HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th September, 2011

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th September, 2011, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Peter Sass**
Telephone: **01622 694002**

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 E 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):	Councillor J Burden, Councillor R Davison, Councillor G Lymer and Councillor Mr M Lyons
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 - 8)

5.	NHS Transition (9 - 42)	10:00 – 11:00
6.	Trauma Services in Kent and Medway (43 - 60)	11:00 – 12:00
7.	East Kent Maternity Services Review (61 - 98)	12:00 – 13:00

8. Date of next programmed meeting – Friday 14 October 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

1 September 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, 22 July 2011.

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

ALSO PRESENT: Cllr J Cunningham

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting

(Item 1)

2. Membership

To note that the Borough and District Councils have now agreed to their four voting members on the Committee. The Members are as follows:-

- Councillor John Burden, Gravesham Borough Council
- Councillor Richard Davison, Sevenoaks District Council
- Councillor Geoffrey Lymer, Dover District Council
- Councillor Michael Lyons, Shepway District Council

3. Minutes

(Item 4)

RESOLVED that the Minutes of the Meeting of 10 June 2011 are recorded and that they be signed by the Chairman.

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

(Item 5)

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

Adrian Crowther declared a personal interest in this item as a Governor of Medway NHS Foundation Trust.

(1) Mr Devlin began by providing an overview and explained that the process was still in its early stages and that they were endeavouring to make it a transparent and open one. The driving force behind all the work was that both Trusts desired to provide first class services. As for the background to the rationale for bringing the two Trusts together, it was explained that both were mid-sized district general hospitals with Darent Valley being the smaller of the two and serving a population of 300,000 and Medway serving a population of 350,000. As a critical mass of population is necessary before certain services can be provided, serving a population of 650,000 will mean more services can be offered, including new ones which currently are not. The Royal College of Surgeons recommended population coverage of at least 500,000 for safe surgery and together the two Trusts achieved this. The population size meant that there would continue to be the full range of services such as maternity and accident and emergency on both sites.

(2) Economies of scale in back office functions will mean savings realised to invest into services. The Trusts are currently in the feasibility testing stage and the Boards of both Trusts would decide at their meetings in September as to whether to proceed. It was stressed that the option could well mean acquisition of one Trust by the other, rather than merger, and that the processes were different with acquisition being in some regards the more straightforward option. The point was also made that the history of mergers in the NHS was mixed. The merger in South East London had taken place three years before but the combined Trust still had problems, whereas in East Kent the Trust was working well but it had taken time. There was also a national policy drive encouraging all NHS Trusts to achieve Foundation Trust status by 2014.

(3) One Member questioned whether the merger of the two Trusts would be sufficient to realise the gains intended. Residents of Swale often accessed services at Medway or Maidstone and an argument could be made that these two hospitals would make a better merger. Another Member questioned the value of the merger to residents of Sheppey. In reply to these points, it was acknowledged that Maidstone was closer to Maidstone than Darent Valley but that the centre of gravity for Maidstone and Tunbridge Wells NHS Trust was further away due to the opening of the new hospital at Pembury. In addition, the populations that looked to Darent Valley and Medway shared more similarities in terms of health need. On the issue of Sheppey, the counter argument was given that services would be made available closer to home which would previously have involved travelling to London and the increase in critical mass would improve the quality of the services delivered to all patients, including those delivered in the community hospitals on Sheppey and in Sittingbourne. In addition, the joining together of the Trusts did not preclude other partnerships; one such currently existed with Maidstone Hospital relating to cancer services.

(4) Transport was one of the major areas of concern expressed by Members and the representatives of the two Trusts acknowledged this was something which needed to be addressed. Darent Valley itself was served by the Fast Track bus system and there was a good relationship with the bus companies. Transportation links between the two sites was an issue, as was car parking, though this was being looked at and very speculatively the possibility of a shuttle bus between the two sites was mooted by the Trust representatives. Travel issues around a number of specific areas were raised by Members, including travelling from Gravesham which was situated between the two Trusts and had bus links to Darent Valley but was less well served for Medway, and Sevenoaks and Swanley which were similar in that it was quicker to access hospitals in London. In answer to a specific question, the volunteer driver service was reported to still be in existence and use was based on need.

(5) The impact of patient choice was also discussed. The two Trusts were looking to ensure that the same general services were available on both sites and would continue to be delivered in a sustainable way. More widely, patients were looking to choose good quality local services and this would involve being innovative in how they were delivered and how patients accessed them, including looking at transportation. For more specialised services like nephrology where patients currently have to travel to London, where this service could be developed and provided locally, then patients would have that additional choice.

(6) The particular challenge of the Darent Valley Private Finance Initiative (PFI) was also discussed. Some Members were sceptical as to the usefulness of the scheme as it involved a large financial commitment each year in order to keep up repayments. This was recognised by Trust representatives but the positive side was outlined in that the Darent Valley PFI included comprehensive building and support services which meant that the estate was in better condition than non-PFI estates of the same age and so there would not be the longer term maintenance costs. The contract was for 30 years but the support services were tested for benchmarking every 5 years.

(7) The joining together of the two Trusts was presented as the optimal option and in response to Members' question as to what alternatives had also been considered it was explained that these included vertical integration with the mental health or community health Trust, or linkages with a London teaching hospital or network. These would be revisited if the feasibility study recommended against a formal joining.

(8) The Chairman thanked the Committee's guests for the useful and open discussion and the Trusts' representatives undertook to keep the Committee informed and return at the appropriate time.

(9) AGREED that the Committee note the report and return to this issue again at a later meeting.

5. East Kent Maternity Services Review

(Item 6)

Hazel Carpenter (Director of Commissioning Development and Workforce, NHS Kent and Medway), Dr. Neil Martin (Medical Director, East Kent Hospitals NHS University Foundation Trust), Dr. Sarah Montgomery (GP Clinical Commissioner) and Sara Warner (Assistant Director Citizen Engagement, NHS Eastern and Coastal Kent) were in attendance for this item.

Michael Lyons declared a personal interest in this item as a Governor of East Kent Hospitals University NHS Foundation Trust.

(1) The Chairman introduced the item by welcoming his guests and explaining to the Committee that the next meeting of the East Kent Maternity Review Board was going to be that afternoon and Members had the opportunity to make comments which would be fed back to the meeting through the NHS representatives attending for this item. NHS colleagues would return and present an update at the 9 September meeting, and in the interim the Chairman had approached a small number of Members who may be willing to form an informal HOSC Liaison Group to be involved in discussions over the summer and feed back to the Committee as well at the 9 September meeting. Several Members expressed an interest during the meeting.

(2) Hazel Carpenter began by explaining that the Review Board included representatives from the emerging Clinical Commissioning Groups (CCGs) in East Kent. Of the 6 CCGs, 5 had patient flows into East Kent Hospitals NHS University Foundation Trust (EKHUFT). The detail required in the evidence was recognised. Representatives of the NHS welcomed the opportunity to return on 9 September with options and a consultation plan and looked forward to engaging with a smaller group of Members over the summer.

(3) As a representative of one of the CCGs, Dr Montgomery explained that GPs are deeply concerned with this issue and were very close to the families affected. She explained that feedback from the 4 GPs on the Board was fed back to all Chairs of the CCGs and any options regarding future services would need to be based on robust evidence and the services needed to be safe and sustainable. The distance between hospitals was being considered by the panel but it needed to be made clear that standalone midwifery led units were not appropriate for all women and the admissions criteria was the same as for home birth and it was often the case that it was women from the more deprived areas which needed to travel to consultant led services more than others. These consultant led services were still available at Ashford and Margate.

(4) In response to a range of questions Dr Neil began by explaining that all birth units in East Kent were safe and provided excellent care. The standalone midwifery units in Dover and Canterbury provided quality 1 to 1 care and this level of care in labour was the ideal. However, there was a cost related to the time for midwives to care. At Dover and Canterbury, there was a ratio of around 11 births for each midwife, but across Kent this was on average 35 births per midwife, sometimes reaching 48 in the high risk units. Also, while

the care in Dover and Canterbury was exceptional, the condition of the estate was not.

(5) In terms of problems recruiting midwives, Dr Neil said he was not aware of a real midwife recruitment problem. While staffing levels at neonatal intensive care units were not quite at British Association of Perinatal Medicine levels, they were comparable with similar units. The review came from the observation of nursing, midwifery and consultant staff at William Harvey Hospital about a possible safety issue there. The Trust decided to increase midwifery levels at this high risk site but this meant moving staff from other areas of East Kent. Regarding costs, it was a general truism across England that Trusts were underfunded for maternity services. A recent benchmarking exercise undertaken by EKHUFT along with other Foundation Trusts showed that while the cost of a normal birth in an obstetric unit was roughly equivalent to the tariff, the costs of a birth in midwifery led units was twice that.

(6) The point was also raised that in an obstetric unit it was still midwives who carried out the majority of deliveries, though consultant obstetricians and paediatricians were on hand for advice. The question in East Kent was how best to use the skilled midwifery resource and the midwifery recruitment issue could be overcome if that was deemed the best solution. For home births, 2 midwives were required for the actual delivery and so this had cost implications. The maternity service was learning that there was a role for maternity support workers.

(7) There was a broader discussion about the communications aspect of the process and comments on the different messages which are sometimes found in the media. Comparisons with the situation relating to women's and children's services at Maidstone and Tunbridge Wells NHS Trust were also made; though it was stressed there were also important differences. Representatives from the NHS explained that communicating and developing proposals were a complex equation and that the driving force behind them was to ensure the safety and sustainability of the service. There was also a recent report from the Royal College of Obstetricians and Gynaecologists which needed to be taken into account.

(8) AGREED that the Committee note the report and examine this issue in more depth at a later meeting and that a small working group of Committee Members be established to further investigate and prepare a report for HOSC.

6. Legacy Document

(Item 7)

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

(1) The Chairman introduced the item and explained that the current full draft version of the Legacy Document ran to 89 pages and that it was an interesting document and Members were invited to suggest ways that the document could be improved.

(2) One Member commented that a number of items were strategic documents which would be rewritten when new commissioning arrangements were brought in and that of more importance were the minutiae of daily business. Another Member suggested details of which Arms Length Bodies were still operating, or the ones which had been created, should be included. It was also felt important that arrangements be made to preserve the archives of the Primary Care Trusts so that records of key decisions could be located easily in the future.

(3) Judy Clabby explained that the production of the Legacy Document was a requirement of the National Quality Board and it would go down to the level of detail suggested. It was also being used as a central collation point for the three Primary Care Trusts across Kent and Medway. As the handover to the Clinical Commissioning Groups approached, it would include the hot and topical information required. The current version was a draft and it would be continually refreshed until this time. On the issue of Arms Length Bodies, these were unlikely to be included if they were national organisations rather than local.

