HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 10th June, 2011

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 10th June, 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 N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr R Brookbank, Mr N J Collor, Mr A D Crowther, Mr K A Ferrin, MBE, Mr C P Smith, Mr K Smith, Mr R Tolputt Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	To be confirmed
LINk Representatives (2)	Mr M J Fittock and Mr R Kendall

Webcasting Notice

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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 (1 - 6)

5.	Trauma Services in Kent and Medway (7 - 24)	10:00 – 10:40
6.	NHS Financial Sustainability: Part 3 - Mental Health, Community Health, and Ambulance Services (25 - 46)	10:40 – 12:15
7.	Forward Work Programme (47 - 48)	12:15 – 12:30

8. Date of next programmed meeting – Friday 22 July 2011 @ 10:00

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
(01622) 694002

2 June 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 Darent Room, Sessions House, County Hall, Maidstone on Tuesday, 19 April 2011.

PRESENT: Mr N J D Chard (Chairman), Mr B R Cope (Vice-Chairman), Mr R Brookbank, Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Cllr M Lyons, Mr M J Fittock, Cllr Mrs A Blackmore (Substitute for Cllr Mrs M Peters) Cllr R Davison (Substitute for Cllr J Cunningham)

ALSO PRESENT: Gordon Court

IN ATTENDANCE: Mr P Sass (Head of Democratic Services) Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Minutes
(Item 4)

RESOLVED that the Minutes of the Meeting of 25 March 2011 are recorded and that they be signed by the Chairman.

3. Proposal to Establish Informal HOSC Liaison Groups
(Item 5)

(1) In response to questions from Members, clarification was provided that Borough/District representatives on the Committee would have an equal right and opportunity to participate and lead any of the proposed groups.

(2) Members expressed the views that it was important to try new ways of working in order to add value and that flexibility was important given the varied progress localism was making in different areas.

(3) RESOLVED that authority be delegated to the Head of Democratic Services in consultation with the Chairman, Vice-Chairman and Group Spokespersons, to establish informal HOSC Liaison Groups where a Member of the Committee wishes to lead one, or establish a time-limited Task and Finish Group where this is the more appropriate way of dealing with a specific issue.

4. NHS Financial Accountability: Part 2 - Acute Sector
(Item 6)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust), Stuart Bain (Chief Executive, East Kent Hospitals NHS University Foundation Trust), Colin

Gentile (Interim Director of Finance, Maidstone and Tunbridge Wells NHS Trust) and Patrick Johnson (Director of Operations/Deputy Chief Executive, Medway NHS Foundation Trust) were in attendance for this item.

(1) The Chairman thanked the representatives of the Acute Sector in Kent and Medway for attending and asked if they were each willing to provide a short overview of the subject from the perspective of their respective organisations.

(2) The position of Dartford and Gravesham NHS Trust needed to be seen in the context of its Private Finance Initiative (PFI) scheme which added complexity to the financial challenge. Broadly, the challenges fell into four areas. The first was the requirements of the Quality, Innovation, Productivity and Prevention (QIPP) challenge which meant £6 million worth of efficiency saving were needed within this financial year. Secondly, there were the actions of the Primary Care Trusts (PCTs) intending to spend less on acute care and decommissioning certain services which equated to £25 million less income for Dartford and Gravesham over the next four years. Thirdly, the NHS Operating Framework for the current year meant that Acute Trusts would be receiving less for what they did do. Fourthly, there was a limit on what efficiencies could be achieved as things stood, so a partnership with Medway NHS Foundation Trust was being explored. The temporary closure of accident and emergency and maternity services at Queen Mary's Sidcup did add work pressures on the Trust but also added income. Among other developments at the Trust was repatriating services to Kent, normally accessible only in London, like a number of cardiology services.

(3) Medway NHS Foundation Trust echoed the interest in a partnership between it and Dartford and Gravesham NHS Trust, though this was a change from the view a year ago. However, the proviso was made that while a merger would save money, particularly in back office costs, it would not completely offset the financial pressures. Medway NHS Foundation Trust had to make 7% efficiency savings. This was challenging, but the national decision for no pay inflation helped produce a seven figure saving. Reducing the number of bed days at the hospital was a key drive for the current year with different initiatives being pursued to realise this, such as nurses being able to discharge patients and providing the capacity to care for twenty patients in their own homes; the latter policy was going to expand to cover Swale and non-medical patients, neither of which were included in the scheme at present. Following questions from Members, further detail was provided on the scheme for allowing nurses to discharge patients which was due to be implemented in a month's time. It was explained that there was not the capacity at the Trust to enable patients to be seen by consultants each day, but if the requirements set by the consultant for discharge were met, then the appropriate nurse would have the ability to approve discharge to prevent patients staying in hospital longer than necessary. This point was supported by East Kent Hospitals NHS University Foundation Trust arguing that keeping patients in hospital longer than necessary increased the clinical risks of infection.

(4) Several Members expressed broad approval for the potential of merging Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust, as long as the levels of service provision remained the same at both sites. It was explained that the populations served by both meant this was not likely. The

two Trusts were invited to return to the 22 July meeting of the Committee in order to explore the merger potential further.

(5) The perspective from East Kent Hospitals NHS University Foundation Trust was that there were three macro-level challenges. Firstly, there were stricter criteria being used for referrals to treatment by commissioners so that some were not done at all and others treated as a low priority. Comparing the last quarter of 2009/10 to the last quarter of 2010/11, there was a 6.8% reduction in referrals. The QIPP challenge meant services were being redesigned to take place in lower cost settings; this applied to areas such as dermatology and long term conditions. The Government's set price for the tariff was deflationary and meant the equivalent of finding 5% efficiency savings, or £24 million in year. This had to be seen against a budget of £480 million and the wider savings target of £67 million set by commissioners in East Kent, of which this £24 million was a part. Added to this was the requirement to make a surplus of 6-7%. Without making a surplus, there would be no service reinvestment. The close relationship between financial balance and service stability was explained carefully.

(6) Rising public expectation was named as a key demographic challenge. The impact of the new hospital at Pembury on patient remained to be seen, but it was a possibility that some people around Maidstone may choose to go to William Harvey Hospital at Ashford and not Pembury. The development of the Any Qualified Provider policy also had the possibility to destabilise Acute Trusts as tariffs were largely based on average prices and if alternative providers took the easier procedures (for example, cataracts), then Acute Trusts would lose money providing the more complicated ones. The broader point was also made that Foundation Trust Terms of Authorisation included a list of services which the Trust needed to provide, even if they lost the Trust money, as was often the case with maternity services. The current Health and Social Care Bill made provision for Monitor to maintain a list of local designated services which would need to be provided on an ongoing basis.

(7) The challenges as seen from Maidstone and Tunbridge Wells NHS Trust could be divided between national and local ones. Nationally there was a tension and possible conflict between the moves to increase competition and increase collaboration on clinical pathways. The tariff changes meant the Trust had to save 4% just to stand still and so any decommissioning of services would add an additional financial strain. On top of this there was a strong desire to ensure there was no reduction in quality; a goal supported by the outcomes framework which would be measuring outputs. Locally there was a need to collaborate on pathways in the context of the ageing population. NHS West Kent had its own QIPP programme aimed at realising £59 million in savings, part of which involves £10 million worth of income diverted from the Trust to other providers. The new PFI hospital at Pembury was currently 40% open, and would be 100% operational in September. While this added to the cost base, it could attract work from East Sussex and elsewhere, and needed to be fully open in order to run efficiently. There were also financial pressures on social services and the emergence of GP Commissioning Consortia, all of which also added to the difficulties of resolving the tension between competition and collaboration.

(8) As a positive model, the primary angioplasty service based at William Harvey Hospital was given as it involved all four Acute Trusts collaborating to provide cover for the one rota.

(9) The Chairman made the observation that the proposed Health and Wellbeing Board, involving Kent County Council as it will, may be able to play a useful role in promoting future service collaboration.

(10) Developing the theme of the impact of PFI schemes, the point was made that each one is different. This was illustrated by car parking. At Dartford and Gravesham NHS Trust, though they had planning permission to extend car parking, it was not actually the Trust's car park and any change needed to be agreed with the hospital company. In the shorter term, changes were being made to staff car parking. At the new Pembury PFI development, the car park was owned by Maidstone and Tunbridge Wells NHS Trust.

(11) The actual cost to the NHS of patients receiving treatment under the tariff varied from Trust to Trust because of the Market Forces Factor. Treatment in London was more expensive than in Kent, so the point was made that if patients either chose to go to London, or needed to be referred there, that was an additional cost to the commissioners in Kent and a loss to the providers. For this reason, establishing services locally which were otherwise only available in London, a process known as repatriation, was reported as being a double win. Looking locally, one Member of the Committee made the observation that the two Acute Trusts in West Kent had the highest Market Forces Factors in Kent and Medway, but that NHS West Kent had the lowest per capita PCT allocation. To this was added the point made by East Kent Hospitals NHS University Foundation Trust that the Market Forces Factor for the Trust had got lower, though it had increased for the others in Kent and Medway. This meant the Trust was receiving less income for each service provided and needed to improve efficiencies even more to keep up. The Trust representative also noted that staff costs were nationally set in most cases.

