HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 22nd July, 2011

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 22nd July, 2011, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Peter Sass**
Telephone: **01622 604002**

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):	TBC
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 - 10)

5. Dartford and Gravesham NHS Trust and Medway Foundation Trust: Developing Partnership (11 - 18)

   Mark Devlin (Chief Executive, Medway NHS Foundation Trust) and Gerard Sammon (Deputy Chief Executive, Dartford and Gravesham NHS Trust) will be in attendance for this item.

6. East Kent Maternity Services Review (19 - 32)

   Hazel Carpenter (Director of Commissioning Development and Workforce, NHS Kent and Medway), Dr. Neil Martin (Medical Director, East Kent Hospitals NHS University Foundation Trust), and Dr. Sarah Montgomery (GP Clinical Commissioner) will be in attendance for this item.

7. Legacy Document (33 - 40)

   Judy Clabby (Assistant Chief Executive, NHS Kent and Medway) will be in attendance for this item.

8. NHS Transition: Written Update (41 - 52)

9. NHS Financial Sustainability: Draft Recommendations (53 - 70)

10. Date of next programmed meeting – Friday 9 September 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

14 July 2011

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 10 June 2011.

PRESENT: Mr N J D Chard (Chairman), Mr R Brookbank, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr J D Kirby (Substitute for Mr A T Willicombe), Mr J N Wedgbury (Substitute for Mr N J Collor), Mr M J Fittock, and Mr R Kendall

ALSO PRESENT: Cllr J Cunningham, Cllr R Davison, and Cllr M Lyons

IN ATTENDANCE: 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 19 April 2011 are recorded and that they be signed by the Chairman.

3. Trauma Services in Kent and Medway
(Item 5)

Dr Robert Stewart (Medical Director, Kent and Medway Cluster and Chair of the Kent and Medway Trauma and Critical Care Network), Dr Patricia Davies (Locality Director, Dartford, Gravesham and Swanley GPCC and Lead Director for the Kent and Medway Trauma and Critical Care Network), Helen Belcher (Project Manager, East Kent Hospitals University NHS Foundation Trust), Dr Marie Beckett (Deputy Medical Director and Emergency Care Consultant, East Kent Hospitals University NHS Foundation Trust), Karen Barkway (Performance and Governance Manager, NHS West Kent) were in attendance for this item.

(1) The Chairman introduced the item and explained that there were a number of options the Committee could take following the developments of the trauma network in Kent and Medway. As the network did cover two local authority areas, Kent and Medway, the two Committees exercising the health scrutiny function may need to form a Joint HOSC to consider the item if both considered it a substantial variation of service.

(2) Dr Stewart provided an overview of the proposals and the reasons underlying them. There was a need to develop trauma services in Kent and Medway because while there were no Major Trauma Centres in the area, not all

patients could be taken to either London (mainly King's) or Brighton within the recommended 45 minutes. A Major Trauma Centre required cardiothoracic, neuroscience and other specialities to hand to provide a full service as well as a certain throughput of patients in order to maintain skill levels. These factors precluded one being established in Kent and Medway, but the development of improved services as well as repatriation for rehabilitative care was possible. The Air Ambulance, although useful, could not be the complete solution as there were too many restrictions on when they could be used. Closer links were being developed with the South East London Trauma Network.

(3) When responding to a major trauma incident, the paramedics assessed the situation and there were three options – taking the patient straight to a Major Trauma Centre, stabilising the patient before transfer, or treating the patient locally. The Kent and Medway Clinical Care and Trauma Network's proposal was to develop three Major Trauma Units across Kent and Medway where additional expertise from consultants would be available and rehabilitation would be coordinated. These Major Trauma units would be linked to Major Trauma Centres which would assist with training and recruitment. The South East Coast Strategic Health Authority and London Trauma Board were supporting the proposals. The proposed sites for the Major Trauma Units were:

- Pembury Hospital,
- William Harvey Hospital, and
- Medway Hospital

(4) A range of questions were asked by Members over different aspects of the proposals. On the number of patients involved it was clarified that in Kent and Medway each year ½ million patients are seen in Accident and Emergency Departments each year; of these the 200 most severe, major trauma cases, go to King's. The Network stressed the proposals were improvements to existing services and not the downgrading of Accident and Emergency Departments. On the selection of the sites, it was explained that the Acute Trusts had to express an interest but that there were strict criteria around what needed to be provided, such as 24 hour coverage by an Accident and Emergency specialist.

(5) The sites proposed led to Members posing a number of specific questions. One Member suggested that the Pembury and Ashford sites were too close to the other, and specifically in relation to Pembury, it was pointed out that it was not on a motorway and served a large number of people outside of Kent and more information was needed on patient flows from those areas. Following on from this, the lack of any Major Trauma Centre between Brighton and London meant that Pembury was likely to become a hub and this raised questions around whether Pembury had sufficient capacity.

(6) Issues around capacity were also raised around Darent Valley, with the additional pressures caused by the closure of the Accident at Emergency Department at Queen Mary's. It was explained that Darent Valley was not

selected as one of the sites as it falls within the 45 minute isochrones for accessing a Major Trauma Centre within London.

(7) Capacity across the entire system was also questioned and the issue rose of where people would be taken if King's was full. It was pointed out that while there was some prediction possible, trauma could not be completely planned for as to when and where it happened. One Member raised the issue of the possible use of private hospitals, such as the one being built in Maidstone.

(8) The representatives attending on behalf of the Network were thanked for providing a succinct overview of the proposals in the time allowed and Members were asked to forward any outstanding questions they had to the Committee Researcher for answering when the Committee returned to the subject.

(9) AGREED that the Trauma Network be invited to return to a future meeting of the Committee and that this meeting be in the form of a Joint HOSC with Medway should the equivalent Committee wish also to explore this matter further.

4. NHS Financial Sustainability: Part 3 - Mental Health, Community Health, and Ambulance Services
(Item 6)

Philip Greenhill (Interim Deputy Chief Executive, Kent Community Health NHS Trust), Chris Wright (Interim Director of Finance, Kent Community Health NHS Trust), Oena Windibank (Interim Director of Operations – East, Kent Community Health NHS Trust), Marie Dodd (Acting Chief Executive, Kent and Medway NHS and Social Care Partnership Trust), James Sinclair (Director of Partnerships and Social Care, Kent and Medway NHS and Social Care Partnership Trust), Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust), Robert Bell (Acting Director of Finance, South East Coast Ambulance Service NHS Foundation Trust) were in attendance for this item.

(1) The Chairman introduced the item and explained that this was the third and final meeting in a series examining NHS Financial Sustainability and that the Trusts present would be invited to provide an overview from their perspective.

(2) Philip Greenhill from the Kent Community Health NHS Trust began with the information that the Trust employed 5,700 staff and had a budget of around £200 million. They needed to find £14 million in efficiency savings. Most of the income for the Trust came from block contracts but the value of these had been reduced by 1.5% which equated to a £2.6 million cost pressure. There were also cost pressures because of pay uplifts and high cost drugs. Part of the solution was in back office savings but the biggest was in workforce productivity and this was being examined as the Trust was carrying out the largest community services staff study in England. Nationally, district nurses spend 22% of their time with patients; Kent has managed to increase this to 45-46%. Another area is improving community hospital throughput. The biggest cost pressure was identified as demand in the acute sector as the tariff increases the cost with activity. Both community services and social services

have a role to play in reducing demand, as does the new 111 number which will assist in getting the entry point for patients correct.

(3) Responding to a particular question about the hospital at home scheme run in Medway, it was explained that this did not involve a double-payment as the service was provided by Medway NHS Foundation Trust and paid for out of the tariff paid to the hospital before the patient is discharged to the care of his or her GP.

(4) It was further explained that the £14 million which the Community Health Trust needed to find was 8% of the revenue budget. This provided part of the context within which the Trust was embarking on the journey to Foundation Trust status because attaining FT status meant there was more freedom to focus on the right financial strategies.

(5) On the subject of the Minor Injuries Unit at Sheerness it was explained that this was only a temporary closure on safety grounds and that it was back open 9am to 9pm Monday to Friday and would be open at the weekend again soon. More broadly on the subject of community hospitals, it was explained that the whole of community services support the work the community hospitals undertake, rather than the hospitals causing funds to be diverted from elsewhere.

(6) Marie Dodd outlined the issues for the Kent and Medway NHS and Social Care Partnership Trust as being roughly similar to those in the community health sector. The block contracts were also facing a 1.5% reduction in value and there was a 4% savings, with £13.2 million efficiency savings to find and a £2.9 million QIPP negotiation with commissioners in order to find money for reinvestment. Similarly there were also pay uplifts. There was also a need for investments in Information Technology; currently there were two systems, a paper and an IT record system and this needed unifying.

(7) The main policy drivers were in early intervention, with money invested in a second Crisis Resolution Home Treatment Team in East Kent last year as coverage there had not been as full as in Medway and West Kent. NICE guidance around the use of dementia medicine earlier has had a £3 million cost impact. Work is ongoing with the Police and Ambulance Trust on making sure people did not end up in the wrong place; there had been a big rise in the use of 136 suites, but only 20% of people ended up being detained under the Mental Health Act. There was also a project being undertaken with Kent County Council involving housing and support to move people from inpatient facilities to community ones. The Trust had 3,600 staff with 90 off on long term sick leave.

(8) The issue of sick leave at the Trust was picked up by Members, specifically around long term sickness rates within the Thanet teams. Marie Dodd undertook to find out detailed information and pass it on to the Committee Researcher. More broadly, the long term sickness rate at the Trust was 4.5% which was higher than the NHS as a whole, due to staff being attacked on duty, but average for the mental health sector.

(9) Moving forwards, money for mental health would still reside within the NHS and useful discussions were underway with future GP commissioners; they had, for example, approved the move from Ashford to Canterbury. The Strategic Health Authority had approved the capital spend for the St. Martin's development for 2013.

(10) On dementia services, the Mental Health Trust picked up referrals after it had been identified by GPs and had fully trained staff for assessments. The Community Services Trust explained that community nurses were trained to identify dementia and early intervention was being included in the training programme.

(11) Geraint Davies gave a short overview of the situation of the South East Coast Ambulance Service NHS Foundation Trust. As part of achieving Foundation Trust status, the organisation needed to have a 5 year viable plan. The turnover is £165 million and has a £10 million cost improvement programme. The Trust has around 3,000 staff.

(12) The Ambulance Trust is looking to build on the work it has undertaken with NHS Pathways to provide a single point of access service directing people to the right place at the right time. It was currently talking to Primary Care Trusts on this and the 111 service would be tendered under the Any Qualified Provider model. The ambulance service was paid for on cost and volume contracts rather than block contracts, and a local PbR tariff was being developed.

(13) In response to a question on the co-responders scheme with the Fire Service, Geraint Davies explained that the Trust had funded the scheme to the sum of £90,000, but it has been decided not to continue with it because it was not best for patients.

(14) Dealing with some specific questions on the ambulance service, it was explained that the Make Ready programme had been funded from the Trust's own resources. If necessary, a Foundation Trust was able to borrow money, under strict controls.

(15) Across all Trusts there was a feeling that the block contract was not the most helpful funding mechanism and there was a need to hold the whole health economy to account for delivering complete pathways of care. This would help ensure efficiencies with patients seeing the right people at the right time.

(16) The Chairman thanked the Committee's guests 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.

(17) 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.

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

5. Forward Work Programme
(Item 7)

(1) The Chairman indicated that a written update from NHS Eastern and Coastal Kent on the East Kent Maternity Services Review had been provided for Members (see Appendix). This item would also be on the Agenda for the 22 July meeting.

(2) The Chairman also undertook to have a written update on the NHS Transition for the 22 July meeting. This would be followed up be a fuller discussion at the 9 September meeting, though the comments from some Members that the full picture may still not be known was acknowledged. As part of this it was felt that a fuller understanding of the role of locality boards and the Health and Wellbeing Boards would be useful.