(4) Members were invited to submit any further suggestions to Judy Clabby through the Research Officer to the Committee.

(5) AGREED that the Committee note the report.

7. NHS Transition: Written Update.
(Item 8)

(1) The Chairman indicated the written update on the NHS Transition produced by the Research Officer to the Committee and reminded Members that there would be an opportunity at the 9 September meeting to examine this topic further.

(2) AGREED that the Committee note the attached report.

8. NHS Financial Sustainability: Draft Recommendations
(Item 9)

(1) The Chairman introduced the item and explained that the work undertaken by the Committee in looking at financial sustainability across the whole spectrum of the NHS had been a very useful exercise. The report highlighted a number of the dichotomies facing the NHS, such as the dilemma between localism and what is often referred to as the postcode lottery. The Research Officer to the Committee was thanked for his assistance in producing the draft report.

(2) A Member expressed the view that a combination of the financial sustainability report and written update from previous item would, read together, answer a lot of questions as the Committee continued its work after the summer.

(3) One Member commented that the individual character of Kent compared to other areas of the country be highlighted. Kent was in part peninsular and had

a number of separate population centres to which people looked for core services. This made delivering financial sustainability across the Kent health economy uniquely challenging.

(4) The Committee agreed that this point should be included in the final version.

(5) AGREED that the Committee approve the report.

9. Date of next programmed meeting – Friday 9 September 2011 10:00
(Item 10)

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 September 2011

Subject: NHS Transition.

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1. Background

(a) The Health Overview and Scrutiny Committee has maintained an ongoing overview of the proposed changes arising from the NHS White Paper, *Equity and Excellence: Liberating the NHS* and received a written update at the previous meeting.

(b) While accepting that the situation is still developing, Members of the Committee agreed to examine the subject of NHS Transition at this meeting in order to receive a more detailed update.

2. Recommendation

That the Committee note the report and decide how best to monitor developments.

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

To: Health Overview and Scrutiny Committee, 9 September 2011

Subject: NHS Transition: Background Note.

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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 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 or GPCC)

(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 with the selection of at least three locally agreed community or mental health services to be selected by October 2011 for introduction between April and September 2012. Contract currencies will be developed for any service covered by Any Qualified Provider. AQP will not apply to accident and emergency and critical care services

(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 CCG 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, Health 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

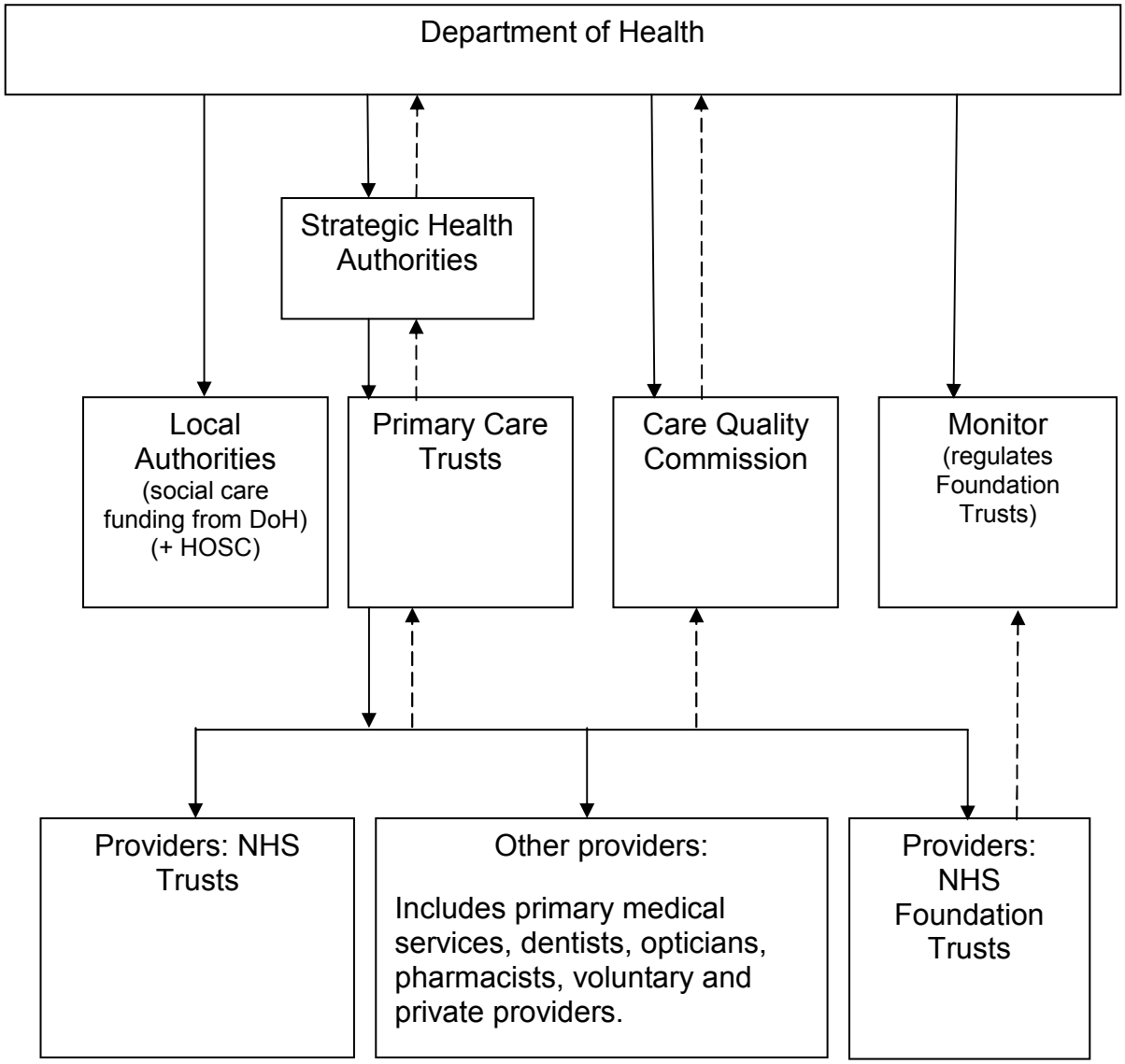
to PHE for spending the grant. It will be separate from the current funding of local authority functions with public health implications, such as leisure).

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

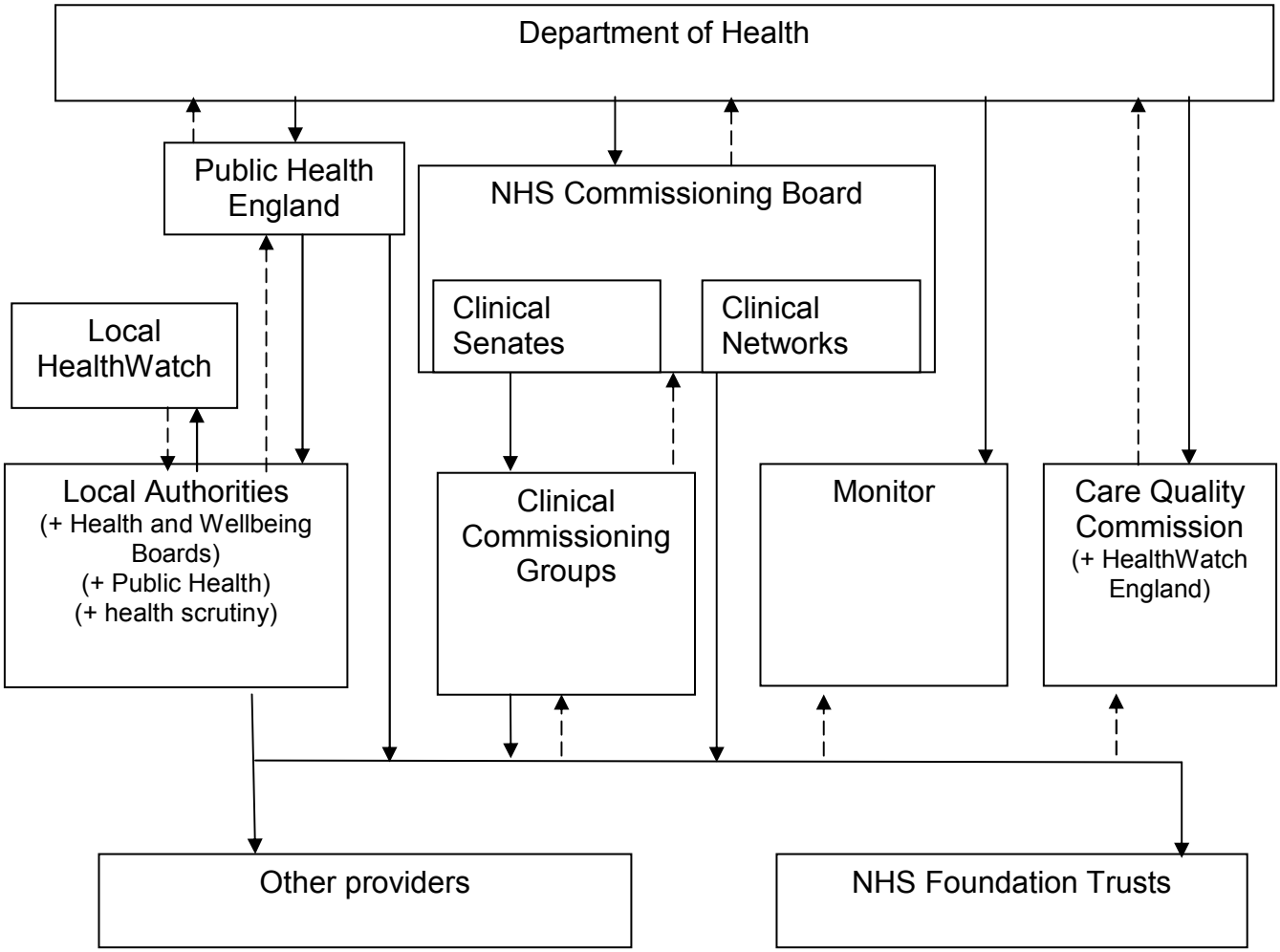
(e) Directors of Public Health will be employed by local government and jointly appointed by the local authority and Public Health England. The DPH will play a leading role in the development of the JSNA and JHWBS through the HWB. One other key role will be to produce an authoritative independent annual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

