HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 4th February, 2011

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 4th February, 2011, 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 B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mr K A Ferrin, MBE, Mrs J A Rook, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor J Cunningham, Councillor C Kirby, Councillor M Lyons and Councillor Mrs M Peters
LINk Representatives (2)	Mr M J Fittock and Mr R Kendall

Webcasting Notice

Please note: this meeting may be filmed for live or subsequent broadcast via the Council's internet site – at the start of the meeting the Chairman will confirm if all or part of the meeting is being filmed.

By entering the meeting room you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If you do not wish to have your image captured then you should make the Clerk of the meeting aware.

UNRESTRICTED ITEMS

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

Item		Timings
1.	Introduction/Webcasting	
2.	Substitutes	
3.	Declarations of Interests by Members in items on the Agenda for this meeting.	

4. Minutes (Pages 1 - 4)

5. The Future Shape of Community Service Provision (Pages 5 - 38) 10:00 – 12:00

6. Update on Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust (Pages 39 - 42) 12:00 – 12:15

7. Date of next programmed meeting – Friday 25 March 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

27 January 2011

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, 7 January 2011.

PRESENT: Mr B R Cope (Vice-Chairman, in the Chair), Mr D L Brazier (Substitute for Mrs J A Rook), Mr A D Crowther, Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr R Tolputt, Mrs J Whittle, Mr A T Willicombe, Cllr Mrs A Blackmore (Substitute for Cllr Mrs M Peters), Cllr J Cunningham, Cllr M Lyons, Mr M J Fittock and Mr R Kendall

ALSO PRESENT: Cllr R Davison, Su Brown, Mr M Cayzer, Gordon Court, Ms T Gailey, Ferne Haxby, Mr R Kenworthy, Mr J F London, Mr R A Marsh, Mrs K Nowowiecki, Mrs P A V Stockell, Emma Cain, Graham Cooke and Roger Hart

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Minutes
(Item 4)

RESOLVED that the Minutes of the Meeting held on 26 November 2010 are recorded and that they be signed by the Chairman.

3. Dentistry
(Item 5)

Elaine Biddle (Compliance Manager, Care Quality Commission), Maureen Hall (Dental Contract Manager, NHS West Kent), Dr Tim Hogan (Chairman, Kent Local Dental Committee), Stephen Ingram (Director of Primary Care, NHS West Kent), Bill Millar (Head of Primary, Community and Elective Care Commissioning Directorate, NHS Eastern and Coastal Kent), Allan Pau (Specialist Registrar in Public Dental Health), and Paula Smith (Lead Commissioner for Max Fax, Orthodontics and Dental, NHS Eastern and Coastal Kent) were present for this item.

(1) As a representative of the Local Dental Committee (LDC), an organisation with the stated aim of representing the interests of the dental profession and patients, Dr Tim Hogan outlined some of the challenges inherent to the current dental system. He believed that the present system pleased no one and that what was needed was one that concentrated on oral health prevention and administering the appropriate treatments while paying dentists appropriately without any perverse incentives.

(2) Two main issues were identified concerning finance and the current system. Firstly there was the system of three bands which determined the cost to NHS patients who were not exempt from charges. Mr Ingram reported that charges typically only covered two-thirds the cost of actually delivering the treatment and dentists were paid by the Primary Care Trust (PCT) for delivering Units of Dental Activity (UDAs). Dentists received a certain amount of money for each UDA and the income of the dentist was the difference between the dental charge and the money received for the number of UDAs involved. This was complicated by the value of a UDA being different for different dentists. Dr Hogan gave the view of the LDC as being that this system achieved the opposite outcome of that intended.

(3) The second issue was that PCT allocations for dentistry were set on historical spending in 2006. Mr Ingram reported that if NHS West Kent received the average allocation, the money available to spend on dentistry would increase by 21%, or around £5 million.

(4) Representatives of the NHS outlined how the Department of Health was currently piloting different models for a future NHS dentist contract and how dental commissioning would be carried out by the proposed NHS Commissioning Board. This led to a discussion on the merits of capitation forming part of any new system, with the idea of a pure capitation contract where dentists are paid based on the number of patients registered with them, not finding favour amongst Members of the Committee. Dr Hogan made the observation that some private insurance schemes were akin to capitation through having a monthly fee.

(5) This led to a discussion on private dentistry and how it was unknown how much treatment was provided privately as these figures were not collected so the true levels of dental access were unknown. It was also difficult to determine whether there was a shortage of dentists or a shortage of dentists willing to provide NHS services under the current system. Dr Pau was able to report a recent survey in West Kent which revealed over 80% of people had visited a dentist within the previous 24 months. Several Members mentioned some specific local issues around access, which the NHS undertook to look into.

(6) The LINk representatives on the Committee reported that they had received no complaints around access, although there was an issue around ensuring the information available on NHS Choice was kept up-to-date regarding what dental surgeries were open to new NHS patients.

(7) Dentists are currently being registered by the Care Quality Commission (CQC) and no dentist will be able to practice after 1 April 2011 without having done so with the CQC having a range of inspection and enforcement powers. This will include private dentistry and it was acknowledged by the whole panel that this was a positive aspect. There was some discussion around how much registration would benefit dentists in the context of professional regulation, but the counter point was made that registration was more about being in the interests of patients.

(8) On prevention, there was a difference of emphasis between different members of the panel between those who felt the real preventive work needed to be undertaken by schools at an early stage and those who felt dentists had a more direct role to play in preventive dentistry. Several Members felt the schools angle was one they could explore further through other platforms within Kent County Council.

4. Draft Forward Work Programme
(Item 6)

(1) Members were informed that alternative dates for the meeting with Roger Gough were being explored and would be conveyed to Members in due course.

(2) RESOLVED that the Forward Work Programme be approved.

5. Update on Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust
(Item 7)

(1) Members had before them correspondence from the Secretary of State for Health, NHS South East Coast and NHS West Kent concerning the recent decision concerning changes to women's and children's services at Maidstone and Tunbridge Wells NHS Trust.

(2) They also had in front of them, the NHS South East Coast report on changes to women's and children's services at Maidstone and Tunbridge Wells NHS Trust.

(3) A range of different opinions were expressed about different features of the report by NHS South East Coast, particularly around the opinions of GPs in the Maidstone area.

(4) A number of Members felt that the recently announced review of maternity services in east Kent meant that the whole issue of maternity services across Kent needed to be reviewed.

(5) Mrs. Whittle moved, Mr Cooke seconded:

1. That the Vice-Chairman of the Health Overview and Scrutiny Committee (HOSC) writes to the Secretary of State for Health, expressing profound disappointment with his decision to downgrade maternity and paediatric services at Maidstone that overrides the near-unanimous views of HOSC on 19 February 2010 and the local GPs opposing the reconfiguration plans.

2. That the Vice-Chairman of HOSC also requests that the Secretary of State for Health defers his decision until Maidstone GPs as future commissioners of local clinical services, are able to determine the future scope of maternity provision in the County Town.