(3) The Chairman also undertook to explore when mental health could be considered, perhaps incorporating a review of the responses received from the NHS to reports produced in 2010 by both the Kent LINk and the Maidstone and Tunbridge Wells Borough Councils Joint Mental Health Services Working Group. Similarly, the feasibility of considering neurology services would be considered.

(4) APPROVED the Forward Work Programme.

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

NHS
Eastern and Coastal Kent

Briefing paper – east Kent maternity services review

A joint review of maternity services across east Kent by East Kent Hospitals University NHS Foundation Trust (EKHUFT) and NHS Eastern and Coastal Kent (ECKPCT) is being undertaken to ensure the rising number of mothers-to-be continue to receive safe, high quality care and patient choice. A briefing note in respect of this review was circulated to Members in February.

a. Current Service Provision (East Kent Hospitals University NHS Foundation Trust only)

Maternity services are delivered across a variety of locations by East Kent Hospitals University NHS Foundation Trust, as detailed below:

Ante natal care – *Including:* • *Midwife led* • *Consultant Led* • *Foetal Medicine* • *Maternity Day care*	William Harvey Hospital Queen Elizabeth Queen Mother hospital Kent and Canterbury Hospital Buckland Hospital Royal Victoria Hospital Variety of community settings ie GP surgeries and Children Centres Patients own Home
Intra partum Care (Delivery)	William Harvey Hospital – Obstetric Unit and Midwifery-led Unit Queen Elizabeth Queen Mother hospital – Obstetric Unit Kent & Canterbury Hospital – Midwife led birth centre Buckland Hospital – Midwife led birth centre Home birth
Post Natal care	At family homes GP surgeries and children's centres

EKHUFT have developed two new Midwifery Led Units (MLUs) on the William Harvey and QEQM sites. The William Harvey MLU opened in July 2009. The QEQM MLU has not yet opened. Unlike the current MLUs in Dover and Canterbury, the new units are co-located with obstetric units.

b. Birth rates

	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Total live births delivered by EKHUFT	6462	6477	6671	7080	7100	7373	7336	7454

Births across EKHUFT had increased year on year up to 2008/09, and showed a 1.6% increase from 2009/10 to 2010/11.

Total live births delivered by EKHUFT	WHH	QEQM	DFBC	KCH	TOTAL
2010-11	4208	2729	217	300	7454
2009-10	3976	2746	249	365	7336

As can be seen from the table above since the opening of the Singleton Midwifery Led unit at the William Harvey Hospital in July 2009, births on this site have increased while all other sites have decreased. More than 50% of the births within EKHUFT are now at the William Harvey site.

Of the births in 2010 at the William Harvey 662 were births that took place on the midwifery led unit. However, some women who choose the midwifery led unit for birth may require transfer to the acute unit for obstetric, medical or personal reasons (e.g. further pain relief such as epidural).

In September 2010, EKHUFT identified an increase in neonatal admissions to the William Harvey Hospital (WHH) neonatal intensive care unit (NICU) which had occurred between July and August 2010. A decision was made to investigate this increase and, as a precautionary measure, to enhance staffing levels at the high risk obstetric unit at WHH while the investigation was being carried out.

To achieve the enhanced staffing levels, births within the Dover birthing centre at Buckland Hospital were temporarily stopped and midwives were diverted to WHH. All other services provided at the centre continued as normal.

c. Suspension of services

Dover Family Birth Centre suspended inpatient services on 11 October 2010 and reopened on 10 January 2011. The Canterbury Birth Centre suspended in-patient services from 10 January whilst the wider strategic review of services and staffing is undertaken. This will continue until the outcome of the full review. EKHUFT Board took this decision to ensure consistency in service delivery and avoid confusion.

At both sites consultant and midwifery antenatal clinics have continued, as have day care and parent education classes.

The suspension of services at the Birth Centres has been required to allow skilled senior midwifery staff to move to work on the labour ward at the William Harvey Hospital where the number of births has increased and where the most high risk births tend to take place (as this is where the NICU is based).

d. Investment to date

As commissioners, the PCT undertook a wide consultation process two years ago to review all local maternity services against national/local targets/quality of service provision. This resulted in the Maternity Strategy being agreed which is now in year 2 of its implementation. The aim of this strategy was to streamline service provision, ensure universal safe service provision and provide women with choice.

Commissioner payment and investment for midwifery services at EKHUFT has increased since 08/09. Inpatient care is paid through PBR and in 09/10 this increased

nationally to deliver 'Maternity Matters', increasing the payment to EKHUFT by £4.7 million. In addition to PBR the PCT has a contract for £6.4 million for out of hospital care which has been enhanced locally by £1million since 2008/9 again to support an increase in midwives as part of Maternity Matters.

e. Improving maternity services

Commissioning of breastfeeding services over the last 12-18 months has improved significantly enabling the 48-hour target to be met (which historically had not been delivered). There has also been significant improvement in relation to the six-eight week target, which again historically has been at 26% but is presently at 48%.

f. Midwifery staffing levels

A nationally recognised tool for assessing midwifery numbers known as birth rate plus has been used for all South East Coast Maternity services. The recommended midwife to mother ratio in birth for EKHUFT using this tool is 1:33[1] which the Trust has achieved. The extra resource provided by the PCT was specifically to enable midwifery recruitment.

EKHUFT is working to improve service quality and productivity through internal initiatives to normalise birth and decrease c. section rates, and increase the number of midwife support staff (MSW) (the current ratio of midwives to MSW is higher than other trusts) to free up midwifery time.

g. Long term Clinical Strategy

The Trust has chosen to increase the settings of care through building two new units and is continuing to work to improve quality and productivity, the PCT has invested in services. However, the increasing birth rate and the change in volume of deliveries at the William Harvey have led to a need to review the maternity service provision.

EKHUFT, the PCT and local GPs are now working together to consider the Trusts longer term clinical strategy for Maternity Services.

h. Engagement and consultation

The experience of service users is a key strand of evidence being considered in the current review of maternity services. The Citizen Engagement Team have worked with children and parents coordinators from across East Kent to identify suitable groups or clinics happening within Surestart centres and Children's centres so they could easily talk to and interview 93 new parents who had recently used the maternity services in East Kent.

The interviews took place over two weeks stopping on 8.4.2011 to allow for the local elections and the onset of purdah. All geographic districts across East Kent were included, the team visited a range of services from: health visitor clinics to messy play and breast feeding support groups to ensure that a broad range of mothers and some dads could contribute. In addition a Young Adults Parent focus group was held in Canterbury.

[1] Birthrate plus review 2009 LOCAL SUPERVISING AUTHORITY
Annual Report to the Nursing and Midwifery Council

A further survey is being conducted with current service users who could be affected by the closure of the Midwife led unit at Canterbury. The questions used are based upon the Care Quality Commission maternity survey, as this will allow a direct comparison with data collected in 2010 maternity survey, allowing us to quantify any impact of the temporary closures on current service users.

Staff will also have the opportunity to complete individual surveys as well as contribute to the wider engagement and consultation processes. There will be a series of roadshows across the six districts in June culminating in two stakeholder workshops at the end of June to consider the evidence which has been gathered to date and the options going forward. These workshops will be on 28th and 30th June briefings will be sent to a wide range of stakeholders so that they can contribute. In addition information will be available on both the Trust and the PCT websites and we will be publicising all the events so that the wider community can take part in the discussion.

Should the evidence suggest the need for a sustained change of service provision a formal 13 week consultation will take place between July and October.

7th June 2011

Item 5: Dartford and Gravesham NHS Trust and Medway Foundation Trust: Developing Partnership.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 22 July 2011

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

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1. Background

The Health Overview and Scrutiny Committee heard from both Dartford and Gravesham NHS Trust and Medway Foundation Trust during the meeting of 19 April as part of its inquiry into NHS Financial Sustainability. Information of the proposed merger between the two organisations was provided as part of this and Members requested that an opportunity be found at a later date to return to this specific topic.

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, 22 July 2011

Subject: Trust Mergers

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1. Introduction.

(a) Under the proposals contained within the Health and Social Care Bill, NHS Trust status will cease to exist. There is an expectation that NHS Trusts will become Foundation Trusts by 1 April 2014 and NHS Trust legislation would be repealed. However, the strict deadline has been removed to allow flexibility. The FT process will be overseen by Strategic Health Authorities until their abolition in April 2013 when a Trust Development Authority will continue this aspect of SHA work. The ten SHAs will cluster into a smaller number later this year[1].

2. Mergers involving a Foundation Trust[2]

(a) Mergers involving one or more FTs are allowed under sections 27 and 28 of the Health and Social Care (Community Health and Standards) Act 2003. The approval of the Secretary of State for Health is required where one organisation is an NHS Trust. If the merger is authorised, the two applicant Trusts are dissolved and a new NHS Foundation Trust is created.

(b) The merger assessment process is similar to the regular FT authorisation process with additions relating to the merger itself.

(c) The steps on the merger assessment process are as follows:

Step 1 Secretary of State must support the application to merge.

Step 2 Public consultation.

Step 3 Joint application to Monitor

Step 4 Pre-approval by Monitor

Step 5 Detailed review by Monitor

Step 6 Authorisation to be an NHS foundation trust

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[1] Department of Health, *Government Response to the NHS Future Forum Report*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444

[2] Information from this section sourced from: Monitor, *Applying for a Merger involving and NHS Foundation Trust. Guide for Applicants*, July 2006, http://www.monitor-nhsft.gov.uk/sites/default/files/publications/Merger_guide_0.pdf

Step 7 Secretary of State Order

(d) As part of Monitor's assessment, the applicants for must be able to demonstrate that the merged entity will be able to meet the requirements with respect to:

- Legal constitution and taking steps to ensure representative membership;
- Governance in accordance with best practice;
- Financial stability and remaining a 'going concern'; and
- Provision of mandatory services.

Dartford and Gravesham NHS
NHS Trust

Medway NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S OFFICE
Direct Line 01634 833944
Fax No: 01634 825290

Our ref: MD/MJ

8 July 2011

Tristan Godfrey
Research Officer to the HOSC
Kent County Council
Members' Suite
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Dear Tristan

Re: **Health & Overview & Scrutiny Committee Meeting – 22 July 2011**

Further to your invitation for us to attend the above meeting.

Please find listed below answers to your questions.

1. **What are the reasons for considering closer partnership and possible merger?**

With significant changes and challenges for the Trust in mind, over the last year there has been a large element of innovative thinking to ensure that under the current economic environment, and with the proposed changes to the NHS under the government's Health and Social Care Bill, we can continue to provide excellent healthcare, to the highest standards for local people. You may be aware that in March this year Medway NHS Foundation Trust and Dartford & Gravesham NHS Trust, which runs Darent Valley Hospital, announced plans to explore the feasibility of integrating the two organisations. Over the past year, successful collaborative working has been taking place between the trusts in both clinical and non-clinical areas; this includes work in urology, pathology and information technology. This has shown there are more efficient and cost effective ways in which we can work. However, the decision to explore a longer-term partnership arises for a number of reasons.

Underpinning the decision to explore integration, is our belief that joining the two trusts could lead to a strengthening of services at both hospitals as well as in the region as a whole. For example, we can improve patient experience and care through sharing best practice, and we can maximise the use of each hospital's facilities and estate, increasing the scope and range of services we provide. A stronger, integrated organisation could allow for improved access to specialist services too, preventing the need for local patients to make long and expensive journeys to hospitals in London. Essential services, like emergency departments and maternity, will remain local to both Medway and Dartford – the purpose of integration would be to build on the range and quality of local services we already have.

Feasibility testing is currently underway and within this work we are examining all the services offered by each of the trusts taking account of specialist expertise, service quality and financial performance to identify the options available to us. We will also be looking at ways in which we could harness the cultural strengths of both hospitals to ensure we lay the foundations for an excellent and thriving organisation. The entire process will be open to scrutiny – we will consult with staff, patients, the public, governors, GPs, commissioners, LINks and local authorities. Any decision will be subject to a thorough process requiring approval from the Department of Health and Monitor, the Foundation Trust's regulator.

