public consultation if any significant clinical service changes were to be proposed in line with the above Act. **Q14**

6.3

Although formal public consultation is not required NHS ECK and NHS WK are committed to strong engagement throughout this transition. There has been good engagement with other stakeholders including other NHS organisations, Kent LINk and CASE Kent (Community Action South and East Kent). Both Kent LINk and CASE Kent have written letters of recommendation to support NHS ECK Community Services becoming an NHS Trust.

7.0

Conclusion

7.1

This paper aims to provide a summary of the work being undertaken to commission and provide Community Services in Kent. It also aims to provide answers to the questions posed in the letter of the 1st April. Both NHS ECK and NHS WK will welcome questions on this matter at the Health Overview and Scrutiny Committee on the 14th May.

Appendices

Appendix 1: Services provided by NHS Eastern and Coastal Kent Community Services and NHS West Kent Community Health

Appendix 2: Number of staff and their associated staff groups for both NHS Eastern and Coastal Kent Community Services and NHS West Kent Community Health

Appendix 3: The role of Health Visitors within NHS Eastern and Coastal Kent Community Services and NHS West Kent Community Health and the current and historical establishment figures.

Appendix 1 - Services provided by NHS Eastern and Coastal Kent Community Services and NHS West Kent Community Health

Eastern and Coastal Kent	West Kent
Primary Care Nursing Teams Community Hospitals Community Matrons Intermediate Care Specialist Teams Walk in Centre and Minor Injury Units Community Learning Disability Team Counseling Services for Children Health Visiting School Nursing Primary Mental Health Team Around the Child Service Looked After Children Adult Speech and Language Therapy Podiatry and Podiatric Surgery Chronic Pain Orthopedics Primary Care and Specialist Dental Clinical Dietetics and Healthier Living Services Physiotherapy Integrated Equipment and Wheelchair Services	**ADULT SERVICES** Community Nursing Service Specialist Nursing Community Hospitals Intermediate Care Teams Community Dietitian Home Enteral Feeding Adult Speech & Language Therapy Service Community Triage Orthoptist Specialist Nurse Safeguarding Vulnerable Adults (SVA) /Mental Capacity Act (MCA) **CHILDREN YOUNG PEOPLE AND FAMILIES** Newborn Hearing Service CAMHS Liaison CASH (Contraception and Sexual Health) Community Paediatrician Community Paediatric Diabetes Specialist Nurse Specialist ADHD Nurse (Attention Deficit Hyper Activity Disorder) Special Needs Team Health Visitors and School Nurses Orthoptist TB Service Children's Community Nursing Team Children's Resource Centre Nursery Maidstone Child Development and Therapy Centre Nursery Children's Therapies Services to Specialist Schools West Kent Children's Hearing Service Safeguarding Children Services **ADULT THERAPY AND EQUIPMENT SERVICES** Advanced Musculoskeletal Practitioner Service (AMPS) Outpatient Physiotherapy Community Equipment and Wheelchair Service Podiatry **INFECTION CONTROL** Infection Control Team Practice Nurse Advisors

Appendix 2 - Number of staff and their associated staff groups for both NHS Eastern and Coastal Kent Community Services and NHS West Kent Community Health

Eastern and Coastal Kent (as at 20 Apr 10)

Summary of Headcount	
Staff Group	**Total**
Add Prof Scientific and Technical	**16**
Additional Clinical Services	**731**
Administrative and Clerical	**845**
Allied Health Professionals	**463**
Estates and Ancillary	**190**
Healthcare Scientists	**4**
Medical and Dental	**88**
Nursing and Midwifery Registered	**1156**
Grand Total	**3493**

Summary of Full Time Equivalent	
Staff Group	**Total**
Add Prof Scientific and Technical	**11.99**
Additional Clinical Services	**567.86**
Administrative and Clerical	**665.77**
Allied Health Professionals	**396.59**
Estates and Ancillary	**113.94**
Healthcare Scientists	**2.05**
Medical and Dental	**52.12**
Nursing and Midwifery Registered	**955.30**
Grand Total	**2765.62**

West Kent

Summary of Headcount	
Staff Group	**Total**
Add Prof Scientific and Technical	**3**
Additional Clinical Services	**376**
Administrative and Clerical	**387**
Allied Health Professionals	**210**
Estates and Ancillary	**116**
Healthcare Scientists	**4**
Medical and Dental	**125**
Nursing and Midwifery Registered	**631**
Students	**17**
Grand Total	**1870**

Summary of Full Time Equivalent	
Staff Group	**Total**
Add Prof Scientific and Technical	**2.09**
Additional Clinical Services	**274.85**
Administrative and Clerical	**271.30**
Allied Health Professionals	**157.76**
Estates and Ancillary	**75.95**
Healthcare Scientists	**3.65**
Medical and Dental	**19.16**
Nursing and Midwifery Registered	**468.98**
Students	**17**
Grand Total	**1290.7**

Appendix 3 - The role of Health Visitors within NHS Eastern and Coastal Kent Community Services and NHS West Kent Community Health and the current and historical establishment figures.

Eastern and Coastal Kent

Health Visiting teams in Eastern & Coastal Kent Community Services play a key and fundamental role in the delivery of the Healthy Child Programme 0-5 years. The Healthy Child Programme is a national screening and support programme for children and constitutes a number of assessments to be undertaken at key points in the child's development. This includes delivering a range of services to all families (Universal Service) with additional support offered to families and children who through our Family Health assessment model have been identified as requiring additional support (Progressive Universalism).

All families have a comprehensive assessment, taking into account both Health and Social needs, whilst also considering resilience and protective factors such as additional family support and access to available services. This assessment is undertaken by a qualified Health Visitor.

The key purpose of the service is to ensure that all families have access to a range of assessment and support at key stages in their baby and child's life, and also includes promotion of healthy lifestyle choices to all families. This aims to engage in and promote key health priorities such as raising breast feeding rates, early identification of Postnatal Depression, increase immunisation uptake, reduce obesity, smoking and substance misuse, reduce teenage conception rates, promote positive parenting with a particular emphasis on supporting young parents. Additionally we work closely with our School Nurse colleagues identifying those families who will require support on transition into school.

Through early detection of vulnerability we identify and support high level complex families requiring additional support such as those suffering domestic abuse, mental health issues, substance misuse or poor socio economic factors. These supportive services seek to reduce inequalities and deprivation, prevent social exclusion, and reduce criminal behaviour in the long term. We support the Child In Need process through working in partnership with our Social Work colleagues and when required produce professional reports and attendance in addition at Case Conferences, Core groups and Court. Health Visiting also directly supports families in the CP process.

Within Eastern and Coastal Kent area due to the high levels of deprivation in areas such as Thanet, Swale and Shepway a large proportion of Health Visiting service time is undertaken to support this Safeguarding Children agenda.

We are developing close working relationships with colleagues in Childrens Centres and delivering many of our services collaboratively through these centres. EG family clubs, infant feeding groups, support for young parents and first time families, postnatal depression, self esteem groups and domestic abuse freedom groups.

We continue to work closely in partnership with our colleagues in Midwifery, G.P practices, therapies such as Speech and Langue and Early Support, voluntary sector, early year's education and Social Services. We have a range of skilled staff in our teams including Health Visitors and Specialist Lead Health Visitors. They lead our teams and ensure appropriate delegation of work to our Community Health nurses and Community Nursery nurses who provide vital elements of our service.

There has been a remodelling of the workforce over recent years ensuring that the highly specialised skills of qualified Health Visitors is used appropriately. This has created the skill mix team as described and also enabled a career pathway both into the profession and within it.

The last two years have also seen particular difficulties in recruitment of Health Visitors and we have an aging demographic within the workforce. This has also resulted in skill mix in order to maintain safe effective services. Both of these issues are reflected in the establishment figures below.

2005 - 2006

	Band 4		Band 5		Qualified Health Visitor	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
Ashford	*	6.14	*	1.00	*	16.43
Canterbury & Coastal	*	5.92	*	5.44	*	19.09
Dover/Deal	*	5.54	*	1.00	*	15.44
Shepway	*	6.30	*	0.80	*	14.49
Swale	*Swale figures unavailable prior to merger of PCTs*					
Thanet	*	10.01	*	1.00	*	18.46
TOTAL for Band	*	**33.91**	*	**9.24**	*	**83.91**
Service FTE TOTAL	**127.06**					

2006 - 2007

	Band 4		Band 5		Qualified Health Visitor	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
Ashford	*	5.81	*	2.00	*	17.18
Canterbury & Coastal	*	5.92	*	6.10	*	19.36
Dover/Deal	*	5.27	*	2.00	*	16.72
Shepway	*	6.21	*	0.80	*	16.44
0	*Swale figures unavailable prior to merger of PCTs*					
Thanet	*	10.47	*	0.00	*	20.36
TOTAL for Band	*	**33.68**	*	**10.90**	*	**90.06**
Change on previous year	*	**-0.23**	*	**1.66**	*	**6.15**
Service FTE TOTAL	**134.64**					
Change on previous year	**7.58**					

2007 - 2008

	Band 4		Band 5		Qualified Health Visitor	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
Ashford	*	6.45	*	2.00	*	16.66
Canterbury & Coastal	*	5.12	*	4.26	*	22.39
Dover/Deal	*	5.41	*	2.00	*	16.32
Shepway	*	5.35	*	2.33	*	16.50
Swale	Some Swale figures unavailable prior to merger of PCTs			1.00	*	12.74
Thanet	*	8.27	*	2.40	*	19.71
TOTAL for Band	*	**30.60**	*	**13.99**	*	**104.32**
Change on previous year	*	**-3.08**	*	**3.09**	*	**14.26**
Service FTE TOTAL	**148.91**					
Change on previous year	**14.27**					