3. That KCC monitors the impact of the reconfiguration on the number of admissions to the consultant-led maternity units at Medway and Ashford Hospitals.

4. In view of reported shortages of midwives and the temporary closure of the birthing units in East Kent over the Christmas and New Year period, that HOSC requests an urgent review of all birthing units and consultant-led maternity services in Kent.

Carried by 8 votes to1.

(6) RESOLVED:

1. That the Vice-Chairman of the Health Overview and Scrutiny Committee (HOSC) writes to the Secretary of State for Health, expressing profound disappointment with his decision to downgrade maternity and paediatric services at Maidstone that overrides the near-unanimous views of HOSC on 19 February 2010 and the local GPs opposing the reconfiguration plans.

2. That the Vice-Chairman of HOSC also requests that the Secretary of State for Health defers his decision until Maidstone GPs as future commissioners of local clinical services, are able to determine the future scope of maternity provision in the County Town.

3. That KCC monitors the impact of the reconfiguration on the number of admissions to the consultant-led maternity units at Medway and Ashford Hospitals.

4. In view of reported shortages of midwives and the temporary closure of the birthing units in East Kent over the Christmas and New Year period, that HOSC requests an urgent review of all birthing units and consultant-led maternity services in Kent.

6. Committee Topic Discussion
(Item 8)

Dentistry

(1) Members felt they had a good in depth exploration of many of the key issues around dentistry but as the Department of Health was in the process of piloting new dental contract models, it would be appropriate to revisit the subject once the results of these were known so that Members were better placed to evaluate the options for the future and make recommendations. More broadly, they would welcome further information about the Care Quality Commission and the work it does.

Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust

(2) Some Members expressed reservations about the length of notice given about the wording of the motion and the amount of time allowed for the debate. Given recent events in east Kent, a number of Members hoped there would be the opportunity to find out more about changes to maternity services across the County and how they may affect each other.

7. Date of next programmed meeting – Friday 4 February 2011 @ 10:00 am.
(Item 9)

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 4 February 2011

Subject: The Future Shape of Community Service Provision: Outcomes.

---

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 recent meetings, a Committee Topic Discussion has been held at the end of each meeting. In order to maintain the focus on the main item(s) under discussion during the meeting, it is proposed that the last section of each item to which people have been invited be given over to deciding whether the Committee had achieved the aims of the meeting in exploring a given topic, or whether further information or action is needed. The presence of the relevant guests would enable them to respond if appropriate.

(3) For background information, the questions asked of guests in advance of the meeting are contained in the Appendix to this report.

2. Recommendations

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.

Appendix

(1) Overarching questions sent to all attendees:

1. How can first class community health services best be provided for the people of Kent?
2. What are the challenges to realising this provision?

(2) Questions submitted to West Kent Community Health and Eastern and Coastal Kent Community Services NHS Trust:

1. Can you provide an updated timeline for the proposals around the future of community service provision?
2. Can you provide a summary of the business case in favour of your proposal for a Pan-Kent Community Services NHS Trust?
3. What weaknesses and risks have been identified in the proposal and how are these being mitigated or resolved?
4. What other proposals for the future organisational forms of community services in Kent were considered and why were they rejected?
5. Have stakeholders such as Practice Based Commissioners, community services staff, the Kent LINk and KCC been involved in the development of the proposals?
6. Can you provide details of any services currently provided by ECKCS or WKCH which will not form part of any future community services Trust, for example through vertical integration?
7. Either:
   a. What was the outcome of the Cooperation and Competition Panel's assessment of the pan-Kent business case and what are the implications of this on the proposal?
   b. If the CCP has not reported its findings by the time the HOSC meeting is due to take place, what are the potential implications of the different conclusions the Panel could reach?
8. If the Kent Community Health Trust does not go ahead, what organisational form will ECKCS and WKCH take?
9. Has any property, including the ownership of community hospitals, transferred from the PCTs to the community services Trust, and are there any plans for transfers in the future?
10. Will community hospitals continue to be used where the properties are leased and not owned by the NHS?
11. Can you outline the role community hospitals play in your business and operational plans for the future?

(3) Questions to NHS Eastern and Coastal Kent and NHS West Kent:

1. Can you provide a summary of why your Board voted in favour of the Proposal for the Establishment of a Pan-Kent Community

Services NHS Trust along with any concerns expressed by the Board?

2. What other proposals for the future organisational forms of community services in Kent were considered and why were they rejected?
3. Have stakeholders such as Practice Based Commissioners, community services staff, the Kent LINk and KCC been involved in the development of the proposals?
4. How many Right to Requests (to form social enterprises) have been received from community service staff and what has been the outcome of these requests?
5. Have you any plans to carry out tendering processes for any services currently provided by ECKCS or WKCH?
6. What is your understanding of what will happen to the present PCT estate, including community hospitals, up to and beyond the proposed abolition of PCTs in 2013?
7. How will the establishment of the proposed pan-Kent community services Trust affect the development of the 'Any Willing Provider' model of competition into the provision of community services?
8. What progress is being made in developing currencies and tariffs for community services?

(4) Kent Adult Social Services, the Department of Public Health and the Kent Local Medical Committee were invited to attend and asked for any information they wished to provide on this topic.

(5) In addition, the League of Friends of all 12 community hospitals in Kent were invited to submit written information if they so wished.

This page is intentionally left blank

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

To: Health Overview and Scrutiny Committee – 4 February 2011

Subject: The Future Shape of Community Service Provision

---

1. The Transforming Community Services Programme.

(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) both commissioned and provided these services. It is not uncommon across the country for neighbouring community service provider organisation to provide a different range of services and/or provide similar services in different ways.

(b) Across England, the annual expenditure on community health services is £11 billion and around 250,000 staff are involved in providing them. Ninety per cent of contacts between health professionals and patients take place in primary care or community health settings[1].

(c) The policy direction over the last few years has been towards the increasing separation of the commissioner and provider functions of PCTs[2]. The development of the options for the provider arms is often referred to as the Transforming Community Services (TCS) programme. A range of organisational forms has been made possible including integration with an Acute or Mental Health Trust, Social Enterprise, Integration with another Community Provider, Community Foundation Trust and the independent sector (or combination of these).

(d) A deadline to complete the separation of the commissioning and provision functions of PCTs has been set for April 2011[3]. The provider arm of NHS Eastern and Coastal Kent was established as The Eastern and Coastal Kent Community Health National Health Service Trust on 1 November 2010[4].

---

[1] NHS Confederation, Primary Care Trust Network Briefing, *Transfer and transform. The challenges for community health services*, November 2010, http://www.nhsconfed.org/Publications/briefings/Pages/Transfer-and-transform.aspx

[2] 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

[3] Department of Health, *Equity and Excellence: Liberating the NHS,* 12 July 2010, p.37, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf

[4] http://www.legislation.gov.uk/uksi/2010/2463/made

(e) All NHS Trusts are to become Foundation Trusts by 1 April 2014[5]. This includes new Trusts formed out of PCT provider arms[6]. Foundation Trusts have a range of freedoms around governance and finance not available to NHS Trusts[7].