2. Summary Transition Timeline[9]

Planned date	Commitment
October 2011	• NHS Commissioning Board established in shadow form as a special health authority • SHA cluster arrangements in place • By October 2011, PCT clusters are expected to identify three or more community or mental health services in which to implement patient choice of Any Qualified Provider in 2012/13
During 2012	• Health Education England and the NHS Trust Development Authority are established as Special Health Authorities, but in shadow form, without full functions
April 2012	• The next step in extending the choice of Any Qualified Provider, which will be phased in gradually
By October 2012	• NHS Commissioning Board is established as an independent statutory body, but initially only carries out limited functions – in particular, establishing and authorising clinical commissioning groups
October 2012	• Monitor starts to take on its new regulatory functions • HealthWatch England and local HealthWatch are established
April 2013	• SHAs and PCTs are abolished and the NHS Commissioning Board takes on its full functions • Health Education England takes over SHAs' responsibilities for education and training • The NHS Trust Development Authority takes over SHA responsibilities for the FT pipeline and for the overall governance of NHS Trusts • Public Health England is established • A full system of clinical commissioning groups is established. But the NHS Commissioning Board will not authorise groups to take on their responsibilities until they are ready
April 2014	• The expectation is that the remaining NHS trusts will be authorised as foundation trusts by April 2014. But if any trust is not ready, it will continue to work towards FT status under new management arrangements
April 2016	• Monitor's transitional powers of oversight over foundation trusts will be reviewed (except for newly authorised FTs, where Monitor's oversight will continue until two years after the authorisation date if that is later)

[9] Adapted from Department of Health, *The Month. NHS modernisation special issue*, 20 June 2011, p.11, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127736.pdf with additional information from Department of Health, *Operational Guidance to the NHS Extending Patient Choice of Provider*, 19 July 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128462.pdf

Eastern and Coastal Kent Primary Care Trust
and West Kent Primary Care Trust

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Kent Public Health Department
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Maidstone
ME14 1XQ

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30th August 2011

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

Dear Nick

Health Overview and Scrutiny Committee Meeting – 9th September 2010

Thank you for your letter dated 18th July 2011. I have liaised with my colleagues involved in NHS Transition and we have constructed this joint response below.

In terms of the two strategic questions you have asked, I am more than happy to talk about these at the meeting on the 9th September, however, I thought I would give a brief update below.

We are working very closely with our colleagues in the Kent and Medway Cluster to ensure that all policy proposals associated with the Health and Social Care Bill are being given due consideration and are being acted upon. We currently have policy support from within KCC and officers are advising us on steps that need to be taken to ensure we understand and comply with our obligations. We also have monthly meetings with Ann Sutton, the Chief Executive of the Cluster and Colin Tomson, the Chairman of the Cluster, along with key Cluster Directors and with Senior Managers and Cabinet Members of Kent County Council to ensure that the transition is smooth. These meetings discuss the joint working we need to undertake and also ensures that the continuity of care people receive is constant.

I understand that Ann Sutton will be writing separately on the current state of development of Clinical Commissioning Groups in Kent. What I can tell you is that following on from the listening exercise the H&WBB has more of a voice on this subject.

We have held two H&WBB workshops, one in March and one in July 2011, where we have involved District Councils, GPs, representatives from the Kent and Medway Cluster and Kent LINk. These have been well attended and feedback has been positive. Now that the County Council have agreed that the H&WBB will become a statutory committee of the Council, we plan to hold the first Shadow meeting on 28th September this year. The first meeting will focus on the election of the Chair, formally accepting the terms of reference and standing orders, agreeing a code of conduct and future dates. We will also focus on substantive issues including Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy.

In your letter you requested an update on HealthWatch and I have attached for information a paper which sets out progress to date.

In terms of the involvement of key partnerships, as mentioned above, we are heavily involved with our colleagues from the Kent and Medway Cluster on all things relating to health reforms. I have regular contact with GPs and have been on the road visiting many practices. We also engage with key partners on a regular basis to ensure that Kent is well prepared for the changes within the health service.

Independent scrutiny of the performance, functions and outcomes of the Shadow H&WBB in Kent will be provided by KCC's Health Overview & Scrutiny Committee and KCC's Policy Overview & Scrutiny Committees for Adult Social Services and Specialist Children's Services.

I understand that Graham Gibbens has communicated separately on an update on Public Health and has suggested this be moved to early next year once the budgets are known and the HR framework has been published.

I hope you have found this brief update helpful and I shall look forward to discussing the above with you in more detail when we meet on the 9th September. At that meeting I shall also cover the second question in your letter regarding how continuity of the care people receive is being ensured during the transition. Meradin Peachey, Director of Public Health, will also be attending with me.

Yours sincerely

Roger Gough
Cabinet Member for Business Strategy,
Performance and Health Reform

LOCAL HEALTHWATCH

1) National context

a) **Background.** Local HealthWatch (LHW) is a key part of the NHS reforms. The principle for the Health and Social Care Bill is “no decision about me without me” and this phrase sets out concisely the aims of the bill in putting the public, patients and users of adult social care services at the heart of the commissioning and provision of health and social care services. Local HealthWatch will be procured and funded by Local Authorities who will be held accountable for them. Local HealthWatch (LHW) organisations will also have a strong relationship with HealthWatch England (HWE), which will be a statutory committee of the Care Quality Commission. The relationship between Local HealthWatch and HealthWatch England is still being defined but it is expected that the relationship will be reciprocal; LHW advising HWE of local issues that may need national support and HWE providing support and guidance to LHW so that it can operate effectively at local level.

b) **Functions** Local HealthWatch will have three main functions :-

- citizen engagement, the role currently performed by Local Involvement Networks (LINks), so that people can influence how health and social care are commissioned and delivered in their area

- an Information and Signposting service that will support individuals to choose how their individual health and social care needs are met

- an NHS Complaints Advocacy Service for when things go wrong

Local HealthWatch will be a statutory voting member of the Health and Wellbeing Board and will continue to play a role in the Scrutiny of Health and Social Care Services. Current LINk powers to:

- enter certain types of premises and view the services provided;
- request information and receive a response in a specified timescale;
- make reports and recommendations and receive a response in a specified timescale; and refer matters to a health or social care Overview and Scrutiny Committee and receive a response
- refer matters of concern directly to the Secretary of State for Health will all be passed to Local HealthWatch

2) Current Timeline for the set up of Local HealthWatch

- The first two functions of Local HealthWatch, Citizen Engagement and Information & Signposting, must be in operation by October 2012. The NHS Complaints Advocacy role will be added from April 2013.

- The Health and Social Care Bill was originally expected to be enacted by Autumn 2011. The "Listening Pause" and subsequent changes means that the Bill is now expected to be enacted in May 2012.

For large Local Authorities like Kent County Council, the new timescales may bring added pressures in meeting procurement deadlines, especially where the value of the contract falls under the Official Journal of the EU.

3) Local Authority Role

Government expects Local Authorities to play a key role in the set-up of Local HealthWatch including the smooth transfer of Citizen Engagement responsibilities from LINk to LHW

a) Commissioning/Procurement

Local Authorities must ensure that all three functions of LHW are procured and in place by the deadlines given above.

The Citizen Engagement function is expected to evolve from the Local Involvement Network with an additional legal requirement that LHWs must be representative of the population they serve added as a result of the Listening Pause. As a volunteer organisation, LINks membership and governance can become unrepresentative with, for example, an unintended bias towards those of retirement age or older. Local Authorities may have to commission other voluntary agencies to ensure more balance, if their current LINks cannot demonstrate representativeness or at least a clear trend and pathway towards them becoming representative

Local Authorities or LHW must commission an Information and Signposting service. Eastern and Coastal and West Kent both have a Patient Advice and Liaison Services which currently provide information, signposting and individual help for patients in their area. The new Local HealthWatch Information and Signposting service is likely to be very similar and it is possible that TUPE may apply on a case by case basis.

NHS Complaints Advocacy Service. It is expected that all providers of health care will manage complaints about their own service but advocacy services will be commissioned by the Local Authority, or by Local HealthWatch itself. Currently the Independent Complaints Advocacy Service helps patients who are unhappy with a service that they have received from a hospital, doctor, dentist, local surgery or any other NHS service to complain about it, or raise their concerns. The new Local

HealthWatch Advocacy service may be similar and it is possible that TUPE may apply on a case by case basis.

b) **Accountability.** Local Authorities are likely to have some accountability to CQC/DH for ensuring that the Local HealthWatch they have commissioned for their area:
   - Operates effectively
   - Provides value for money

   Inherent in the commissioning/procurement process is that each Local Authority would ensure these two basic requirements are met through the performance management of the contracts.

c) **Funding.** Until 2011, Local Authorities were given a ring fenced grant to run the LINks. From 2011, the LINks grant is no longer ring-fenced but is included in the Personal Social Services formula grant. The intention is that funding for Local HealthWatch will not be ring fenced. Concerns continue to be raised about this by the National Association of LINks Members. Further funding will be given to Local Authorities to provide the Information & Signposting Service and the NHS Complaints Advocacy Service, likely to be in the region of £23 million nationally although the funding levels for this have not yet been resolved. There is a DH consultation currently being conducted that discusses options for the specific funding each Local Authority will receive

In Kent

1. Roger Gough, within his Cabinet role in NHS Reform, is providing strategic leadership for the set up of Local HealthWatch in Kent.

2. Lorraine Denoris, Director of Citizen Engagement and Communications for Eastern and Coastal PCT is the strategic officer lead for the development of Local HealthWatch for KCC. Lorraine is also working for the Department of Health on the National HealthWatch Programme Board. This has given Kent an excellent route in raising issues around the development of Local HealthWatch and the opportunity to lead a pilot programme of work in partnership with the Centre for Public Scrutiny that has enabled us to assess our local readiness for LHW, baseline activity and develop and action plan across all key stakeholders

3. Tish Gailey, Health Policy Manager for KCC is operational manager. Staff from Customers and Communities are providing help with media and communications, tie in with Locality Board development, in-house complaints management, commissioned complaints advocacy and tie in with voluntary organisations.

4. As well as the tie in to the Department of Health through the Local HealthWatch Advisory Group and the Local HealthWatch programme provided through Lorraine, Tish is also part of two national LHW Task and Finish Groups – one which looked at "what a good HealthWatch would look like" and one currently considering LA Commissioning of LHW functions

5. Medway, like all Councils, are also considering how to set up Local HealthWatch for their area and have recently agreed to explore the potential of working more closely with Kent so that economies of scale can be considered alongside possible joint commissioning of LHW functions.

6. Similarly, KCC is sharing learning with a group of South Eastern LA LINk reps and may also explore joint commissioning with them.

7. The success of LHW relies heavily on stakeholders working together so we have set up the Local HealthWatch Development Group to oversee the set up of Local HealthWatch in Kent. (see attached Terms of Reference). The group is chaired by Lorraine Denoris with membership drawn from the Kent LINk, Kent and Medway Networks (the organisation providing the administrative support to the Kent LINk), KCC, Eastern and Coastal and West Kent PCTs, Medway Council and Dover District Council. This group will also advise on expenditure from the LHW development fund of £90k which was created out of part of the Kent LINk underspend.