2008 - 2009

	Band 4		Band 5		Qualified Health Visitor	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
Ashford	9	6.30	3	2.20	24	18.44
Canterbury & Coastal	6	4.64	7	5.35	23	18.94
Dover/Deal	5	3.44	6	5.20	22	16.35
Shepway	8	4.59	7	5.93	17	14.34
Swale	7	4.88	7	6.45	18	15.01
Thanet	12	9.41	6	4.65	21	16.26
TOTAL for Band	**47**	**33.26**	**36**	**29.79**	**125**	**99.35**
Change on previous year	*	**2.66**	*	**15.80**	*	**-4.97**
Service Headcount TOTAL	**208**					
Change on previous year	**59.09**					
Service FTE TOTAL	**162.39**					

2009 - 2010

	Band 4		Band 5		Qualified Health Visitor	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
Ashford	9	5.86	4	2.68	23	17.53
Canterbury & Coastal	8	5.48	8	5.75	22	17.86
Dover/Deal	6	4.64	8	6.60	17	12.07
Shepway	9	5.23	6	4.84	19	14.78
Swale	7	5.04	7	6.20	15	13.03
Thanet	12	8.58	7	5.49	21	15.75
TOTAL for Band	**51**	**34.83**	**40**	**31.56**	**117**	**91.02**
Change on previous year	**4**	**1.57**	**4**	**1.77**	**-8**	**-8.33**
Service Headcount TOTAL	**208**					
Change on previous year	**0.00**					
Service FTE TOTAL	**157.41**					
Change on previous year	**-4.98**					

Present (Including Vacancies)

	Band 4		Band 5		Qualified Health Visitor	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
Ashford	9	5.86	4	2.68	23	17.53
Ashford Vacancies		**0.00**		**0.40**		
Canterbury & Coastal	8	5.48	8	5.75	22	17.86
Canterbury Vacancies						**1.00**
Dover/Deal	6	4.64	8	6.60	17	12.07
Dover/Deal Vacancies		**0.80**		**0.80**		**1.80**

Shepway	9	5.23	6	4.84	19	14.78
Shepway Vacancies						1.00
Swale	7	5.04	7	6.20	15	13.03
Swale Vacancies				2.00		3.60
Thanet	12	8.58	7	5.49	21	15.75
Thanet Vacancies		0.80		0.90		4.72
TOTAL for Band	**51**	**35.63**	**40**	**34.76**	**117**	**98.42**
Change on previous year	**0**	**1**	**0**	**3**	**0**	**7**
Service Headcount TOTAL	**208**					
Change on previous year	**0.00**					
Service FTE TOTAL	**168.81**					
Change on previous year	**11.40**					

Key:

* =	No information currently available
Green =	Increase
Red =	Decrease
Balck =	No change

West Kent

Public Health Nursing Services are delivered across West Kent Community Health by geographically based teams, made-up of qualified community practitioners (health visitors and school nurses) supported by community staff nurses, nursery nurses and administrators. Each team is lead by a team leader, responsible for the line management of staff and providing clinical expertise. The Public Health Nursing Service overarching objective is to deliver the best available healthcare for people in our community by developing a multi agency approach to the delivery of the service and to develop a multi-skilled workforce to support a modern public health nursing service. Through progressive universalism, the teams offer universal access by offering home visiting, clinics based in local communities and schools, group work and telephone support. Many teams are co-located within children's centres and work closely with their multi-agency partners.

Through a mixture of home visiting, clinics based in local communities and schools, group work and telephone support, our aim is to deliver the best possible healthcare for children in our community and allow everyone to access the services in a way which suits them.

Based in six localities, our teams of health visitors and school nurses are supported by community staff nurses, nursery nurses and administrators. By developing a multi-agency approach with multi-skilled staff we hope to help families to lead as healthy a life as possible.

Teams are based at the following locations.

Gravesend: The Child Health Clinic, Gravesend

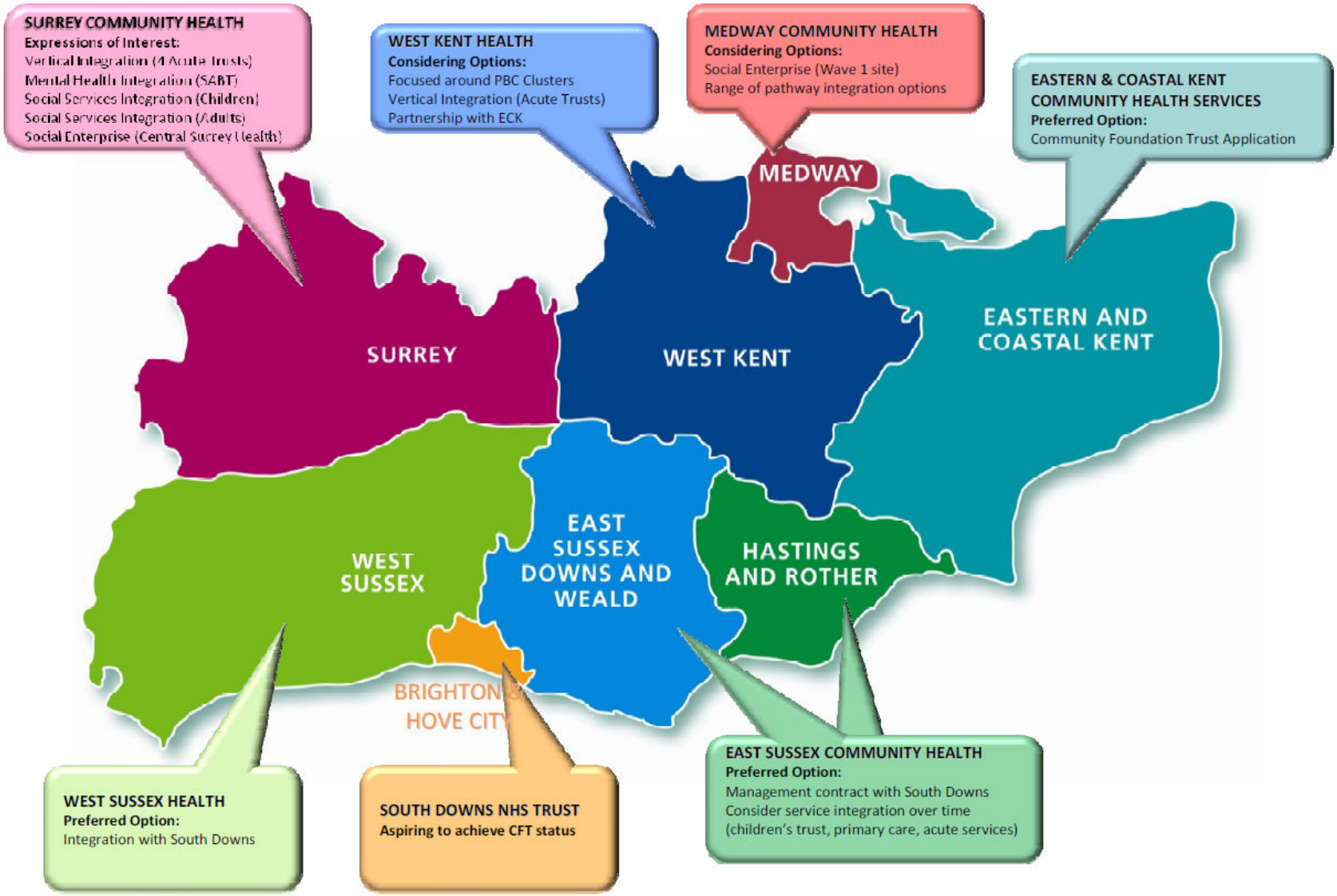
Larkfield : Larkfield Health Centre
Maidstone : Molehill Copse Clinic
Swanley : The Oaks Clinic
Tunbridge Wells : Allen Gardiner Cottage
Dartford: The Livingstone Hospital

The staffing numbers of Health Visitors in West Kent are shown below.

Health Visitors Employed	FTE	Head Count
Apr-06	40.67	52
Apr-07	43.78	55
Apr-08	37.06	46
Apr-09	64.32	86
Apr-10	64.08	85

Please note that following a data cleansing exercise at WKCH, the accuracy of the data before 2009 is unknown.