2. **What could be the possible consequences of not doing so?**

There is no acceptable "Do nothing "option for either Trust. The financial realities of the next 4-5 years mean that redesign of hospital infrastructure are inevitable. The two Trusts feel that approaching this together will have a more constructive outcome than doing so separately. Dartford and Gravesham NHS Trust must find a pathway to Foundation Trust status over the next few years. Should this partnership not be an option, then an alternative would have to be found.

3. **What are the implications for the range and location of health care services delivered at both sites?**

Core services including A&E, Maternity and Children's services will be maintained at both hospitals. More specialist services including new services developed as a result of the integration opportunity may be located at one hospital or the other. These decisions would be based on a balance of population and economic factors.

4. **Can you set out the timescale for your developing partnership and explain the stages it is required to go through?**

The present stage of feasibility testing will continue until the end of September. If at that stage both Trust Boards are assured of feasibility then a formal Transaction process will commence which would take place over a 9-10 month period.

5. **What are the biggest challenges to achieving a successful outcome?**

Demonstrating financial viability in the context of a decreasing NHS spend envelope within the acute hospital sector is the main challenge, although this challenge also exists independently for both Trusts

Continued.....

6. **Does the existence of a Private Finance Initiative scheme at Darent Valley pose any particular challenges?**

The PFI does present particular challenges, which we would be happy to discuss with the committee.

Yours sincerely

Mark Devlin
Chief Executive
Medway NHS Foundation Trust

Susan Acott
Chief Executive
Dartford & Gravesham NHS Trust

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 22 July 2011

Subject: East Kent Maternity Services Review

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1. Background

(a) The Health Overview and Scrutiny Committee received written updates on the East Kent Maternity Services Review at the meetings of 4 February 2011 and 10 June 2011.

(b) Members agreed at the 10 June meeting the NHS representatives should be invited to this current meeting to provide further information and answer any questions Members may have.

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, 22 July 2011

Subject: Maternity Services

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1. Maternity care pathway

(a) Looking at the entire care pathway, four stages can be broadly identified[1]:

1. pre-pregnancy care
2. antenatal care
3. care during labour and delivery
4. postnatal care

2. Location of birth

(a) Before 1945, the majority of births occurred in the home. By 1970, almost 90% of births took place in hospital. The 1993 report *Changing Childbirth* recommended the availability of more choice in the place of birth. The 2004 *National Service Framework for Children, Young People and Maternity Services*[2] and 2007 *Maternity Matters*[3] actively promoted midwife and home birth services[4].

(b) A commitment to choice in maternity services was more recently made in the NHS Operating Framework for 2011/12[5].

(c) Broadly speaking, the options for place of birth are fourfold[6]:

1. Home birth, supported by a midwife.
2. Freestanding Midwifery Unit (FMU), separate from an obstetric unit.

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[1] Healthcare for London, *Maternity care pathways*, http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Maternity-services-care-pathways1.pdf

[2] Department of Health, National Service Framework for Children, Young People and Maternity Services: Maternity services, September 2004, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089101

[3] Department of Health, *Maternity Matters*, April 2007, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074199.pdf

[4] National Institute for Health and Clinical Excellence, *Intrapartum care*, p.48, http://www.nice.org.uk/nicemedia/live/11837/36275/36275.pdf

[5] Department of Health, The Operating Framework for the NHS in England 2011/12, p.28 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf

[6] Healthcare Commission, *Towards better births. A review of maternity services in England*, p.31, http://www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf

3. Alongside Midwifery Unit (AMU), next to, or integrated with, an obstetric unit.
4. Obstetric unit, in an acute setting, consultant-led and supported by a maternity team.

(d) Care in the first three settings is mainly provided by midwives handling low risk births.

(e) Across England as a whole, in 2008, 93% of births took place in obstetric units, 3% in alongside midwifery units, 2% in freestanding midwifery units and 2% at home. The review of maternity services carried out by the Healthcare Commission in 2008 revealed that out of 150 Trusts in England, two-thirds had no AMU or FMU. Across all the Trusts there were 181 obstetric units, 57 FMUs and 25 AMUs[7].

3. Midwifery and Consultant Staffing Levels

(a) All maternity services in the South East Coast region use the nationally recognised Birthrate Plus planning tool in assessing midwifery numbers. Trusts collect data on a large sample of births and allocate each to different categories relating to complexity and need[8].

(b) "Integral to Birthrate Plus® is the classification of case mix by categories I–V:

- Category I and II: Low-risk midwifery care: normal birth, no intervention, good birth weight and Apgar, no epidural.
- Category III: Moderate degree of intervention: instrumental delivery, induction, fetal monitoring, third-degree tear, preterm.
- Category IV: Higher-risk/higher choice or need: normal birth with epidural for pain relief, elective caesarean sections, post-delivery complications, induction and instrumental tear, preterm birth.
- Category V: Highest risk, including emergencies: emergency caesarean sections, medical or obstetric complications, multiple births, stillbirths, severe pregnancy-induced hypertension.
- Other categories: Other events reflecting additional client needs are also recognised within the Birthrate Plus® evaluation; for example, antenatal admissions to obstetric labour ward."[9]

(c) Standards for the obstetric consultant role have been set by the Royal of Obstetricians and Gynaecologists. The recommended standards for consultant presence on delivery suite units are as follows:

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[7] Healthcare Commission, *Towards better births. A review of maternity services in England*, p.31, http://www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf
[8] Ibid., p.88.
[9] Royal College of Obstetricians and Gynaecologists, *Safer Childbirth*, October 2007, p.64-5, http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirthReport2007.pdf

- "Units delivering 2500–4000 births/year should have a 60-hour presence, those delivering 4000–5000 births/year a 98-hour presence; those delivering over 5000 births/year should achieve a 168-hour presence at varying times. Those units delivering less than 2500 births would need to reach a local decision based on availability, financial resource and other clinical demands"[10]

4. PbR and maternity[11]

(a) Commissioning responsibility for maternity services currently rests with Primary Care Trusts. In the future, responsibility is set to rest with Clinical Commissioning Groups, supported by the NHS Commissioning Board to enable the improvement of quality and extensions of choice, and may involve the proposed clinical senates and networks.[12] The NHS Commission Board will commission specialist neonatal services directly.[13]

(b) Under PbR, maternity services are divided into three discrete elements:

1. birth
2. antenatal care
3. postnatal care

(c) The national tariff applies whether the birth occurs in an obstetric unit, AMU or FMU, though the Market Forces Factor (MFF) also applies. The MFF is used to reflect the fact that providing services in some areas of the country is more expensive than in others due to staff costs, land and so on.

(d) Home births have the same tariff as a normal birth without CC (see below).

(e) Routine antenatal care (attendance and scans) is paid for through the outpatient tariff, regardless of location. The exception is antenatal care provided in the woman's own home. Postnatal care is similar, with a tariff for care in a clinical setting but not where planned postnatal care is delivered in the mother's home.

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[10] Royal College of Obstetricians and Gynaecologists, *The Future Workforce in Obstetrics and Gynaecology*, June 2009, p.47, http://www.rcog.org.uk/files/rcog-corp/uploaded-files/RCOGFutureWorkforceFull.pdf

[11] Where otherwise indicated, information in this section derived from: Department of Health, *Maternity Services and Payment by Results*, July 2010, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_118002.pdf

[12] Department of Health, *Government response to the NHS Future Forum* Report, June 2011, p.22-23, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127719.pdf

[13] Department of Health, *Liberating the NHS: Legislative Framework and Next* Steps, p.80, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122707.pdf

(f) Community midwifery can be funded through PbR where the functionality exists, or through other arrangements such as the block contract.

(g) There is no set price for parent education or antenatal classes. There is no tariff currently for health visiting, but currency options for the Healthy Child Programme have been published[14].

(h) Maternity service tariffs are currently based on average reference costs, but maternity is one area where best practice tariffs are being considered[15].

(i) Table showing birth episode tariff prices:

Description	2010/11 prices (£)	Long stay trim point	Excess bed day payment (3)
Normal delivery 19 years and over with CC	2,101	9	367
Normal delivery 19 years and over without CC	1,324	4	384
Normal delivery 18 years and under with CC	2,160	9	342
Normal delivery 18 years and under without CC	1,393	4	412
Assisted delivery with CC	2,612	7	379
Assisted delivery without CC	1,970	6	373
Caesarean section 19 years and over	2,539	5	378
Caesarean section 18 years and under	2,864	7	390
Caesarean section with complications	3,311	8	385

Key:

1. Trim point = the period the payment covers. the excess bed day payment is what the commissioner pays for each extra day the mother needs to stay in hospital.
2. CC = complications and co-morbidities.

[14] Department of Health, *Currency options for the Healthy Child Programme*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113833

[15] Department of Health, *Government response to the NHS Future Forum* Report, June 2011, p.26, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127719.pdf

Maternity Review in East Kent

East Kent Hospitals University NHS Foundation Trust (EKHUFT), Kent and Medway PCT cluster and local east Kent Clinical Commissioning Groups are working to confirm a service model solution to ensure safe, high quality maternity care for all mothers and families.

A review group comprising clinical leaders from EKHUFT, the PCT and emerging Clinical Commissioning Groups are due to meet on 22 July 2011 to consider further the available information and make a recommendation to the Trust and Kent and Medway PCT Cluster Boards as to a safe model of service. Appropriate public consultation will be undertaken in the autumn of 2011 if any service recommendation requires this.

This paper sets out the current position with regard to maintaining a safe service configuration for maternity services provided by East Kent Hospitals University Foundation Trust (EKHUFT).

Background

East Kent Hospitals University NHS Foundation Trust currently offers a wide range of choice in of place of birth within the maternity services, including:

- Home birth
- Birth in a stand alone birth centre at either Canterbury or Dover
- A co-located midwifery led unit at William Harvey Hospital
- Two consultant-led maternity units at William Harvey and Queen Elizabeth Queen Mother.

There is also a newly built co-located midwifery unit at the QEQM which has not yet opened.

In 2010, it became apparent that maintaining services in the current configuration was becoming operationally challenging to ensure a safe skill mix of staff were allocated across all services to maintain care on all sites.

The reason for this is two-fold. Firstly, a rise in births – especially in Ashford – and secondly more parents choosing to use co-located Singleton Unit at the William Harvey for the reasons of safety and reassurance.

In meeting safe staffing levels consideration must be given to the continued need to cater for more high risk births that occur at the William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital, Margate.

Engagement and consultation

Engagement with the Kent Health Overview and Scrutiny Committee (HOSC), women who have recently used these maternity services and other key stakeholders is ongoing. The initial work of the Review Board, working with the HOSC, will determine whether full and formal public consultation on any permanent change is required. Formal consultation is dependent on the scale and type of any options for change proposed. In any event the local NHS will continue to informally engage with local people and stakeholders throughout the discussions on how best to ensure the future delivery of sustainable, high quality, safe maternity services for local people.

The experience of service users is a key strand of evidence being considered in the current review of maternity services. This information has been collected:

- through a series of 93 interviews in March
- a focus group with young parents in April
- a focus group with mums with learning disabilities
- an ongoing survey of current maternity patients' experience began in May. 231 received by 7 July 2011
- an online survey of parents with recent experience of maternity services (ongoing) began in May. 91 have responded far.
- 49 staff and community members gave their views on the priorities for maternity services, based on their experience of maternity care, at a series of roadshows in June
- the Maternity Services Liaison Committee (MSLC) has a provided a record of a series of comments from the MSLC Face book page recorded in May and June
- GP clinical leads have been updating their colleagues through their locality meetings and other commissioning committees.

Two stakeholder events were planned for the last week of June to share the emerging evidence with stakeholders. However these have been postponed to ensure that we have received and analysed all available evidence and in addition are in possession of some significant national research: 'The national birth place study', which is anticipated in July 2011.