(12) The role of the Acute Trusts in Kent and Medway in training was discussed, and all were involved. As an example, East Kent Hospitals NHS University Foundation Trust currently had 400 medical undergraduates from King's College and 400 doctors ranging from junior doctors to those undergoing specialist training. In addition the Trust worked with nursing colleges. At the Trust the roles of specialist nurses was being looked at, and the skills of Healthcare Assistants being improved. The number of junior doctors was controlled by the Deaneries and the main challenge was that it took 6-7 years to train a junior doctor, and another 6-7 for specialist training, meaning a total of around 14 years to make a consultant. However, the medical landscape often changed faster than the training could produce doctors, so there was inevitably always going to be a shortfall in some areas.

(13) Members picked up on information provided by the Trusts on the proportion of their annual budgets which was spent on administration. In response, further detail was given on what this covered and how necessary it was to the medical activities. Administration included medical records as well as staff like receptionists, porters and cleaners.

(14) A distinction was made during the discussion between the two Trusts which were based on a single site and the two which covered a number of sites. This meant a different challenge in planning and providing services in Medway where there was a defined population and one Acute hospital site and East Kent, where there was a less defined population and three main sites. As Acute Trusts were not simply nine-to-five businesses, telemedicine and other complex systems were involved to ensure there was always a consultant accessible. The observation was made that currently East Kent Hospitals NHS University Foundation Trust had one main commissioner, but that in the future there was likely to be a number of GP Commissioning Consortia, possibly up to nine. This would bring additional ethical and design challenges as different commissioners may wish to commission different services from the one Trust covering several GP Commissioning Consortia populations.

(15) The Chairman expressed his hope that the Committee would be able to meet with the emerging GP Commissioning Consortia in the future and undertook to explore this possibility.

(16) Clarification was sought on the policy that Acute Trusts were financially responsible for readmissions and it was explained that the policy only applied if it was for the same condition as the original admission. The intention of the policy was to reduce inappropriate hospital discharges. However, there were a number of unintended consequences. Firstly, the majority of patients were elderly, many of whom had long term conditions, and a readmission to hospital may have more to do with the nature of the condition and the patient's age than any action on the part of the hospital. Secondly, there was a chance that Acute Trusts could be penalised for the failure of other organisations and the example of stroke care was given where it could be the after care which let down the patient.

(17) This returned the Committee to the earlier discussion about the tension between competition and collaboration. There was a perceived danger that where there was a lack of collaboration on a patient pathway there could instead be the shunting of debts between organisations.

(18) A similar point was made around the provision of GP out-of-hours services in the past where doctors involved in providing the service were averse to risk and lacked knowledge of local services meaning attendances at Accident and Emergency departments increased.

(19) A number of Members of the Committee echoed the same plea that through all the changes and financial challenges, the core business of providing care not be forgotten. Trust representatives accepted this but indicated the progress which had been made, with the 18-week referral to treatment target having largely been met along with the 2-week wait for cancer appointments following GP referral.

(20) The specific issues was raised that, whilst the care received may be very good, customer care for patients entering the system and between appointments needed to be looked at so that patients had certainty about who they were going to see and when. East Kent Hospitals NHS University Foundation Trust conceded cancelled outpatient appointments were a struggle

and there was a cost involved in remaking appointments. The Trust was moving to a full booking system, where all the appointments for a patient on a pathway could be made in advance, though this did require capacity in the system.

(21) The Chairman thanked the Committee's guest for the useful and open discussion and asked Committee Members to forward any suggestions for recommendations on NHS Financial Stability to the Officers supporting the Committee.

(22) AGREED that Members delegate authority to the Head of Democratic Services in consultation with the Chairman, Vice-Chairman and Group Spokesmen to prepare a list of recommendations to present to a future meeting of the Committee for discussion and agreement prior to their submission to the NHS for a response.

(23) AGREED that Members assist this process by suggesting recommendations to the Committee Officers following each meeting.

5. Date of next programmed meeting – Friday 10 June 2011 @ 10:00
(Item 7)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 10 June 2011

Subject: Trauma Services in Kent and Medway

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1. Background

(a) The Health Overview and Scrutiny Committee last considered the topic of trauma on 5 February 2010 as part of a larger meeting examining "Emergency Care Pathways." The same meeting also considered cardiac and stroke services as part of the broader subject. An update on the primary angioplasty service was received by the Committee on 26 November 2010.

(b) An extract from the Minutes of the meeting of 5 February 2010 relating to the discussion on trauma is included as an Appendix to the Background Note following this report.

(c) As agreed at the meeting of 25 March 2011, the Committee accepted the request from NHS West Kent that an update on local developments around trauma networks be presented to the Committee at a subsequent meeting.

2. Recommendation

That the Committee note the report and determine whether to examine this issue in more depth at a later meeting.

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

To: Health Overview and Scrutiny Committee, 10 June 2011

Subject: Trauma Services

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1. Background

(a) Selected key facts about major trauma[1]:

- Major trauma = serious/multiple injuries where there is the strong possibility of death or disability.
- Blunt force causes 98% of major trauma, mainly through car accidents and falls. Gunshots, knife wounds and other penetrating injuries account for 2%.
- It's the leading cause of death in England for those aged under 40.
- Major trauma accounts for 15% of all injured patients.
- Major trauma admissions to hospital account for 27-33 patients per 100,000 population per year and represents less than 1 in 1,000 emergency department admissions.

2. Regional Trauma Networks

(a) Over the years, there has been a growing body of evidence concerning the need to improve trauma services. In 2007, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) produced a report entitled *Trauma: Who Cares?* This found "Almost 60% of the patients in this study received a standard of care that was less than good practice. Deficiencies in both organisational and clinical aspects of care occurred frequently."[2]

(b) A National Audit Office report, *Major trauma care in England* (published 5 February 2010), made the following overall findings:

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[1] Key facts extracted from a) National Audit Office, *Major trauma care in England*, 5 February 2010, http://www.nao.org.uk/publications/0910/major_trauma_care.aspx b) The Intercollegiate Group on Trauma Standards, *Regional Trauma Systems. Interim Guidance for Commissioners*, December 2009, http://www.rcseng.ac.uk/news/docs/Regional_trauma_systems.pdf

[2] NCEPOD, *Trauma: Who Cares?,* 2007, p.10, http://www.ncepod.org.uk/2007report2/Downloads/SIP_report.pdf

- "Despite repeated reports identifying poor practice, the Department and NHS trusts have taken very little action to improve major trauma care."

- "Survival rates for major trauma vary significantly between hospitals, reflecting variations in the quality of care."

- "As major trauma is a relatively small part of the work of an emergency department, optimal care cannot be delivered cost-effectively by all hospitals."

- "Evidence shows that care should be led by consultants experienced in major trauma, but major trauma is most likely to occur at night-time or at weekends when consultants are not present in emergency departments."

- "The delivery of major trauma care lacks coordination and can lead to unnecessary delays in diagnosis, treatment and surgery."

- "Information on major trauma is not complete and quality of care is not measured by all hospitals."

- "Ambulance trusts have no systematic way of monitoring the standard of care they provide for people who have suffered major trauma and opportunities for improving care may be missed."

- "The availability of rehabilitation varies widely across the country, and services have not developed on the basis of geographical need."

- "The costs of major trauma are not fully understood, and there is no national tariff to underpin the commissioning of services."[3]

(c) The need for specialist trauma services formed part of the 2008 NHS Next Stage Review[4]. On 1 April 2009, Professor Keith Willett was appointed as the first National Clinical Director for Trauma Care and his team assists strategic health authorities (SHAs) in developing regional trauma networks[5].

(d) The NHS Operating Framework for 2011/12 stated the following:

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[3] National Audit Office, *Major trauma care in England*, 5 February 2010, pp.6-7, http://www.nao.org.uk/publications/0910/major_trauma_care.aspx

[4] Department of Health, *High Quality Care For All. NHS Next Stage Review Final Report*, June 2008, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf

[5] Department of Health, National Clinical Directors, http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/Nationalclinicaldirectors/DH_101369

- "All regions should be moving trauma service provision into regional trauma network configurations in 2010/11. Tariff changes will be introduced from April 2011 that are designed to recompense for the complexity of multiple-injury patients. Designated Major Trauma Centres should be planning the continuous provision of consultant led trauma teams, immediate CT scan options, and access to interventional radiology services for haemorrhage"[6].

3. Injury Severity Score (ISS)

(a) An anatomical scoring system, the injury severity score, is used to classify trauma. The score goes from 0 – 75 and a score of 16 and over is classed as major trauma.

Table: Injury severity score group and mortality[7]

injury severity score	**percentage of major trauma patients**	**percentage mortality of this injury severity score group**
16-25	62.6	10.5
26-40	28.9	22.1
41-74	7.7	44.3
75	0.8	76.6

[6] Department of Health, *NHS Operating Framework 2011/12,* 15 December 2010, p.43, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

[7] National Audit Office, *Major trauma care in England*, 5 February 2010, p.11, http://www.nao.org.uk/publications/0910/major_trauma_care.aspx

Appendix: Selection from Minutes, Health Overview and Scrutiny Committee, 5 February, 2010[8].