South East Coast SHA - Assessment of Community Provider Intentions



Obtained from SHA March 2010 Board Papers – ref 025/10

This page is intentionally left blank

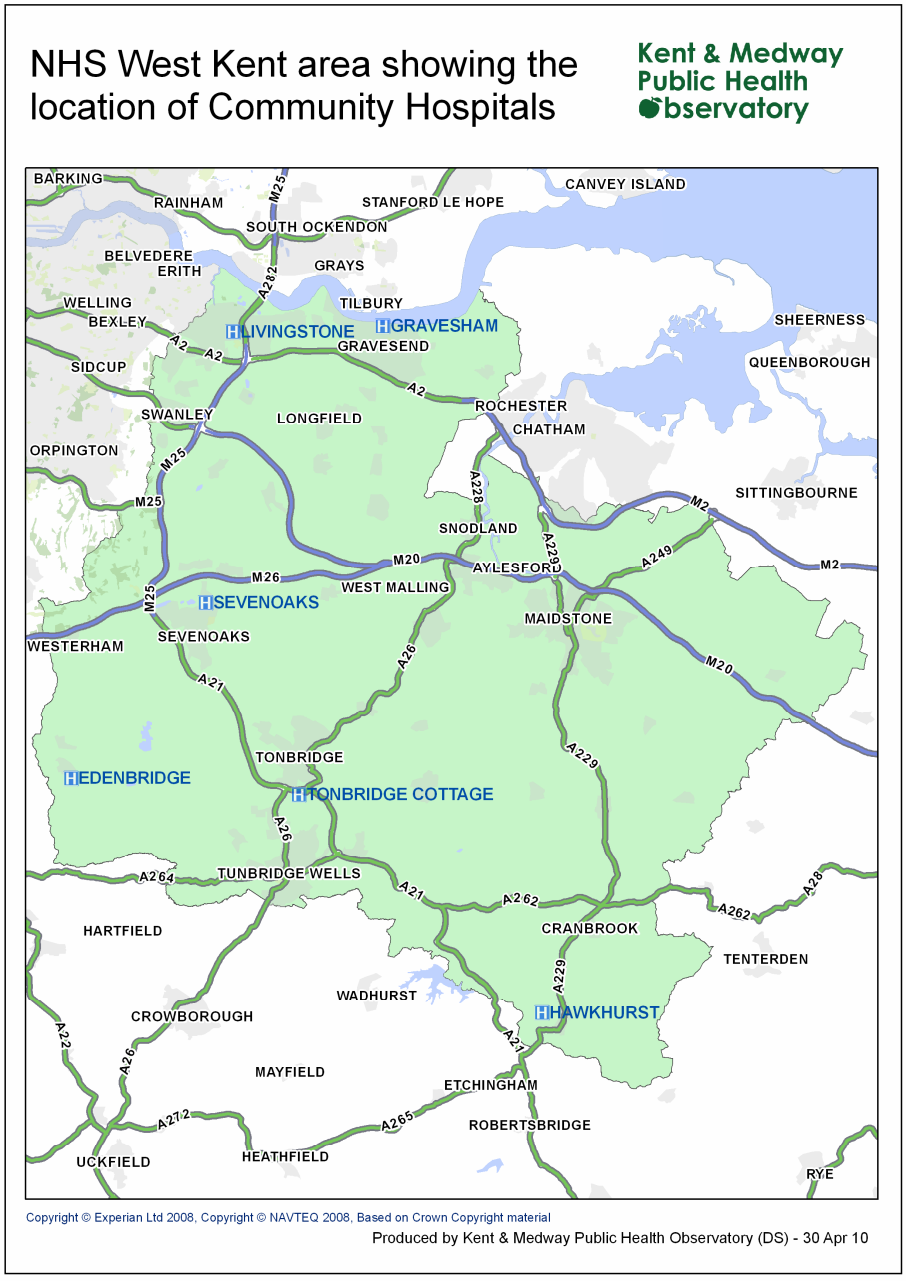
Community Hospitals in West Kent
Health and Overview Scrutiny Committee, 14th May 2010

Introduction

West Kent Community Health (WKCH) currently manages six community hospitals across West Kent. These are based in Gravesend, Dartford (Livingstone Hospital), Edenbridge, Hawkhurst, Tonbridge and Sevenoaks (see map 1).

The community hospital sites are owned by NHS West Kent and managed by WKCH.

Map 1



There are two commonly used definitions of a community hospital: one focusing on primary care and the other on acute care. Modern community hospitals are likely to be a meeting point bridging acute and primary care.

Acknowledging the bridge between primary and acute care, Professor Lewis Ritchie defines a community hospital in the following way: “A local hospital, unit or centre providing an appropriate range and format of accessible health care facilities and resources designed to meet the needs of local people. These will typically include inpatient beds, out-patient clinics, diagnostic facilities, day care, minor injuries service and other extended primary care and intermediate care services. Medical care is predominantly provided by GPs working with consultant medical colleagues. Staff work in multi-disciplinary and multi-agency teams to provide services including rehabilitation, acute medical care, palliative and terminal care, step-down care and respite care.”

Professor Geoff Meads has focused on the primary care elements of community hospitals in his definition: “The community hospital is a service that offers integrated health and social care and is supported by community-based professionals” (Meads, G. Participate. University of Warwick, 2004). **(Q15)**

The Department of Health also provides guidance on the function of a community hospital within the healthcare system.

• A modern community hospital service aims to provide an integrated health and social care resource for the local population to which it belongs.

• These local facilities develop as a result of agreements between local people, service providers and the NHS.

• Community hospitals are an effective extension to primary care with medical support provided largely by GPs.

• The health and social care provided may include medical care, rehabilitation, palliative care, intermediate care, mental health, maternity, surgical care and emergency care.

• Community hospital care is characterised by care pathways that make the most of local sources of support.

• The community hospital provides a focus for local community networks.

Services provided at our community hospitals. (Q17, Q18)

1/ Livingstone Hospital

The unit is divided into three sections consisting of an acute assessment and intervention area, where patients are located on admission in order to observe and monitor their health care needs; a progression area, for those patients that have been identified as requiring moderate to high nursing support for their rehabilitation; and an independent area for those patients that are

progressing well and are achieving their mutually agreed goals. The hospital offers 29 inpatient beds.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a care manager, a pharmacist, a visiting medical officer and medical consultants upon request.

The Impact (Rapid Response) and Community Liaison Teams, which support people in their own homes, are also based at the Livingstone Hospital.

2/ Hawkhurst Community Hospital

The unit is divided into three, three bedded wards and single rooms. Following initial holistic assessment patients are placed in the area most appropriate to their needs. This will be based upon whether they have a high health care requirement; require a moderate level of nursing with support for their rehabilitation; or need support to gain maximum independence to assist with the progression towards their jointly agreed rehabilitative goals. The hospital offers 22 inpatient beds. Other services onsite include outpatient physiotherapy and speech and language therapy, and consultant outpatient clinics.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a speech and language therapist, a care manager, visiting consultants, GPs, and a pharmacist.

3/ Edenbridge and District War Memorial Hospital

The unit has a variety of small bays (of up to 3 patients) and single rooms and offers 17 inpatient beds.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a care manager, a pharmacist, a visiting medical officer and medical consultants upon request.

In addition there is a day hospital facility where patients can be referred for individualised programmes of rehabilitation that are time limited and goal focussed.

Edenbridge and District War Memorial Hospital also provides a Minor Injuries Unit which is open 8.30pm – 4.30pm

4/ Sevenoaks Hospital

The unit has a variety of small bays and single rooms and offers 24 inpatient beds.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a care manager, a pharmacist and medical consultants.

In addition there is a day hospital facility where patients can be referred for individualised programmes of rehabilitation that are time limited and goal focussed. There are also specialist services within the day hospital for long term maintenance, Parkinson's sufferers and falls prevention.

Sevenoaks Hospital also offers outpatient clinics such as fracture and dressings clinics, X-ray facilities, daily phlebotomy (blood testing) clinic. There is also a Minor Injuries Unit which is open from 8am – 8pm.

5/ Tonbridge Cottage Hospital

The unit has a variety of small bays and single rooms and offers 24 inpatient beds.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a care manager, a pharmacist, and a community medical officer.

In addition there is a day hospital facility where patients can be referred for individualised programmes of rehabilitation that are time limited and goal focussed. There is also a specialist service for falls prevention and rehabilitation.

Tonbridge Cottage Hospital also offers a range of outpatient clinics and is a base for the on call GP service.

6/ Gravesham Community Hospital

Gravesham Community Hospital offers a variety of services the outpatient clinics listed below:

- Child behaviour,
- BCG Clinic,
- ENT,
- retinal eye screening,
- school nurse hearing screening,
- psychiatric clinics,
- orthopaedic & rheumatology treatment clinic,
- fracture clinic,

- family planning,
- smoking cessation,
- young persons' clinic,
- ultrasound,
- vascular clinic,
- cardiac rehab,
- physiotherapy.
- Dressings clinic
- Phlebotomy (blood testing)
- Access point for needle exchange
- Chlamydia screening and the morning after pill.

In addition to the outpatient clinics, there is a day hospital provided which specialises in building up people's confidence and independence as they recover from illness or injury. It also offers specialist sessions for people with dementia.

The hospital also provides a Minor Injuries Unit which is open from 9am – 9pm.

Gravesham Community Hospital also houses the Sapphire Unit which is a specialist neuro-rehabilitation unit providing 15 inpatient beds and the following services:

- Specialist care of patients with a neurological condition such as multiple sclerosis, Parkinson's Disease, stroke, head injury.
- The highly skilled and experienced nurse-led team specialise in supporting patients' rehabilitation.

Gravesham Place (located at Gravesham Community Hospital)

Gravesham Place is a care home run by Kent Adult Social Services offering residential care and intermediate care, for people recovering from illness or injury.

There are currently no plans to add or remove services from any of the community hospitals. However, there is service modernisation plans active throughout the community services provision in line with the Transforming Community Services agenda.

Inpatient Beds (Q21, Q22)

All of our six community hospitals provide inpatient beds and in total there are 131 beds available. The average length of stay in one of these beds is currently 21.6 days.

Minor Injuries Units (Q19, Q20)

There are three MIUs operating in West Kent at Edenbridge Hospital, Sevenoaks Hospital and Gravesend Community Hospital. These are open seven days a week, 365 days a year. The opening hours are dependent on the site:

Edenbridge Hospital MIU: 8.30am – 4.30pm
Sevenoaks Hospital MIU: 8am – 8pm
Gravesham Community Hospital: 9am – 9pm

The MIUs currently treat non-emergency injuries. These are walk-in centres (no appointment required) and are staffed by emergency nurse practioners.

Emergency Nurse Practitioners at an MIU can clean and stitch cuts or grazes, remove foreign bodies from ears/noses etc, dress minor wounds, treat minor burns, treat minor eye injuries and more.