(f) The Any Willing Provider model means that any local healthcare provider able to offer a particular service at a particular tariff will be able to be considered as a contractor for that service. This will be introduced in community services in a phased way from April 2011; this is intended to support the development of patient choice in this sector[8]. Work is also ongoing to develop currencies and tariffs for community services and move away from block contracts[9].

(g) QIPP (Quality, Innovation, Productivity and Prevention) is a series of 12 workstreams[10] aimed at making efficiency savings to be reinvested in services (£20 billion over the next four years)[11]. This relates to community services in a number of ways, as for example through the release of "hospital capacity to allow the better use of community services"[12].

(h) On 13 September 2010, a Parliamentary Question was asked on "what organisations will have responsibility for community hospitals following the introduction of GP commissioning." An extract from the Written Answer is provided below:

> "Under our proposals GP consortia will commission the great majority of national health service services for their patients, including, where appropriate, community hospital services. There will, however, be some exceptions, where it makes sense for the NHS Commissioning Board to

[5] Department of Health, *Liberating the NHS: Legislative framework and next steps,* p.162, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122707.pdf

[6] Department of Health, *The Operating Framework for the NHS in England 2011/12,* 15 December 2010, p.18, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf

[7] Monitor, http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/what-are-nhs-foundation-trusts

[8] Department of Health, *Transforming Community Services: An Introduction to the Programme*, October 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_121965.ppt#408,15,Any Willing Provider

[9] Department of Health, *A simple guide to PbR*, 30 September 2010, p.45, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf

[10] See Department of Health website for details of workstreams: http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm

[11] Department of Health, *The Operating Framework for the NHS in England 2011/12,* 15 December 2010, p.5, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf

[12] Ibid., p.31.

have responsibility for commissioning services. The proposed exceptions include primary medical care. This may also include community hospital services, where these provide primary care services.

Organisations providing community services will be responsible for responding to the commissioning intentions of the GP commissioning consortia and the NHS Commissioning Board, and the day-to-day management of community hospitals"[13].

2. Estates.

(a) On 6 January 2011, the Department of Health made the following statement on *Community foundation trusts – proposed estate acquisitions*[14]:

"All aspirant community foundation trusts (CFTs) are to be given the opportunity to acquire the PCT owned estate required to support the delivery of services for which they have responsibility.

The nature of the PCTs' estate is diverse, including for example; freeholds, leaseholds and licences. The extent of the legal interest, which can be offered, will therefore vary and will need to be the subject of discussion with the PCT on a case-by-case basis. It should be noted that PFI and LIFT interests are excluded for the time being from this process.

All acquisitions of freehold interests or capitalised leasehold interests will be financed by public dividend capital. They will be subject to an overage provision, which will provide that 50% of any profit made on the future disposal of the asset will be payable to the Secretary of State for Health. There will also be provision for the Secretary of State or a body nominated by him to be allowed to buy back the asset, in the event that the trust is no longer to provide the services.

All transfers of legal interests agreed by the PCT will be subject to approval by the strategic health authorities. Approval will only be granted where they are taking all of the property interests associated with the services transferring to them. Full guidance relating to the approval process will be available shortly. This is an extension of the assurance and approvals process for PCT community services.

---

[13] House of Commons Hansard, 13 September 2010, PQ14715, http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm100913/text/100913w0003.htm#1009145000005

[14] Department of Health, 6 January 2011, http://www.dh.gov.uk/en/Healthcare/TCS/Abouttheprogramme/DH_123297

Aspirant CFTs and their PCTs should immediately commence the process of identifying and agreeing the estate which will be made available to CFTs, in order to ensure completion by 1 April 2011 (or by the date of NHS trust establishment if later than 1 April 2011)."

(b) For reference, the PFI (Private Finance Initiative) is where private capital is made available for health service projects through a public-private partnership between an NHS organisation and a private sector consortium. NHS LIFT (Local Improvement Finance Trust) is geared towards encouraging investment in primary and community care facilities and is similar to PFI but is a joint venture between the private and public sectors[15].

3. The Co-operation and Competition Panel (CCP).

(a) The CCP was formally established on 29 January 2009. The role of the panel is to provide advice on the application of the *Rules and Principles of Co-operation and Competition*. The *Rules and Principles* are produced by the Department of Health to govern the behaviour of commissioners and service providers[16].

(b) The CCP undertakes cases in the following four categories: mergers, conduct cases, procurement dispute appeals, and advertising and misleading information dispute appeals[17]. It cannot initiate its own investigations[18].

(c) In a written update to the Health Overview and Scrutiny Committee on "The Future of PCT Provider Services", the local NHS reported the proposal to establish a Kent wide provider of community services from 1 April 2011 had been submitted to the CCP for consideration[19]. The outcome is reported in the NHS report following this Background Note.

---

[15] For further information on PFI and LIFT see Department of Health, http://www.dh.gov.uk/en/Managingyourorganisation/NHSprocurement/Publicprivatepartnership/index.htm

[16] The Co-operation and Competition Panel, *Guide to the Co-operation and Competition Panel*, http://www.ccpanel.org.uk/content/Guide-to-the-CCP.pdf. The latest version of the *Rules and Principles* can be accessed here: http://www.ccpanel.org.uk/reports-and-guidance/index.html

[17] The CCP, http://www.ccpanel.org.uk/about-the-ccp/index.html

[18] The Co-operation and Competition Panel, *Guide to the Co-operation and Competition Panel*, p.6, http://www.ccpanel.org.uk/content/Guide-to-the-CCP.pdf.

[19] Health Overview and Scrutiny Committee meeting Agenda 26 November 2010, submission from Eastern and Coastal Kent Community Health NHS Trust, NHS Eastern and Coastal Kent and NHS West Kent, http://democracy.kent.gov.uk/Published/C00000112/M00003072/AI00014716/$ProviderServicesupdate.docA.ps.pdf

NHS Eastern and Coastal Kent NHS West Kent Eastern and Coastal Kent Community Health NHS Trust

The Future Shape of Community Service Provision
Progress Report – February 2011

1.0 Introduction

1.1 Kent Health Overview and Scrutiny Committee (HOSC) have followed the journey of community services in both East and West Kent over recent years under the national Transforming Community Services Programme. The government are now bringing this programme to an end and this brings with it a series of milestones.

1.2 Members last had an update on this matter in November 2010 and previous to that in September 2010, May 2010 and October 2009 so are aware of the context of the transformation. A summary of the Business Case for the Kent integration was provided in September and a summary of the benefits from the Business Case can be found in Appendix One.

1.3 In the written update in November 2010 members learnt that the provider arm of NHS Eastern and Coastal Kent had become a separate NHS Trust in their own right on 1 November 2010 with further integration proposed with West Kent Community Health from 1 April 2011.

1.4 This would provide Kent with a strong and locally focussed NHS community provider that could really drive care into the community and focus on supporting the young and old alike in times when they need it most, especially in the care of long term conditions, rehabilitation and at the end of life, as well as in the promotion of good health throughout peoples lives.