(a) *Professor Roche, Medical Director (South East Coast Strategic Health Authority). Ms Evans, Head of Business Planning and Strategy, and Mr Reynolds, Head of Business Development (South East Coast Ambulance Trust), Ms Thomas, Director of Service Redesign (NHS West Kent) and Andrew Cole, Head of Commissioning Urgent and Continuing Care (NHS Eastern and Coastal Kent) were present for this item.*

(b) (22) Mr Roche referred to the major trauma report that had today been issued by the National Audit Office. Major trauma was not currently a success story, the UK was just starting to look at major trauma services. In Kent one of the issues was logistics, in 2008 66 people in Kent died in road traffic accidents, and most of these were in the coastal area away from the major road network. Patients with complex trauma need to be rapidly assessed by ambulance crews. Approximately 60% of those with complex trauma had head injuries. Many patients from Kent were taken to King's College Hospital, London. However King's could not accept transfers by air ambulance at night. It was recognised that there was a problem with trauma treatment in Kent and a review had already been commissioned across the Strategic Health Authority area. Trauma Leads had been appointed in Brighton and Kent who would form the basis of a trauma board. The message was that major trauma patients like heart attack patients needed a 24/7 service available with senior staff and urgent access to further services if necessary. He stated that he was determined to come back to the Committee in the future with a success story for trauma.

(c) (23) The Chairman stated that he was encouraged that Mr Roche had approached this Committee at this early stage to seek the Committees views as representatives of the layperson.

(d) (24) In relation to a question from Councillor Blackmore seeking clarification on the air ambulance and night flying, Mr Roche explained that only police pilots could fly at night, but another issue was the affect of adverse weather on the air ambulance. Accidents involving major trauma were more likely to occur in poor weather conditions.

(e) (25) Councillor Lyons asked whether there were likely to be a number of dedicated centres in Kent or whether there would be a shared facility with Sussex. Mr Roche explained that 600 – 700 patients a year were needed to support a fully equipped trauma centre. It was anticipated that Kent would produce less than 100 patients a year and therefore it was very unlikely Kent could host a centre. In Kent the issue was logistics and there was a need to ensure that

[8] Kent County Council, http://democracy.kent.gov.uk/mgAi.aspx?ID=11160

patients were assessed, any immediate problems resolved and then were able to access good pathways to appropriate care in a timely manner. It was then necessary to repatriate and properly rehabilitate these patients. This needed to be put in place across Kent to ensure the best outcomes for the patient.

(f) (26) In response to a question from Mr Cooke, Mr Roche confirmed that the most significant number of road deaths in Kent occurred outside of the M25 and M20 corridor, along class "A" roads and in the coastal areas. The aim was to provide the best possible service and not disadvantage people because of where they lived or where an accident occurred.

(g) (27) Mr Daley asked whether when Pembury Hospital was open it would be able to deal with aspects of the major trauma services that patients currently had to go to Brighton or London to receive. Mr Roche replied that patients with brain or chest injuries would still need to go to other centres. He stated that Kent was to be congratulated in centralising its heart treatment, which had been done by clinicians working together to provide a service that was best for patients and he was keen that the same principle would drive the reconfiguration of acute trauma.

(h) (28) In response to a question from Mr Lyons, Mr Roche confirmed that the trauma leads would inform him of relevant organisations to seek views from, However, the service would be developed around the benefits to the patients and not any vested interests.

(i) (29) In answer to a question from Mr Kendall, Mr Roche stated that very few cyclists were killed in Kent but that there was evidence from America that the use of helmets reduced injuries for cyclists.

(j) RESOLVED That the Committee supports the developments taking place in emergency care pathways and health colleagues be thanked for bringing the paper on trauma to this Committee to enable Members to have an input at an early stage.

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Proposal for the Development of Major Trauma Units for Kent and Medway

1. Purpose of this document

This document provides a overview of the Outline Business Case in support of the development of Major Trauma services across Kent and Medway; specifically the development of local Trauma Units to provide enhanced services for patients following major trauma, and links with pathways for rehabilitation for all patients following treatment for major trauma.

The development of Trauma Networks and process per region is a national requirement set out within the revised NHS National Operating Framework for 2010/11 and 2011/12. Within this framework, each region is expected to have Regional and local Major Trauma Networks, and a strategy for delivery in place during 2010/11 with Trauma Units being operationalised by 2012.

It is proposed that three Trauma Units are developed for Kent and Medway based on a full review of data and assessment of Acute Trusts against nationally validated criteria. The three trauma units proposed, therefore, are:

- Maidstone and Tunbridge Wells NHS Trust (Pembury Hospital Site)
- East Kent Hospitals NHS Foundation Trust (William Harvey Hospital Site)
- Medway NHS Foundation Trust

All three Acute Trust CEO (or their designated representatives) and internal clinical leads support the application to become a Trauma Unit.

Emergency Departments not designated a Trauma Unit will continue to receive and treat trauma patients appropriate to the services currently provided within that facility.

The development of these three Trauma Units is based on the reconfiguration of existing services. It is likely that there will be a national tariff structure, but it is unclear at this stage whether this tariff arrangement will be nationally mandated or serves as a guide for local commissioning discussion. It is, therefore, anticipated that for year 1 of the implementation process activity will be paid under the existing Payment by Results (PbR) arrangements.

2. Executive Summary

In order to identify and define the requirements for treating major trauma cases across Kent and Medway, the Critical Care and Trauma Network agreed a set of key principles for local trauma services which supports the development of a hub and spoke model:

- Kent and Medway do not require a local Major Trauma Centre due to an insufficient number of trauma incidences per year (estimated at 202). National recommendations are that major trauma centres treat 400-650 cases per year, in order to maintain clinical expertise

- Trauma Units are required to enable appropriate stabilisation of patients, prior to referral to specialist services, which have been shown to reduce mortality from major trauma by 40% by reducing the time to diagnosis and onward referral.

- Trauma Units will require support from the clinical lead(s) (or Clinical Director on call) at the Major Trauma Centre(s) ensuring effective and appropriate clinical accountability and transfer of patients.

- Self assessment of each emergency department across Kent and Medway has been undertaken, combined with geographical considerations and review of data, to inform the location of the Trauma Units.

- Submission of Trauma Audit and Research Network (TARN) data by all Trusts in Kent and Medway has been agreed to enable accurate data collation and review of services going forward

- Agreement to a focussed review of current rehabilitation pathways, which is key to enabling the effective and efficient use of specialist resources by the appropriate transfer of patients from tertiary centres to clinically appropriate rehabilitation services. In addition this may help to:
  - reduce the length of stay
  - minimise hospital readmissions
  - reduce the use of NHS resources following the initial period of hospitalisation.

These principles were developed following review and discussion of the key national guidance and requirements relating to and referencing Major Trauma. These principles, supported by self assessment of emergency departments, have been the basis for the proposal to develop three trauma units across Kent and Medway.

3. Background

Major trauma is described as serious and often multiple injuries where there is a strong possibility of death or disability; and is identified as the leading cause of death in people under 40. However, in order to identify and address care for all patients suffering trauma injuries the classifications as described by the injury severity score (ISS) have been used within this paper.

Over recent years there have been a number of national drivers promoting the review and strengthening of arrangements for the treatment of major trauma cases in order to reduce death and disability. The 2010 review of Major Trauma Care in England undertaken by the National Audit Office (NAO), highlighted that there had been little progress nationally against recommendations from reviews and audits since 1988. Both

the recommendations from the NAO report, and the assertion within Lord Darzi's 2008 NHS Next Stage Review that there were 'compelling arguments for saving lives by creating specialised centres for major trauma' have been supported by the Department of Health through its Regional Trauma Networks Programme and the appointment of the first National Clinical Director for Trauma Care to lead the development of clinical policy. In addition, the continuation of these developments has been reiterated within the National Operating Framework for 2011/12.

The Departments of Health's overall national imperative for trauma care is for the development of care models and pathways based on:

- patients' needs;
- local expertise and facilities, and
- geography and transport options,

with ongoing monitoring of performance against professional standards. The Kent and Medway Critical Care and Trauma Network have used these criteria to support decision making for the review of local services.

4. Local context:

Within Kent and Medway, there are four NHS Hospital Trusts, consisting of eight acute hospitals, with seven type 1 Emergency Departments.

Pre-hospital triage is currently undertaken by the Ambulance Trust supported by HEMS where an air ambulance is deemed necessary. Following triage, patients may be transferred directly to a major trauma centre or to a local emergency department dependent on clinical need.

Patients are transferred from the scene of an incident to a local emergency department for stabilisation and assessment; following which a decision is made regarding the location of further treatment. This may be undertaken locally, regionally or within a tertiary (major trauma) centre, and appropriate arrangements for transfer are made.