There are currently no plans in place to change the MIU services available. However, we will be reviewing how the MIU interfaces with other services in an effort to look at how MIU can further assist with the effective navigation and treatment of patients to reduce the impact on emergency care services.

In comparison, Accident and Emergency Centres and Emergency Care Centres are designed to assess and treat those patients with serious illness or injury which could present a threat to life. There is also an Urgent Care Centre in Dartford which is able to treat minor illness as well as injury.

All of these centres are open seven days a week, 365 days a year. The A&E and Emergency Care Centres are open 24 hours a day.

The difference between the acute hospitals and community hospitals. (Q16)

Acute trusts provide services such as surgery, intensive care units, A&E departments, specialist medical intervention, interventions requiring medical technology, neonatal intensive care and other services which fall under the category of 'acute brief interventions.' Community hospitals provide services which are more designed to be an extension of the primary care service in an environment where health and social care are more integrated to provide services such as:

- Rehabilitation (eg physiotherapy)
- Palliative care
- Intermediate care
- Minor surgery (such as podiatrics)
- Public health and wellbeing services
- Dental Care
- Counselling
- District-nurse led clinics

- Health Visitor led clinics
- Chiropody and podiatry
- Health promotion
- Older people's services
- Children's services
- Maternity Services
- Mental Health
- Inpatient Beds
- Acute and community outpatient clinics
- Continuing care beds
- Diagnostic facilities
- Day Care
- Minor Injuries Care

Relationship with other trusts (Q23)

The community hospitals provide a supportive role for the acute trusts in the area, specifically for those patient requiring intermediate care and rehabilitation which could not be achieved in the home. The community and acute teams work closely together to facilitate patient discharge and the relationship with social services allow therapists and nursing teams to effectively review patient progress and ensure that patients are discharged efficiently and into an appropriately managed home environment.

Properties owned or managed by PCTPS (Q9)

Following the PCT – provider split, the PCT is following the principle of the commissioner retaining the assets and as such, West Kent Community Health do not own any of the PCT premises. The management of the premises in terms of hard FM/ estates management is outsourced to a shared services provider and the operational day to day reporting of the premises issues is the responsibility of West Kent Community Health.

Future Development of Community Hospitals. (Q3)

There are no immediate plans to change the focus of our community hospitals which concentrate on the rehabilitation of patients in terms of step down from acute hospitals and assessment of patients needs in terms of step up from GPs. In line with Transforming Community Services, we have been a national pilot site for the "Productive Community Hospitals" toolkit and we will continue to look for opportunities to improve the quality of what we do and the productivity of our staff.

Conclusion

This paper aims to provide a summary of community hospitals in NHS WK. NHS WK will welcome questions on this matter at the Health Overview and Scrutiny Committee on the 14th May.

This page is intentionally left blank

NHS
Eastern and Coastal Kent

Community Hospital Services
Overview of NHS Eastern and Coastal Kent Health Overview and Scrutiny Committee - 14th May 2010

1. Introduction

1.1 This paper aims to provide Members of the Committee with an overview of the current position of community hospitals in NHS Eastern and Coastal Kent (NHS ECK).

1.2 The questions answered in each section of this paper are referenced on the right hand side of the paper.

1.3 Appendix one shows a map of where community hospitals are located within NHS ECK

2 What are community hospitals?
Q15

A community hospital is a venue/ site outside of the main acute hospitals which provides a variety of services to local people. These typically include inpatient-beds, out-patient clinics, diagnostic facilities, daycare, minor injuries service and other extended primary and intermediate care services although services will vary between hospitals depending on other services available in the local area. Medical care is predominately provided by GPs working with consultant medical colleagues. Staff work in multi-disciplinary and multi-agency teams to provide services including rehabilitation, acute medical care, palliative and terminal care, step- down care and respite care that are integrated with the full range of services provided by ECK CS.

3 Community Hospitals in NHS ECK
Q17

There are eight community hospitals within NHS ECK the Royal Victoria Hospital and Buckland Hospital and managed and run by East Kent Hospitals Foundation Trust all other community hospitals are run and managed by ECK CS. Listed below is summary of the services that are provided on each of the community hospital sites;

3.1 VICTORIA HOSPITAL DEAL

General opening hours: 8.15 – 6pm Monday - Friday

Minor Injury Unit

- Minor Injuries Unit is open from 8.00 a.m. – 6.00 p.m. 7-days per week

Outpatients Department

- Range of out patient departments facilities for acute and community clinics:

Include ECG (Heart tracings) Phlebotomy Service for GP's (blood tests) X-Ray facilities Orthopaedic	General Medicine General Surgery Gynaecology Paediatric (children) Gastroenterology	Rheumatology Care of the Elderly Ear, nose, throat Ophthalmology

Inpatients – two wards comprising:

- 26 beds of which 4 are continuing healthcare
- 22 Intermediate care beds – includes 2 palliative care suites

3.2 QUEEN VICTORIA MEMORIAL HOSPITAL HERNE BAY

General opening hours: 8.30 6pm Monday - Friday

Day Centre

- Multi -disciplinary support for older people
- Blood Transfusions
- I.V. Therapies (drugs administered into a vein, through a cannula)

Outpatients Department

- Wide range of acute and community clinics:

Phlebotomy (blood tests) General Surgery Gynaecology Paediatric	Gastroenterology Orthopaedic X-Ray Dermatology	Rheumatology Care of the older person (HCOOP) Hearing Tests

Inpatients – 23 Beds

- For intermediate care including palliative care beds

3.3 **WHITSTABLE and TANKERTON HOSPITAL**

General opening hours: 8.30 6pm Monday - Friday

Outpatients Department

- Small Outpatients department providing facilities for acute and community clinics;

General Surgery Gynaecology	General Medicine Ophthalmology	Rheumatology

Inpatients - 2 Wards comprising:

- 1 ward with 9 beds
- 1 ward with 24 beds for intermediate care

3.4 **FAVERSHAM COTTAGE HOSPITAL**

General opening hours: 8.30 6pm Monday - Friday

Treatment Centre

- Minor Treatments – 9.00 a.m. – 5.00 p.m. 7-days per week
- Outpatients – Multi-agency provided in adjoining Health Centre – OPD facilities for acute and community clinics supported by:

Gynaecology Paediatric Care of the older person	Vascular Nurse Hand Clinic East Grinstead	Rheumatology Physiotherapy

Inpatients – two wards comprising:

- 1 ward of 14 continuing care beds
- 1 ward of 15 Intermediate care

3.5 **SITTINGBOURNE MEMOIRAL HOSPITAL**

General opening hours: 8.30 6pm Monday - Friday

Minor Injury

- Services for Minor Injury/Illness from 9.00 a.m. – 9.00 p.m. 7-days per week

Outpatients Department

- range of outpatient services for acute and community clinics supported by:

General Surgery Obstetrics/Gynae (women's health) Children's Clinics Medical Urology (bladder) Obesity Clinics Lymphoedema Clinic Dietician Audiology (hearing)	Orthopaedic (bones) Ophthalmology (eyes) Dermatology (skin) Speech Therapy Podiatry (feet) Physiotherapy Psychiatry ECG (heart tracings) Rheumatology Nurse	Elderly Medicine Ear, nose throat Sexual Health Public Health Clinics Continence Service District Nurse Clinics Phlebotomy Weight Management Team

Inpatients

- 1 ward x 24 – primary/intermediate care including palliative care

3.6 **SHEPPEY COMMUNITY HOSPITAL**

General opening hours: 8.30 8pm Monday - Friday

Minor Injury

- Currently open from 9.00 a.m. – 9.00 p.m. for minor injury/illness 7-days per week

Outpatients Department

- Wide range of Out patient services for acute and community clinics support by:

General Surgery Obstetrics/Gynae Children's Clinics Medical Urology Obesity Clinics Lymphoedema Clinic	Orthopaedic Ophthalmology Dermatology Speech Therapy Podiatry Physiotherapy Psychiatry	Rheumatology Nurse Elderly Medicine ENT Sexual Health Public Health Clinics Continence Service District Nurse Clinics

Dietician	ECG	Audiology

- Open access centre provided by Dulwich Medical Centre – walk-in primary care services

Inpatients –

- 1 ward x 20 – primary/intermediate care including 8 x stroke beds
- 1 ward x 20 – primary/intermediate care - including palliative care

3.7 **Buckland Hospital Dover**

Buckland Hospital in Dover provides a range of outpatient services, a minor injuries service, a renal dialysis unit and a birthing unit. There are no in-patient beds on this site.

3.8 **Royal Victoria Hospital Folkestone** **Q16**

Royal Victoria Hospital, Folkestone, provides a range of outpatient services.

It is also home to the Folkestone Walk-In Centre, which treats minor injuries and illnesses. There are no in-patient beds on this site.

3.9 Minor Injuries Units treat minor injuries and Walk in Centres can treat minor injuries and minor illnesses. No appointment is needed. They are staffed by Nurse Practitioners. These services have variable opening times but are usually open 365 days a year. Examples of illness and injuries where a Walk in Center would provide treatment include;

- Minor cuts and bruises.
- Minor burns.
- Strains and sprains.
- Stomach upsets.
- Coughs and colds.
- Minor infections.
- Minor bites and stings.
- Emergency contraception.

3.10 An emergency care centre is provided at Kent and Canterbury Hospital to treat emergency medical cases for example stroke, whilst serious road traffic accidents would be seen at Accident and Emergency (A&E) departments at either William Harvey or Queen Elizabeth Queen Mother Hospitals . People who have a serious injury or illness should call 999 or go to an A&E department. These units are staffed by specialist doctors and nurses and are open 24 hrs a day and 365 days a year. The

emergency care centre would treat patients with a number of more serious conditions including:

- Loss of consciousness.
- Pain not relieved by simple analgesia.
- Acute confused state.
- Chest pain.
- Breathing difficulties.
- Serious accidents.
- Severe bleeding.
- Deep wounds.
- Suspected broken bones.