1.5 In November there was a period of engagement underway and a series of local decisions to be made on this approach. At the time the Department of Health had agreed the integration in principle with the final decision resting with the Strategic Health Authority; NHS South East Coast.

1.6 This paper aims to appraise HOSC members on the current position of the Kent Integration and answer the questions posed in its letter of the 13 December 2010.

2.0 Engagement

2.1 A period of engagement with stakeholders on the proposals to integrate NHS West Kent's provider arm into Eastern and Coastal Kent Community Health NHS Trust completed at the end of November 2010. During this time all GPs and NHS Trusts in Kent, Kent County Council, district councils, social services, patient representative groups, the voluntary sector and staff in both organisations were written to. In total over 6000 leaflets tailored to each type of stakeholder were sent out, outlining the proposal and asking for views on the approach. 23 formal responses were received, generally supporting the move.

Many non-formal responses given to leaders within the two organisations supported the move, however many were with the caveat around ensuring the need for locality working to support local communities and new GP consortia. This intelligence has been invaluable in recent months and members of the HOSC and stakeholders should be assured that the integrated organisation will have strong locality clinical leadership at its heart. More detailed plans for this are being developed in partnership with our partners on the front line.

3.0 Decision Making

3.1 Members will remember that in the decision making process for Kent, options ranging from vertical integration with acute hospitals, integration with the Kent and Medway Partnership Trust and Social Services, as well as creating social enterprises and devolving services to GPs were all proposed. Stakeholder engagement processes in West Kent concluded that integration with Eastern and Coastal Kent Community Health NHS Trust was in the best interest of our communities and for the services we deliver as there are already many synergies. NHS Eastern and Coastal Kent initially proposed the development of a community focused organisation to better aid integration on the front line especially between community and primary care, and community and social care.

3.2 One of the other key stages in the assessment process for Kent was the consideration of the proposal by the national Co-operation and Competition Panel (CCP). The Co-operation and Competition Panel's role are to advise the Department of Health, Strategic Health Authorities and Monitor (where appropriate) on the application of the Department of Health's Principles and Rules of Co-operation and Competition, which ensure competition is not unduly restricted in transactions such as the Kent Integration.

3.3 A submission was made in November 2010 and the process concluded on the 20 December 2010. Their conclusion stated they would not need to formally consider the application as the proposal did not meet its prioritisation criteria. This means the proposal was free to move to final sign-off by NHS South East Coast.

3.4 NHS South East Coast have undertaken a period of scrutiny and challenge on the proposal since October 2010 and their Board is formally and finally considering the proposal on the 25 January 2011. Due to the timing of these papers members of the HOSC will be updated on this decision at its meeting on the 4 February.

3.5 The integration, if accepted by the Strategic Health Authority, will be completed on the 1 April 2011. At this time Eastern and Coastal Kent Community Health NHS Trust will change its name to Kent Community Health NHS Trust.

4.0 Leadership

4.1 Members may already be aware that a Chair Designate for the proposed Kent Community Health NHS Trust has been appointed. This is David Griffiths, the current chair of NHS West Kent. David has a number of years of NHS experience. Prior to being Chair of NHS West Kent (since 2006) he was a Non

Executive Director of Kent and Medway Strategic Health Authority and Interim Chair of Swale PCT. He also served for a short period as interim chair of NHS Medway. David qualified as a chartered accountant and then moved into management consultancy where he spent a long professional career with Accenture. He was a partner there for over 12 years so brings considerable experience to the integrated Kent organisation.

4.2 The Chief Executive is currently being appointed and will be announced in February. Following their appointment we would welcome an opportunity for them to meet with members of the Health Overview and Scrutiny Committee after they have determined their vision and strategy, to build on what is outlined here.

4.3 In the meantime the leadership teams of Eastern and Coastal Kent Community Health NHS Trust and NHS West Kent Community Health are working closely together to ensure the transition is smooth and coordinated with focus remaining on the delivery of our services to our patients through the winter months; whilst evolving our locality model. To aid the integration on the front line there are a series of 12 staff engagement workshops underway across Kent introducing the leaders from each organisation to staff and providing opportunities for staff to get under the skin of the plans and the actions being taken to bring the two organisations together. These are proving invaluable.

5.0 Service Provision

5.1 On the 1 April most of the services currently provided by West Kent Community Health will transfer into the Kent organisation, together with five public health provider functions, Chlamydia, Stop Smoking, Health Trainers, Healthy Schools and the Health Information Service. Additionally there will be some back office functions currently hosted by NHS West Kent that will also transfer. It is possible that three clinical services (Community Paediatrics, Stroke Rehabilitation and TB) will not transfer into the new organisation as these align well with current hospital provision but these are subject to ongoing discussion with Maidstone & Tunbridge Wells Hospital Trust and Dartford & Gravesham Hospital Trust.

5.2 All service provision provided by the Kent Community Health NHS Trust will be subject to normal service review by commissioners in the coming years and potential competition and tendering. This will be part of PCTs and GPs working together in the coming few years to set future commissioning strategies. However teams in the two provider organisations are already working together to develop the five year business strategy for Kent Community Health NHS Trust, and in their own right the two current organisations have already won contracts to deliver services in other parts of the country; predominately in London.

6.0 Property and Community Hospitals

6.1 Community Hospitals form an integral part of the PCTs, GPs and the Community Trusts strategies. They are local centres of the community and provide invaluable services to local communities, delivered by many different providers of health and social care.

6.2 Members will recall the national direction for PCT property; where the PCTs retain the property including the community hospitals, and providers including Kent Community Health NHS Trust would rent space in those buildings to deliver services. This was a policy of the previous government and at the beginning of January 2011 the Department of Health altered their position on this.

6.3 They are now allowing NHS Community Trusts who are on the road to become a Foundation Trusts to acquire property owned by PCTs. This is a fundamental shift and means that Kent Community Health NHS Trust will become the owner of much of the two PCTs estate from a proposed date of April 2011. As this is a recent change, work is in progress, but early indications show that the majority of estate including community hospitals will move to the Community Trust.

6.4 There is one exclusion from this; which is Gravesham Community Hospital. The direction from the Department of Health state that any estate funded by Private Finance Initiative (PFI) or Local Improvement and Finance Trust (LIFT) schemes will remain with PCTs. Gravesham Community Hospital is a LIFT scheme so at this time will remain with NHS West Kent. However this will not affect any front line delivery as the Kent Community Health NHS Trust will have a lease with the PCT to run services from that building in the same way we were previously expecting for all other estate.

6.5 This change of direction is welcomed as it means the Community Trust will have the flexibility and knowledge to really utilise these local buildings to maximum effect and work with local partners on the ground including the League of Friends in each hospital to make best use of each property for local benefit.

7.0 Managing Risk

7.1 Any change of this size carries risk and all partners in this proposal are working hard to mitigate this risk as much as possible.