We shall continue to arrange focus groups with other seldom heard communities and intend going to other large scale community events where there will be a large numbers of families and parents such as:

- Lark in the Park – Thanet 12 to 21 August
- Teddy Bears Picnic 19 August – Dover (Crabble)
- National Play Day in Ramsgate and Canterbury - 3 August
- Hothfield fete.

Early analysis of the patients' experience:

The interviews in March were completed at venues in each district. The overwhelming majority of respondents were women. Their ages varied from 15 years to 44 years. 90% were white British, 4% were white other, 1% were Asian, 1% black British/Caribbean, The majority of those parents interviewed had a child under the age of one.

Every respondent commented on ante natal care. The vast majority were positive in their response.

'*Brilliant – I had extra scans and felt supported. I could always phone if needed.'*

However there were some comments about the lack of consistency. Some women who were being managed by a team of midwives had to repeat their circumstances to different staff, and different specific aspects of the support weren't as positive.

When asked what type of delivery service they would prefer the majority of respondents favoured the midwife-led units co-located with obstetric support:

- 42% chose midwife-led unit co -located
- 20% home birth
- 26% stand alone midwife units
- 13% obstetric-led acute services

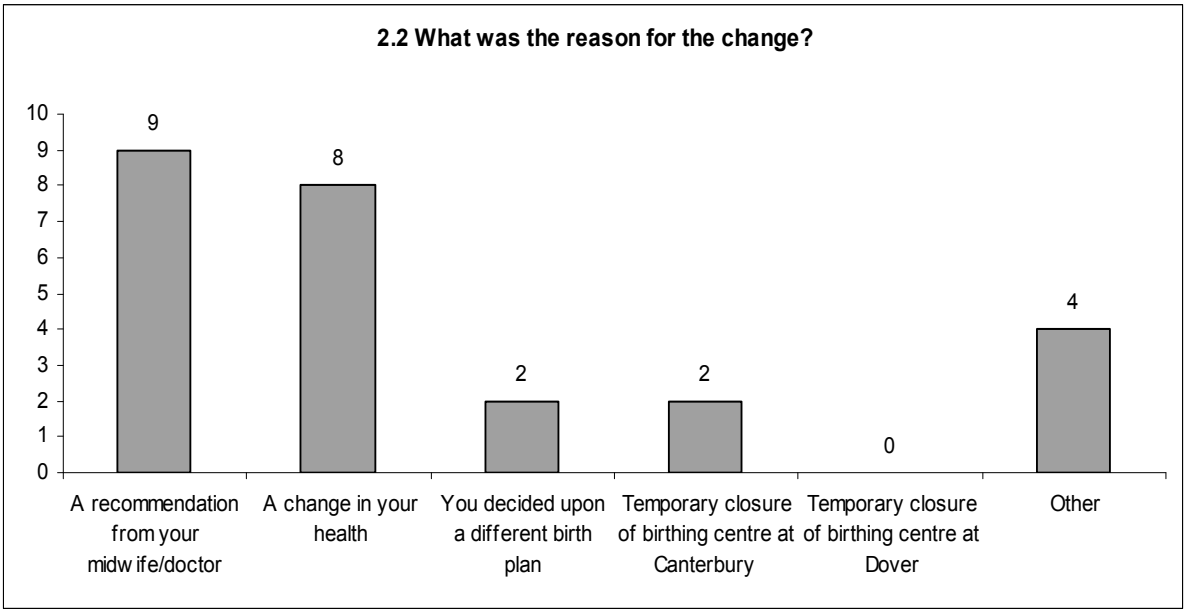
The respondents included mothers who had collectively experienced the entire range of maternity services in East Kent, from home births, to stand alone birthing centres, the co-located service and obstetric departments. There were also respondents who had experience of the services at both Medway and Maidstone hospitals.

94 surveys by current service users have been analysed to show a similar positive record for ante natal care.

The responses regarding the scans taken during ante natal care and the information given during this period are very strong:

- 93% had the dating scan explained to them
- 95% had the downs syndrome test explained
- 89% took the downs syndrome scan, 9% didn't, with 2% not answering this question
- 96% of respondents had the 20 week scan explained to them.

Fig. 1

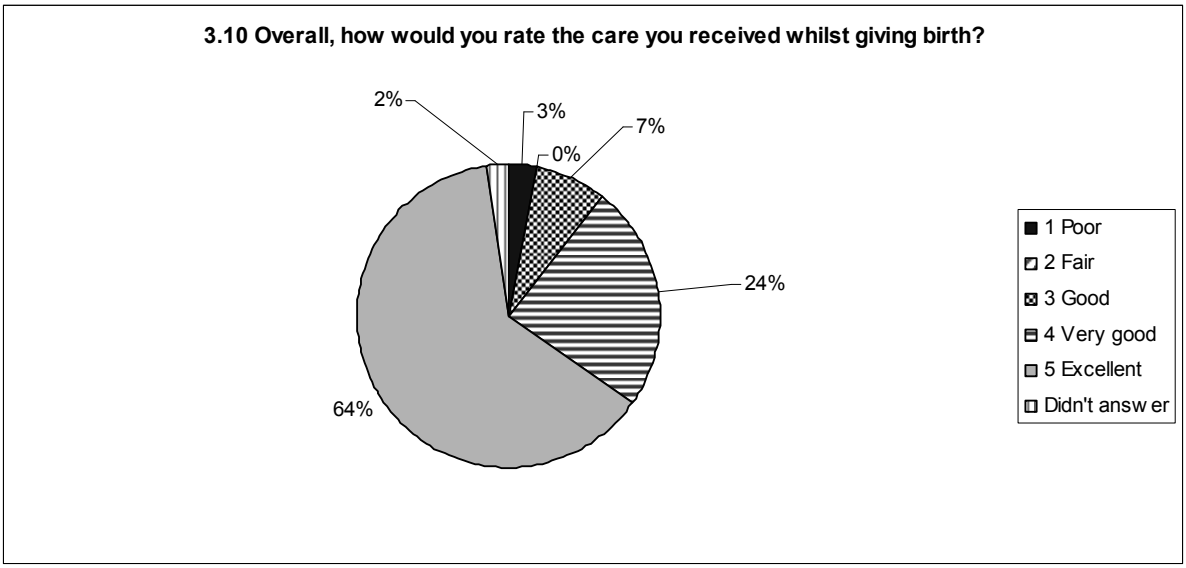


These surveys have all taken place over the last two months so we asked people whether they had had to change their birth plans: 25% of respondents changed their birth plans. The reasons varied see table Fig. 1.
Only 15% of respondents felt they had been affected by the temporary closure of the midwife-led unit at Canterbury, 37% of respondents felt they hadn't been affected and 48% didn't answer.

However there was a positive affirmation from the respondents that they had been offered alternative choices despite the temporary closure. Whilst only 6% of respondents felt the change had influenced where they had their baby in the future.

Overall 88% of respondents rated their care as very good or excellent see Fig. 2 below.

Fig. 2



The results from the responses on labour aren't as positive showing a slight deterioration, for example:

- 74% responded positively in 2011 rather than 79% in 2010.
- 78% of respondents reporting 'skin to skin contact immediately after birth' rather than 87% in 2010.
- 87% of respondents were confident they had received sufficient pain relief during labour rather than 79% in 2010.

Overall these results would seem to support the theory that there is a tendency for greater intervention during labour in the acute site and respondents receiving less of the benefits of natural birth.

This was confirmed by the comments: many respondents had caesarean sections, or were limited by monitoring of the baby, or similar instructions from staff. *'I had monitoring machines attached so could not get of the bed'.* 25% of those who commented had been restricted by monitoring required.

Staff and community views gathered from 49 participants during roadshows in June highlighted those issues which they felt it was important for the review to address:

- Staffing – the pressure on staff, their role, the number of staff, staff skills and the mix of identifiable staff.
- Pressure on the system, particularly on William Harvey Hospital by opening the Queen Elizabeth Queen Mother birthing centre as soon as possible to relieve pressure on William Harvey units.
- Promote normal birth – as the number of Caesarean sections at Queen Elizabeth the Queen Mother (QEQM) is higher than elsewhere, the review should look at reducing this, and the impact that opening QEQM's birthing unit would have. Women feel safer in hospital than at birthing units and there is a misconception that birthing units placed in hospital are safer than stand alone birthing units. Inform women of all the services available to them.
- William Harvey Hospital birthing unit and maternity ward should be looked at as separate entities. The Singleton unit has only two staff and is under pressure from acute ward.
- Demographics of local population figures, the number of births, where and when etc.
- Facilities and services – what is available, where it is, whether it is being well used and can people access it?
- Breastfeeding should be supported - mothers want expert, practical support from someone who knows what to do – leaflets aren't sufficient.
- Wrap around care including post natal support. Birthing centres provide invaluable post natal support services, but not everyone knows that they do this and that you can transfer there after giving birth in an acute setting. Dover birthing centre supports 200 births a year and should also be used for breastfeeding support and ante natal care and parenting support.
- There is disparity over what ante natal classes can be accessed and where.
- Patient notes and poor communication between hospitals, and community midwives and Health Visitors etc. The notes and information not always passed on. Hospitals charge for copies that are made.

Current Service Provision

Maternity services are delivered across a variety of locations by East Kent Hospitals University NHS Foundation Trust, as detailed below:

Ante natal care – *Including:* • *Midwife led* • *Consultant Led* • *Foetal Medicine* • *Maternity Day care*	William Harvey Hospital Queen Elizabeth Queen Mother hospital Kent and Canterbury Hospital Buckland Hospital Royal Victoria Hospital Variety of community settings, i.e. GP surgeries and children's centres Patient's own home
Intra partum Care (Delivery)	William Harvey Hospital – Obstetric Unit and Midwifery-led Unit Queen Elizabeth the Queen Mother hospital – Obstetric Unit Kent and Canterbury Hospital – Midwife led birth centre Buckland Hospital – midwife-led birth centre Home birth
Post Natal care	At family homes GP surgeries and children's centres

EKHUFT has built and equipped two new midwifery-led units (MLUs) on the William Harvey and QEQM sites. The William Harvey MLU opened in July 2009. The QEQM MLU has not yet opened. Unlike the current MLUs in Dover and Canterbury, the new units are co-located with obstetric units.

Maintaining safe maternity services

In September 2010, EKHUFT identified an increase in neonatal admissions to the William Harvey Hospital (WHH) neonatal intensive care unit (NICU) which had occurred between July and August 2010. A decision was made to investigate this increase and, as a precautionary measure, to enhance staffing levels at the high risk obstetric unit at WHH while the investigation was being carried out.

Suspension of services

To achieve the enhanced staffing levels, Dover Family Birth Centre suspended inpatient services on 11 October 2010 and reopened on 10 January 2011. The Canterbury Birth Centre suspended in-patient services from 10 January whilst the wider strategic review of services and staffing is undertaken. Midwives were diverted to WHH. All other services provided at the centre continued as normal. This will continue until the outcome of the full review.

At both sites consultant and midwifery ante natal clinics have continued, as have day care and parent education classes.

The suspension of services at the birth centres has been required to allow skilled senior midwifery staff to move to work on the labour ward at the William Harvey Hospital where the number of births has increased and where the most high risk births tend to take place (as this is where the Neonatal Intensive Care Unit is based).

Evidence to date: Birth rates

	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Total live births delivered by EKHUFT (excluding home births)	6462	6477	6671	7080	7100	7373	7336	7454

Births across EKHUFT had increased year on year up to 2008/09, and showed a 1.6% increase from 2009/10 to 2010/11.

Total live births delivered by EKHUFT (excluding home births)	WHH	QEQM	DFBC	KCH	TOTAL
2010-11	4208	2729	217	300	7454
2009-10	3976	2746	249	365	7336

As can be seen from the table above since the opening of the Singleton midwifery - led unit at the William Harvey Hospital in July 2009, births on this site have increased while all other sites have decreased. More than 55% of the births within EKHUFT are now at the William Harvey site. Around 35% of births are taking place. This is also seen as a reflection of the need to cater for more high risk patients that would require more skilled care.