Q19

3.11 There are 197 inpatient beds across all six community hospitals. These beds are primarily used to provide intermediate care for patients who either do not require admission to an acute hospital but require treatment that cannot be delivered in their own home or patients who are able to be discharged from an acute hospital but are not yet ready to return home. Examples of this would include Stroke patients who need further support to mobilise. Non weight bearing orthopaedic patients needing 6/8 weeks bed rest before starting rehabilitation. Amputees, needing help mobilising from bed to chair. Intermediate care is also provided in a number of other venues including nursing homes where community nurses provide in-reach services to support patient care and in facilities such as Westview and Westbrook through joint working with KCC.

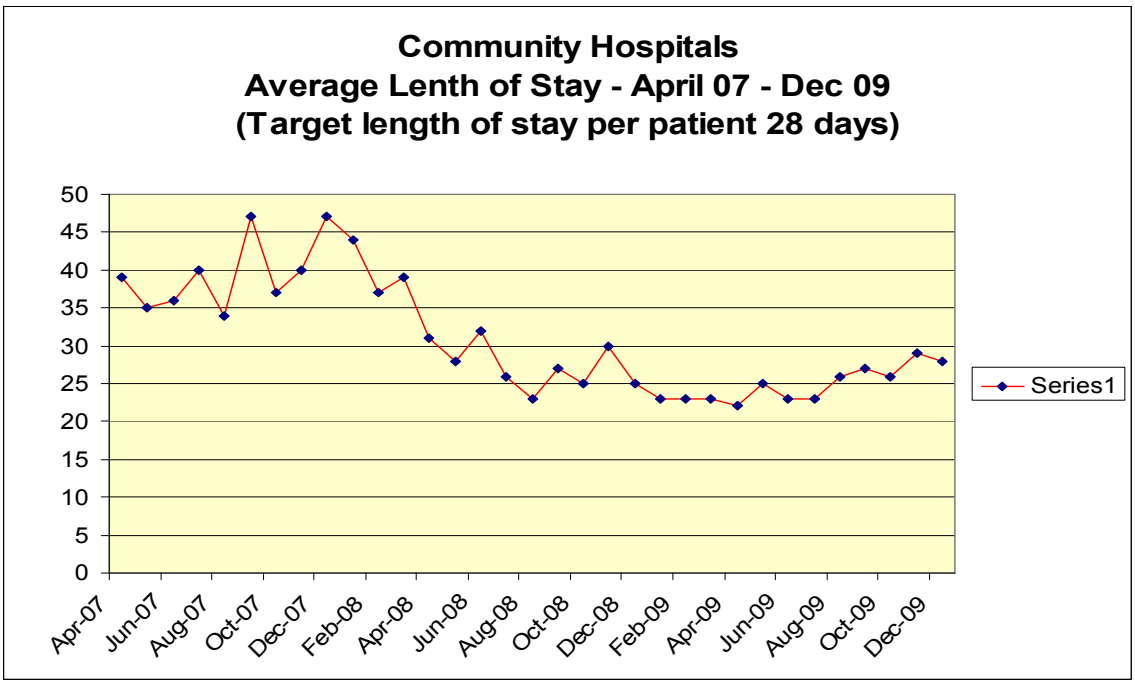
3.12 Intermediate care provision in Shepway is provided at Broadmeadow, a Kent County Council facility in Folkestone which has 20 intermediate care beds. Intermediate care beds are also available at West View in Tenderden, (30 beds), Westbrook House, Margate (30 beds) and Cornfields in Dover (14 beds). West View and Westbrook House are both integrated care centres and are subject to Section 75 funding arrangements between KCC and NHS Eastern and Coastal Kent. The beds are staffed by KCC care staff and nursing staff who have been seconded to KCC from NHS Eastern and Coastal Community Services. Cornfields is a KCC provided unit.

Intermediate care is provided to all four units by the community intermediate care teams who in-reach into the facilities to provide the rehabilitative support required. This model of intermediate care has been achieved by good joint working between the local authority and NHS Eastern and Coastal Kent.

3.13 The table below illustrates the reduction over the past two years of the average length of stay in the in-patient beds in ECK-CS run community

hospitals with a current average length of stay of 28 days for rehabilitation patients. This is now in line with other facilities (Social Services and Independent Sector) intermediate care beds. There are still, on occasion, difficulties caused by lack of care home beds or long waiting lists in care homes of choice which can impact on length of stay figures in some areas. A proactive approach is applied in supporting families in seeking alternative long term placements in these situations.

Q21, Q22



Community Hospitals support patients who require on-going rehabilitation and a higher level of medical and nursing input than could be safely be provided in a home setting thus preventing patients from being admitted to or staying in an acute hospitals when the nature of their illness means this is not clinically necessary.

ECK CS work closely with the acute hospitals and KASS to identify suitable patients for community hospitals. Intermediate care reaches into the acute hospital wards as part of the discharge process. They provide support and easy access to the ward staff to facilitate quicker discharge. Care mangers from social services are a part of this process.

Patient's progress is managed proactively in partnership with KASS in weekly multidisciplinary team meetings that include nursing team therapists and Social Services review all patients progress to ensure clear treatment and discharge plans are made in a timely manner.

Q23

4. The future of community hospitals?

4.1 Community hospitals play a critical role in supporting the implementation of the PCTs community services commissioning strategy. One of the goals of the strategy is to commission more and better services closer to or within people's homes and to make it easier for them to access health services so that as a consequence there is a reduction in referrals into acute hospitals. In order to deliver this the PCT needs to ensure community hospitals are able to:

- Increase the range of services available
- Increase the accessibility of services
- Ensure services are responsive to the public's needs

It is clear that considerable strides have been made to meet the PCTs strategic commissioning plan but further work is underway to ensure community hospitals are fully utillised and that the buildings are updated and modernised. The further development of community hospitals will be based upon the following key principals.

- Ensuring the safe delivery of clinical services
- Increasing productivity and achieving optimum utilisation of estate
- Consolidation of services and accommodation.
- Improved local access to services

Q3

4.2 The provision of minor injury services in East Kent is subject to regular reviews, both as part of the NHS Eastern and Coastal Kent's Urgent Care Strategy and through periodic performance management of the providers with the emphasis on delivering better patient care whilst ensuring enhanced value. In addition to provision in minor injuries units and walk in centres minor injury services are provided by eight GP practices in areas where patients do not have easy access to minor injury units or walk in services.

Q18

5. Consultation

NHS ECK has ensured there has been strong engagement involving all services users at each of the community hospitals. As an example in March 2009, the NHS Eastern and Coastal Kent Patient and Public Engagement team commissioned a market research project from Opinion Leader to inform the development of a revised service specification for

Faversham Minor injuries unit. By using street surveys, service user surveys and public meetings the market researchers were able to test the local community awareness of the service and to identify people's experience of using the Minor Injury Unit.

More than 500 people from Faversham gave their views during this market research. The results showed that 11 per cent of people did not know there was a Minor Injuries Unit based at Faversham Cottage Hospital. Further engagement activities from April to June 2009 concluded that the community of Faversham was in favour of the Minor Injury Unit continuing and for it to be developed further.

The results of the market research were shared at a public meeting. The meeting was also an opportunity for NHS Eastern and Coastal Kent to confirm the following:

(a) The commitment that local people should have access to minor injury services and that a pilot (from 1 July 2009 to 31 March 2010) would be run to test an enhanced service with dedicated specialist nurses;

(b) During the pilot the service would be promoted and communicated in an attempt to increase usage and reduce the number of Faversham residents attending other urgent care services including Accident and Emergency Departments.