- The greatest risk is that staff lose focus on their patients and service users whilst the transition occurs which is why staff engagement has been a top priority from the beginning. We aim to make the transition as efficient and effective as possible with minimal impact on front-line services. Much of the change will be in back-office functions where change would have been needed anyway, in the context of the financial climate.

- The move to locality services and locality engagement is another risk being managed, as failure to do this will result in a clear dissatisfaction with local communities and local stakeholders in those communities. We already have strong locality working in many of our services including front-line integration with GPs for our community nursing services and that will continue. Our continued aim will be to strengthen this across all our services in order to provide locality clinical management where this is already not in place.

- We understand stakeholder concerns regarding whether a large Trust is able to understand local needs and so it is our absolute intention to

ensure local management of services and local connection with communities is at the heart of our ethos and mission. The benefits of size mean we can benefit from leaner and cheaper back-office and management functions meaning more can go into front line care. The savings made here will mean we can provide a strong local focus in our clinical services. We will be closer to GPs and their needs; closer to our partners needs and most importantly closer to our patients needs; at the front line where it counts.

7.2 Our other risks are being managed through our Kent Integration Board chaired by David Griffiths and mitigation plans are in place for each one.

8.0 Next Steps

8.1 As described earlier in the paper the decision by NHS South East Coast marks the final decision point in this proposal. If positive, work will continue to align the two organisational structures, systems and functions in preparation for the transfer of West Kent Community Health on the 1 April 2011.

8.2 We have work streams in place to deliver a smooth and effective transition including the Kent Integration Board chaired by David Griffiths and a Provider Transition Group where the senior teams of the two community providers regularly meet to deliver our Integration Plan.

8.3 Following the transfer the journey towards Foundation Trust status continues. Current projections show Kent Community Health NHS Trust becoming a Foundation Trust on 1 April 2013. This would involve a full public consultation in 2012. We will keep HOSC fully appraised of this journey as it develops.

9.0 Conclusion

9.1 In answer to the question posed by HOSC members; How can first class community health services best be provided for the people of Kent, we believe this proposal provides the best platform for this. Both Eastern and Coastal Kent Community Health NHS Trust and West Kent Community Health already provide many first class community health services to the communities of Kent and in coming together these strengths can be built upon and any weaknesses or gaps can be reduced.

9.2 The sharing of ideas and coming together, even in this interim stage have already proved invaluable, especially in the development of our financial strategies and our clinical ways of working on the front line. This organisation will be best placed to enhance services delivering in the community and work with our GP, social care and voluntary sector partners to keep people at home; as independent as possible, for as long as possible.

9.3 This is an exciting time for community services; we are at the centre of the NHS strategy nationally and at the heart of the NHS in Kent. The leaders within the two current community organisations are passionate about community healthcare and they would absolutely welcome the support of HOSC to really make this change work for the long term; for the benefit of the people we collectively serve.

Appendix One: Summary Business Case

The full Business Case can be found at

http://www.eckcommunityservices.nhs.uk/media/76574/cs076-10%20pan%20kent%20community%20nhs%20trust%20proposals.pdf

This Business Case highlighted significant benefits including efficiency gains and reduction in management costs as well as:

- Sharing clinical expertise and best practice across the county.
- Reduced service inequalities.
- Greater integration between health, KCC and social care to realise the benefits of single assessment processes, personal health budgets for health and social care and a single point of access for referrals, carers and clients/patients .
- A stronger community focus with locality working across the GP consortia and districts of Kent within a community ownership framework possible through the NHS Foundation Trust model.
- Strengthened opportunities for innovation, clinical careers, audit and research.
- Improved interface with the acute sector with standardised approaches, for example in hospital discharges.
- A strong community employer working with the voluntary sector, volunteers and local communities.
- The opportunity for Kent to become a strong, national voice and centre for community service innovation and delivery.
- Reduced duplication of back office functions.

It will also ensure:

- Integration of clinical services with other sectors and agencies at a patient, rather than organisational level.
- The broad spectrum of health needs associated with the demographics and health inequalities of Kent are met.
- Choice to patients in a geographical area that hinders competition in the eastern and southern parts of Kent.
- Care traditionally delivered in hospital can be safely and appropriately delivered in the community especially in the care of children, treatment of long term conditions, rehabilitation and end of life care.
- Strong community engagement and involvement in community services.
- Delivery of the PCTs' Strategic Commissioning Plans in the current economic climate.
- Effective economies of scale in a tough economic climate with a reduction in overheads and an increasing level of productivity and efficiencies.
- Good staff engagement and satisfaction and ensuring NHS staff terms and conditions are retained during organisational change.
- GP commissioning, as it evolves, is strongly linked to community care, whilst maintaining governance and safety.

THE REPORT

Item XX/

Decision No *(as appropriate)*

By: Meradin Peachey Kent Director of Public Health

To: HOSC 4th February 2011

Subject: **Public Health commissioned services from East and West Kent Community Services**

Classification: Unrestricted

Recommendations

1. That HOSC note the range of public health services that community services provide and consider how community services are delivering these.

Introduction

2. (1) The main proposals for changes to public health have been announced in the NHS White Paper *(Equity and Excellence Liberating the NHS)* and Healthy Lives Healthy People. In the future a number of these public health commissioned services will be the responsibility of the County Council.

(2) The PCT currently commissions this selection of important public health services from community health services.

Relevant request question number	(1)	(2)	(3)	(5)
Public Health/Health Promotion Service				
Area (e.g. Healthy weight)		**Cost of service/ contract value**	**Service Provider**	**What performance measures in place?**
East Kent Stop Smoking Service	1-1 and group based stop-smoking support with Nicotine Replacement Therapy within a range of local settings and venues.	£1,609,000	Eastern and Coastal Kent Community Services NHS Trust	4 week smoking quitters -reporting of weekly figures via webstar database. Information Governance reporting. Annual service user survey Qrtly reporting on service user social class, locality and high risk groups. Annual record keeping audit Initial access/response time measurement
Healthy Weight Services	Breastfeeding promotion (£90k) Primary care based services (£180k) Weight Management service (£244k) Exercise Referral (£64k) Health Walks (£62k) Healthy Eating (£51k) MEND (£20k) -Lottery Funded >BMI35 service	£987,000	Eastern and Coastal Kent Community Services NHS Trust	Still in development due to recent handover of service, but will include activity reporting, service user satisfaction reporting amongst others.
Health Trainer Service	1-1 personalised support to help people identify and achieve their own health goals and to make healthier lifestyle choices.	£671,000	Eastern and Coastal Kent Community Services NHS Trust	Annual service user survey Information Governance reporting. Activity data still to be agreed but will include Number of referrals received • Source of referrals • Number of patients triaged and signposted elsewhere • Demographics of patients • Unregistered patients • Telephone activity