Of the births in 2010 at the William Harvey 662 were births that took place on the midwifery led unit.

National Birthrate plus directives indicate a birth to midwife ratio of 28:1. The current position in EKHUFT is 33:1 (ranging from 45:1 at WHH to 13:1 at Dover)

The above activity trend should be seen as an opportunity to maintain choice by maximising safe levels of staffing at QEQM and by so doing opening the second co-located midwife led unit.

Time frame

2010: September – December – temporary closure of Dover MLU

2011: January to present – maternity review initiated: Pre engagement and evidence collection

2011: January to present – temporary closure of Canterbury MLU for maintaining safety of services

2011: July national birth place study anticipated

2011: Autumn – formal consultation if service change required on permanent basis.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 22 July 2011

Subject: The Legacy Document.

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1. Background

The Kent and Medway PCT Cluster have requested feedback from the Health Overview and Scrutiny Committee in order to contribute to the production of the Cluster-wide Legacy Document.

2. Recommendation

That the Committee note the report and provide feedback on the summary of the Legacy Document.

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

To: Health Overview and Scrutiny Committee, 22 July 2011

Subject: The Legacy Document

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1. Introduction

(a) The National Quality Board (NQB) was established in 2009 bringing together the Department of Health and the main regulatory bodies to look at quality and safety across the whole system. It is chaired by David Nicholson, the NHS Chief Executive.

(b) In March 2011, the NQB published a report titled *Maintaining and improving quality during the transition: safety, effectiveness, experience Part One: 2011/12*[1]. Part Two is due during the summer of 2011.

2. The Legacy Document

(a) The NQB report is mainly concerned with emphasising the need to retain an emphasis on quality and patient care during the transition. Particular stress is given to the elements and organisations which will remain as a constant during the transition period and beyond – staff and patients are highlighted as elements of continuity for example, as well as the majority of NHS provider organisations and local authorities. Not mentioned, though relevant, is the continuation of statutory HOSC powers and duties until at least April 2013.

(b) HOSCs are mentioned explicitly in connection with Legacy Documents. Legacy Documents are one mechanism through which organisational memory is transmitted from the current commissioners to future ones:

i. "At both PCT/PCT Cluster and SHA level, all legacy documents should be subject to a (public) board level discussion for assurance purposes. We also recommend that these documents are available publicly to enhance and ensure their vigour. PCTs and SHAs should consider how they could involve LINks, Overview and Scrutiny Committees (OSCs) and other local bodies and draw on them to support the production and maintenance of the documents. Additionally, we recommend that CQC and Monitor should have sight of the Legacy Documents to provide them with the opportunity to flag any

[1] National Quality Board, *Maintaining and improving quality during the transition: safety, effectiveness, experience*, March 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125497.pdf

concerns they have and that should be in included in the documents."[2]

(c) The minimum requirements for a Legacy Document are set out below:

- "Information on all services provided to the local population, including primary care services;
- 'Pen Portrait' of the patch to include the key facts and figures on population, geographical boundaries and so forth;
- Current state of play with regard to quality, finance, performance, capacity, and people; recognising that this will be a snap shot in time;
- Relevant organisational memory – in each of the above categories, For example if a Trust is currently in surplus but actually has had many years of deficit and brokerage, or has seen 5 changes in leadership in 5 years, or has a long standing reconfiguration issue;
- Future challenges/risks - a formal risk register to capture each of the above issues with proposed mitigating actions;
- Library of knowledge/skills – a depository of all useful resources such as strategy documents, consultancy reports, so that incoming teams are not required to rediscover problems and/or reinvent answers; and
- Directory of services and skills – to help people navigate their way round the various information sources/skills available regionally, including contact details for people who have corporate memory."[3]

3. Legacy Document – Kent and Medway PCT Cluster

(a) The latest draft version of the Legacy Document is included in the Board Papers for the meeting of the Kent and Medway Cluster Board for 20 July 2011. It can be accessed here:

i. http://www.easternandcoastalkent.nhs.uk/about-us/the-board/pct-cluster-board/board-meeting-wednesday-20-july-2011/?assetdet3907929=178773

[2] Ibid., p.28.
[3] Ibid., p.27.

NHS
Kent and Medway

NHS Kent and Medway Legacy Document

This paper is for information and aims to:

- Provide background and context for the NHS Primary Care Trust legacy document.
- Describe the legacy document process.

Background

The Government's White Paper, *Equity and excellence: Liberating the NHS* set out the programme for change in the NHS aimed at:

- Putting patients at the heart of all NHS care;
- Delivering improved healthcare outcomes; and
- Empowering local organisations and professionals to improve quality

The transition to the new system architecture for the service will result in structural changes in how the NHS is organised and run. Subject to legislation, the following organisational changes will have been achieved by 2014:-

- A national commissioning board responsible for overseeing the commissioning of NHS services and allocation of the NHS budget will have been established
- Strategic Health Authorities and Primary Care Trusts will have been abolished
- Clinical Commissioning Groups responsible for commissioning the majority of local health services for their populations will have been established
- All NHS Trusts will be Foundation Trusts
- HealthWatch, a new champion for the patient voice will have been created
- A number of arms length bodies will have been abolished

Managing a smooth transition to the new system whilst ensuring the quality of NHS services is both maintained and improved is essential. Research in the NHS and elsewhere has demonstrated an increased potential risk to service during times of major change.

In it's document, *Maintaining and improving quality during the transition: safety, effectiveness, experience* the National Quality Board proposed that outgoing organisations, i.e. Strategic Health Authorities and Primary Care Trusts developed 'Legacy documents' as part of a robust system of handover that effectively captures and transfers organisational memory.

Purpose of the Legacy Document

The Primary Care Trusts (PCTs) in the Kent and Medway cluster rely heavily upon the professional and organisation knowledge and corporate member of its 1,000 employees. The reform of the NHS will remove several tiers of management. The legacy document, therefore, seeks to preserve the collective knowledge of the local service at a point in time during the transition to the new system architecture and to refresh the information contained in it in the light of experiences throughout the transition to organisational closure. As part of this process, the involvement of local key stakeholders is essential.

The document will form part of the eventual handover process with both outgoing and incoming organisations having a responsibility for ensuring that the new organisations have a good understanding of the whole quality picture of the providers for whom they are taking on responsibility. This will be augmented by face-to-face processes involving the departing chief executive and all managers and clinicians, as part of their public sector duties.

Content of the document

As a minimum, for the PCTs in the Kent and Medway cluster, the legacy document will provide:-

- information on the services provided to the local population,
- a 'Pen Portrait' overview of the key information on the local population including key population facts and figures, geographical boundaries, assessment of strategic needs, population trends, etc.
- the current state of play with regard to quality, finance, performance, capacity, and people
- relevant organisational memory, i.e. financial trends, staff turnover, quality trends
- future challenges and risks, through the formal risk register detailing mitigating actions and ongoing monitoring, etc
- a library of knowledge/skills, i.e. strategic documentation, consultancy reports, public consultation reports, etc.
- a directory of services and skills such as information sources, skills available regionally, key contact information

Development of the document

Development of the legacy document is part of the cluster's transition plan. Judy Clabby, the Assistant to the Chief Executive, will oversee this work stream with a small project team covering each of the three constituent PCTs.

A common template is in use across the South East Coast region which will be augmented by further key information headings as these documents develop over the next two years

The Cluster will ensure that the document is maintained until organisational closure

PCTs' legacy documents will be amalgamated at SHA level to ensure robust handovers between SHAs, the NHS Commissioning Board and Provider Development Authority and are modelled on the practice of due diligence to ensure a transfer of both hard and soft intelligence from the outgoing to the incoming organisations.

Public and stakeholder engagement

The legacy document will be subject to a (public) board level discussion for assurance purposes and it is recommended by the National Quality Board that the documents are available publicly to enhance and ensure their vigour.

We intend that these documents will be available via PCTs' websites together with signposting to the sources of reference used in them, as part of their publication schemes.

Due to the nature of some of the information to be provided ultimately there will also be a confidential section to the document including, for example contact details for key outgoing staff and details of patient-specific issues at the time of handover.

The Care Quality Commission and Monitor are expected to have sight of the legacy documents at the SHA stage and will have the opportunity to flag any issues they may have and address any areas they feel should be in included in the documents.

Proposal and/or Recommendation

The Overview and Scrutiny Committee is asked to support the production and maintenance of the documents as appropriate.

Matthew Capper
Associate Director Corporate Services
July 2011

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 22 July 2011

Subject: NHS Transition: Written Update.

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1. Background

(a) The Health Overview and Scrutiny Committee agreed to look at the subject of NHS Transition at is meeting on 9 September.

(b) It was felt that before then a written report providing an overview of the recent changes around the proposals would be appropriate at the 22 July meeting.

2. Recommendation

That the Committee note the attached report.

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

To: Health Overview and Scrutiny Committee, 22 July 2011

Subject: NHS Transition: Update.

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1. Equity and Excellence: Liberating the NHS

(a) The current proposals for reforming the health sector were originally set out in the NHS White Paper, *Equity and Excellence: Liberating the NHS*[1], and a suite of associated documents.

(b) Following a consultation process, the Health and Social Care Bill[2] began its process through Parliament to give effect to the proposals.

(c) On April 6th the Government announced a 'pause' in the legislative process, to accommodate a two-month listening exercise. A group of patient representatives, doctors and nurses and other health professionals were brought together to conduct the listening exercise and report back to Government. The Forum reported back to the Government on 13 June 2011[3] and a Command Paper containing the Government's response was published on 20 June 2011[4].

(d) The Health and Social Care Bill has subsequently recommenced its passage through Parliament. As before, the detail of a number of the Government proposals will follow Royal Assent in the form of guidance and secondary legislation. The power to bring in some of the other changes already exists.

(e) The following summary is intended to provide an overview of the proposals as they currently stand taking into account the NHS White Paper documents and the results of the listening exercise. They are therefore subject to Parliamentary approval. The main elements of the proposals are set out in the follow sections.

2 Department of Health

(a) The Secretary of State for Health will maintain responsibility for promoting a comprehensive health service. This will be exercised in

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[1] The range of NHS White Paper document can be accessed here: http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

[2] Health and Social Care Bill proceedings and documents can be accessed here: http://services.parliament.uk/bills/2010-11/healthandsocialcare.html

[3] Department of Health, *NHS Future Forum Recommendations to Government*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

[4] Department of Health, *Government Response to the NHS Future Forum Report*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444

large part through a mandate to the NHS Commissioning Board. This is likely to be a three-year document with yearly updates.

(b) The Secretary of State will have a range of intervention powers in the event of significant failure.

3. NHS Commissioning Board (The NHSCB)

(a) This will be a non-departmental public body accountable to the Secretary of State with an overarching duty to promote a comprehensive health service and promote the NHS Constitution. It is likely to be structured around the five domains of the NHS Outcomes Framework. These are:

1. Preventing people from dying prematurely;
2. Enhancing the quality of life for people with long-term conditions;
3. Helping people to recover from episodes of ill health or following injury;
4. Ensuring people have a positive experience of care; and
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

(b) Two distinct types of group will be established, hosted by the NHSCB;

1. Clinical Networks – These already exist in some areas such as cancer and bring together clinical experts, patient representatives, carers and so on. These will be strengthened and expanded to cover more areas to support the NHSCB and Clinical Commissioning Groups (CCGs).
2. Clinical Senates – These will bring together locally a range of experts, include doctors, nurses, allied health professionals, social care and public health professionals. They will provide pathway advice for commissioners and Health and Wellbeing Boards (HWBs).

(c) Both the above groups will also support the NHSCB regarding CCG authorisation as well as feeding back the views of CCGs on what is required in terms of service specification, tariffs and other areas falling within the NHSCB remit.

(d) The NHSCB will be responsible for authorising Clinical Commissioning Groups. Those that are ready will be authorised before the previous date of April 2013 and others will be authorised as soon as they are ready, which may be after April 2013. There will also be the possibility of partial, or limited, authorisation. The advice of the local Health and Wellbeing Board and clinicians will be sought prior to authorisation.