Patients requiring specialist major trauma intervention may be treated at a number of Major Trauma Centres, including:

- Kings College Hospital NHS Foundation Trust
- Queens Hospital, within Barking, Havering and Redbridge University Hospitals NHS Trust
- The Royal London Hospital, within Barts and The London NHS Trust

The process for transfer from specialist trauma services into rehabilitative services is currently based on local protocols.

Key issues for consideration within Kent and Medway:

- The NHS Clinical Advisory Groups Report into Regional Networks for Major Trauma (September 2010) reiterated the imperative for patients involved in major trauma to be transferred to a Major Trauma Centre within 45 minutes. However, the Clinical Advisory Group also acknowledges that for many areas transfer within this 45 minute

isochrone is not possible, and local trauma units will therefore be required to provide stabilisation prior to onward transfer to a Major Trauma Centre. Due to the geography of Kent and Medway, the majority of emergency departments fall outside the 45 minute isochrones for Major Trauma Centres (see Figure 1).

Figure 1: Major Trauma Centres (London and Brighton) – Area of Kent and Medway Not Covered by Major Trauma Facilities*

(* Shaded area represents approximate 45-minute road travel times by Ambulance to/from King's College Hospital, London and Royal Sussex County Hospital, Brighton)

The proposed trauma unit locations were based on the ability for all areas of Kent and Medway to be within 45 minutes of either a Major Trauma Centre (as is the case for the Dartford and Gravesham areas proximity to King's College Hospital) or a trauma unit. Figure 2 demonstrates the coverage of services within 45 minutes for Kent and Medway following implementation of the proposed Trauma Unit sites:

Figure 2: Major Trauma – 45-Minute Ambulance Road-Travel Isochrone around SEC Major Trauma Centres and Kent and Medway (potential) Trauma Units*
(* Shaded area represents approximate 45-minute road travel times by Ambulance to/from KCH, London; RSCH, Brighton; WHH, Ashford; MMH, Gillingham; Pembury, Tunbridge Wells)

- Whilst there is a high potential for major incidents within the Kent and Medway area – due to the high volume of international traffic using the multiple motorways within the region, air corridors and the channel tunnel – this is not borne out by data modelling
- Multiple transfers increase morbidity rates and therefore clear pathways for the transfer of patients from incident to suitable locations for diagnosis and treatment are vital

5. Trauma Units

Nationally a Trauma Unit is defined as a unit that 'provides care for most injured patients' (NHS Clinical Advisory Group recommendations to the Department of Health) and:

- 'is optimised for the definitive care of injured patients. In particular, it has an active, effective trauma Quality Improvement programme. It also provides a managed transition to rehabilitation and the community.
- has systems in place to rapidly move the most severely injured to hospitals that can manage their injuries.
- may provide some specialist services for patients who do not have multiple injuries (e.g. open tibial fractures). The Trauma Unit then takes responsibility for making these services available to patients in the Network who need them. Other Trauma Units may have only limited facilities, being able to stabilise and transfer serious cases but only to admit and manage less severe injuries.'

Due to the geographical constraints within Kent and Medway and the proximity of the nearest Major Trauma Centre, as described above, the Critical Care and Trauma Network have deemed it necessary to develop local trauma units. This is to ensure adequate and appropriate services locally which meet the needs of seriously injured patients, both in terms of treatment for some patients where the required clinical expertise is available locally and for stabilisation of patients prior to transfer to a Major Trauma Centre for specialist treatment.

Emergency Departments not designated a Trauma Unit locally will continue to receive and treat trauma patients appropriate to the services currently provided within that facility. Network wide protocols will define the clinical criteria for each unit, and be developed to support full implementation of trauma services across Kent and Medway.

6. Proposal for Kent and Medway Trauma Units

The Critical Care and Trauma Network have proposed the development of three Trauma Units across Kent and Medway, as fully described within the Outline Business Case. This decision was based on:

1. review of trauma incident data and Trust data available

2. review of the geographical constraints within Kent and Medway, and the ability for patients to be transferred from the scene of an incident to trauma services within the recommended 45 minute time window. For the majority of patients within Kent and Medway it is not possible for patients to be transferred to a London Major Trauma Centre within this time frame. Trauma Units, providing services to stabilise and, where possible, treat patients prior to transfer to specialist services are therefore deemed necessary.

3. review of Trusts self assessment against Trauma Unit Designation Criteria.

The Network has therefore identified the following hospitals for development as trauma units:

- Maidstone and Tunbridge Wells NHS Trust (Pembury Hospital Site)
- East Kent Hospitals NHS Foundation Trust (William Harvey Hospital Site)
- Medway NHS Foundation Trust

Dartford and Gravesham NHS Trust was deemed not to require a trauma unit due to its proximity to Kings College Hospital, and the ability of patients to be transferred to the Major Trauma Centre within the recommended 45 minute timeframe. This proposal is fully supported by clinical leads and Acute Trusts.

As patients meeting specific pre-hospital triage criteria will continue to be directly transferred to a major trauma centre, it is proposed that major trauma centre services will continue to be commissioned from a range of providers. This will include both London providers (as outlined above), and with the Major Trauma Centre in Brighton when this service 'goes live' in 2014. This will enable the needs of the Kent and Medway population to be met both in terms of geographical location, and therefore time to transfer for specialist services, and specialist services available at each provider. This will require the development of clearly defined service level agreements, service specifications and clinical processes for the transfer (to and from specialist services) and rehabilitation.

7. Benefits

The key benefits to the development of local Trauma Units are:

- Local health economy:
    - Reduction in death and disability for patients suffering major trauma due to the reduction in time to diagnosis and treatment or transfer to specialist services.
    - Ensuring clinical quality for trauma patients
    - Enables care to be provided local to the patients where this is clinically appropriate
    - Efficient and effective use of NHS resources, both in terms of use of Major Trauma Centre specialist services and local services.
- Trusts:
    - Designation results in a higher profile
    - Training and education opportunities
    - Deanery recognition for training
    - Tariff attached for major trauma patients
    - Benefits for all Trusts with the transfer of patients to local services for rehabilitation when specialist services are no longer required

8. Payment Structure for Multiple Trauma

The development of Trauma Units will be based on the reconfiguration of existing local services.

A revised payment structure for multiple trauma patients, which uses two scores based on diagnosis and treatment, has been released by the Department of Health for 2011/12. However, it is unclear whether this will be mandated and therefore on which local tariffs will be based.

Trusts will need to consider that there are no additional monies available for the development of Trauma Units. Costs attributable to becoming a Trauma Unit will only be

apparent following a detailed review against the Trauma Unit Designation criteria and these will therefore differ by the requirements at each site.

However, based on the experience within the London Trauma System, the main changes required to meet these criteria relate to governance arrangements, staffing rotas, and development and implementation of protocols. This work will be supported by the Network.

Working to agreed Trauma Network protocols, designated Trauma Units are likely to see an increase in activity owing to treating/stabilising a number of trauma cases that would otherwise have been treated initially at another DGH. It is not anticipated that these numbers will be high particularly for the first year of implementation, as there is not expected to be an increase in the case load, which is currently being managed within existing services. However, this will be monitored through TARN and reviewed by the Network. Payment for patients will be made under the PbR mechanism route.

For Trusts not identified as a Trauma Unit, there is a potential for patients to bypass the emergency department. Based on national data, estimates of local Acute Trust attendances of all significant trauma cases have been reviewed. This review has identified that, potentially, up to approximately 80 trauma cases per annum of ISS 9 or above (major trauma cases are considered to be ISS 15 or above) currently treated at Darent Valley Hospital could, under Trauma Network protocols, be treated at a Major Trauma Centre either directly or via a Trauma Unit. However, this data is based an approximation and, on review by clinical leads, is considered to be an over estimate.

Evidence from the London Trauma System suggests that concerns on the part of those hospitals that do not become Trauma Units (i.e. in respect of the potential financial impact of losing major trauma cases) is largely unfounded, as major trauma cases represent a very small proportion of their caseload. It is estimated that c.90% of emergency departments see less than one major trauma case (ISS 15 or above) per week and c.75% have less than one per fortnight. Any financial losses associated with this reduction can be recouped via participation in rehabilitation pathways, and ensuring that patients occupying Major Trauma Centre critical care beds unnecessarily can be appropriately repatriated within local services.

9. Major Trauma Networks

The NHS Clinical Advisory Group recommended that Major Trauma Networks, consisting of all providers of trauma care, should be in place within each region, centred around a Major Trauma Centre. In order to implement this recommendation, the Kent and Medway Critical Care and Trauma Network have agreed to further develop links with South East Coast Trauma Network with a view to becoming part of this Network.

Further work on this arrangement is required including:

1. commitment from the Major Trauma Centre and local Trusts regarding the appropriate and swift transfer of patients to the most appropriate service
2. arrangements for the provision of 24/7 advice and guidance on the management of local major trauma patients by a Major Trauma Consultant
3. review and development of operational policies from South East London Network

for implementation across Kent and Medway

In order to address local issues, it is expected that the current Kent and Medway Critical Care and Trauma Network Board will continue as a subgroup of the South East London Network. In addition, a forum for commissioning discussion and decision making will be identified – dependent on the confirmation of national commissioning arrangements for major trauma.