Sexual Health services	Young Peoples provision Contraceptive services Sexual Health Outreach Psychosexual therapy GUM services HIV Services Chlamydia screening Sexual Health Information line	£7,605,000	Eastern and Coastal Kent Community Services NHS Trust	Achievement of the GUM 48 hour access target Achievement of the Chlamydia target Increase uptake of long acting contraception Monthly activity reporting service user satisfaction reporting
Sexual Health Promotion	Prevention of sexual ill health Promoting access to services, focussing on high risk or hard to reach groups	£374,000	Eastern and Coastal Kent Community Services NHS Trust	Quarterly monitoring against service action plan.
Healthy Schools programme	Supporting all schools to engage with the Healthy Schools enhancement model by 2020	£305,000	Eastern and Coastal Kent Community Services NHS Trust	Number of schools maintaining Healthy Schools status and working towards enhancement model.
West Kent Stop Smoking Service	○ One to one and group based stop-smoking support with Nicotine Replacement Therapy within a range of locality settings and venues ○ LES with GPs and community pharmacies ○ Web based stop smoking ○ Stop Smoking Specialist support within Acute Hospital setting (Healthy Hospital initiative)	£1,000,000	Stop Smoking Team (Public Health)	○ 4 week smoking quitters -reporting of weekly figures via webstar database. ○ Monthly Board performance reporting ○ Information Governance reporting. ○ Annual service user survey ○ Qrtly reporting on service user social class, locality and high risk groups. ○ Annual record keeping audit Initial access/response time measurement
Healthy Weight Services	○ Service specification for the provision of : ○ Adults weight management ○ Family weight management (including MEND) ○ Dietetic Support (for Dartford & Gravesham) ○ Change4Life ○ Supporting physical	£437,999	Local Authorities and Healthy Living Centres Dartford & Gravesham NHS Trust (dietetics dept) NB: In addition, PCT awarded Pilot Status for DoH Change4Life (one-off funding from Community fund - £50k)	Quarterly data Breastfeeding data uploaded to national database Monthly performance monitoring reports

	activity and Let's Get Moving ○ Local Authority training to support evaluation (PCT funded) ○ Local Authority Database to support evaluation ○ Breastfeeding ie delivering Baby Friendly Initiative in hospitals and community drop-ins to support continuation ○ Weighing and Measuring of Children Years R and 6	£36,000 £8,000 £130,000 £47,000	One off programme of training from accredited training providers Acute Hospitals (DVH, Maidstone and Pembury); Community Breastfeeding Support workers; individual contracts with National Childbirth Trust; West Kent Community Health	SLA requirement of evidence of staff training and accreditation Quarterly LA activity reports Weighing and Measuring uploaded annually to national database but PCT receives periodic reports on progress
Health Trainer Service	1-1 personalised support to help people identify and achieve their own health goals and to make healthier lifestyle choices accessible through a range of venues	£75,000	NHS West Kent	Activity data uploaded to national database including: ○ Number of referrals received • Source of referrals • Number of patients triaged and signposted elsewhere • Demographics of patients • Unregistered patients • Telephone activity
Sexual Health services	Young Peoples provision Contraceptive services including LARC Sexual Health Outreach GUM services HIV Services Chlamydia screening Health Promotion: Prevention of sexual ill health Promoting access to services, focussing on high risk or hard to reach groups	1,000,000	NHSWK Chlamydia Team West Kent Community Health Acute Trusts for GUM GPs and community pharmacies Healthy Living Centres Urban Blue bus	Achievement of the GUM 48 hour access target Achievement of the Chlamydia target Increase uptake of long acting contraception Monthly activity reporting service user satisfaction reporting Social marketing

Local Authority Community Development (Health and Wellbeing programmes)	The annual allocation of funding to the 6 local authorities is proportionate between healthy weight programmes (60%) – see above; and 40% for health and wellbeing programmes. In addition, the PCT supports community development through SLAs with Healthy Living Centres (Dartford, The Grand; Fuzion) and virtual HLCs for Tunbridge Wells, Sevenoaks, & Tonbridge & Malling Includes signposting to other services (alcohol, stop smoking, sexual health, health trainers, healthy weight etc)	£291,999 £270,000	6 Local Authorities	Monthly activity with Quarterly reporting Service user satisfaction reporting
Alcohol services	Tier 2 Alcohol Brief interventions Alcohol Treatment Referral Programme Tier 3 alcohol services	£90,000 £40,000* £133,000	KDAAT * commissioned jointly with Probation Service who contribute £60k	Achievement of reduced hospital admissions target
Healthy Schools programme	Supporting all schools to engage with the Healthy Schools enhancement model by 2020	£180,000	NHS West Kent	Number of schools maintaining Healthy Schools status and working towards enhancement model.
	Total:	£15,289,998.00		

This page is intentionally left blank

KENT ADULT SOCIAL SERVICES

Written Submission to the Health Overview and Scrutiny Committee Meeting 4 February 2011

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 is 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 and is in line with the policy set out in the Government's recent White Paper :" Equity and Excellence, Liberating the NHS ".

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 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) and more* recently in the Government's White Paper:" *Equity and Excellence, Liberating the NHS ".*

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 Eastern and Coastal 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 shows 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 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)
    - Westview, Westbrook House 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 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 as set out in the NHS 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

Officer contact details:

Anne Tidmarsh
Director of Commissioning and Provision (East)
anne.tidmarsh@kent.gov.uk
Tel: 01227 598840

LEAGUE OF FRIENDS

EDENBRIDGE & DISTRICT WAR MEMORIAL HOSPITAL

Mill Hill, Edenbridge, Kent TN8 5DA

www.edenbridgehospital.co.uk

Submission to the Health Overview and Scrutiny Committee meeting – 4th February 2011 on The Future Shape of Community Service Provision.

How can first class Community Health Services best be provided for the people of Kent?

The League of Friends of Edenbridge Hospital is broadly in favour of the changes to the NHS currently being introduced by the coalition Government.

1. Co-operation and co-location.

a) Co-operation and working together across all NHS Community Services, Local Authority and Charity provision in integrated teams to provide a seamless service is of paramount importance.

b) Co-location of services and expansion of facilities (perhaps with use of Mobile Units)

c) Greater use and recognition of local charities in assisting the achievement of these aims.

d) Encouragement of 24/7 health cover with GPs supporting each other within consortia.

2. Patients first.

a) We applaud the recognition that patients must be encouraged to make a genuine and informed choice regarding their Health Care

b) Greater and more flexible use of Community Hospitals and their facilities including recognition of the need to use these facilities in the evenings and at weekends.

c) More visiting Consultants, access to the Hospital for local volunteer groups and community support groups resulting in a reduction in patient travelling time, patients and visitor inconvenience and greater use of Hospital facilities

d) Local provision of Minor Injury Units, X-ray and Physiotherapy departments, Out Patient Clinics, and Day Care Centres within the Community Hospitals resulting in NHS savings as more expensive Acute and A&E departments concentrate on what they alone can do.

e) Requirement for the inpatient facilities at Community Hospitals to be used for patients other than predominantly the elderly or end of life patients

3. Finance.

a) The overriding objective must be to ensure that the maximum amount of available money is directed towards patient and clinical services and support.
b) Statistical analysis must recognize the work being done at Edenbridge for patients living and /or working in Sussex and Surrey. This will also require uplift in the revenue benefit received so that services may be developed and enhanced to reflect this need.
c) We would urge all interested parties to lobby for a re-negotiation of the 2004 GP contract so that standards of service may be raised whilst also saving money.
d) In recognition of the urge for "bottom up" changes to the NHS, encouragement must be given to make local management more opportune and less bureaucratic. Local connection to local suppliers and "handymen" must be encouraged. This is particularly important as and when a Pan Kent Community Health NHS Trust comes into being.