(e) The NHSCB will take on the responsibility for allocating resources to CCGs. It will have a legal duty to produce, with Monitor, standardised pricing currencies for the national tariff. As part of its role in promoting integrated care, tariffs for integrated pathways are possible. It will also develop model and standard contractual terms for providers.

(f) It will publish commissioning guidance and model care pathways. These will be based on Quality Standards produced by NICE, which will keep the acronym but be renamed the National Institute for Health and Care Excellence to incorporate a social care remit. Both the NHSCB and Department of Health will be forbidden from interfering with NICE Quality Standards.

(g) The NHSCB will be responsible for the financial performance of consortia and hold them to account for the quality outcomes they achieve. It will also have some specific powers in connection to consortia – ensuring there is comprehensive coverage of England by consortia; ensuring all GP practices are part of a consortium; overseeing a failure regime for consortia.

(h) The NHSCB will also undertake some commissioning. It will commission primary care services (such as community pharmacy, ophthalmology and dental services along with primary medical services provided by GPs). It will also commission a number of specialised services currently commissioned regionally or nationally.

(i) The NHSCB will have shadow status by October 2011, become a statutory body by October 2012 and take on its full responsibilities by April 2013. PCT Clusters will move to becoming regional arms of the NHSCB.

4. Clinical Commissioning Groups (CCG, formerly GP Commissioning Consortia)

(a) The majority of health services will be commissioned by GPs and their practice teams through CCG. These will be statutory bodies and all holders of a primary medical services contract must belong to a CCG.

(b) CCGs will be responsible for commissioning health services for patients registered with constituent practices and unregistered patients within their boundaries, as well as arranging emergency and urgent care within their boundaries. Boundaries will not normally cross local authority (upper tier/unitary) boundaries.

(c) CCGs will be authorised by the NHS Commissioning Board under the principle of earned autonomy (see above). The official names of CCGs are likely to require the inclusion of ‘NHS’ and a reference to the locality it covers. All practices will either be part of a CCG or a shadow CCG by April 2013.

(d) They will be required to put robust governance arrangements in place and will have an Accountable Officer (not necessarily a clinician). They must have a decision making governing body, with at least two lay members (a patient representative and one on the governance and audit side). One of the lay members must be Chair or Vice-Chair. Meetings must be held in public, publish minutes and details of contracts.

(e) The boards of CCG must also contain a registered nurse and secondary care specialist (normally a hospital doctor). These must be from outside the area so as not to have a conflict of interest by representing actual or potential providers.

(f) CCGs will receive quality premiums to reward commissioners for improving health outcomes and reducing inequality in outcomes. Premiums will partly relate to a CCG's contribution to the outcomes set out in the Joint Health and Wellbeing Strategy.

(g) CCGs must involve patients and the public in commissioning plans and their annual plans.

5. Monitor

(a) Monitor currently regulates NHS Foundation Trusts but under the proposals would become the economic regulator for the health sector. The Bill allows for Monitor's role to be extended to regulating adult social care at a later date by Government.

(b) Questions had been raised around Monitor's duty to "promote competition." There will be a shift of emphasis so that competition is not viewed as an end in itself and move to a focus on preventing abuse and anti-competitive behaviour to ensure a "level playing field between providers." Competition between providers will be on quality, not price, and areas like pricing and eligibility criteria will be looked at to prevent "cherry-picking." There will also be a requirement on Monitor to support the delivery of integrated care where this would improve quality.

(c) The current rules around co-operation and competition will remain, and the Co-operation and Competition Panel will move into Monitor but retain a distinct identity.

(d) Monitor will maintain its oversight role of Foundation Trusts until 2016, or two years following an FT's authorisation.

(e) Monitor will have a function in licensing providers (along with the Care Quality Commission), a role in price-setting, and a role in supporting the continuity of vital services in the event of failure.

6. Foundation Trusts (FTs) and Other Providers

(a) There is an expectation that NHS Trusts will 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). However, the deadline has been removed to allow flexibility. The FT process will be overseen by Strategic Health Authorities until their abolition in April 2013 when a Trust Development Authority will continue this aspect of SHA work. The ten SHAs will cluster into a smaller number later this year.

(b) FTs will be required to hold board meetings in public. Separate accounts must be produced covering public and private activity.

(c) The areas covered by patient choice of Any Qualified Provider (AQP) will be gradually extended in the future, beginning in April 2012 and starting with selected community services. AQP will not apply to accident and emergency and critical care services and will be restricted to those services for which there is a national or local tariff. A fixed national or local tariff will be developed for any service covered by Any Qualified Provider

(d) There will be a robust provider failure regime.

(e) Any policy aimed at deliberately increasing or maintaining the market share of any sector (private, public or voluntary) will be forbidden. Choice and competition will need to add value.

(f) The scope for 'right to provide' (R2P) where staff are able to form mutuals or social enterprises and run services is to be increased.

(g) Personal health budgets will be extended and include integrated personal health and social care budgets.

7. Health and Wellbeing Boards (HWBs)

(a) Upper tier authorities will be required to set up a HWB, which will be a statutory committee. The membership will consist, at a minimum, of one elected representative, the director of adult social services, director of children's services, director of public health and representative from the local HealthWatch, and one representative from each relevant CCG (unless the HWB agrees to a single representative of more than one CCG). There will also be involvement from the NHS Commissioning Board. As it will be an executive arm of the local authority, the authority can insist on a majority of the membership being elected councillors.

(b) Local authorities and CCGs will have a responsibility to produce a Joint Strategic Needs Assessment (JSNA) and will develop them through the HWB. They must also develop a joint health and well-being strategy (JHWBS) which will set out how the needs identified in the JSNA will be

met. The HWB will be required to involve the public in the production of the JSNA and JHWBS beyond the participation of the HealthWatch representative.

(c) Other powers and responsibilities, except that of scrutiny, can be conferred on the HWB. It will have a strong role in promoting joint commissioning and integrating service provision. It can also be the vehicle for commissioning certain services. Members of the HWB will be subject to local authority overview and scrutiny.

(d) The CCG will involve the HWB as they develop their commissioning plans and there is an expectation that they will be in line with the JHWBS. The HWB will not have a veto on the plans but can refer them back to the CCG or up to the NHSCB. The CCG will have to amend the plans or explain why the particular decision was made.

(e) The HWB will also have a role in authorising CCG as well as in their ongoing assessment.

8. Scrutiny

(a) From April 2013, the functions of the current Health Overview and Scrutiny Committee will be conferred on the local authority directly. The exercise of this function could be through a specific health scrutiny committee or through a different arrangement (with the exception that it cannot be exercised by the HWB).

(b) The powers of health scrutiny will expand to include any NHS funded provider and any NHS commissioner. The ability to challenge substantial service change will remain, though it is possible that the decision to refer will require a vote of the full Council. As is the case currently, the details around health scrutiny will be contained in official guidance and Statutory Instruments. There is likely to be consultation specifically on health scrutiny regulations at a later date.

(c) The Operating Framework for 2011/12[5] states that the four tests for service reconfiguration set out in May 2010 stand. These are likely to continue in the future. These are:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

(d) The duty of PCTs to consult overview and scrutiny committees on substantial service change is to remain during the transition.

[5] Department of Health, *The Operating Framework for the NHS in England 2011/12,* p.33, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

9. HealthWatch

(a) HealthWatch England (HWE) will be established as a subcommittee of the Care Quality Commission. The CQC must respond to advice from HWE and the Secretary of State must consult with it on his or her mandate to the NHSCB. The HWE will also provide support to local Healthwatch.

(b) Local Involvement Networks (LINks) will transform into local HealthWatch. They will be commissioned and funded by upper tier local authorities and be based in local authority areas. The functions of promoting and supporting public involvement in the commissioning and provision of local health services will continue. The local authority will be able to commission HealthWatch to provide advice and information to people about health and social care.

(c) Local HealthWatch are explicitly required to ensure the membership represents different users, including carers.

(d) Commissioners and providers are to have due regard to findings from local HealthWatch.

(e) Where there are local disputes involving local HealthWatch, the emphasis will be on local resolution with the Health and Wellbeing Board likely to be the forum in which this is pursued, rather than invoking HWE as arbitrator.

(f) HWE will be established as soon as possible and local HealthWatch from October 2012. Local authorities and local HealthWatch will take on formal responsibility for commissioning complaints advocacy from April 2013.

10. Public Health

(a) A separate Public Health White Paper, *Healthy Lives, Healthy People*, was published by the Department of Health on 30 November 2010[6]. Separate papers on the commissioning and funding of public health and public health outcomes have also been published.

(b) A new service, Public Health England (PHE), will be set up as an executive agency of the Department of Health. This will involve the transfer of functions and powers from the Health Protection Agency and National Treatment Agency for Substance Misuse.

(c) Local health improvement functions will transfer to local government, along with ring-fenced funding. Local Government will be accountable

[6] The Public Health White Paper and related documents can be accessed at the Department of Health website, http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

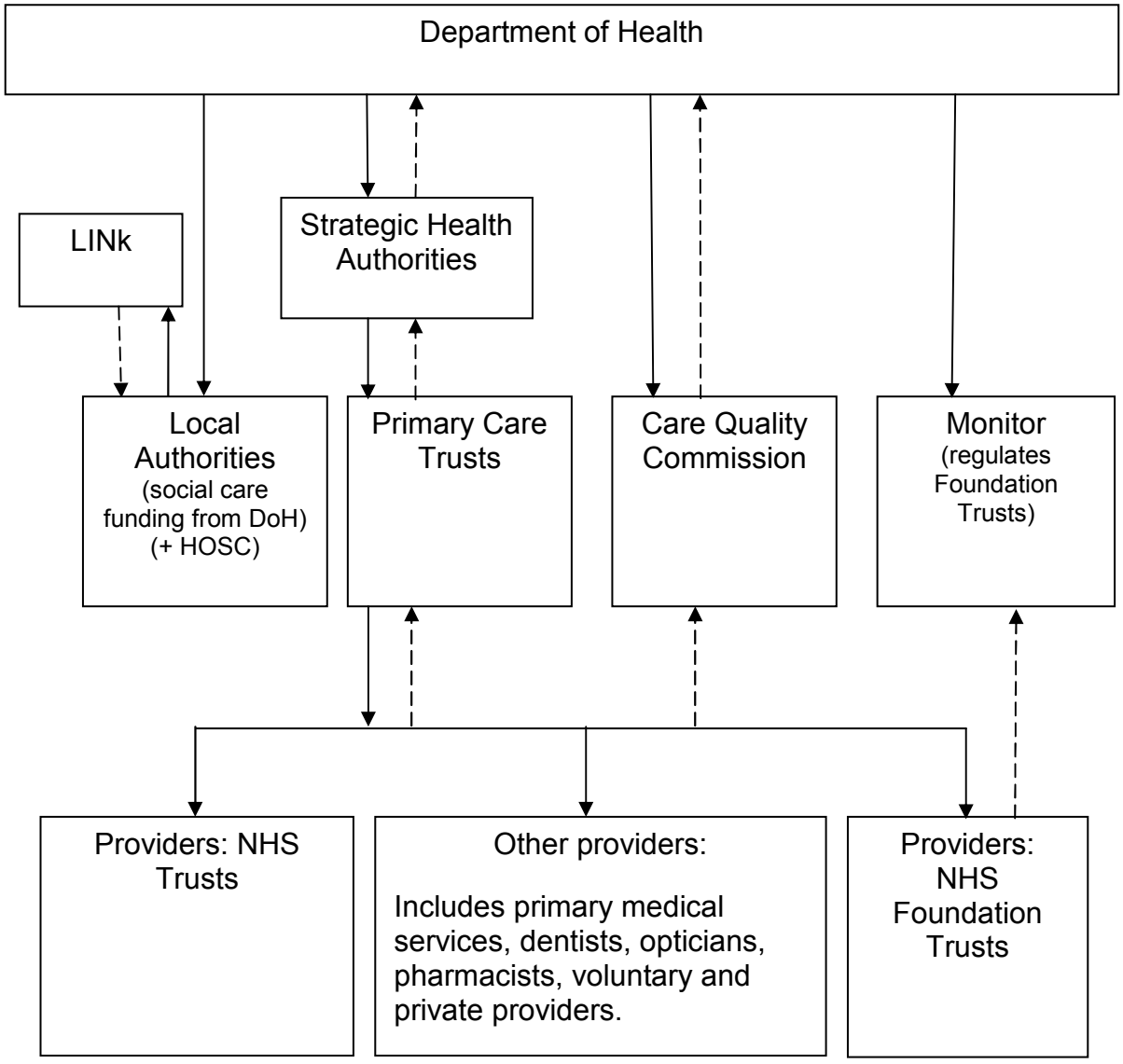
to PHE for spending the grant. It will be separate from the current funding of local authority functions with public health implications, such as leisure).