10. Rehabilitation

It is acknowledged that not only is rehabilitation essential to 'address the physical and psychosocial needs' of patients following major trauma, there are generally limited facilities for providing this service (NHS Clinical Advisory Group 2010). Patients who do not receive rehabilitation are unlikely to return to their maximum levels of function; with implications for individuals, carers and society as a whole.

In order to enable provision of appropriate rehabilitation for individuals, and efficient use of specialist resources, arrangements for the transfer of patients from tertiary trauma centres to local, or specialist, rehabilitation services will be reviewed. This work will be undertaken as part of the closer links with South East London Trauma Network, and by the Kent and Medway Critical Care and Trauma Network.

11. Conclusion

The development of local Trauma Units within Kent and Medway is required in order to ensure:

- That death and disability is reduced for Kent and Medway patients suffering major trauma
- Swift diagnosis, treatment and transfer of patients to specialist centres is enabled, as clinically required
- High quality clinical care is provided
- Effective and efficient use of NHS resources

The Kent and Medway Critical Care and Trauma Network has reviewed the options in relation to the development of such units and deemed that, at this stage, three hospitals be developed as Trauma Units. The location of these units were based on the ability of patients to be transferred to a Major Trauma Centre within the 45 minute target time, review of incident data and Trust self assessment against Trauma Unit designation criteria.

In addition to the development of Trauma Units, the Network will continue to actively link with Major Trauma Centres to ensure that protocols, policies and procedures to facilitate the diagnosis, treatment, transfer and rehabilitation of major trauma patients are implemented across Kent and Medway.

12. References / Guidance Documents:

- Major Trauma Care in England; National Audit Office, February 2010.
- Revision to the Operating Framework for 2010/11; published 21st June 2010
- NHS Operating Framework 2011/12; published December 2010.
- The Operating Framework for the NHS in England 2010/11 (DH, 2009)
- The Operating Framework for the NHS in England 2011/12 (DH, 2010)
- Healthier People, Excellent Care (South East Coast SHA, 2008)
- Regional Networks for Major Trauma (NHS Clinical Advisory Groups Report, September 2010)
- Major Trauma Care in England (National Audit Office, February 2010)
- Implementing trauma Systems: Key Issues for the NHS. (Ambulance Service Network and the NSH Confederation. August 2010)
- Modeling Trauma Workload – A Project for the Department of Health from the Trauma Audit and Research Network (TARN) – South East Coast Trauma Activity.
- London Trauma Office – Designation Criteria for Trauma Units v 3.4. (June 2010.)
- Regional trauma systems, interim guidance for commissioners. (The Intercollegiate Group on Trauma Standards. December 2009.)

Item 6: NHS Financial Sustainability: Part 3 – Mental Health, Community Health, and Ambulance Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee – 10 June 2011

Subject: NHS Financial Sustainability: Part 3 - Mental Health, Community Health, and Ambulance Services

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1. Background

(a) Following the approval of the Forward Work Programme of the Health Overview and Scrutiny Committee on 7 January 2011, this will be the third of three meetings dedicated to the topic of NHS Financial Sustainability. In overarching terms, the intention is to determine answers to the following strategic questions:

1. What are the challenges to ensuring the NHS in Kent is financially sustainable?

2. Are there any implications for the range and quality of health services available to the people of Kent as a result of any measures being taken to achieve or maintain financial sustainability?

(b) The focus of the first meeting was on the Primary Care Trusts and the second on the Acute Trusts. The intention of today's meeting is to consider mental health services, community health services and ambulance services.

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

2. Recommendations

The Committee is asked to agree the following:

1. Members are asked to delegate authority to the Head of Democratic Services in consultation with the Chairman, Vice-Chairman and Group Spokesmen to prepare a list of recommendations to present to a future meeting of the Committee for discussion and agreement prior to their submission to the NHS for a response.

2. To assist this process, Members are asked to suggest recommendations to the Committee Officers following each meeting.

Appendix – Questions from the Health Overview and Scrutiny Committee for the meeting of 10 June 2011.

1. Why is achieving financial balance across the local health economy important and what are the potential consequences of not doing so?

2. What kinds of measures have been taken in 2010/11 in terms of changing what services you provide and the way in which they are provided within your organisation in order to try and achieve financial balance?

3. What kinds of measures are being considered for 2011/12?

4. What do you see are the main challenges to achieving financial balance across the health economy as a whole?

5. What has been the impact of the NHS Operating Framework for 2011/12 and the financial settlement for this next financial year?

6. How is the QIPP challenge being met within your organisation?

7. Are there any particular challenges and/or opportunities that come from your organisation covering more than one Primary Care Trust area?

8. Are there any particular demographic trends in Kent that will have an impact on the kinds of services you provide?

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

To: Health Overview and Scrutiny Committee, 10 June 2011

Subject: NHS Financial Sustainability. Part 3: Mental Health, Community Health, and Ambulance Services

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1. Introduction

(a) Previous Background Notes on NHS Financial Sustainability have focused on Primary Care Trusts and the Acute Sector.

(b) The focus of this Note is on the financial structure of the ambulance service, community health and mental health sectors. The main NHS providers of these services in Kent are the following:

1. South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

2. Kent and Medway NHS and Social Care Partnership Trust (KMPT).

3. Kent Community Health NHS Trust (KCHT) (established 1 April 2011).

2. NHS Finances - ambulance service, community health and mental health sectors

(a) In the background note on NHS finances in the acute sector, information was provided of the Payment by Results (PbR) tariff which accounted for over half of an Acute Trust's income and a third of PCT budgets[1].

(b) PbR is currently under development for ambulance services, community services and mental health. As PbR is developed for other services, they may not take the same form as it has in the acute sector. They may not, for instance, have both a national currency and a national tariff. A distinction is made between currencies and tariffs in NHS finances. A currency is the unit of healthcare for which a payment is made and the tariff is the price paid for that unit of healthcare[2].

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[1] Department of Health, *A simple guide to Payment by Results*, September 2010, p.63, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119985

[2] Ibid. pp.58, 61.

(c) Mental health has been identified as the main priority for the expansion of PbR, initially with a national currency and local prices[3].

(d) A national mental health currency was published in 2010/11 - the 'care cluster'. It was developed by the NHS in the North East and in Yorkshire and Humber.

1. "The clusters identify patient need over a given period of time, and apply to both admitted patient and community care. They therefore balance the risk between commissioners and providers. Commissioners do not have to pay extra for each contact and intervention. Providers know they will be get paid for each patient they care for and they also have an incentive to innovate and support the patient in the most cost effective setting. "[4]

(e) The NHS Operating Framework 2011/12 mandated "the allocation of service users to mental health care clusters"[5]. Work is being undertaken locally by KMPT and the lead commissioner, NHS Medway, on local tariffs based on these clusters[6].

(f) A number of specialised services where the number of affected patients is relatively small are commissioned either regionally by one of the ten Specialised Commissioning Groups, or nationally by the National Commissioning Groups. In mental health this includes secure services and some personality disorder services[7].

(g) Emergency ambulance services in the area covered by SECAmb are commissioned collaboratively by the relevant PCTs. The South East Coast Specialised Commissioning Group (SECSCG), hosted by NHS West Kent, leads on this[8]. Patient Transport Services (PTS) have historically been commissioned by health service providers, but the commissioning responsibility moved to PCTs in April 2009; PCTs took over PTS funding from hospital Trusts from April 2010[9].

(h) Ambulance services are currently commissioned on a cost and volume basis but the Operating Framework stated the Department of Health

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[3] Ibid., p.44.
[4] Ibid., p.44.
[5] Department of Health, *The Operating Framework for the NHS in England 2011/*12, p.53, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf
[6] Kent and Medway NHS and Social Care Partnership Trust, *2010-11 Annual Report*, pp.40-41, http://www.kmpt.nhs.uk/Downloads/whats-happening/april-2011/tbm270411-att16.pdf
[7] SECSCG, *Specialised Mental Health*, http://www.secscg.nhs.uk/home/specialised-services/specialised-mental-health/?locale=en
[8] SECSCG, *Ambulance Commissioning*, http://www.secscg.nhs.uk/home/tertiary-contracts/ambulance-services/?locale=en
[9] SECAmb, *Integrated Business Plan 2010-2015*, p.18-19, http://www.secamb.nhs.uk/about_us/document_library.aspx?cat=34

will "seek to amend the scope of ambulance service reference cost data collection to underpin currencies for use in 2012/13"[10].

(i) Work is also ongoing in developing currencies and tariffs for community services and move away from block contracts[11]. For example, currency options have been developed for the Healthy Child Programme[12].

(j) The Commissioning for Quality and Innovation (CQUIN) payment framework is a national framework within which local quality improvement goals can be agreed between commissioner and provider. A proportion of provider income is made conditional on achieving the goals of the CQUIN scheme. In 2011/12 the full CQUIN payment value is 1.5% of the Actual Outturn Value of the provider contract[13].