8. **The Pathfinder programme** - In May, a joint application between KCC, the Kent LINk and Kent and Medway Networks with support from District Councils and the local NHS, was put in to the Department of Health to be part of the Pathfinder programme - see attachment. Kent's application had three integrated areas of focus:

    - Patient Participation Groups (PPGs) work with their GP practices to provide practical support, to help patients to take more responsibility for their own health and to provide strategic input and advice to the practice. As part of the Kent Pathfinder work, we would like to explore how PPGs can work with Local HealthWatch to influence and shape health and social care services

    - Identifying skills that the public and especially those in LINks and other voluntary organisations will need to participate more effectively in the new world of enhanced community engagement

    - Using the existing and new skills of the LINk and PPGs to identify what is required from the LHW Information and Signposting Service

    One of the key reasons for our application was that we would then be well placed to test out the new ways of working that the NHS reform will bring through the LHW Pathfinder programme, the Early Implementer programme for Health and Wellbeing Boards (which both KCC and Dover District Council are part of) and the Pathfinder programme for GP Consortia (now Clinical Commissioning Consortia) which most GP Surgeries in Kent are now a part of.

    In August we received confirmation that our bid had been successful though there is now to be no funding from the DH to support the pathfinder programmes. Whilst this is disappointing, we are expecting support from the DH in sharing learning with other LHW Pathfinders. Decisions on how to fund the areas of work will be taken once the Readiness Programme report is received (see below)

9. The Readiness Programme

The Readiness Programme has been jointly commissioned by Kent County Council and the Department of Health. The Centre for Public Scrutiny will undertake the work and provide an independent assessment of, literally, how ready Kent is (all partners) to set up Local HealthWatch. The aims of the programme are:

- To work with LINks, Kent County Council, the PCT cluster, the community and voluntary sector and other partners in Kent to share their knowledge and perspectives for the transition to HealthWatch.

- To deliver a 'state of readiness' report that synthesises these contributions and offers recommendations for the Kent HealthWatch pathfinder during the transition.

- To use the process as a form of action learning to provide a space for all partners to learn and reflect on their roles in the process and three wider issues:

The Readiness Programme has started with 1:1 interviews and small focus groups conducted by the CfPS with key stakeholders to tease out the vision and expectations for Local HealthWatch. Those interviewed were:

Name	Role
Brenda O'Neill	LINks Host - Kent & Medway Networks Ltd
Richard Beckwith	LINks Host - Kent & Medway Networks Ltd
Ann Sutton	Chief Executive, Kent and Medway PCT Cluster
Colin Tomson	Chair, Kent and Medway PCT Cluster Board
Councillor Roger Gough	Cabinet Member - Health Reform brief
Councillor Graham Gibbens	Cabinet Member - Public Health brief
Sarah Andrews	Director of Nursing
Carol Cassam	Associate Director Nursing & Quality (East) and Lead for Safety and Patient Experience
Cathi Sacco	Director of Strategic Commissioning for Families and Social Care (Interim), Kent County Council
Kent and Medway PCT Cluster NEDs	Kent and Medway PCT Cluster
Anne Tidmarsh	Director of Older People and Physical Disability, Kent County Council
Kent LINks	Workshop with 10 members, 3 governors and 3 host staff
Meradin Peachey	Director of Public Health
Tish Gailey	Health Policy Manager
Amanda Honey	Director of Customer and Communities
Mike Hill	Cabinet Member for Customer and Communities
Andrew Ireland	Director of Families and Social Care
Dover District Council	Members and officers

From these interviews and focus groups common themes are being identified which will then be discussed in workshops designed to pick up and address any differences in vision. There will be four workshops held on 19th September in Oakwood, facilitated by the Centre for Public Scrutiny.

After the interviews, focus groups and workshops are completed, a report will be produced giving recommendations for the work needed in Kent. Once this report has been delivered a detailed programme plan for the set up of Local HealthWatch will be produced.

Terms of reference for the Local HealthWatch Development Group

Purpose: To support and oversee the creation of the new Local HealthWatch

1. Contribute to the Readiness Assessment project being conducted by the Centre for Public Scrutiny (CfPS) and act upon their recommendations.

2. Develop a governance model suitable for Kent where the three separate functions of LHW will liaise appropriately, e.g. passing collated information on advice, complaints etc to the citizen engagement part of the organisations.

3. Explore an operational model that will embed mutually beneficial relationships at a national, county and local level.

4. Map out what an information and signposting service and a complaints advocacy service would look like to facilitate procurement/commissioning.

5. Consider how KCC will be able to fulfil its new obligations under the Health and Social Care Bill to assess if LHW is "operating effectively" and "providing value for money", through, for example, benchmarking against other LHWs, tracking changes from LHW recommendations etc.

6. Develop a program to improve the representativeness of the current LINk, particularly for the seldom heard in order to fulfil new legal obligations.

7. Oversee the work of the LHW Pathfinder. If not given pathfinder status then develop learning opportunities for LHW volunteers to allow them to engage at a variety of levels that suit the needs of the organisation and the volunteers.

8. Advise on expenditure of the Local HealthWatch Development Fund and receive budget reports.

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KENT & MEDWAY NETWORKS LTD

the KENT LINk

a LOCAL INVOLVEMENT NETWORK

NHS
Kent and Medway

Kent County Council

Gateway Reference: 15679

11 May 2011

Kasey Chan
Department of Health
Room 213
Richmond House
79 Whitehall
London SW1A 2NS

Dear Kasey

Local HealthWatch Pathfinders in 2011-12

Thank you for the invitation to apply to become part of the Pathfinders Programme for Local HealthWatch. We wish to apply and there is strong support for the application from the Kent LINk, Kent County Council, the District Councils in Kent[1], Kent and Medway Networks (the Kent LINk host) as well as the local NHS. Nick Chard, Chairman of Health Overview and Scrutiny Committee of Kent County Council has also offered his support to this bid. We feel that we have a lot to offer the Local HealthWatch Pathfinder programme:

Building on Existing LINk Success

- The Kent LINk is considered to be one of the most successful. It regularly produces reports highlighting areas for improvement in commissioning and provision which provides evidence of their understanding of the health and social care needs of the people of Kent, at both a County and more local level. The Kent LINk has experienced and dedicated Governors and well a thought-out and stable governance structure, backed up with clear policies, with the flexibility to make changes when circumstances dictate.

[1] Ashford Borough Council; Canterbury City Council, Dartford District Council, Dover District Council, Gravesham Borough Council, Maidstone Borough Council, Sevenoaks District Council, Shepway District Council, Swale Borough Council, Thanet District Council, Tonbridge & Malling Borough Council, Tunbridge Wells Borough Council

- A successful host organisation Kent and Medway Networks enjoys the full support of the Kent LINk. They consistently demonstrate strong levels of professionalism and have an experienced and skilled workforce. KCC considers KMN to perform over and above the current contractual terms and is currently in the process of renewing the contract. KMN is also Host to the Medway LINk and so are well-placed to share areas of good practice across both LINks. For example The Medway LINk is already adding the formation of PPGs (the focal point of this application) in its area to their Work Programme for this coming year as they have been impressed by the success of Kent LINk in this field.

  Kent County Council has a reputation for innovation with their "can do" philosophy, a commitment to community engagement and listening to the public. The Council's three priorities include putting the citizen more in control whether that is as individuals, local communities or through their democratic representatives. "Bold Steps for Kent" published in December 2010 states that "...power and influence must be in the hands of local people so they are empowered to take responsibility for their own community and service needs - reducing the role of the state and encouraging the growth of the Big Society". The application for the Local HealthWatch Pathfinder programme will enhance this stated commitment and as such enjoys the support of elected members and senior officers.

Building on Partnerships that Already Work

The Kent LINk, has mature and good working relationships with all local NHS Trusts and has seats on various Boards Both PCTs have offered help and support in the transition to Local HealthWatch and have well-developed plans to ensure that their skills and knowledge are also passed on to successor organisations.

The strengths of all these organisations are further enhanced by a strong commitment to partnership working which will equip them to take up the new ways of working set out in the Health and Social Care Bill

Kent's potential for developing Healthwatch

Kent is well placed to test out and share the issues pertinent to a large, diverse, two tier authority. There is wide variation in levels of deprivation which are well documented in national statistics, resulting in pronounced health inequalities across the County. The different needs of communities such as the Sikhs, Gurkhas and travellers have been recognised in the current work of the LINk. There is also a substantial range of communities within the County ranging from the isolated communities of the Romney marsh, to the ex-mining communities of East Kent as well as the deprived seaside towns in the Margate and Ramsgate but also there are the affluent communities in West Kent around Royal Tunbridge Wells.

Kent is close to London and the European continent and is recognised as a major gateway into the country not only for migrants from the EU but also well beyond.

KCC has been accepted onto the Health and Wellbeing Board Early Implementer Programme and there are a number of Practice Based Commissioning Groups, operating in very different ways, which are part of the

GP Consortia Pathfinder Programme. Strong relationships have been built between KCC and the emerging GP Consortia. If successful in our application, we would expect the work we do as part of the Local HealthWatch Pathfinder Programme to both support and be supported by the other transition programmes.

Our Proposed Pathfinder Focus
The Focus Area that the Kent LINk and its partners are particularly keen to progress involves Patient Participation Groups. The project would comprise three integrated elements:

1. Building on the work of the Patient Participation Groups, already well established in East Kent, and taking up the opportunities in the guidance given in the "Patient participation directed enhanced service for GMS contracts" issued this month.

    - We aim to increase the numbers of PPGs across Kent.
      We will explore how the Patient Participation Groups can influence health and social care services
    - We will identify effective ways of engaging with and representing communities at GP Practice and Consortia level and how the patient and public voice might then be better represented at all local authority levels.
    - We will aim to build up a cohesive and sustainable relationship between the Local HealthWatch and the PPGs and develop effective, two way communications that will give the public a variety of ways to input to health and social care commissioning and provision decisions. This work will complement parallel initiatives intended to support emerging GPCCs with their Patient and Public engagement responsibilities.
    - The ultimate aim of all of this work is to give the public the opportunity to get involved and to contribute to decision-making.

2. Identify the learning requirements that will enable local people to participate more effectively in the new environment of enhanced community engagement. For example :

    - influencing skills, negotiation techniques, understanding and promoting the integration of health and social care services

    Within the relatively short timescales of the Pathfinder Programme, we aim to identify learning needs and appropriate tools and techniques; determining

exactly how these needs will be met. We will set up learning opportunities to meet them and this work is likely to continue after September as part of the ongoing Kent LINk/Local HealthWatch Transition Plan. We hope that the relationships we build during the Pathfinder Programme will assist us all in continuing to share good practice with other stakeholders. An outcome of this work would be to support the principles of the Big Society, by building up social capital and so empowering citizens to become more involved in the decisions about their local services

3. Use the existing and new skills and expertise of both LINk and PPG for the benefit of the new Local HealthWatch Information and Signposting service; KCC has been 'green flagged' for the Gateway service. This service would be an obvious conduit for information, and signposting, KCC has also set up a Kent Healthwatch which currently provides a signposting service; both Kent PCTs run successful Patient Advice and Liaison Services with staff whose skills in this area we are keen to retain.