(d) There will be a health premium linked to progress made against a proposed public health outcomes framework.

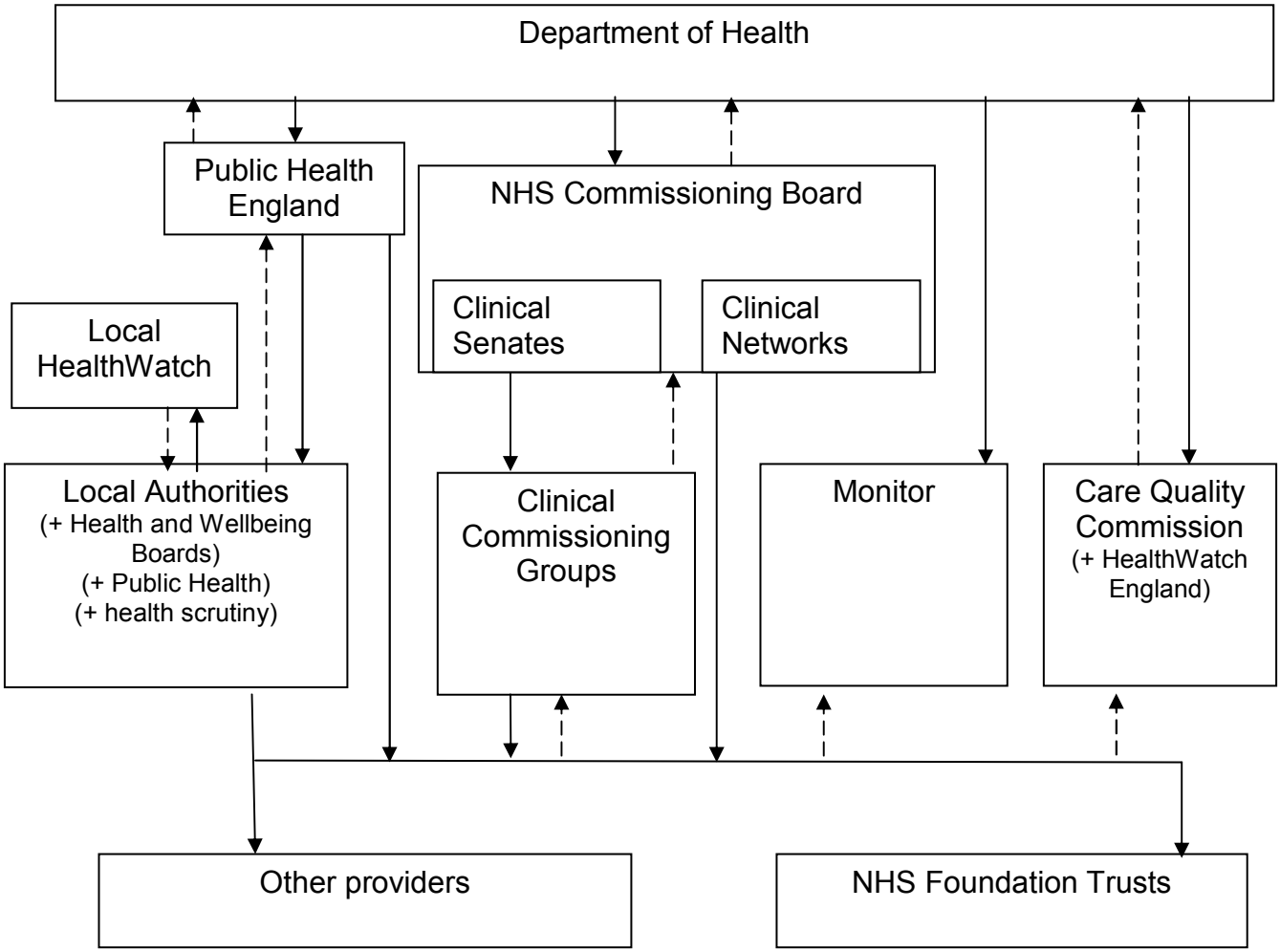
(e) Directors of Public Health will be employed by local government and jointly appointed by the local authority and Public Health England. The DPH will play a leading role in the development of the JSNA and JHWBS through the HWB. One other key role will be to produce an authoritative independent annual report on the health of their local population.

11. Current and Proposed Structure of the NHS

- **Chart 1: Current Structure of the NHS**



➢ **Chart 2: Proposed Future Structure of the NHS[7]**



(a) Key to charts[8]:

⇢ Accountability → Funding

[7] Chart incorporates changes following the recent listening exercise and should be seen as indicative only.
[8] Both charts adapted from: House of Commons Library, Research Paper 11/11, *Health and Social Care Bill*, p.7, http://www.parliament.uk/briefingpapers/commons/lib/research/rp2011/RP11-011.pdf

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 22 July 2011

Subject: NHS Financial Sustainability: Draft Recommendations.

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1. Background

(a) At the meetings of 15 March, 19 April, and 10 June, the Committee considered the subject of NHS Financial Sustainability in depth.

(b) Members agreed the following resolutions at each meeting:

1. 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.

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

(c) The draft report including recommendations is attached.

2. Recommendation

That the Committee discuss and approve the report.

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NHS Financial Sustainability

Key Issues and Recommendations

Health Overview and Scrutiny Committee, Kent County Council July 2011

Part 1 - Introduction

(a) The Health Overview and Scrutiny Committee of Kent County Council undertook to carry out a comprehensive review of financial sustainability across the whole health economy. Because of the interconnected nature of the subject, the Committee heard from all the major commissioners and providers across the County. Although detailed questions were asked in advance and during the meetings, the focus was on answering the following two 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 Committee held three formal meetings on the subject and heard from the following organisations:

- 25 March 2011
  - NHS Eastern and Coastal Kent
  - NHS West Kent
  - Kent Local Medical Committee
- 19 April 2011
  - Dartford and Gravesham NHS Trust
  - East Kent Hospitals NHS University Foundation Trust
  - Maidstone and Tunbridge Wells NHS Trust
  - Medway NHS Foundation Trust
- 10 July 2011
  - Kent and Medway NHS and Social Care Partnership Trust
  - Kent Community Health NHS Trust
  - South East Coast Ambulance Service NHS Foundation Trust

(c) The relevant sections of the Minutes from the above meetings are appended to this report.

(d) The Committee would like to thank everyone involved in the inquiry for their openness and informative engagement with the process. The HOSC has always aimed at a constructive engagement with the local NHS and believes that scrutiny should lead to positive outcomes. The following findings and recommendations are offered in this spirit.

Part 2 - Key Issues

(a) Throughout all the sessions and running through all the evidence provided, a number of recurring themes could be identified. The most important are set out below. While none of these should be seen as irreconcilable opposites, they do highlight some of the difficult balancing acts that our colleagues in the NHS must strike when planning, commissioning and delivering healthcare across the county.

1. Allocations v. Need

The Committee heard that Primary Care Trusts are responsible for around 80% of the total NHS budget and that their role is to use the money allocated to commission services to meet the health needs of the people living in their area. The 'weighted capitation formula' used to determine how much money PCTs receive each year is complex and so looking at the **money received per head of population** is a bit misleading. That said, doing so reveals that NHS Eastern and Coastal Kent received **£1,725** per person for 2011/12 whereas NHS West Kent has received **£1,499** per person for the same year.

2. Short term v. Long term planning

One of the many balancing acts that commissioners have to undertake is how much resource to allocate to services where there is a recognised need such as improving the time from referral to treatment and how much to allocate to preventive and public health services which will reduce demands on the health services in the future, but **possibly not for a number of years**.

3. National v. Local targets

The Department of Health sets the strategic direction for the health services and the annual NHS Operating Framework sets out what the NHS needs to achieve during that year and includes financial targets as well as areas of healthcare that need improvement. While many of these are issues that all areas of the country do need to improve on, and may be a priority locally, there will always be some areas of healthcare which are of particular importance locally.

4. Localism v. Post code lottery

Each area of the country and, more locally, each area of the county, has different health needs and preferences around how and where these services are delivered. On the one hand this is a positive thing, on the other this can be seen as providing an inequitable service if something is not available everywhere. The point was well made during our inquiry that the important point was the equity of outcomes, rather than the equity of services.

5. Providers v. Commissioners

One of the more challenging aspects of the role undertaken by Primary Care Trusts is to make decisions around what the priorities should be for health spending locally, particularly in the context of the NHS as a whole being required to make £20 billion worth of efficiency savings by the end of 2014/15. The Committee heard that the stricter criteria had been introduced over referral to treatment. This in turn had an impact on the income received by providers who have to make hard decisions about whether a certain services can be provided at all.

6. Competition v. Collaboration.

The Committee heard lots of good examples of partnership work across the NHS, and the costs to the NHS as a whole were often lower where organisations work together. Yet it was also important that patients had a **choice of where to receive treatment** and providers are understandably keen to make the case for why they should be the ones chosen.

7. Repatriation v. Centralisation of services

To be effective, health care needs to be based on clinical evidence. In broad terms this means that people need to be seen by the right people, at the right time, and in the right place. Sometimes this means that patients will go past their local Accident and Emergency Department to receive the right treatment, as with primary angioplasty at William Harvey Hospital, but there are also some treatments being provided locally which previously would have involved a journey to London

8. Transition planning v. Continuity of care

The whole NHS is currently undergoing a series of changes following on from last year's NHS White Paper and this has major implications for those responsible for both commissioning and providing health services. While it is right that everyone involved plans ahead effectively for the new system, people still require treatment and care without disruption.

Part 3 - Recommendations

To Department of Health

1. **Improved Allocations Formula**. We ask that the Department of Health consider carefully the allocation formula which will be used to determine commissioning budgets for Clinical Commissioning Groups and involve local authorities closely in any work being undertaken in this area.

2. **Forward Financial Planning.** We recommend that once agreement has been reached on a fair allocation formula, the future indicative budgets for Clinical Commissioning Groups be announced as early as possible prior to the Groups assuming full commissioning responsibility to enable effective advance planning and a smooth transition.

To Kent and Medway PCT Cluster

3. **Transition Updates.** We ask that the Kent and Medway PCT Cluster Chief Executive's Office provide a written update for the HOSC on the transition planning across the County, including the latest stage of Clinical Commissioning Groups development.

4. **Zero Legacy Debt.** In order to be assured that the Clinical Commissioning Groups, and others, are able to pursue effective commissioning plans, we ask the PCT Cluster produce a clear outline plan as to how they will ensure zero legacy debt for their successor commissioning organisations. Current financial forecasts should be included in the above report.

To all NHS Trusts in Kent and Medway

5. **Communication of Service Changes.** Despite the impression that the entire NHS is changing on a weekly basis, effective forward planning is essential if the appropriate services are to be delivered in the most effective and efficient way. We therefore encourage all provider NHS Trusts in Kent and Medway to ensure they work with commissioners on setting out a clear timeline of proposed major service changes over the next two years. We also ask the PCT Cluster to take responsibility for coordinating said timeline and making it available to the HOSC and other stakeholders.