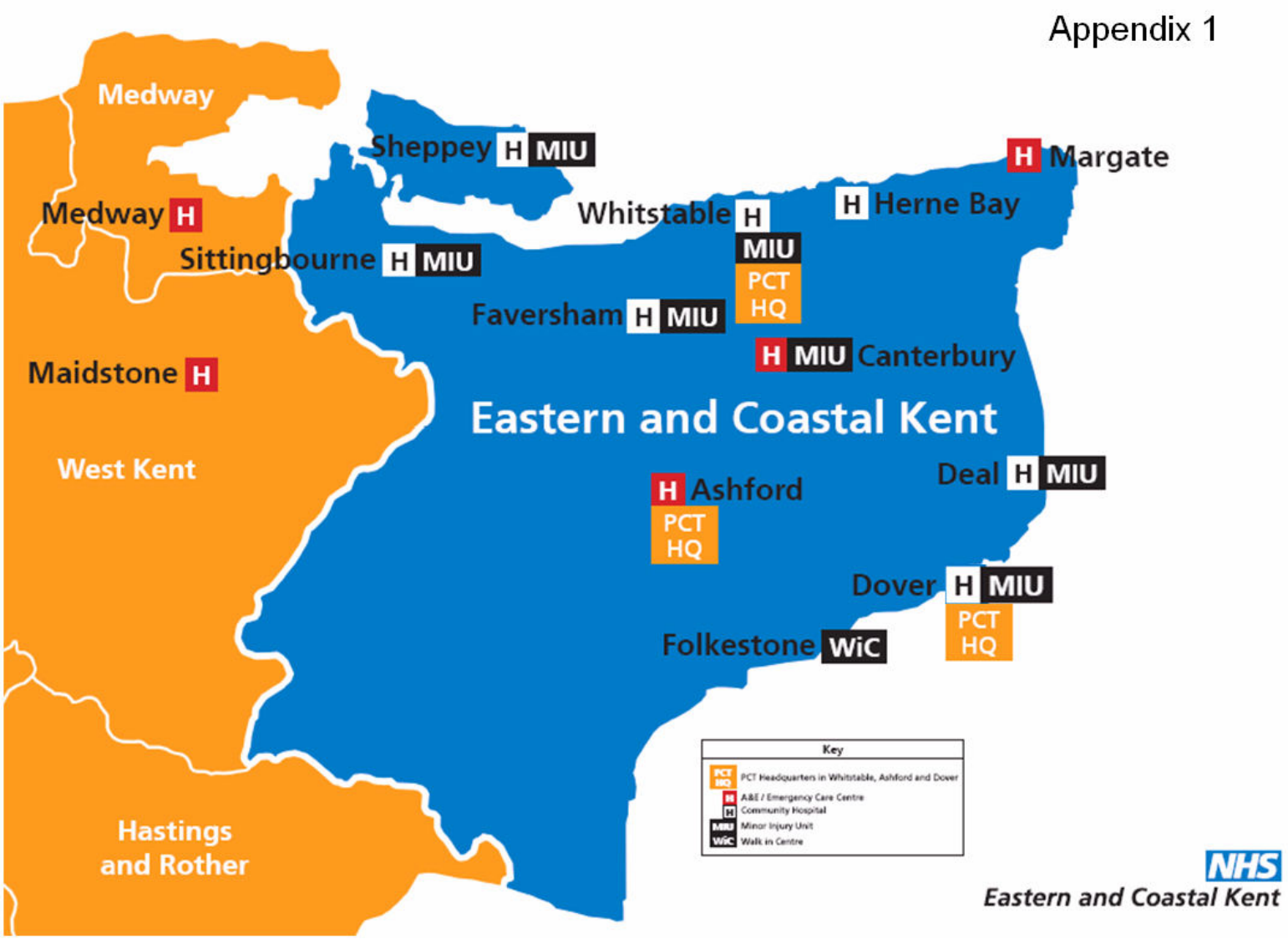
There has also been good engagement with other stakeholders about plans to develop a community hospital in Dover. NHS ECK is committed to ensuring service users continue to be involved in the development of services at all of the community hospitals. A revised service specification has now been drafted which will extend the opening hours to twelve hours per day seven days a week and reflects comments and feedback from the public co-design events. The PCT has secured a provider for this service from 1st July onwards.

Q20 and Q4

6. Appendices

Appendix one shows a map of the locations of community hospitals with services managed by ECK CS within NHS ECK. In addition Buckland Hospital in Dover is managed by East Kent Hospitals University Foundation Trust.

Appendix 1


Medway
Medway H
Sittingbourne H MIU
Maidstone H
West Kent
Hastings and Rother
Sheppey H MIU
Whitstable H MIU PCT HQ
Faversham H MIU
H Margate
H Herne Bay
H MIU Canterbury
Eastern and Coastal Kent
H Ashford PCT HQ
Deal H MIU
Dover H MIU PCT HQ
Folkestone WiC
Key
PCT HQ PCT Headquarters in Whitstable, Ashford and Dover
H A&E / Emergency Care Centre
H Community Hospital
MIU Minor Injury Unit
WiC Walk in Centre
NHS
Eastern and Coastal Kent

This page is intentionally left blank

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 14 May 2010

Subject: Item 5. Care Quality Commission Registration.

---

1. Background

(a) On 1 April 2010, all 378 NHS Trusts providing services in England were required by law to be registered with the Care Quality Commission. Registration is dependent on compliance with 16 principle essential standards of quality and safety.

(b) For 22 Trusts, registration was conditional on improvements being made. Of these Trusts, 2 are based in Kent and Medway - Medway NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership Trust.

(c) Following a request from the Chairman of the Health Overview and Scrutiny Committee, the attached reports have been received from Medway NHS Foundation Trust.

2. Recommendations

(a) The Committee is asked to note the information provided.

This page is intentionally left blank

Medway NHS
NHS Foundation Trust

Committee: Health Overview & Scrutiny Committee **Date**: 14 May 2010

Report of: Chief Executive, Medway NHS Foundation Trust

Author: Company Secretary, Medway NHS Foundation Trust

CQC Registration action plan

1 Care Quality Commission registration

1.1 As Members will no doubt recall, earlier this year all NHS Acute Trusts were obliged to prepare an application for registration by the Care Quality Commission (CQC). The registration scheme came into effect from 1 April 2010 as a result of the provisions of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and currently requires healthcare providers to be registered in order to continue to provide any of the 15 regulated activities.

1.2 Healthcare providers must register each of the premises at which they carry out regulated activities. Medway NHS Foundation Trust (the Trust) applied to register Medway Maritime Hospital in respect of the majority of regulated activities, and Preston Skreens and Woodlands Nursery in respect of relevant regulated activities, as indicated below.

Activity	Medway Maritime Hospital	Woodlands Nursery	Preston Skreens
Personal care			
Accommodation for persons who require nursing or personal care	✓	✓	✓
Accommodation for persons who require treatment for substance abuse			
Accommodation and nursing or personal care in the further education sector			
Treatment of disease, disorder or injury	✓	✓	✓
Assessment or medical treatment for persons detained under the Mental Health Act 1983	✓		
Surgical procedures	✓		

Diagnostic and screening procedures	✓		
Management of supply of blood and blood derived products			
Transport services, triage and medical advice provided remotely			
Maternity and midwifery services	✓		
Termination of pregnancies	✓		
Services in slimming clinics			
Nursing care	✓		
Family planning service			

1.3 The Trust submitted its application in January, as required, indicating that it was compliant with all bar two of the registration requirements. The Trust's application acknowledged weaknesses in respect of Regulation 11, "Safeguarding people who use services from abuse", because of previous findings by the CQC that the Trust's records of training relevant staff in the safeguarding of children were not adequate to assure the Commission that enough training had taken place; and Regulation 15 "Safety and Suitability of premises", again because of previous findings by the CQC that the Trust does not adequately follow up action plans arising from assessments of the needs of people with disabilities.

1.4 The application was accompanied by an action plan to address these issues and achieve compliance with the relevant regulations. Details of the action plan and a statement of progress against it are set out in Appendix 1.

2 Outcome of the application for registration

2.1 The outcome of the Trust's application was published on 1 April 2010. The Trust has been registered in respect of all activities and locations covered by its application. Conditions have, however, been applied to the Trust's registration in respect of all three locations.

2.2 Details of the conditions and the reasons for their imposition are set out in Appendix 1, in the form of an action plan intended to address the necessary steps the Trust must take to have the conditions lifted. In summary, the conditions relate to the provision of evidence that the Trust has trained in adequate number of staff in all relevant aspects of safeguarding children and vulnerable adults; has properly recorded and learned lessons from all untoward incidents that have occurred on Trust premises; and has used the clinical audit process effectively to ensure the continuous improvement of services. The conditions include dates by which the Trust is required to achieve compliance with the relevant regulations; these vary from 1 May 2010 to 1 July 2010.

2.3 There is no bar to the Trust continuing to provide the regulated activities while

the conditions are in place - the CQC can impose "restrictive conditions" which limit the provision of regulated services (eg by location or by age range), but the conditions imposed on the Trust do not fall into that category. Carrying out the regulated activities otherwise than in accordance with a CQC registration and any conditions (including non-restrictive conditions) attached to it is a criminal offence under the 2008 Act and punishable on conviction by a fine of up to £50,000.

2.4 The Trust will need to apply to have the conditions attached to its registration lifted and demonstrate in the course of doing so that it is compliant at the time of that application with the associated Regulations. Additionally, the CQC will assess the Trust's evidence in respect of its compliance with the Regulations cited in its application as non-compliant. Failure to tackle these areas of non-compliance in accordance with the action plan submitted with the Trust's original application and to achieve compliance by the dates indicated in those action plans is likely to lead to the imposition of further conditions.

2.5 The existence of the conditions on the Trust's registration is a matter of public record, and clearly has implications for the Trust's reputation amongst partners and service users.

4 Measurement and Monitoring

4.1 The action plan has been monitored weekly at the Trust's Executive Directors' meeting, and will continue to be reviewed on a weekly basis by the Executive team, and by the Board on a monthly basis, until all conditions have been lifted.

5 Options Appraisal

5.1 The actions described in the action plan have been considered as the most effective measures likely to achieve the removal of the conditions from the Trust's registration. Given the nature of the conditions, it would not really be possible to change the services provided or the registered locations as an alternative to addressing the CQC's concerns.

6 Financial Resources

6.1 Like all other Trusts, the Trust will be required to pay an annual fee for its registration, but the fees regime has yet to be confirmed. It is not clear whether there will be a separate fee for each location.

6.2 Trusts will also be required to pay a fee for each application to have a condition removed, but again, the CQC has not yet announced how much this will be. The Consultation on the fees regime closed in April. No date for announcement of the fees has been made public. Because of this uncertainty, no budget allocation has yet been made or sought. It is not anticipated that

	the fee will give rise to any detrimental impact on the provision of services across the Trust.
7	**Other Resources**
7.1	The action plan and associated monitoring arrangements will not of themselves require additional resources. Compliance with the CQC's requirements, particularly in respect of training, will require significant resources on an annual basis but such costs have been built into existing budgets.
8	**Risk Analysis**
8.1	Failure to achieve and maintain compliance with the Regulation will lead to significant limitations on the Trust's ability to function, and may lead to criminal prosecution. The risk of these outcomes is noted on the Trust's corporate risk register. Strict adherence to the action plan and any amendments to it agreed by the CQC will be necessary to obviate this risk.
9	**Equality Impact Assessment**
9.1	There is no known potential for the proposed action plan to give rise to inequitable treatment as a result of any person's disability, age, race, religion or belief, gender or sexual orientation.
10	**Information Governance Assessment**
10.1	There is no known potential for the proposed action plan to compromise the Trust's ability to comply with the main planks of Information Governance legislation (Freedom of Information Act, Data Protection Act).
11	**Environmental Assessment**
11.1	There is no known potential for the action plan to have an adverse impact on the environment.
12	**Recommendation to the Committee**
12.1	The Committee is recommended to note the action plan and the arrangements for monitoring its progress.