We are currently working on a detailed timeline for the project and have included a draft proposal of how we see the work progressing.

In Summary
These proposals support the fundamental approach detailed in "Equity and Excellence – "no decision about me without me". The focus area will also support and celebrate the independence of the Kent LINk and will complement their work programme for the year. This will be achieved through three interconnecting elements

- supporting and extending the set up of Patient Participation Groups,
- on Learning and Skill requirements of participants for community engagement and
- fitting Information and Signposting requirements to the needs of the local population

This work will have value and traction across other health and social care economies. Whilst there has been some work on the training and development needs within healthcare organisations (NICE, Picker), there has only been limited work to develop the skills required by the general public.
This project would begin to fill that gap and could provide guidance for emerging GP Commissioning Consortia going forward and for Health and Wellbeing Boards

In identifying this focus area, we are also identifying part of the transition work that all LINks, Hosts and Local Authorities need to accomplish. KCC and the Kent LINk are working together to create a development fund to support the transition. We have already identified staffing resources in KCC, KMN and in PCTs involved in community engagement and in learning and development. The extra costs of the pathfinder programme are likely to be mainly for project work which we estimate to be approximately £28,000. We can offer to meet

some of these costs through the Development Fund but may also require some financial support from the Department of Health.

Conclusion
Kent is keen to take advantage of the opportunities that NHS Reform offer and play a part in the successful transition of health and social care services, both locally and nationally. We are confident that the learning and outcomes we will derive from the project could be shared and rolled out nationally

We look forward to a positive response to our application.

Yours sincerely

Katherine Kerswell
Managing Director
Kent County Council

Ann Sutton
Chief Executive
Kent & Medway Cluster

Roger Gough
Cabinet Member for Health Reforms
Kent County Council

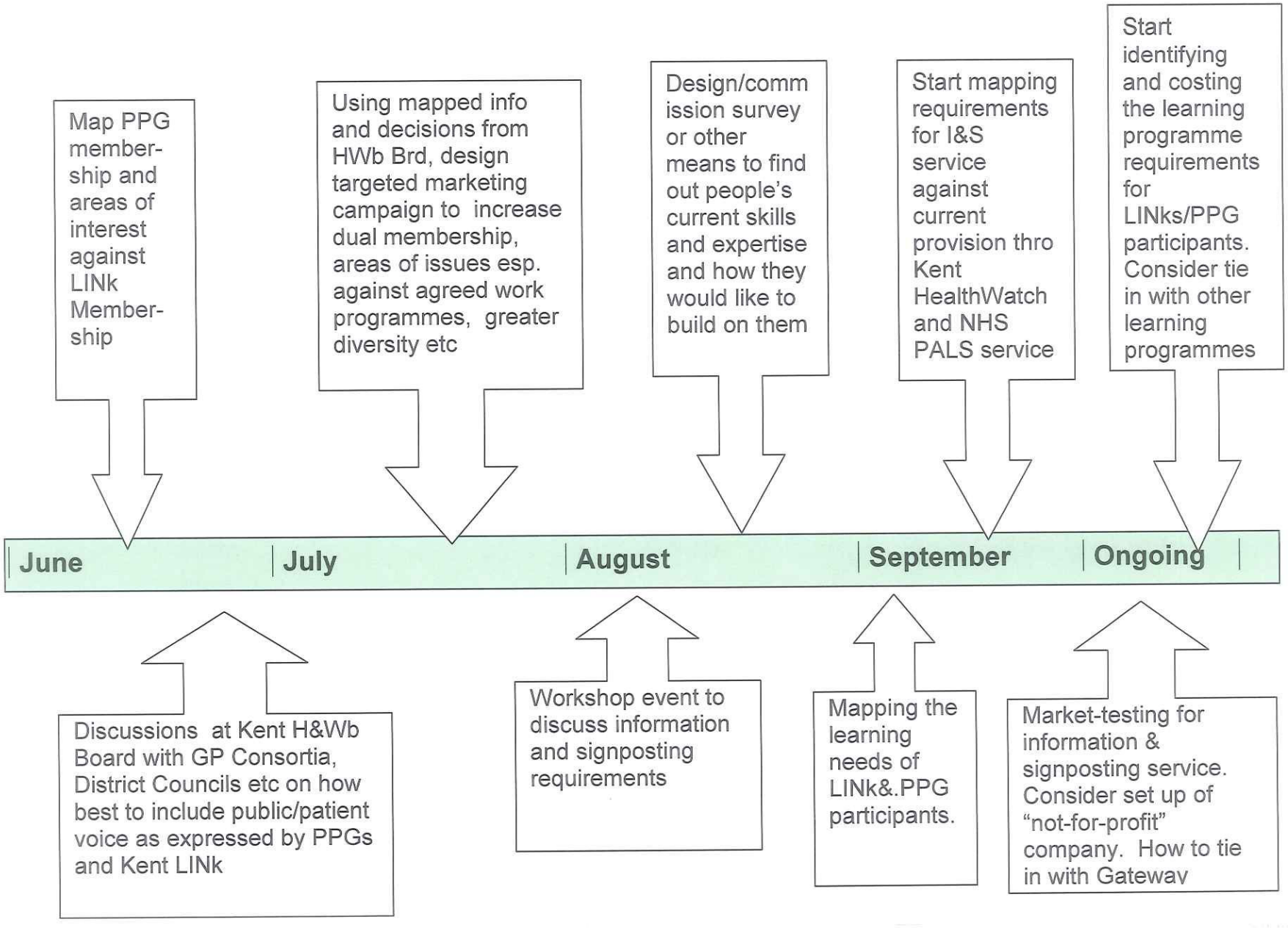
John Fletcher
Chairman, Governors' Group
Kent LINk

Graham Gibbens
Cabinet Member for Adult Social Care
and Public Health – Kent County Council

Brenda O'Neill
Director
Kent and Medway Networks

Nick Chard
Chairman of Health Overview and Scrutiny Committee

Draft LHW Proposed Timeline



NHS
Kent and Medway

By: Hazel Carpenter: Director of Commissioning Development and Transition

To: Health Overview and Scrutiny Committee, 9th September

Subject: NHS Transition: Update.

Executive Summary

Background

On the 22nd July, the Health Overview and Scrutiny Committee were provided with an update on the current proposals and arrangements outlined in the NHS White Paper: *Equity and Excellence: Liberating the NHS'.*[1] The Committee will be aware that the Health Bill is currently progressing through the English Parliament.

The Kent and Medway PCT Cluster (NHS Kent and Medway) have responsibility for the successful establishment of the new health commissioning architecture outlined in the White Paper and described in detail through the Department of Health: '*Shared Operating Model for PCT Clusters'* [2].

NHS Kent and Medway have a Commissioning Development and Transition Plan to enable the safe transfer of the commissioning functions of PCTs [and some SHAs] to designated receiving organisations including Clinical Commissioning Groups (CCG), local government and the NHS Commissioning Board (NHSCB) whilst maintaining focus on continued service delivery. The specific requirements determined through national policy, regional guidance and local clinically led objectives are:

- To successfully establish the new commissioning architecture such that it can accelerate the delivery improvements in health and healthcare.
- Ensure that clinical leadership remains at the heart of the new system with cluster management aiming to support and nurture clinical leadership
- Safe and comprehensive transfer of all PCT functions to appropriate successor organisations where the functions continue in the new system.

How the policy implications are being development and Implemented

The Commissioning Development and Transition Plan pulls together the new commissioning architecture outlined in the Health and Social Care Bill with the inclusion of a number of specific NHS Kent and Medway enabling workstreams (table 1). The Plan focuses on delivery of:

- The successful establishment of the new commissioning architecture such that it can accelerate the improvements in health and healthcare outcomes for the population of Kent and Medway.
- Sustainable capacity of clinical leadership to underpin the safe transfer of accountabilities in the new system.
- Safe and comprehensive transfer of all PCT functions to appropriate successor organisations where the functions continue in the new system.

Specifically, the Plan addresses these areas:

- Supporting the development of Clinical Commissioning Groups (CCGs) which are fit to be authorised as statutory bodies in their own right by April 2013.
- Developing Commissioning Support (CSO) arrangements and solutions for the new commissioning organisations in Kent and Medway.
- Transferring specific functions which will include specialist and primary care commissioning functions to the NHS Commissioning Board.
- Supporting development of new arrangements for Health and Well Being (HWB) Boards, Health Watch and Public Health developed with Kent County Council and Medway Council.
- Minimal cost of transfer e.g. necessity for redundancy through effective people transfer arrangements for PCT staff to new roles in NHS Commissioning Board, Local Government and other identified 'receiver' organisations.

Table 1

Programme Areas and Enabling Workstreams

	Programme areas	Lead body.	NHS Kent and Medway Director Lead
1	Clinical Commissioning Group development	NHS	Dr Robert Stewart, Medical Director
2	Commissioning Support	NHS - Cluster	Daryl Robertson, Director of Performance & Assurance
3	NHS Commissioning Board – including transfer of SHA responsibilities as required.	NHS – Department of Heath	Ann Sutton, Chief Executive
4	Health and well being boards – including Health Watch	Kent County Council and Medway Council	Meradin Peachey, Director of Public Health (Kent) Dr Alison Barnett, Director of Public Health (Medway)
5	Public Health Transfer	NHS	Meradin Peachey, Director of Public Health (Kent) Dr Alison Barnett, Director of Public Health (Medway)
6	Local NHS Education and Training Partnerships	NHS - SHA	Hazel Carpenter, Director of Commissioning Development and Workforce
Enabling work streams			
7	Clinical leadership development	NHS	Dr Robert Stewart, Medical Director
8	People Transition	NHS	Hazel Carpenter, Director of Commissioning Director and Workforce
9	Financial Accountability	NHS	Helen Buckingham, Director of Whole Systems Commissioning
10	Communication and engagement	NHS	Steph Hood, Director of Communications & Citizen Engagement
11	Business Continuity, legacy and closure	NHS - Cluster	Judy Clabby, Assistant Chief Executive

A small K&M cluster Commissioning Development team provides co-ordination of the programme, on behalf of the cluster and facilitates convergence of the plan with national and regional development and implementation approaches. In addition, the team supports the NHS Kent and Medway executive to ensure that there is robust co-ordination of each programme within the plan and to provide management overview of risks across NHS Kent and Medway and with key local partners.

Each programme area and workstream has an NHS Kent and Medway Director sponsor and a senior-named staff member who has commissioning development as part of their role. It is the responsibility of these staff to provide the link between the core commissioning development team and the functions within their directorate.