3. Any Qualified Provider

(a) The areas covered by patient choice, and the Any Willing Provider model (AWP), will be gradually extended in the future. The 2011/12 Operating Framework made clear that AWP will be introduced for community services during 2011/12.[14]

(b) On 30 March 2011, the Department of Health published further details on provision in *Making Quality Your Business. A guide to the right to provide*[15]. This document shifted to discussing choice of Any Qualified Provider (AQP). It provides the following outline of how AQP will work in the future:

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[10] Department of Health, *The Operating Framework for the NHS in England 2011/12*, p.53, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf

[11] Department of Health, *A simple guide to Payment by Results*, September 2010, p.45, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119985

[12] Department of Health, *Currency options for the Healthy Child Programme,* http://www.dh.gov.uk/en/Healthcare/TCS/Currencyandpricingoptionsforcommunityservices/index.htm

[13] Department of Health, *Using the Commissioning for Quality and Innovation (CQUIN) payment framework – A summary guide*, 20 December 2010, p.6, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123008.pdf

[14] Department of Health, *Dear Colleague Letter from Sir David Nicholson, NHS Chief Executive, Equity and Excellence: Liberating the NHS – Managing the Transition*, 17 February 2011, p.14, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124479.pdf

[15] Department of Health, 30 March 2011, *Making Quality Your Business. A guide to the right to provide*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125578

1. "Patients choose any provider who meets NHS standards and prices. Money follows them and the choices they make about where and by whom to be treated."

2. "To qualify as an AQP, providers will be subject to a qualification process. They will be required to show that they can meet the conditions of their licence with CQC and/or Monitor (if necessary), provide safe quality services to the contractual standards set by the NHS Commissioning Board and meet NHS prices – either set nationally or locally."[16]

(c) This same document also provided information on the development of staff-led enterprises through right to provide (R2P).

1. "At the widest level, the right to provide is for all staff working within health and social care. Depending on where you work, the process you go through will differ."[17]

4. Foundation Trust Status

(a) There are a number of differences between NHS Trust and NHS Foundation Trust (FT) status. Under the current proposals as set out in the NHS White Paper[18] and Health and Social Care Bill[19] (in its current form), all NHS Trusts are to become Foundation Trusts (or part of an FT) by 1 April 2014 and NHS Trust legislation would be repealed (meaning non-FT NHS Trusts will not exist). Monitor currently regulates FTs but under the proposals it would become the economic regulator for the health sector. A Provider Development Authority will be set up to performance manage NHS Trusts until they become Foundation Trusts; this Authority will then be wound down. A number of changes are also being made to the governance and financial freedoms of FTs.

(b) One areas of difference is around financial duties:

1. NHS Trusts have a duty to break even, meaning that their expenditure must not exceed their income, taking one financial year with another. Spending on capital and cash held must be within certain limits.

2. FTs are not statutorily required to break even, but must achieve the financial position set out in their financial plan. One main measure of an FT's financial performance is EBITDA (earnings before interest, tax, depreciation and amortisation)[20].

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[16] Ibid., p.32.
[17] Ibid., p.8.
[18] Department of Health, http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm
[19] Parliament, http://services.parliament.uk/bills/2010-11/healthandsocialcare.html
[20] Academy of Medical Royal Colleges and Audit Commission, *A Guide to Finance for Hospital Doctors*, July 2009, p.23, http://www.audit-

5. NHS Operating Framework

(a) The NHS Operating Framework for 2011/12 was published by the Department of Health the same day as the PCT allocations were announced (15 December 2010). This document sets out what the NHS needs to achieve during what it refers to as a 'transition year'[21].

(b) The key points of the NHS Operating Framework for 2011/12 are as follows:

1. Average growth in PCT recurrent allocations of 2.2%.

2. PCTs will receive allocations totalling £648 million to support social care in addition to the £150 million funding for reablement services incorporated into recurrent PCT allocations.

3. The delivery of the QIPP (Quality, innovation, productivity and prevention) challenge of £20 billion efficiency savings for re-investment has been extended by one year to the end of 2014/15.

4. No automatic capital allocation for PCTs – any capital funding to be granted on a case-by-case basis.

5. An overall tariff reduction between 2010/11 and 2011/12 of 1.5%.

6. New outpatient attendance tariffs to be introduced. New currencies and tariffs to be developed (and led locally).

7. Hospitals will not be reimbursed for emergency readmissions within 30 days of a discharge from an elective admission. Other readmission rates to be agreed locally.

8. Where providers and commissioners agree, services can be offered below the tariff price.

9. Strategic Health Authorities are to oversee the development of PCT 'clusters' with a single executive team to oversee the transition and support emerging GP consortia (including the assignment of PCT staff to consortia).

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commission.gov.uk/health/audit/financialmgmt/hospitaldoctors/Pages/hospitaldoctors9jul2009.aspx

[21] Department of Health, *NHS Operating Framework 2011/12,* 15 December 2010, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

10. GP consortia will not be responsible for PCT legacy debt prior to 2011/12. PCTs and consortia to work closely together to prevent PCT deficits prior to 2013/14, when GP consortia will have their own budgets.

11. Developing consortia will receive £2 per head to support this process. Running costs of £25 to £35 per head are expected by 2014/15.

12. A number of new commitments were made on health visitors, family nurse partnerships, the cancer drugs fund, military and veterans' health, autism, dementia and carers support.

13. The areas listed as areas for improvement include healthcare for people with learning disabilities, child health, diabetes, violence, respiratory disease and regional trauma networks.

(c) QIPP (Quality, Innovation, Productivity and Prevention) is a series of 12 workstreams[22] aimed at making efficiency savings to be reinvested in services. These twelve are divided into three areas, as set out below:

Table 2: QIPP Workstreams[23]

Commissioning and Pathways	Provider Efficiency	System Enablers
• Safe care • Right care • Long term conditions • Urgent and emergency care • End of life care	• Back office efficiency and optimal management • Procurement • Clinical support • Productive care • Medicine use and procurement	• Primary care commissioning • Technology and digital vision

[22] Department of Health website, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm
[23] Adapted from Department of Health, *QIPP workstreams*, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/index.htm

NHS
Eastern and Coastal Kent

Appendix - Additional information on NHS Financial Sustainability provided by NHS Eastern and Coastal Kent.

1. At the end of the meeting of the Committee meeting on 25 March, Members agreed that further information on the following five areas would be useful for their inquiry into NHS Financial Sustainability. The additional information supplied by Bill Jones, Acting Director of Finance at NHS Eastern and Coastal Kent, follows each point. In addition, the 2011/12 Department of Health exposition book was attached. This is a large spreadsheet and is available to Members on request*.

2. Further information supplied:

    1. Details around the per capita aspect of PCT allocations;

        The 2011/12 exposition book is attached*, saved on the 'Allocations' tab. This shows, inter alia, the Difference From Target (DFT – columns L and M) – this being how far each PCT is from exactly matching the most recent funding formula.

        There are also a number of non-recurrent allocations shown on the same tab. These are usually funded on a recurrent basis, but not included in the formula. Column AC shows the total allocation per weighted head of population - £1,725 in East and £1,499 in West Kent.

        The "Unified" tab shows different weightings, and the preceding 4 tabs show how these weightings are derived. You will see it is extremely complex, and there isn't a specific "deprivation" formula as such.

    2. Clarity around the future number of GPCCs, as well as their geographic coverage

        We currently have 9 in East Kent – 6 of which are pathfinders. There is some discussion of the number reducing to 5, but there is also a view of there just being a single one. Most probable at present is 5 – Ashford; Canterbury; Dover, Deal & Shepway as one and Swale and Thanet.

    3. Further information around how areas of severe deprivation impacted the allocations received by commissioners;

        Please refer to the third paragraph of the response to point 1.

4. Further detail around running cost comparisons between organisations; and

   This is complicated and we still await guidance on what running costs targets will be in 2011/12. We had to report actuals for 2010/11 in our annual accounts, these are currently being audited. The Department of Health gave us the definition for those accounts. For East Kent the total running costs per weighted head of population was £39 (this is 2.26% of total allocations). We are currently calculating the forecast for 2011/12 based on the same definitions. It will be somewhat lower because costs would have been much higher at the beginning of 2010/11 and lower at the end as staff numbers and other savings were made during the course of the year. I understand West Kent returned the same figure of £39 in their accounts (to be confirmed).

   The NHS Operating Framework for 2011/12 stated that GPCC running costs would be between £25 and £35 per head of weighted population.

5. Granularity concerning the possible legacy debts which could accrue to GPCC.

   At present there is no legacy debt (i.e. negative financial values) in East Kent that will accrue to GPCC. This is because the PCT has delivered against its statutory and other financial duties. My understanding is that this also applies in West Kent. There is a legacy document that we are pulling together – this includes a section on 'Organisational Assets and Liabilities' which requires information on:

   - Physical assets of the organisation, including estate, equipment (including computers), information systems, software, etc.

   - Contracts for support (as opposed to healthcare) services.

Report for the Kent Health Overview and Scrutiny Committee Meeting – 10 June 2011
From Kent Community Health NHS Trust (KCHT)

OVERARCHING QUESTION 1:

What are the challenges to ensuring the NHS in Kent is financially sustainable?