4. Competition.

a) Private health providers must be as strictly controlled and regulated as NHS ones.
b) Use of GP premises and Community Hospitals for private clinics and complimentary Health care outside of usual working hours would be popular as well as economic.
c) We can visualize the growth of smaller, independent yet autonomous health units competing within looser and larger administrative control.

5. Administration.

a) The new GP consortia should be encouraged to make use of the valuable skills available to them from ex PCT and SHA employees.
b) The benefits of local Hospitals and GP practices joining larger liaison groups will offer the possibility of staff sharing, joint purchasing etc.
c) The public, unions and NHS employees must be kept informed of progress and their co-operation sought so that the potential benefits of the reforms are achieved.

What are the challenges to realising this potential?

Our main concern is that without the positive active involvement and enthusiasm of our local GPs, our Community Hospital will not flourish.

1. Skill shortages.

a) Support and encouragement must be provided to current GPs so that they meet the challenge of their new responsibilities.
b) The selection and early training of GPs must reflect the need for non- medical skills now required.
c) Consortia will not be truly representative of the area they serve as few GPs will have the motivation or support from their own GP partnerships to put themselves forward.

2. Attitudes.

a) We recognise a human tendency towards conservatism and as a result, a reluctance to embrace the proposed changes.
b) A genuine recognition by all of the importance of putting patient needs first will hopefully see an end to any parochial insecurities and rivalries.
c) Local communities are not always aware of what is available to them locally – money must be set aside to ensure a greater awareness of local facilities and services offered.
d) We do not expect the differing agendas of Health and Social Services to be resolved overnight but are hopeful that with a true willingness on behalf of everyone these can be minimised.

3. Finance

a) These changes must be properly funded to ensure that they have a good chance of success.
b) Edenbridge suffers from poor and infrequent public transport making it difficult for patients to access the new Pembury Hospital. Parts of Edenbridge are very deprived; allocation of finance must recognise this and help alleviate our very atypical problems.
c) We are concerned that due to the demands for financial return the previous decision for reducing the number of outpatient clinics at the new Pembury Hospital has been reversed. Many in Edenbridge have neither the finance nor transport facilities to make attendance at Pembury a possibility without considerable hardship.
d) Currently, our GP practice, MIU and X-ray unit do not offer many evening sessions, if any at all. The reasons for this are mixed and not all financial but the reasons will need to be explored for there to be a genuine desire to put the patient first.

Our comments on plans to form a pan Kent Community Health Trust.

Our main concern relates to the fact that this new Trust appears to contradict what the Government is trying to establish. The new Health and Social Care Bill demands a "bottom up" not "top down" reform. The creation of a pan Kent Trust to serve a huge disparate population cannot, we believe, put the local needs of patients in Edenbridge high up the agenda.

1. Geography.

a) Edenbridge at the very western edge of Kent and also one of the most deprived in Kent will be isolated and forgotten.
b) The large communities found in the larger towns and cities will have more voice and more influence as per capita they will contribute more.
c) The differing demands of rural and urban communities will not be properly understood or met.

2. Centralisation.

a) We accept that there will be a possible saving in administrative costs but the risk of not meeting the needs of the community will be greater. Greater centralisation is not the answer – to be genuinely able to meet a patients' needs, hospitals and GPs need to be free from any interference which prevents them from getting the job done.
b) The Bill emphasises the need for competition and patient choice. We do not see how creating a pan Kent Trust will achieve this.
c) Since the creation of NHS West Kent Community Health we have worked closely with its officers to, we believe, the benefit of Edenbridge Hospital and its patients. We have had many formal and informal meetings with those responsible in that organisation and although we will strive to do the same with the new team their responsibilities will cover a very wide geographic area. We are concerned that time and cost constraints will dictate the frequency of contact and we will all be the poorer for it.
d) We have heard some discussion as to the numbers of non-Exec Directors being sought from both West and East Kent for the new organisation. We would urge those taking the decisions to ensure that West and East Kent are equally represented.

League of Friends Queen Victoria Memorial Hospital Herne Bay

HOSC Submission

The Queen Victoria Memorial Hospital Herne Bay occupies a large site with room for expansion.

The main hospital has Heron Ward which has 23 beds, 2 of which are suitable for terminal, palliative and respite care, otherwise dealing with generally step-down rehabilitation transfers from the acute sites.

There is a new state of the art operating theatre at the moment dealing with podiatric surgery but this is underused and there is space for other surgery to be carried out though no general anaesthesia is carried out. If possible we would like to have a tie up with the Horder Centre, Crowborough, Sussex which specialises in orthopaedic surgery. Many local patients are referred there for surgery and clinics could be held locally to save a long journey.

There is a large outpatients department. Patients prefer to use this rather than travel to the acute hospitals saving time and stress and good parking is available. At weekends we have the emergency doctor service operating there. We would like to see a minor injuries unit set up there especially as we already have an excellent x-ray department next to it and this is one of the criteria for a MIU. The x-ray unit has new equipment provided by the League of Friends but this is run by the acute trust and only open Mon-Thurs. We would like it to be open every day.

There is a separate rehabilitation centre used for day case patients – mainly elderly. There is a physiotherapy department attached to this and a busy phlebotomy clinic.

The orthotics department has a separate building. The League of Friends purchased a milling machine from America – one of the first in the NHS in the UK – which increased their production of othoses immensely. Unfortunately space is at a premium and although the League has offered to help extend the premises this was stopped in order to consider the possibility of finding further accommodation elsewhere on the site. This has not happened and in the meantime expansion of work possibly generating additional income from other NHS areas has been frustrated. Also they have further equipment in ramshackle stores which they are unable to use. We would like to have this issue resolved satisfactorily.

In essence there is a large ground area which could accommodate further expansion and this we would like to see if it can provide better local provision of healthcare. Herne Bay has an elderly population who find it difficult not only to travel to appointments but also to visit relatives in hospital.

This page is intentionally left blank

Thank you for inviting us to contribute towards your consideration of the future provision of health services in the community. Whilst we do not have any specific ideas to propose for future provision it is important that existing services are not reduced and should, if possible, be improved and it is very important that community health service should as far as possible be provided locally, be it through GP services or hospital based clinics.

The proposed Governmental changes to NHS provision will of course affect future provision but to provide a starting point for you consideration I would outline the current position in Swale.