Each programme and workstream Director sponsor reports monthly to the Commissioning Development and Transition Committee, which is a sub committee of the PCT Board. In addition, summary reports on progress are provided to key partners; through

- The Strategic Oversight Board - a partnership board with Kent County Council
- the Medway Delivering Health Together – a partnership board with Medway Council

both established to work together at strategic level to deliver the vision for the NHS in the White Paper and to track progress of the transition of functions.

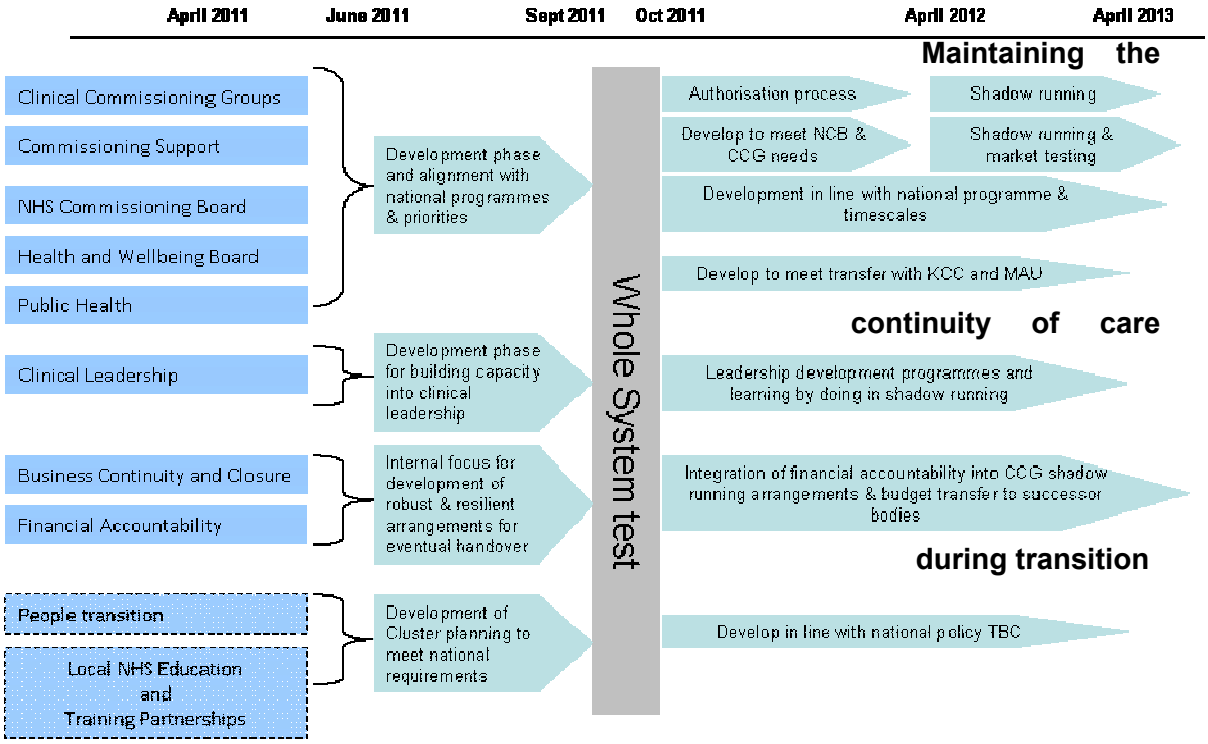
- The SHA Commissioning Development Board

The approach is guided by the SHA Commissioning Development Plan and informed by Kent and Medway partners. The approach includes Whole System Testing at agreed points during the transition period, the first being October 2011 to test assumptions and maximise design, ambition and ability to accelerate delivery.

The first Whole System Test is being developed for October/November (Figure 1) and will provide all stakeholders with the opportunity to identify any unintended consequences of current transition approaches on delivery and inform the development of each programme and workstream. Specifically, it will provide the shadow Health and Wellbeing Boards with a sound evidence base from which to develop their understanding and role in the authorisation process for emergent Clinical Commissioning Groups (CCGs)

Figure 1

Delivery Timetable for indiviudal programme and workstreams



Ann Sutton, Chief Executive, has recently set out the NHS Kent and Medway ambition to delivering sustainable healthcare for the residents of Kent and Medway. This vision sets out the scale of the challenge and describes the need to work together to find new ways of doing things, working across organisational boundaries to improve health and prevent illness and disease.

The Commissioning Development and Transition Plan is specifically designed to ensure that there is strong connectivity between development of the new commissioning architecture (for example, emerging CCGs) and continued delivery of this ambition for sustainable healthcare. This will be achieved through clinical leadership and co-design of the current delivery (11/12 and the ongoing development of the 12/13 Operating plans).

Working with CCG clinical leads, the delivery of priorities and issues; including maintaining delivery and monitoring key areas of effectiveness, safety and patient experience are being built into emergent CCG organisational development plans. These plans are essential for CCGs to build up a track record of delivery which will be reviewed by the NHS Commissioning Board as part of the CCG Authorisation process.

This approach, of building a track record through developing earned autonomy will ensure that NHS Kent and Medway maintains oversight and accountability of continuity of care, safety and quality of services but maximises the responsibilities delegated to CCGs, allowing these new organisations to have the appropriate earned autonomy/delegations.

Clinical Commissioning Group development and progress

Emergent Clinical Commissioning Groups have been working with their constituent practices of the past months to confirm the current arrangements for nine emergent CCGs across Kent and Medway (Table 1).

Table 1

Emergent K&M Clinical Commissioning Groups (August 11)

CCG	Patient list size	Pathfinder status	Pipeline Induction	Unaffiliated practices
Maidstone Malling	96,502	2nd Cohort	Aug 11	0
Swale	103,381	Application submitted	Sept 11	1
Ashford	121,533	5th Cohort	Aug 11	0
Thanet and Eastcliffe	138,391	2nd Cohort	Sept 11	1
South Kent Coast	199,192	2nd Cohort	Sept 11	0
C4 Canterbury and Whitstable	210,107	2nd Cohort	Sept 11	0
Dartford Gravesham and Swanley	248,364	1st Cohort	Aug 11	0
Medway	281,923	5th Cohort	July 11	0
West Kent and Weald	367,239	4th Cohort	Sept 11	0

All but one CCG are confirmed as Pathfinder status, the final application is being considered as part of the 6th national cohort this month.

The five East Kent CCGs have worked consistently together for the past 9 months, meeting weekly to review emergent policy and negotiate a way of working together to enable locality approach but making use of shared resources. In July, the 5 CCGs agreed, through a Letter of Intent, to work collectively under the East Kent Federation.

All eight Kent CCGs have developed a local approach to engaging with local practices and there are some excellent examples of strong leadership which is already resulting in changes in clinical behaviors such as better prescribing and improved clinical pathways. Some CCGs have developed constitutions and agreements with their practices, most have established CCG boards with formal governance arrangements in place.

There is good evidence that CCGs are engaging with the development of the shadow Health and Wellbeing Board.

With the focus currently on the development of the Operating Plans for each CCG, the Clinical Leads are also taking the initiative on contract negotiations, supported by the Contracting and Quality teams in NHS Kent and Medway. For example, the East Kent Federation has arranged planning meetings with the main providers, East Kent Hospitals Trust, the Kent Community Health Trust and the Kent Mental Health Partnership Trust to discuss approaches to planning services; Dartford, Gravesham and Swanley CCG is working closely with the secondary provider to speed up the sharing of key information that will help clinicians plan the use of resources in a better way.

Each of the CCG groups is currently preparing to undertake a self assessment of development needs using the SEC SHA Development tool know as the Self Assessment Pipeline. The Pipeline tool is a developmental, interactive self-assessment tool to allow emerging CCGs to understand and reflect upon their: values; culture; behaviours and wider organisational health.

The Pipeline supports emerging CCGs to focus on delivering tangible benefits to their patients, the wider community and the health system overall by stimulating discussion within CCG leadership teams about the skills and capabilities required of commissioners. It includes some of the key areas which are likely to be required for authorisation and also provides insight into how emerging CCGs can create vibrant organisations that can continually improve beyond the point of authorisation.

The 2012/13 planning round will be led by CCGs, supported by NHS Kent and Medway Directors and their teams. It is anticipated that each CCG will produce an operational plan for the coming year, and that those plans will be aggregated up to form the PCT and cluster level plans. This will form a substantive part of the development of a track record for each CCG and is integral to developing the organisational maturity of each CCG.

The detailed plans for 2012/13 planning round are likely to be presented to the Commissioning Committees of NHS Kent and Medway by December. We anticipate all Kent CCG to have undertaken the self assessment and prepared a Development Plan by this stage, using the experience of the planning round to inform and guide the development needs.

The key issues of note are:

	Milestone
The confirmation of size and geography of the CCG	December 11
Self assessment and Development Plan	December 11
Take a lead role in the Planning round	December 11
Begin to build a track record	October 12
CCG to articulate their commissioning support requirements	October 12
Cluster to begin delegating responsibilities through 12/13	October 12
Ensure CCG have appropriate earned autonomy/delegation of budgets	October 12
Support CCG in engagement with critical aspects of provider development	October 12
Ensure CCG have, in addition to the £2ph and appropriate management support, either directly assigned or working across several groups	October 12

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 September 2011

Subject: Trauma Services in Kent and Medway

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1. Background

(a) The Health Overview and Scrutiny Committee last considered the topic of Trauma Services in Kent and Medway on 10 June 2011. The Committee agreed to invite the Trauma Network back to a future meeting.

(b) An extract from the Minutes of the meeting of 10 June 2011 relating to the discussion on trauma is included as an Appendix to the Background Note following this report.

(c) Members of Medway Council's Health and Adult Social Care Committee have been invited to attend the meeting for this item.

2. Recommendation

That the Committee note the report.

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

To: Health Overview and Scrutiny Committee, 9 September 2011

Subject: Trauma Services in Kent and Medway

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1. Background

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

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

2. Regional Trauma Networks

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Injury Severity Score (ISS)

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

Table: Injury severity score group and mortality[7]

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

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

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

Appendix: Extract from Minutes, Health Overview and Scrutiny Committee, 10 June 2011[8].

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:

[8] Kent County Council, http://democracy.kent.gov.uk/mgAi.aspx?ID=17053

- 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.