The challenges from a Kent Community Health NHS Trust (KCHT) perspective are being able to respond to increased demand as Quality Innovation Productivity Prevention plans push acute demand into the community, whilst at the same time achieving Trust efficiency plans. The anticipated change in demographics through increase in aging population will mean larger numbers of elderly and vulnerable patients at home with complex conditions.

OVERARCHING QUESTION 2:

Are there any implications for the range and quality of health services available to the people of Kent as a result of any measures being taken to achieve or maintain financial sustainability?

There is an opportunity for greater integration of services to better address the needs of patients, for example, across Community Services, Primary Care and Social Services. This should also result in improved efficiencies through better management of patient pathways.

1. **Why is achieving financial balance across the local health economy important and what are the potential consequences of not doing so?**

   For KCHT if financial balance is not achieved within the local health economy there will be pressures on Community Services to deliver additional efficiencies to balance the health economy budget. This will have a potentially negative impact on the capacity and quality of our Community Services. Reducing this capacity will in turn not support the Acute shift and therefore mean the continuation of a health economy overspend. KCHT will also not be able to deliver its investment plan, for example, in IT and Infrastructure. KCHT has a statutory duty to deliver a financial balance. The Trust will be seen as a failing organisation and will be subject to special performance monitoring. If we are unable to achieve financial targets then we will not achieve Foundation Trust licence and this will then mean further reorganisation for the local NHS.

2. **What kinds of measures have been taken into 2010/11 in terms of changing what services you provide and the way in which they are provided within your organisation in order to try and achieve financial balance?**

   KCHT have established a Cost Improvement (efficiency) Programme. The programme ensures that the Trust delivers financial targets. The programmes include:

   - reducing management and overhead costs
   - improving efficiencies through new ways of working through the Productive Community Services programme. This has resulted in increased patient facing time, now above the national average.

- reductions in travel and agency costs
- improved efficiencies through better use of IT

KCHT has developed and implemented service visions which have changed the way we organise and deliver our services to improve patient care and deliver efficiencies. There has been a particular focus on integrating services across professions and agencies for example, integrating Community Nurses with Primary Care (GPs), Integrated Children's Teams. There is the potential for integration with Social Services. In addition we are using tools and technology to better manage patients and avoid acute admission or facilitate discharges including Telehealth and predictor tools such as the Sussex and PARR which can predict the risk of admission at individual patient level. There has been no negative impact on access to or quality of the services and we continue to deliver against our contractual requirements.

3. What kinds of measures are being considered for 2011 / 12?

The Cost Improvement Programme for 2011/12 is to deliver approximately £14.5m in efficiency savings which is around 8% with a focus on the following areas:

- Back Office
- Procurement
- Workforce productivity
- Community Information System
- Estates

4. What do you see are the main challenges to achieving financial balance across the health economy as a whole?

The biggest challenge in achieving financial balance across the whole health economy is managing Acute demand. Community Services have critical role in that agenda. There has been an increase in Community Services to support care closer to home, for example, the increase in Intermediate Care / Rapid Response Teams, the establishment of specialist services in COPD, Stroke, the use of Telehealth etc, however Acute demand continues to rise. Better integration across services including social care, improved access to services e.g. telephone number – 111, and improved targeting e.g. user of tools to predict and pre-empt hospital admissions will support the reduction in Acute demand.

The increased demand for Community Services under a reducing block contract is a major challenge. The complexity of the new Commissioning world may make it harder to manage the whole system, however closer working with GPs is an opportunity to improve the system. Opening up the marketplace may bring a number of challenges and opportunities, those challenges may include duplication of provision and loss of economies of scale.

5. What has been the impact of the NHS Operating Framework for 2011/12 and the financial settlement for this next financial year?

The main impact has been a 1.5% reduction in block contract, whilst a requirement to continue to meet high quality and performance.

6. How is the QIPP challenge being met within your organisation?

KCHT participates in Kent and Medway QIPP. KCHT is working with Commissioners in developing and delivering the whole system QIPP plans.

There is more detailed work to do to understand the impact on Community Services of the Commissioners QIPP Plans which plan for a significant reduction in acute spend. This will require an increase in emphasis of care closer to home. We are working with Commissioners to achieve this. The work referred to earlier on predictive modelling and internal capacity and demand management will contribute to the County plans.

7. Are there any particular challenges and / or opportunities that come from your organisation covering more than one Primary Care Trust are?

No.

8. Are there any particular demographic trends in Kent that will have an impact on the kinds of services you provide?

The population of Kent has a high proportion of people over 65 years old. This is predicted to rise considerably in the next 5 years to over 4% higher than the national average.

In Kent elderly people with more than one long term condition live longer than the national average. That is excellent news and a testament to local health services but it brings with it increased pressure on our community services and an increase in demand for the care of long term conditions. These patients are often less able to travel to receive treatment and often require care at home, from our Primary care nursing Teams, Community Matrons or in the short term, Intermediate Care Services.

The four major causes and related percentages of death in Kent in all ages are:

- Cancer (26%)
- Coronary heart disease (17%)
- Respiratory disease (15%)
- Stroke (11%)

These correlate closely with national figures. Deaths related to these diseases will frequently have been associated with long term illnesses.

Compared to national averages Kent also has a high percentage of people living for longer with conditions such as diabetes and mental illness. There is an increasingly high number of younger people living with long term conditions such as diabetes, often related to poor diet and obesity, who require life long management and support from a healthcare professional.

Forecasts predict that the number of children under the age of 5 living in Kent will rise by 10%. This will impact on the children's workforce requiring a similar increase in capacity. This will be most significant in Health Visiting where an increase of approximately 75% on

the current workforce is already required by 2015 to meet the Coalition Government's pledge to increase Health Visiting numbers nationally.

Nationally, the health sector has an ageing workforce, with 73% of staff over 35 years of age. The age profile for Kent is very similar to the National profile with the largest percentages in the 45-49, 50-54 and 40-45 age groups respectively.

Currently 34% of our workforce is recorded as being over 50, slightly higher than the national figure of 31%. However this is balanced by the fact that over 15% of our workforce is recorded as being under 29 compared to 11.49% nationally. The abolition of the statutory retirement age may help to increase capacity within the sector if employees chose to delay retirement.

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Tristan Godfrey
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27 May 2011

Dear Tristan

Re: Health Overview and Scrutiny Committee Meeting – 10th June 2011

I am writing further to Cllr Nick Chard's letter to Paul Sutton of 26th April 2011 regarding the above. I can confirm that Robert Bell (Acting Director of Finance) and I will be attending the HOSC meeting to answer any questions from the Committee. The following highlights SECAmb's responses to the specific questions raised in Cllr Chard's letter.

NHS Financial Sustainability

- What are the challenges to ensuring the NHS in Kent is financially sustainable

The key challenge facing the Kent Health economy is the delivery of the QIPP agenda to ensure that the NHS locally can provide high quality accessible services, whilst achieving the overall efficiency savings required.

This will require commissioners and providers to develop intelligent commissioning that is evidence based and incorporates consultation processes with patients, public and statutory bodies.

- Are there any implications for the range and quality of health services available to the people of Kent as a result of any measures being taken to achieve or maintain financial stability

The key aim of the QIPP program is to ensure continued fair access to appropriate healthcare that meets the needs of the local population. However, we need to recognise the challenge in achieving this aim whilst delivering on financial sustainability of the Kent health economy balance.

- Why is achieving financial balance across the local health economy important and what are the potential consequences of not doing so

The NHS, like all public sector organisations, is required to deliver value for money to the taxpayer and to live within its means. It is important that we deliver financial balance for the patients and public we serve to deliver this aim and also to ensure that we can continue to provide services that meet the clinical needs of patients.

Therefore, a key aim of the QIPP programme is to support local providers of healthcare to work together to develop improvements in the clinical pathways for patient care that are evidence based and reduce inefficiencies. If the Kent healthcare system cannot achieve this aim then the potential consequence for the system will be that we do not deliver value for money and live within our means.

- What kinds of measures have been taken in 2010/11 in terms of changing services you provide and the way in which they are provided within your organisation to try and achieve financial balance

SECAmb has agreed with commissioners that its key role in supporting the QIPP agenda is to ensure that patients get the right clinical response, at the right time and that patients are directed to the right intervention for their healthcare needs. This will ensure that patients are not inappropriately managed within the healthcare system and that resources are effectively used. This is delivered via enhancing the clinical skills of our staff and ensuring that we have the ability to manage patients to the right intervention on receipt of their call.

We are enhancing the skills of our staff by ensuring that all new paramedics are graduates and we have developed the two new post graduate roles of paramedic practitioners and critical care practitioners to ensure that our service can meet the changing need of patients. This will enable our staff to "see and treat" patients and avoid the inappropriate conveyance of patients to hospital. We have recently introduced NHS Pathways, a clinical call triaging system linked to a directory of services, which enables SECAmb to effectively manage 999 calls to the right intervention for the patients. This system enables the Trust to undertake "hear and treat" at the first point of contact with patients. The introduction of "hear and treat" and "see and treat" has been undertaken in partnership with PCTs and local healthcare providers and it will enable SECAmb to be used more effectively to reduce inappropriate admissions to hospital and giving access to healthcare at home or through passing the patient to the most appropriate health professional.