6. **Develop Local Pricing.** While we recognise the fine details around currencies and tariffs might not engage the imagination of the wider public that easily, this review has made it clear how important these details are. While the Payments by Results tariff is fairly well established in the Acute Sector, the development of currencies and

tariffs in other areas is only slowly developing. Due to their technical nature, the Committee has no specific recommendations to make as to the form they should take. However, we ask all relevant organisations to consider how these should best be taken forward locally.

To Shadow Health and Wellbeing Board

7. **Promotion of Integrated Care.** This Committee looks forward to a positive and constructive working relationship with the developing Health and Wellbeing Board. While it is not for us to decide the priorities of the Board, we ask that the development of integrated care pathways to improve efficiencies and, more importantly, the **patient experience be put at the heart of the work carried out.**

8. **Plan for the Long Term Health and Wellbeing of People in Kent.** Sitting within the County Council, the Health and Wellbeing Board will be in a good position from which to ensure the proper balance is struck between short and long term planning and we ask that maintaining this balance be given due priority.

To HOSC

9. **Further Scrutiny Reviews.** This review of financial sustainability across the health sector in Kent has highlighted a number of key areas which pose a particular challenge in achieving it, such as **preventing unnecessary attendance at accident and emergency departments**. The HOSC will include reviews of a number of these going forwards with the aim of developing further, specific, recommendations aimed at assisting the NHS in managing and overcoming them.

Appendix – HOSC Minutes on NHS Financial Sustainability

1. 25 March 2011

Bill Jones (Interim Director of Finance, NHS Eastern and Coastal Kent), Dr Mike Parks (Medical Secretary, Kent Local Medical Committee), Daryl Robertson (Deputy Chief Executive, NHS West Kent) and Di Tyas (Deputy Clerk, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the first of three meetings on the topic of NHS Financial Sustainability by giving his view that the question was not about the overall level of Government funding to the NHS, but rather the issues of whether Kent was receiving its fair share and how resources were prioritised locally. The intention was for the Committee to produce recommendations at the end of the three meetings and suggestions were invited from Members.

(2) One of the key issues discussed was that of legacy debt, where there was the risk that GP Commissioning Consortia (GPCC) may take over full commissioning responsibility from Primary Care Trusts (PCTs) in 2013 with inherited debt. One Member explained how this had been an issue in the past when PCTs were established and reorganised and that there was an argument for saying that this had proved a distraction from improving local health services. Another Member explained how there needed to be an awareness of the different kinds of legacy debt, including straightforward overspends from the previous financial year, as well as ongoing commitments.

(3) Representatives from the NHS explained that both PCTs in Kent were going to break even at the end of this financial year, and that current spending information was available after two weeks so that commissioners were not in a position where spending was authorised after the budget had already been allocated.

(4) Colleagues from the NHS indicated the clear summary of the PCT allocation formula available in the Agenda and summarised even further by explaining that it was larger based on population, with an element of weighting around deprivation. Concern was expressed by Members about the level of detail the allocation formula went into and whether it went into sufficient detail to pick up the pockets of severe deprivation that existed across Kent. The offer was made to provide further details on the per capita funding and the formula itself.

(5) There was also sometimes a difference between a PCT's actual allocation and its target allocation, but both Kent PCTs were on target. There was some discussion about the actual per capita allocation for Kent. In terms of the demographic challenge in future health funding, that of ageing was highlighted as significant in that people aged under

50 consumed relatively few health resources, and most were used in the last two years of a person's life.

(6) A question was asked about the additional funding of £16 million made available to the PCTs to support social services and it was explained that the NHS and Kent County Council had already agreed on how this would best be used.

(7) Details were requested around the £2 per head allocated to support the development of GPCC. Representatives from the NHS explained that a distinction needed to be made between management costs and running costs, and this question needed to be seen in the context of the 40% reduction in management costs currently being made by PCTs, involving redundancies. Current running costs at PCTs were about the equivalent of £40 per head, but that GPCC were expected to have running costs of between £25 and £30.

(8) On pharmacy costs, it was explained that the prices were set nationally and this was an area where the finances could be used up rapidly.

(9) A representative from the Kent LINk raised the issue of PCTs consulting over recent measures both had taken to prioritise treatments in order to achieve financial balance. The opinion was given that while the consultation period of 3-10 December for NHS West Kent was too short, NHS Eastern and Coastal Kent did not hold any consultation.

(10) A number of issues were raised around the proposals in the NHS White Paper and Health and Social Care Bill. One Member felt that the proposed Health and Wellbeing Board would benefit from a greater degree of Member involvement than was proposed in the minimum Health and Wellbeing Board membership requirements. Another Member hoped greater clarification would become available around what precisely the NHS Commissioning Board would commission against what the GPCC would be responsible for.

(11) There was a lot of discussion around the precise number and size of the developing GPCC, a question which Members hoped there would be a final and definitive answer as soon as possible. Financially the GPCC would be subject to the same rules as PCTs and would have an Accountable Office and Chief Financial Officer, as well as a support organisation.

(12) It was explained that at present there were around 12 developing consortia, the majority of which were in the Eastern part of the county, two of which were single practices. The representative from the Kent Local Medical Committee explained that this number was likely to change as a small single practice consortium was unlikely to receive authorisation from the NHS Commissioning Board and there was guidance from the British Medical Association to the effect that a consortia would need to cover 4-500,000 people to be effective. As a

related supplementary point, a representative of the NHS explained that smaller consortia would experience a higher financial risk, particularly around low volume, high cost procedures, so there was a need for risk sharing between GPCC.

(13) Three models of GPCC were generally acknowledged as being workable:

1. A free standing large consortium;

2. A large consortium with a locality structure; and

3. Small consortia forming a federation.

(14) All models were likely to develop in Kent. Depending on how they were counted, 3-5 were likely across the County.

(15) It was generally agreed that one of the main challenges these GPCC would face would be resolving the tension between local freedoms around commissioning and what is sometimes referred to as the 'postcode lottery' where people receive different services depending on where they live. The view was expressed by the representative on the Kent Local Medical Committee that the tension needed to be accepted as differences between areas was likely. However, the point was also made that the distinction needed to be made between the equity of outcomes and the equity of service provision between GPCC areas, with the former being more important.

(16) Members felt that the following information would be useful in enabling them to properly pursue the issue of NHS Financial Sustainability in depth:

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

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

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

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

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

2. 19 April 2011

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 driver 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 patients 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 should 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 issue 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 guests 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.

3. 10 June 2011

Philip Greenhill (Interim Deputy Chief Executive, Kent Community Health NHS Trust), Chris Wright (Interim Director of Finance, Kent Community Health NHS Trust), Oena Windibank (Interim Director of Operations – East, Kent Community Health NHS Trust), Marie Dodd (Acting Chief Executive, Kent and

Medway NHS and Social Care Partnership Trust), James Sinclair (Director of Partnerships and Social Care, Kent and Medway NHS and Social Care Partnership Trust), Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust), Robert Bell (Acting Director of Finance, South East Coast Ambulance Service NHS Foundation Trust) were in attendance for this item.

(1) The Chairman introduced the item and explained that this was the third and final meeting in a series examining NHS Financial Sustainability and that the Trusts present would be invited to provide an overview from their perspective.

(2) Philip Greenhill from the Kent Community Health NHS Trust began with the information that the Trust employed 5,700 staff and had a budget of around £200 million. They needed to find £14 million in efficiency savings. Most of the income for the Trust came from block contracts but the value of these had been reduced by 1.5% which equated to a £2.6 million cost pressure. There were also cost pressures because of pay uplifts and high cost drugs. Part of the solution was in back office savings but the biggest was in workforce productivity and this was being examined as the Trust was carrying out the largest community services staff study in England. Nationally, district nurses spend 22% of their time with patients; Kent has managed to increase this to 45-46%. Another area is improving community hospital throughput. The biggest cost pressure was identified as demand in the acute sector as the tariff increases the cost with activity. Both community services and social services have a role to play in reducing demand, as does the new 111 number which will assist in getting the entry point for patients correct.

(3) Responding to a particular question about the hospital at home scheme run in Medway, it was explained that this did not involve a double-payment as the service was provided by Medway NHS Foundation Trust and paid for out of the tariff paid to the hospital before the patient is discharged to the care of his or her GP.

(4) It was further explained that the £14 million which the Community Health Trust needed to find was 8% of the revenue budget. This provided part of the context within which the Trust was embarking on the journey to Foundation Trust status because attaining FT status meant there was more freedom to focus on the right financial strategies.

(5) On the subject of the Minor Injuries Unit at Sheerness it was explained that this was only a temporary closure on safety grounds and that it was back open 9am to 9pm Monday to Friday and would be open at the weekend again soon. More broadly on the subject of community hospitals, it was explained that the whole of community services support the work the community hospitals undertake, rather than the hospitals causing funds to be diverted from elsewhere.

(6) Marie Dodd outlined the issues for the Kent and Medway NHS and Social Care Partnership Trust as being roughly similar to those in the community health sector. The block contracts were also facing a 1.5% reduction in value and there was a 4% savings, with £13.2 million efficiency savings to find and a £2.9 million QIPP negotiation with commissioners in order to find money for reinvestment. Similarly there were also pay uplifts. There was also a need for investments in Information Technology; currently there were two systems, a paper and an IT record system and this needed unifying.

(7) The main policy drivers were in early intervention, with money invested in a second Crisis Resolution Home Treatment Team in East Kent last year as coverage there had not been as full as in Medway and West Kent. NICE guidance around the use of dementia medicine earlier has had a £3 million cost impact. Work is ongoing with the Police and Ambulance Trust on making sure people did not end up in the wrong place; there had been a big rise in the use of 136 suites, but only 20% of people ended up being detained under the Mental Health Act. There was also a project being undertaken with Kent County Council involving housing and support to move people from inpatient facilities to community ones. The Trust had 3,600 staff with 90 off on long term sick leave.

(8) The issue of sick leave at the Trust was picked up by Members, specifically around long term sickness rates within the Thanet teams. Marie Dodd undertook to find out detailed information and pass it on to the Committee Researcher. More broadly, the long term sickness rate at the Trust was 4.5% which was higher than the NHS as a whole, due to staff being attacked on duty, but average for the mental health sector.

(9) Moving forwards, money for mental health would still reside within the NHS and useful discussions were underway with future GP commissioners; they had, for example, approved the move from Ashford to Canterbury. The Strategic Health Authority had approved the capital spend for the St. Martin's development for 2013.

(10) On dementia services, the Mental Health Trust picked up referrals after it had been identified by GPs and had fully trained staff for assessments. The Community Services Trust explained that community nurses were trained to identify dementia and early intervention was being included in the training programme.

(11) Geraint Davies gave a short overview of the situation of the South East Coast Ambulance Service NHS Foundation Trust. As part of achieving Foundation Trust status, the organisation needed to have a 5 year viable plan. The turnover is £165 million and has a £10 million cost improvement programme. The Trust has around 3,000 staff.

(12) The Ambulance Trust is looking to build on the work it has undertaken with NHS Pathways to provide a single point of access service directing people to the right place at the right time. It was currently talking to Primary Care Trusts on this and the 111 service would be tendered under the Any Qualified Provider model. The ambulance service was paid for on cost and volume contracts rather than block contracts, and a local PbR tariff was being developed.

(13) In response to a question on the co-responders scheme with the Fire Service, Geraint Davies explained that the Trust had funded the scheme to the sum of £90,000, but it has been decided not to continue with it because it was not best for patients.

(14) Dealing with some specific questions on the ambulance service, it was explained that the Make Ready programme had been funded from the Trust's own resources. If necessary, a Foundation Trust was able to borrow money, under strict controls.

(15) Across all Trusts there was a feeling that the block contract was not the most helpful funding mechanism and there was a need to hold the whole health economy to account for delivering complete pathways of care. This would help ensure efficiencies with patients seeing the right people at the right time.

(16) The Chairman thanked the Committee's guests 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.