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

1. Purpose of this document

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

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

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

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

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

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

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

2. Executive Summary

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

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

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

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

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

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

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

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

3. Background

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

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

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

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

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

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

4. Local context:

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

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

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

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

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

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

Key issues for consideration within Kent and Medway:

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

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

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

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

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

<u>Figure 2: Major Trauma</u> – 45-Minute Ambulance Road-Travel Isochrone around SEC Major Trauma Centres and Kent and Medway (potential) Trauma Units*

(* Shaded area represents approximate 45-minute road travel times by Ambulance to/from KCH, London; RSCH, Brighton; WHH, Ashford; MMH, Gillingham; Pembury, Tunbridge Wells)

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

5. Trauma Units

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

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

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

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

6. Proposal for Kent and Medway Trauma Units

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

1. review of trauma incident data and Trust data available

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

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

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

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

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

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

7. Benefits

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

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

8. Payment Structure for Multiple Trauma

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

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

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

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

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

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

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

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

9. Major Trauma Networks

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

Further work on this arrangement is required including:

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

for implementation across Kent and Medway

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

10. Rehabilitation

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

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

11. Conclusion

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

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

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

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

12. References / Guidance Documents:

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

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 September 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 heard from NHS representatives at the meeting of 22 July 2011. At this meeting the Committee agreed to examine this issue in more depth at a later meeting and that a small working group of Committee Members be established to further investigate and prepare a report for HOSC.

(c) The Members of this informal HOSC Liaison Group were Nigel Collor, Dan Daley, Michael Lyons and Roland Tolputt.

2. Recommendation

That the Committee consider and note the report.

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

To: Health Overview and Scrutiny Committee, 9 September 2011

Subject: Maternity Services: Background note

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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[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:

- "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

[7] Ibid.
[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

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.

(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.

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

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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

(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 SERVICES REVIEW

1. Executive Summary

- The primary driver for this review is safety for every woman and baby, whatever her risk or place of birth. This means having the right skills at the right place at the right time.

- The East Kent Hospitals University Foundation Trust (EKHUFT) has been working closely with the commissioners to agree common priorities and a clinical evidence base. It is our joint ambition to provide 1:1 midwifery care in active labour corresponding to a midwife to birth ratio of 1:28 at all birth units in line with "Safer Childbirth" recommendations.

- Accessibility, Choice, Sustainability and Equity/Fairness have also been factored in.

- The current position demonstrated EKHUFT provides excellent choice of place of delivery; home birth, birth centres, co-located Midwifery Led Unit and Acute Obstetric Unit, however the midwife to birth ratio varies from 1:9 at the stand alone birth units to 1:40 at the consultant led service at the William Harvey Hospital (WHH) which caters for the most complex deliveries providing inequity of service.

- Current live births per site are WHH - 4208, Queen Elizabeth Queen Mother (QEQM) - 2729, Dover Family Birth Centre (DFBC) - 217, Canterbury Birth Centre (CBC) - 300. The year on year 1.6% increase in births is expected to continue reaching 8000 deliveries of babies in 2015.

- The review group have identified four options for future service delivery to address current issues.

- Views of users have been sought and the Health and Overview Scrutiny Committee (HOSC) have been kept updated of progress in view of the continuing suspension of the birthing services at the Canterbury unit. The General Practitioner leaders of the future Clinical Commissioning Groups (CCG) have also had opportunity to review this paper. Further meetings with EKHUFT midwives in all four units will be held in the coming months to keep them abreast of the review.

- The review is committed to ensuring a robust engagement and consultation process, early engagement with staff, GPs, parents and local communities and the evidence that has been provided has influenced the options that have been arrived at. We have been fortunate to receive the assistance of the Maternity Services Liaison Committee in our preparations to date.

- It is expected that a decision will be made to go out to public consultation on the four scenarios that are being considered.

- The earliest opportunity for consultation will be October – December 2011. It has been decided in the interim that Canterbury Birth Centre continues to provide all antenatal care and postnatal day care but will not accommodate births or step down postnatal care.

- The view of the Maternity Services Review Group (MSRG) is that the most sustainable option would be to maintain all services except births and step down postnatal care at both Dover and Canterbury. This will enable a midwife to birth ratio at QEQM and WHH of 1:28 and will enable the QEQM co-located Midwifery Led Unit (MLU) to be opened.

- The indicative cost to provide additional midwives and enable a ratio of 1:28 is £700,468. This is in contrast to £2,126,667 which would be required to maintain birth facilities at the birth centres.

2. Introduction

The purpose of this paper is to provide the background to the current position of maternity provision within East Kent and suggests a number of options for future service provision. East Kent Hospitals University NHS Foundation Trust, Kent and Medway PCT cluster and local East Kent Clinical Commissioning Groups are working together to reach a solution to ensure safe, high quality maternity care for all mothers and families. This paper has been written with support from those who sit on the Maternity Services Review Group, terms of Reference and Group Membership is attached at appendix 1. The MSRG has carried out an initial options appraisal and formed a provisional opinion taking into account evidence collected from a wide spectrum of opinion.

The primary driver for this review is for maintaining a safe service configuration for Maternity Services provided by East Kent Hospitals University Foundation Trust (EKHUFT). This paper also highlights the need for a more permanent solution for future services based on:

Safety every women, whatever her risk and wherever her place of birth, should have one to one care in active labour.

Accessibility services as close to home as possible and where appropriate; which meet the needs of hard to reach groups and positively impact on local inequalities.

Choice information to enable women to make a clinically appropriate and informed choice about the type of birth environment.

Sustainability services that will be sustainable for the future in terms of funding, staff mix and experience and birth rates.

Equity/fairness ensuring the best ratio of staff for mother and baby wherever that service is provided.

In addition, this review of services will fully meet the four tests set out by the Department of Health (DH) in relation to service reconfiguration. Shortly after the new coalition government was elected in May the Secretary of State for Health introduced four tests against which current and future NHS service reconfigurations have to be assessed. According to NHS guidance the tests are designed to build confidence within the service and with patients and communities. The tests were set out in the revised NHS Operating Framework for 2010-11 and require existing and future reconfiguration proposals to demonstrate:

1. Support from GP commissioners.

2. Strengthened public and patient engagement.

3. Clarity on the clinical evidence base; and

4. Consistency with current and prospective patient choice

It is recognised that a long term strategic direction and review will be needed in the future; however this is seen to be far more complex due to its whole system requirements and obvious links to a wider Kent and Medway focus.

3. Background

There is significant evidence based in reports and national guidance that inform how maternity services should be provided. These include:

High Quality Women's Health Care: A Proposal for Change (RCOG 2011) The Government White Paper, The Health and Social Care Bill is reflected in the results of the Royal College of

Obstetricians and Gynaecologists (RCOG) expert review to produce a vision of patient centred high quality women's health care. Amongst the principles and values are:

- Care must be the right care, at the right time, in the right place and provided by the right person.

- Care should be provided closer to home (accepting this principle may require women to travel to access very specialist care).

- Care should be personalised, ensuring risk assessment, continuity of care and choice (this may be influenced by safety and availability of services).

Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (RCOG 2007). In "*Safer Childbirth"* the recommended ratio of midwives to assure a safe level of service is **one whole-time equivalent (WTE) midwife per 28 births for hospital births.** In the same document, it is stated that "there should be 1:1 care for women in established labour".

There are three main categories of care provided by a midwife:

- Community based midwives providing antenatal and postnatal care and supporting births at home or within stand alone birth centres.

- Hospital based midwives providing antenatal and postnatal care.

- Hospital based midwives providing care during labour and birth.

It is very important to maintain the number of midwives to support effective antenatal care as this supports women during pregnancy and allows for appropriate risk assessments to be made at the appropriate stage of pregnancy and therefore ensures women are able to make an informed choice when deciding on the place of birth for their baby.

Maternity Matters (Choice, Access and Continuity of Care in a Safe Service – DH 2007) sets out the following national choice guarantee that should be available to all women:

- Choice of how to access maternity care.

- Choice of type of antenatal care.

- Choice of place of birth.

Depending on their circumstances, women and their partners will be able to choose between three different options. These are:

- Home birth.

- Birth in a local facility, including a hospital, under the care of a midwife.

- Birth in a hospital supported by local maternity care team including midwives, anaesthetists and consultant obstetricians; for some women, this will be the safest option.

The Care Quality Commission has stated: "There will be a need to be mindful that choice needs to be realistic, balancing wants (and sometimes needs) with what is affordable and what resources can be made available".

Bliss (national charity dedicated to improving both the survival and long-term quality of life for babies born too soon) also stated "it's not just about extending choice; it's about ensuring that services are in place to deliver the best possible outcomes for women with high risk-pregnancies and babies admitted to neonatal care".

4. Current Position

Maternity services are delivered across a variety of locations by EKHUFT, as detailed below:

Ante Natal Care – *including:* • *Midwife led* • *Consultant Led* • *Fetal Medicine* • *Maternity Day care*	William Harvey Hospital Queen Elizabeth Queen Mother hospital Canterbury Birth Centre (Kent and Canterbury Hospital) Dover Birth Centre (Buckland Hospital) Royal Victoria Hospital Variety of community settings i.e. GP surgeries and Children Centres Woman's own home
Intra Partum Care (Delivery)	William Harvey Hospital – Obstetric Unit (Labour ward) William Harvey Hospital – Singleton Midwifery-led Unit Queen Elizabeth Queen Mother Hospital – Obstetric Unit (Labour Ward) Kent & Canterbury Hospital – Canterbury Birth Centre Buckland Hospital – Dover Birth Centre Home Birth
Post Natal Care	Immediate postnatal care in all birth settings including birth centres. Step down postnatal care in stand alone birth centres Client's own home GP surgeries and children's centres

EKHUFT built and fully equipped two new Midwifery Led Units (MLUs) on the William Harvey (WHH) and Queen Elizabeth Queen Mother Hospital (QEQM) sites. The WHH MLU opened in July 2009. The QEQM MLU has not yet opened, due to insufficient midwife numbers to staff the unit. Unlike the current birth centres in Dover and Canterbury, the new units are co-located with obstetric units (labour wards).

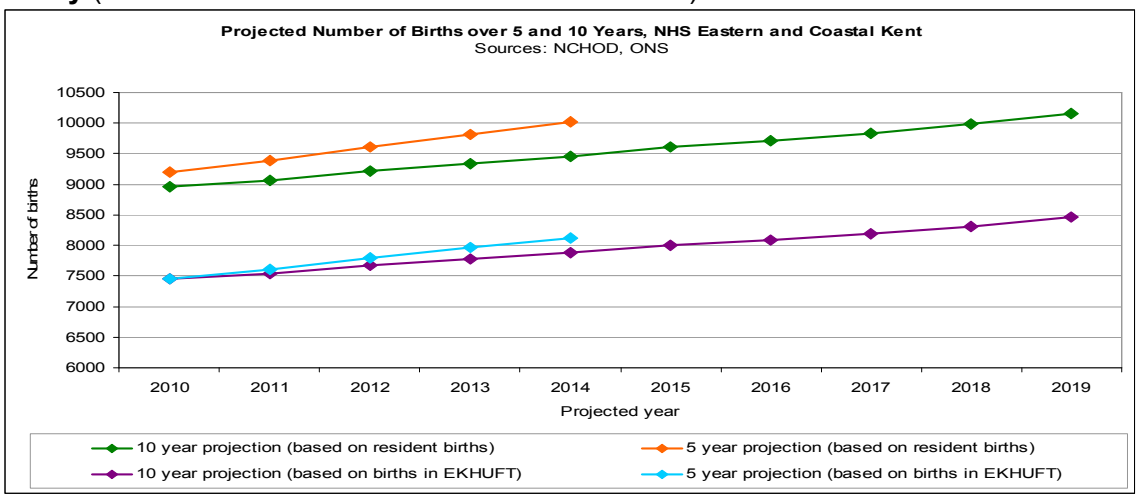
4.1 Rise in Birth Rates

Births across EKHUFT had increased year on year up to 2008/09, and showed a 1.6% increase from 2009/10 to 2010/11. This year on year increase is expected to continue, with the number of babies born in east Kent reaching 8000 by 2015. As demonstrated within the following tables.