This will be delivered through what we call;

Front loaded service model – we are training more professionally clinically qualified staff so that when a call is responded to it is by the most appropriate level of staff. This is so that a patient can be triaged and helped at home/on scene without having to pass them to another healthcare professional, or to avoid taking the patient to hospital for a relatively straight-forward health

issue, or to decide with the patient that actually they do need to see another healthcare professional, whether a community nurse, their GP or a minor injuries unit.

NHS Pathways – we have worked with commissioners, GPs and other healthcare providers to install triage software, that when a call comes in that can be more appropriately dealt with by a clinician over the phone, that clinician can either give the right advise to a patient and prevent any further access to other healthcare, or using what we call a 'directory of service', can see within the patient's area what other available clinical resources there might be, covering GPs, dentists, community nurses, walk in centres, etc. Again this is about directing the patient to the most appropriate source of help for their health need, which traditionally would have been A&E departments within a hospital environment.

- What kinds of measures are being considered for 2011/12

The key measure for 2011/12 is to work in partnership with PCTs, emerging GP commissioners and healthcare providers to develop pathways of care, linked to the directory of service, to support patients to receive the right care at the right time. We will be able to provide the HOSC with information regarding the implementation of NHS Pathways during 2011/12.

We will continue to extend our coverage of the 'see and treat' and 'hear and treat' to more patients and manage more patients through this route. This is planned to see an overall reduction in conveyances to hospital by around 12% over the five year plan period (we are in year 2 of the plan).

We are working with PCTs to understand how the proposed new '111' or 'single point of access' system will be implemented within South East Coast. It is anticipated that this will be via a competitive tendering process during 2011/12 and SECAmb would welcome the opportunity to become the provider of the single point of access for South East Coast. This will enable the Trust to build on the skills and experience it has from the development of the NHS Pathways and directory of services for our existing 999 calls. It would also enable SECAmb as the first point of contact to manage even more effectively the calls received from patients for help and to direct them to the most appropriate healthcare provider, whether to ourselves or others, and to book those patients in with those providers direct.

- What do you see are the main challenges to achieving financial balance across the health economy as a whole

The main challenge will be around developing the system wide approach, so that all providers are bought into the pathway approach for patients and for those providers to be able to scale up or down their resources to deal with the change in numbers of patients, and to get the efficiencies from the anticipated service changes. For example where a community nurse may currently see 3-4 patients in a typical 7 hour day, can that be increased to 4-7 patients? This means an increase in access to healthcare but with no increase in costs.

- What has been the impact of the operating framework for 2011/12 and the financial settlement for this financial year

SECAmb has welcomed the 2011/12 Operating Framework as it enables both commissioners and providers to understand the key aims and deliverables to be achieved. It also acts as the basis for the respective contract negotiations and enables organisations to plan for the negotiation process. The key impact on SECAmb during this financial year has been the local agreement of the development of Payment by Results for the Trust. This change will enable SECAmb to be incentivised to support the QIPP programme and move away from a traditional conveyance model to one providing mobile healthcare and "hear and treat" and "see and treat".

The financial negotiations for this financial year have been extremely challenging for both commissioners and providers as both parties needed to recognise the need for the health economy to balance its books and the pressures we all face in managing patient demand. However, the outcome of the 2011/12 contract negotiations has enabled SECAmb and its commissioners to introduce localised Payment by Results that will incentivise the Trust to support the QIPP agenda and more importantly provide improved quality services to the patients we serve via "hear and treat" and "see and treat".

- How is the QIPP challenge being met within your organisation

The answers to the previous questions highlight how SECAMB is meeting the QIPP challenge and the Trust is becoming more of an enabler to the whole health economy system supporting the overall aims of the QIPP. This is achieved by delivering managed conveyances that will lower the pressure on the secondary care sector and enabling the whole healthcare system to reduce its costs to commissioners. This will mean that commissioners are either only paying one provider for the healthcare for that patient, or more effectively using under-utilised resources in other providers to meet the healthcare needs of the patient.

- Are there any particular challenges and/or opportunities that come from your organisation covering more than one PCT area

The challenge to SECAmb of covering more than one PCT area is that each PCT will have a different financial position, activity growth, patient demographic and maturity of its provider network. It is the aim of SECAmb to be able to be flexible to work within this to support the PCTs and providers in whatever situation they find themselves.

The opportunity for the Health economy across the whole of the South East Coast is that SECAmb has successfully introduced these service delivery changes in other areas and can demonstrate the impact achieved and therefore the opportunities to local commissioners. As the trust also works across PCT boundaries it can also act as an enabler to more effective cross border working.

- Are there any particular demographic trends in Kent that will have an impact on the kinds of services you provide

The demographics of Kent reflect the issues faced across the whole of SECAmb's operational area, namely:

- *Ageing population*
- *Increasing chronic illnesses*
- *Significant levels of new house building leading to influxes of new populations*
- *Levels of immigration*
- *SECAMB is already working across these demographics and working directly with individual communities to try to address their local needs.*

I trust that the above is helpful information for the HOSC and I look forward to the follow up discussion on 10th June 2011.

Yours sincerely

Geraint Davies
Director of Commercial Services
South East Coast Ambulance Service Foundation Trust

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Your LINk for improving health and social care
Your future local HealthWatch

a LOCAL INVOLVEMENT NETWORK

24 May 2011

Mr Nick Chard
Chairman
Health Overview and Scrutiny Committee
Kent County Council
Members' Suite
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Dear Nick

Health Overview and Scrutiny Committee Meeting – 10 June 2011

Thank you for your letter of 26 April 2011 seeking LINk evidence on the subject of 'NHS Financial Sustainability' for the above meeting.

LINk Governors considered your request at their meeting on 18 May 2011 and asked me to respond.

The LINk proposes to enter the debate on funding in the NHS locally. LINk representatives will attend the meeting on Tuesday, 10 June 2011.

The Kent LINk will be very interested in your findings in so far as it will provide useful evidence for identifying where the LINk should be focusing its efforts – to ensure services are in place / being planned to meet patient need. This is particularly important in the changing NHS environment.

Likewise it will be important for local people to know the results of your review – presented in plain English. This would be with a view to ensuring more awareness of the impact of less funding - v - increasing demand on the NHS. It will also warn of the choices they may be required to make, acknowledging the responsibility of individual patients.

In response to the questions posed in your letter:

- *What are the challenges to ensuring the NHS in Kent is financially sustainable?*
  In brief, the county has an increasing aging population with an ever increasing cost of treatments. Matching need with funds available will always be a challenge.

Continued ...

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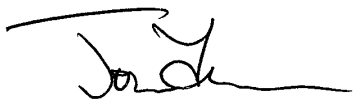
- *Are there any implications for the range and quality of health services available to the people of Kent as a result of any measures being taken to achieve or maintain financial sustainability?*
  If funds are restricted because there is less or there are more demands on the system there will be a need for further radicalisation. The LINk will be keen to look at the HOSC's report and findings of its current review so that it can consider what its focus can or should be.

In the interests of Kent residents using the Trust's services, LINk Governors expressed concerns around the sanctions being placed on Medway NHS Foundation Trust. Is the KCC HOSC including this particular Trust in its review as it is used by Kent people in the Swale area?

Yours sincerely



John Fletcher
Chairman
Kent LINk Governors' Group

cc Roger Kendall, Kent LINk Governor
Mark Fittock, Kent LINk Governor
Brenda O'Neill, Kent & Medway Networks

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 10 June 2011

Subject: Draft Forward Work Programme

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1. Introduction.

(a) At the meeting of 19 April, Members agreed to invite Dartford and Gravesham NHS Trust and Medway Foundation NHS Trust to the meeting of 22 July in order to discuss the proposed merger of the two Trusts in further detail.

(b) Suggested topics for the rest of this year and possible topics for 2012 are outlined in section 2.

(c) The work programme will need to be flexible in order to respond to any consultations that are relevant, or any important issues that arises.

(d) Some issues may require the establishment of a Joint HOSC with Medway and/or other HOSCs.

2. Proposed Forward Work Programme.

(a) 22 July

i. Dartford and Gravesham NHS Trust and Medway Foundation NHS Trust: Developing Partnership.

ii. NHS Financial Sustainability: Draft Recommendations

(b) 9 September

i. NHS Transition - Moving Towards 2013.

(c) 14 October

i. Responses to Recommendations of NHS Financial Sustainability Review – Written Update.

ii. Accident and Emergency Review Part 1: Avoiding Unnecessary Admissions.

(d) 25 November

i. Accident and Emergency Review Part 2: Arriving at Hospital.

(e) Possible Topics for 2012.

i. Commissioning priorities for 2012/13 – January.

ii. Progress of Local Trusts towards Foundation Trust status – February.

3. Recommendations

Members are asked to approve the proposed Forward Work Programme.