Contact details: **Loïs Howell, Company Secretary, Medway NHS Foundation Trust**

Lois.howell@medway.nhs.uk

01634 833824

Medway NHS
NHS Foundation Trust

1) The Registered Provider must ensure that clinical governance and audit systems, to assess and monitor the quality of services provided, are in place across all services by 30 June 2010			
REASON: The registered provider is in breach of regs 9 (care & welfare of people who use services) and 10 (assessing and monitoring the quality of service provision) ...systems to monitor training and outcomes of audit and reporting to the Board are not well established. Improving these systems will enable the service provider to determine the quality of services and outcomes for patients			
ACTION REQUIRED	**BY WHOM**	**BY WHEN**	**UPDATES**
▪ Statutory and mandatory training requirements to be reviewed	HR Director	31.05.10	Essential training review in hand, new statement of requirements to be published 01/05/10 19/04/10:- Review complete with the exception of safeguarding children & adults who have a deadline of the 20th April. Marketing / Publication plan will be put into place following completion of electronic TNA. Whole day training available for those who require it. IT team asked to re-prioritise work to support the completion of access to an electronic TNA which can be interrogated by directorate / department / job title. They have a deadline of 23rd April to launch. 26/4/10:- Marketing/Publication plan in place – ready to communicate to managers and staff. IT team have re-prioritise work to support the completion of access to an electronic TNA. Due to the requirement to ensure user friendly by job titles, this will be reworked to test with managers and launch 3/5/10.

Medway NHS
NHS Foundation Trust

ACTION REQUIRED	BY WHOM	BY WHEN	UPDATES
▪ Training uptake monitoring arrangements to be reviewed and improved	HR Director	31.05.10	Central booking system to be introduced 01/05/10 to improve monitoring arrangements Central booking system to be introduced 01/05/10 to improve monitoring arrangements 19/04/10:- Central booking team will be in place by 26th April. This means 1 place to book and hold central training data. Helpdesk provision, to support getting onto the e-learning system. The team will also be responsible for daily monitoring, dealing with DNAs, cancellations and non-compliance and uptake problems. 26/4/10:- Core Essential Training booking team in place from 26/4/10 & communications plan underway.
▪ Audit plan to be reviewed to ensure that the timeframe for re-audit is in keeping with the timescale set by the CQC	Medical Director	13.04.10	On IAC agenda 13/04/10 – paper written 19/04/10:- We are required to initially submit some data initiation rates via a special collection form in relation to four of the National Priorities of which one is Engagement in clinical audits The deadline for submission of this is 06/05/10 and our data will be scrutinised by the Executive team on 04/05/10 prior to submission.
▪ An update on the audit plan to be provided to the IAC on the 13/04/10	Medical Director	13.04.10	On IAC agenda 13/04/10 – paper written 19/04/10:- The paper was agreed and accepted by the IAC
▪ Actions to be monitored weekly at the Exec team meetings	Execs		

Medway NHS
NHS Foundation Trust

2) The Registered provider must have an effective system for reporting, investigating and disseminating learning from incidents in place before 01 July 2010			
REASON: The provider is in breach of regulations 9 (care & welfare of people who use services) and 10 (assessing and monitoring the quality of service provision) as follows: ▪ There are 1,300 incidents which require risk rating ▪ Monthly reporting to the directorates about incidents has not happened since July 2009 ▪ Monthly reporting to the board about incidents has not happened since March 2009 ▪ The process for disseminating lessons learned from SUIs was not implemented until February 2010 ▪ None of the re-audits scheduled to take place in respect of already audited services have been conducted yet			
ACTION REQUIRED	**BY WHOM**	**BY WHEN**	**UPDATES**
▪ Ensure that all outstanding incident forms are loaded onto DATIX	Medical Director	31.03.10	Backlog of forms cleared
▪ There will be monthly reporting of trends and dissemination of learning from incidents to the directorates and the patient safety committee from 1st May 2010 and bi-monthly to the Quality & Safety Committee	Medical Director	30.04.10	Report coming to April Board
There will be quarterly reporting of trends and dissemination of learning from incidents to the Board from April 2010	Medical Director	31.04.10	This is on the Board work programme
▪ Update on the audit plan to IAC 13/04/10	Medical Director	13.04.10	On agenda, paper written 19/04/10:- The paper was agreed and accepted by the IAC
▪ Actions to be monitored weekly at the Exec team meetings	Medical Director		

Medway NHS
NHS Foundation Trust

3) The Registered provider must have a system for assessing the capacity of patients to consent to treatment , and have trained staff to use this effectively by 01 June 2010			
REASON: The provider is in breach of reg 18 (consent to care and treatment) as follows: ▪ Only 6.9% of eligible staff have undertaken Mental Capacity Act (MCA) training ▪ There is no data on uptake of Deprivation of Liberty (DoL) training ▪ There have been 2 Sudden Untowards Incidents (SUI) concerning patients with reduced mental capacity			
ACTION REQUIRED	**BY WHOM**	**BY WHEN**	**UPDATES**
▪ Ensure that all eligible staff receive MCA training before 1st June 2010	Medical Director	31.05.10	30/03/10:- A training plan is already in place. A meeting is planned for 31/03/10 to strengthen the plan to ensure that the trust is compliant before the 1st June 2010 09/04/10: - meeting took place, all relevant staff have been sent a letter signed by Medical Director & Director of Nursing requiring training to be completed and setting out dates of available sessions. HR Director investigating provision of additional sessions 19/04/10:- Letters now sent to all relevant employees eligible to undertake MCA training. Training Needs Analysis amended to reflect MCA eligibility requirements. Employees encouraged to undertake the training online, but additional face to face training have also been scheduled. Director of HR has not investigated the availability of additional trainers due to the availability of online learning 26/4/10:- Pro-active approach by GM's and Business Partners to address individuals in non-compliant areas. Human Resources Director has asked all General Managers for their degree of confidence in meeting the target.

Medway NHS
NHS Foundation Trust

ACTION REQUIRED	BY WHOM	BY WHEN	UPDATES
▪ Data on uptake of D of L training to be produced	Director of Nursing	16.04.10	19/04/10:- Data on DoL training now available. 189 eligible employees, now undertaking a cross reference of which individuals have already undertaken the training (to be complete by Wed 22nd April). Training is available via e-learning. 26/4/10:- Number of eligible staff increased to reflrect the fact that non-clinical managers on on-call rota should also be trained. Data re: numbers trained not certain as of today's date because of poor quality data from external training provider – issue being pursued as a matter of urgency.
▪ Uptake of D of L training to be reviewed for adequacy – action plan to increase uptake to be produced if required	Director of Nursing	21.04.10	19/04/10:- Data will be collated on a daily basis & circulated to Execs / GMs / CDs. Data provided to exec meetings will be for the proceeding week (48 hour gap). 26/4/10:- Pro-active approach by GM's and Business Partners to address individuals in non-compliant areas.
▪ Actions to be monitored weekly at the Exec team meetings			

Medway NHS
NHS Foundation Trust

4) The registered provider must ensure that staff who have contact with children or vulnerable adults in the course of their duties have received training in adult safeguarding and child protection before 01 May 2010.

REASON: The provider is in breach of reg 11 (safeguarding people who use services from abuse) as follows:

- Not all eligible staff have received vulnerable adults safeguarding training
- Not all eligible staff have received child protection training
- Not all eligible staff have received Mental Capacity Act training

ACTION REQUIRED	BY WHOM	BY WHEN	UPDATES
Ensure that all eligible staff that have contact with children have training in child protection before 1st May 2010	Medical Director	30.04.10	19/04/10:- All data on safeguarding children, adults, MCA and DOLS will be circulated on a daily basis to execs / GMs / CDs and a summary provided to execs on a Tuesday night, for the proceeding week. Line managers & staff have all been communicated with. It is clear who needs the training in each area. Some employees are querying the appropriateness of training, system in place to review these queries within 24hours & amend TNA if necessary. 26/4/10:- process for advising GM's of current non-compliance in place. Pro-active approach by GM's and Business Partners to address non-compliant areas. 26/04/10 data: **Safeguarding children** Incomplete 81 Total 1043 %compliance 92.23%

Medway NHS
NHS Foundation Trust

ACTION REQUIRED	BY WHOM	BY WHEN	UPDATES
Ensure that all eligible staff have training in adult protection before 1st May 2010	Director of Nursing	30.04.10	09.04.10 data **Safeguarding Adults** Incomplete 1266 Total 2334 %compliance 45.76% 19/04/10 data **Safeguarding Adults** Incomplete 1185 Total 2334 %compliance 49.23% 23/04/10 data **Safeguarding Adults** Incomplete 657 Total 2334 %compliance 71.55% 23/04/10:- 10 extra training sessions on next week, GM on call to check all are doing / have done the training when she goes round at weekend.
Ensure that all staff have training on Mental Capacity Act	Director of Nursing	31.05.10	09.04.10 data **MCA** Incomplete 1373 Total 1763 %compliance 22.12% 16.04.10 data **MCA** Incomplete 1271 Total 1763 %compliance 27.91%