Generally a patient's access to services is through their GP unless they are unfortunate in having to be admitted as an emergency to an Acute Hospital. For the majority of people in Swale this means admittance to The Medway Maritime Hospital and, on discharge back to the community, follow-up clinic appointments are through our Community Hospitals at Sittingbourne, Isle of Sheppey and Faversham. The Community Hospitals currently provide excellent services locally and patients can attend clinics quite easily with little stress other than that of attending a doctor's appointment. If patients were required to travel across Kent for routine clinic appointments the adverse health affects would be readily apparent. The lack of frequent public transport would make travelling to, say, Maidstone Hospital a nightmare for most elderly people from Swale.

Our Community Hospitals provide Minor Injuries Units that deal with many patients who otherwise would be waiting at Accident & Emergency at the acute hospitals. Locally based midwives and district nurses are vital in a community where new housing estates are being built at the same time as there is an ageing population with attendant problems.

Whilst it is appreciated there are financial constraints in providing services it is important that those currently in place should not be downgraded. Within Swale there has for many years been a shortage of health professionals and it is to be hoped that in future these shortages would be addressed in any major change in service provision.

How can first class community health services be provided for the people of Kent?
It could be suggested that rationalisation/centralisation of services is the way forward. This would no doubt "save money" but at the expense of the patient's health, which would then cost more money to put right. Efficient local service provision would seem to provide a solution and if all areas of Kent worked to the same "model" cost savings could be made. Acute Hospitals and Specialist Units (e.g. Oncology) would continue to provide the necessary "emergency" services as at present.

What are the challenges to realising this provision?
The need for change has to be accepted throughout the NHS and recognition that there is a cost element to even the smallest change in procedures.

Pan-Kent Community Services NHS Trust
Until the outcome of the Government proposals for the NHS/PCT structure come to fruition it is difficult to see how a Pan-Kent organisation can operate. If a GP Consortia in Swale decides it would be better or more cost effective to purchase services from Medway, rather than from within Kent, it is difficult to see what influence a Pan-Kent Trust would have on that decision.

This page is intentionally left blank

The Friends of Whitstable Hospital & Healthcare

The Friends support Whitstable Hospital, Whitstable Health Centre, Chestfield & Estuary View Medical Centres, Saddleton Rd Surgery and primary healthcare services in the Whitstable area

The future shape of Community Service provision

We would like make the following points for consideration:

- Care to be provided nearer to patients wherever possible and appropriate with services easy for people to access.
- Real integration between the many providers of health and social care services so that the focus is on the patient rather than on the different systems and management of their care.
- Community Hospitals - We are great enthusiasts of Community Hospitals and we do hope that the already excellent care these provide can be further developed and expanded. Not all patients require the hi-tec specialist care in an acute setting and a community hospital provides the alternative for those who need in-patient care – and this need is growing with an increasing elderly population. Local palliative care is important and there is the potential too for the provision of other services and procedures which can safely be carried out in a Community Hospital setting. Community Hospitals are well supported by local people.
- We would like to see consultant and specialist clinics provided locally whenever possible. Elderly folk and those with disabilities find travel particularly difficult and becoming ever more expensive – with the risk that they do not attend for an appointment. Community settings provide more easily accessible and familiar surroundings although it is, of course, recognised that this has to be dependent on the type of clinic and equipment availability.
- Alongside the drive for fewer admissions to hospital and shorter hospital stays, it is important that all services are in place in readiness for a patient's return home. Any gap can cause a setback to a patient's recovery and possibly lead to re-admission to hospital
- It is important for the role of carers to be fully supported and recognised and their health and social needs given full consideration. Respite care – both short and longer spells - is essential for carers. Adequate day care provision should be ensured. Carers also need to be fully consulted about a patient's discharge and on-going support given to ensure they are able to cope.
- Low-key early interventions can often assist in alleviating problems such as loneliness or depression and can often be provided at a relatively low cost
- With a large county-wide Trust we do hope that examples of best practice continue to be built on and that innovation won't be stifled.

This page is intentionally left blank

Item 6 – Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 4 February 2011

Subject: Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.

---

1. Background

(a) At the meeting of this Committee of 7 January 2011 the following resolution was passed:

1. That the Vice-Chairman of the Health Overview and Scrutiny Committee (HOSC) writes to the Secretary of State for Health, expressing profound disappointment with his decision to downgrade maternity and paediatric services at Maidstone that overrides the near-unanimous views of HOSC on 19 February 2010 and the local GPs opposing the reconfiguration plans.

2. That the Vice-Chairman of HOSC also requests that the Secretary of State for Health defers his decision until Maidstone GPs as future commissioners of local clinical services, are able to determine the future scope of maternity provision in the County Town.

3. That KCC monitors the impact of the reconfiguration on the number of admissions to the consultant-led maternity units at Medway and Ashford Hospitals.

4. In view of reported shortages of midwives and the temporary closure of the birthing units in East Kent over the Christmas and New Year period, that HOSC requests an urgent review of all birthing units and consultant-led maternity services in Kent.

(b) The letter responding to the first two points is attached.

2. Recommendations

(a) The Committee is asked to note the attached correspondence.

This page is intentionally left blank

The Rt Hon Andrew Lansley CBE MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London, SW1A 2NS

Members' Suite
Sessions House
County Hall
Maidstone
Kent ME14 1XQ
Tel: 01622 694434
Fax: 01622 694212
E-mail: members.desk@kent.gov.uk

Direct Dial/Ext: (01622) 694486
Fax: (01622) 694383
Email: paul.wickenden@kent.gov.uk
Date: 13 February 2011

Dear Mr Lansley

WOMENS AND CHILDRENS SERVICES – MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

At the County Councils Health Overview and Scrutiny Committee on Friday 7 January I submitted to the Committee your recent letter to me and Candy Morris and made available to the Committee the executive summary of the report you commissioned.

The Committee passed by a majority the following motion and I would draw your specific attention and ask for a reply to the first two paragraphs of this motion which I have highlighted in bold typeface.

1. That the Vice-Chairman of the Health Overview and Scrutiny Committee (HOSC) writes to the Secretary of State for Health, expressing profound disappointment with his decision to downgrade maternity and paediatric services at Maidstone that overrides the near-unanimous views of HOSC on 19 February 2010 and the local GPs opposing the reconfiguration plans.

2. That the Vice-Chairman of HOSC also requests that the Secretary of State for Health defers his decision until Maidstone GPs as future commissioners of local clinical services, are able to determine the future scope of maternity provision in the County Town.

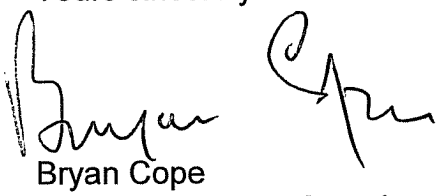
3. That KCC monitors the impact of the reconfiguration on the number of admissions to the consultant-led maternity units at Medway and Ashford Hospitals.

4. In view of reported shortages of midwives and the temporary closure of the birthing units in East Kent over the Christmas and New Year period, that HOSC requests an urgent review of all birthing units and consultant-led maternity services in Kent.

The latter two paragraphs of the motion I am dealing with locally with NHS colleagues.

I look forward to hearing from.

Yours sincerely



Bryan Cope
Chairman, Health Overview and Scrutiny Committee