Medway NHS
NHS Foundation Trust

			23.04.10 data **MCA** Incomplete 672 Total 1763 %compliance 61.40%
Actions to be monitored weekly at the Exec team meetings			

Medway NHS
NHS Foundation Trust

ADDITIONAL CONCERNS (NO CONDITIONS IMPOSED)

5) The registered provider must ensure that service users and others who work in or visit the premises can be confident that in relation to design and layout, the premises meet the appropriate requirements of the Disability Discrimination Act 1995			
REASON: The trust declared non-compliance against regulation 15 because there was insufficient evidence to demonstrate that the Medway Maritime Hospital location had been following up on risk assessments associated with the needs of people with disabilities.			
ACTION REQUIRED	**BY WHOM**	**BY WHEN**	**UPDATES**
▪ Ensure that Disability related risk assessments are followed up and monitored on a routine basis.	Director of Operations	30/04/10	19/04/10:- Risk assessments carried out within each directorate. Subsequent progress on action plans monitored through directorate governance and risk meetings.
▪A system needs to be put in place which will provide evidence of this.	Director of Operations	30/04/10	19/04/10:- Risk assessments available in directorates and on the intranet. Minutes of directorate governance and risk meetings and risk registers where appropriate. 21/04/10:- The Trust Health & Safety Committee monitors the work of the directorate governance and risk meetings in relation to this, to provide assurance to the board via the Quality & Safety Committee
▪ Actions to be monitored weekly at the Exec team meetings			

Medway NHS
NHS Foundation Trust

6) The registered provider must ensure that service users and others who work in or visit the premises can be confident that in relation to design and layout, the premises protect people's rights to privacy, dignity, choice, autonomy and safety.			
REASON: The trust action plan demonstrates that the areas of non compliance will be addressed, and therefore whilst no conditions were issued, the CQC has stated that it will monitor progress.			
ACTION REQUIRED	**BY WHOM**	**BY WHEN**	**UPDATES**
▪ Ensure action plan is implemented, monitored and deadlines met.	Director of Nursing & Strategic Planning	In line with action plan	15/04/10:- Action plan and supporting paper presented to the Board 23/03/10 19/04/10:- Monthly progress reports to P&I committee
▪ Actions to be monitored weekly at the Exec team meetings			

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 14 May 2010

Subject: Item 6. Forward Work Programme.

---

1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on adding value to the planning, provision and operation of healthcare in Kent.

(2) At their last meeting, Members of this Committee requested that an opportunity be provided at each meeting to discuss the key issues raised during that meeting and consider whether they would like to request further information. This is being introduced at this meeting as Item 7.

(3) Members also welcomed the opportunity to add their input into the planning of HOSC meetings through suggesting which aspects should have priority as well as supplying additional questions, where enough advance notice of a topic could be given. This has been requested for the June and July meetings.

(4) There will still be topics on occasion which will need to be discussed but for which time will not allow this process to be used.

(5) Following ongoing discussions with members and stakeholders, the following is a suggested outline work programme for the Health overview and Scrutiny Committee to February 2011:

a) 11 June 2010 –

1) Accessing Mental Health Services: Adult and Older People's Inpatient Services (see Appendix A).

b) 23 July 2010 –

1) Diagnostics – Waiting Times (see Appendix B).
2) Update on Health and Transport.

c) 3 September 2010 –

1) Accessing Mental Health Services:
    a) Crisis Resolution Home Treatment Teams;
    b) Forensic Mental Health Services

d) 8 October 2010 –

1) Disablement services (prosthetics, orthotics and wheelchairs).
2) Pain Management Services.

e) 26 November 2010 –

1) Cancer services: diagnosis and referral to treatment.

f) January 2011 –

1) Stroke Care Pathway

g) February 2011 –

1) Dentistry

(6) At the Scrutiny Board of 22 May, it was decided that the parent POSC for the Select Committee topic review shall be the Adult Social Services Policy Overview and Scrutiny Committee and that there will be an opportunity for the Membership to include Members from both be the Adult Social Services Policy Overview and Scrutiny Committee and the Health Overview and Scrutiny Committee.

(7) This work programme will not preclude additional or alternative items being added to the Agenda as business need determines.

2. Recommendations

(1) The Committee is asked to approve the Forward Work Programme.

Appendix A

Topic	**Accessing Mental Health Services: Adult and Older People's Inpatient Services**
Date of Meeting	**11 June 2010**

Background

At the meeting of the HOSC on 26 March and at the subsequent Agenda Planning Meeting, the Future Work Programme of the Committee was discussed.

Issues brought up as the possible focus for the meeting on Accessing Mental Health Services touched upon a number of different areas, and could be usefully looked at during the course of separate meetings.

Considering the balance between mental health inpatient services and those provided in the community is one area which can be examined in order to gain an understanding what capacity exists within the system and forms the background to some of the services changes currently underway or being planned.

It is anticipated that forensic services and accessing emergency mental health services will be considered for inclusion in the Committee's future work programme.

On 26 March, there was a briefing for Members on Changes to Older People's Mental Health Provision in West Kent.

The intention is that this matter be investigated on the basis of 'health economies' based on the services commissioned by each PCT in turn and involve providers as well as commissioners. The Kent LINk has been invited to nominate an individual or organisation who would be able to represent the views of services users in each part of the county.

Requests for information submitted to:

• The Kent LINk • Kent Adult Social Services • Kent and Medway NHS Social Care Partnership Trust	• NHS Eastern and Coastal Kent • NHS West Kent

Submitted Questions

For the local NHS:

1. What adult mental health inpatient services are commissioned for your resident population under the following headings:
    a. adult mental health;
    b. older people's mental health;

    c. acute inpatient services;
    d. other (please specify).
2. For each of the service listed above please give the following:
    a. Name and location
    b. Provider
    c. Number of beds, including occupancy rates, and average number of bed days per patient.
    d. Staffing
    e. Route of referral
    f. Specific details of the types of conditions dealt with by the service.
3. Are any changes to these inpatient services being carried out or being planned?
4. How much do you spend on adult mental health services each year, and how much is spent specifically on inpatient services?
5. How much is this as a proportion of your overall spend and how does this compare to the other Primary Care Trusts across the SEC SHA area?
6. What are your expectations for both of these amounts in coming years?
7. How are community mental health services being developed and how is it anticipated that these will complement or replace inpatient services?
8. What actions are you taking to reduce mental health inpatient admissions?
9. Are any tertiary or Tier 4 adult mental health services commissioned outside of Kent and Medway?
10. How is commissioning of adult mental health services integrated with that of other Primary Care Trusts in Kent and Medway and Kent Adult Social Services?
11. Can you please provide any relevant PALs data relating to adult mental health inpatient services?
12. More broadly, has there been any increase in mental health referrals that are thought to result from the effects of the economic downturn? And if so, is there sufficient capacity to deal with them?

For the Kent LINk:

1. How has the Kent LINk been involved in any ongoing developments regarding adult mental health inpatient and community services?
2. Have any particular issues concerning plans for these services been received by the Kent LINk from members of the public, LINk members, and/or partner organisations?
3. Is the Kent LINk currently carrying out any work in these areas?
4. Would you be able to nominate a LINk member or partner organisation who would be able to attend the meeting on 11 June to represent the views of service users (one for each ‘health economy’)?

Appendix B

Topic	**Diagnostics – Waiting Times**
Date of Meeting	**23 July 2010**

Background

A diagnostic test or procedure is one which is used to identify a person's disease or condition and which allows a medical diagnosis to be made. As such they are regarded as a key component of the 18-week referral to treatment pathway. In this context diagnostics covers imaging (such as ultrasound), endoscopy, pathology and the elements of physiological measurement (such as ECGs and audiology assessment).

The Department of Health collects and publishes information on the number of patients waiting for imaging, physiological assessments and endoscopies and within this focuses on those waiting longer than 6 weeks and those waiting longer than 13 weeks. In the NHS Operating framework for 2010/11, one of the supporting measures for the 18-week target is the number of patients waiting less than 6 weeks for a diagnostic test.

Diagnostic tests are increasingly available in community settings as well as acute hospitals and are carried out by a range of different staff groups.

Suggested Invitees

- East Kent Health Economy (team representing PCT and Acute sector)
- West Kent Health Economy (as above)
- LINk
- Kent Local Medical Committee

Suggested Questions

1. How many people resident in your PCT area receive the key diagnostic tests (imaging, physiological assessments and endoscopies) and how long do they wait?
2. How many people have their diagnostic tests carried out in a) acute hospitals b) community and primary care settings?
3. How much is spent on diagnostics?
4. How patients exercise choice when choosing where to have a diagnostic test?
5. Are there any areas of weakness which have been identified and what measures have been put in place to improve the situation?
6. What changes have there been to how and where diagnostic tests are carried out in recent years?
7. Specifically, what plans have been, or are being made, to modernise pathology services across Kent?
8. How are test results communicated to a patient's GP, how long does

this normally take, and are there any specific challenges in this area? 9. Has the reported shortage of molybdenum-99 had any impact on carrying out diagnostics tests in Kent?
Members are invited to name the five questions they feel should have priority and/or suggest additional questions. This information is requested by: 11 June 2010. Please send to the HOSC Researcher at tristan.godfrey@kent.gov.uk

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 14 May 2010

Subject: Item 7. Committee Topic Discussion.

---

1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve.

(2) At the meeting on 26 March, Members of the Committee requested an opportunity at each meeting to discuss what they had heard and decide whether the outcomes for each main agenda item had been achieved, or whether there was a need for further information to be requested, and from whom.

2. Recommendations

(a) The Committee is asked to assess whether the outcomes for this meeting have been achieved or if further information on any topic is required by the Committee.

This page is intentionally left blank