Year on Year Increase in Births

	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

Birth Activity (NB. 'based on resident births' includes Swale)



Births by Site

Total live births delivered by EKHUFT	WHH	QEQM	DFBC	KCH	TOTAL
2010-11 (Number of home births included above)	4208 (66)	2729 (57)	217 (59)	300 (65)	7454 (247)
2009 -10	3976 (97)	2746 (50)	249 (53)	365 (51)	7336 (251)
2008 – 09	3762 (114)	2898 (59)	345 (80)	368 (54)	7373 (307)
2007 – 08	3558 (114)	2779 (53)	366 (91)	398 (67)	7101 (325)
2006 - 07	3500 (121)	2697 (55)	433 (45)	450 (70)	7080 (291)

As can be seen from the table above births at the WHH have increased while all other sites have decreased. More than 50% of the births within EKHUFT are now at the WHH site. One reason for this increase on the WHH is the opening of the Singleton Midwifery Led unit. However, the decline in births at the birth centres was an established trend and by 2009-10 a total of 510 births took place in the birth centres. This decline has continued further since the opening of the MLU

Of the births in 2010 at the WHH, 662 were births that took place on the Singleton Midwifery Led unit. However, some women who may have chosen the midwifery led unit for birth will not have delivered there as they have required transfer to the acute unit for obstetric, medical or personal reasons.

This continued increase in activity on the WHH site requires appropriate midwifery staff numbers and expertise in order to support women in active labour.

4.2 Midwifery Staffing

Following a recent benchmarking exercise through the Foundation Trust Network (FTN), the maternity services provided by EKHUFT were compared with seventeen other foundation trusts (FT) that provide maternity services. Only two other trusts within this cohort equalled the number of multiple sites within EKHUFT. Both these had only one acute site offering a 'hub and spoke' service. EKHUFT was the only trust that had two acute sites and three midwifery led units.

This six month review provided a substantial database and adds to local evidence which will be considered within the review. This data highlights a number of important facts, these include the following:

- There are currently some 7,500 births within east Kent and this is likely to rise to 8,000 by 2015 (1.6% per year).

- The average number of deliveries per midwife in east Kent is within the average range for other FTs. However, critically, when this analysis is broken down by birth unit the WHH unit which supports those mothers with the highest health risk has the highest number of births per midwife. The average birth:midwife ratio on the four main sites is as follows:

  1. WHH 1:40

  2. QEQM 1:35

  3. Dover Birth Unit (BHD) 1:9

  4. Canterbury Birth Unit (KCH) 1:10

- Antenatal and postnatal midwifery episodes in line with NICE guidance.
  http://www.nice.org.uk/nicemedia/live/11947/40115/40115.pdf
  http://www.nice.org.uk/nicemedia/live/10988/30144/30144.pdf

- The FTN paper suggests that maternity services operate at a loss nationally. When compared to other FTs in the benchmarking exercise EKHUFT had a 5% greater loss than the cohort considered in the FTN data. However, two trusts within this cohort omitted to provide information about Clinical Negligence Scheme for Trusts (CNST) costs and indirect costs. Had these been added EKHUFT would have been closer to the mean. Additional funding provided to EKHUFT by commissioners this financial year has closed the gap but provides insufficient income to support the service as a whole.

- The majority of maternity services are paid for by the PCT at national tariff which is set by the DH.

- Total pay costs per delivery at the two stand alone birth centres are almost twice as high as the obstetric units within EKHUFT and more than twice the current tariff for a normal delivery (£1292).

Despite investment into midwifery staffing over the previous two years this has only been sufficient to support the increase in births therefore maintaining the status quo in terms of birth to midwife ratio.

As demonstrated through the FTN benchmarking exercise, there is significant discrepancy between the birth to midwife ratio. To further complicate this problem the women who come to the WHH are often high risk and not able to use the services of a birth centre. EKHUFT therefore has a situation where women who are entirely low risk and without complication receive one to one care from a midwife in labour whilst high risk women with complex pregnancies were unlikely to receive this. It has been identified that delivering safe maternity services across EKHUFT is strongly dependent on midwifery staffing numbers.

The table below indicates the future requirements for midwifery staffing alongside the annual increase of births.

Midwifery Staffing Profile

Year	Birth/projected births	Current Establishment	Establishment required for 1:28	Deficit from baseline (2010/11)
2010/11	7454	236	266	30
2011/12	7570	236	270	34
2012/13	7691	236	275	39
2013/14	7814	236	279	43
2014/15	7939	236	284	48
2015/16	8056	236	288	52

4.3 Capacity

Unfortunately, there are times when services have to be suspended to ensure safe levels of care in acute labour wards (as is discussed below). The requirement to move staff to acute areas to support high risk care has an obvious impact on the ability to maintain the choice of birth in a low risk setting. In the majority of cases this is only for a small number of hours. Further details and financial break down can be found at appendix 2.

As has been described throughout this paper, safety is the main priority when considering the provision of maternity care. As such there are times when midwifery managers have to make the decision to divert a unit. This is applicable to all sites; the acute and the birth centres.

There are two main reasons for the need to divert:

Lack of capacity – this problem arises at times of high activity and can be two fold; high numbers of women labouring at the same time filling all available labour beds or high numbers of women who have recently given birth and filling postnatal beds. This is the most common scenario, once the postnatal beds are full it is not possible to move women from the labour ward to the postnatal ward and women have to remain on the labour ward until fit for discharge home or until a bed becomes available on the postnatal ward. When a site is full it is not possible to continue to admit women when there is no bed space. The availability of an additional four co-located beds at QEQM and full utilisation of MLU at WHH will mitigate against this.

It is fortunate that EKHUFT have the benefit of two acute sites and hence women are always able to access maternity care within the trust when one site is diverted although this may necessitate travelling further than they had anticipated (see appendix 4) To date, it has not been necessary to suspend services on both sites simultaneously.

Lack of midwifery or obstetric staffing – this is a problem that results from a deficit of staff through sickness/absence. If staff cannot be found to cover the shifts then services have to be suspended to maintain safety both for those women already on the unit and those who need to access services. Sometimes there is the need to suspend service because of the complexity of cases on the labour ward. In this scenario there may be the required/usual number of staff but the complexity of the women on the labour ward require such intensive care that it is not safe to admit any further women.

The current maternity capacity across the Trust and more in depth information about unit diversions is detailed in appendix 3.

5. Delivering Safe Maternity Services across East Kent

In September 2010, EKHUFT identified an increase in neonatal admissions to the WHH neonatal intensive care unit had occurred between April and August 2010. A decision was made to investigate this increase and, as a precautionary measure, to enhance staffing levels on the obstetric unit (Labour ward) at WHH while the investigation was being carried out.

To achieve the enhanced staffing levels, births within the Dover Birth Centre at Buckland Hospital were temporarily suspended and midwives were redeployed to WHH. All other services provided at the DFBC continued such as antenatal and day care.

The rise in admissions to the neonatal intensive care unit has been further investigated without definitive conclusions but both EKHUFT and the Primary Care Trust (PCT) agree that midwifery staffing levels were a key factor. In January 2011, it was agreed it was necessary to maintain the temporary suspension of a birth centre. It was decided that this should be the Canterbury Birth Centre, this has remained temporarily suspended and the MLU within QEQM remains unopened.

EKHUFT have moved midwives to follow the flow of activity. It is clear the rise in births at the WHH required more experienced midwives to support this. The suspension of the services at one of the

Birth Centres has been agreed by EKHUFT, Kent and Medway PCT cluster and local East Kent Clinical Commissioning Groups as the paramount priority is to ensure safe care on all sites.

Since the suspension of one or other of the birth centres there has not been any adverse effects on safety in any of the other sites. The births that would have taken place at a birth centre have been accommodated within the other units and there has not been a significant increase in home births.

5.1. Choice For Women

The Maternity Matters Framework sets out the national choice guarantee that should be available to all women, comprising choice of how to access maternity care, choice of type of antenatal care and choice of place of birth. East Kent delivers comprehensively on the choice guarantee. Women using services in East Kent are offered choice of antenatal and postnatal care in a range of settings, and choice of place of birth - home birth, birth in a local setting under midwifery led care and birth in an acute hospital supported by a maternity care team. The choice guarantee will continue to be fully met by each of the options set out in this paper.

As well as a tangible shift in women in EKHUFT choosing to have their baby within co-located midwife led units, there is evidence from the interviews conducted as part of the current maternity review. In the spring of 2011 a snap shot survey of 95 recent service users was undertaken. Participants were asked what type of delivery service they would prefer the majority of respondents favoured the midwife led units co-located with obstetric support (near to the Labour ward).

With regards to the future of the services in the longer term, EKHUFT, Kent and Medway PCT cluster and local East Kent Clinical Commissioning Groups need to agree on how maternity services within East Kent will be delivered. The priority remains safety but we are also conscious that services need to be accessible to the local population, that there is appropriate choice for women and that the services are sustainable given the continued rise in birth rates. Hence the review of services has begun which will conclude by December of this year at the earliest. Until this time EKHUFT has decided, in the interest of safety, to keep the Canterbury Birth Centre suspended for births. The immediate future of all the maternity services in east Kent will be decided through this review.

5.2 The engagement of communities and parents

The maternity review has always recognised the importance of working with staff, patients, GPs, stakeholders and the local population to enable a transparent and well informed debate about the issues faced by our maternity services, so that any decisions taken are informed by both local opinion and clinical/workforce evidence that meets section 242 and 244 requirements.

Hence the review leaders are working with the Maternity Services Liaison Committee as champions, and using contacts in children's centres and Sure Start centres or Young Active Parents' groups, to ensure conversations are held with parents where they are most comfortable.

The early engagement has focused strongly on recording patient and parents' experience is an important strand of evidence within the maternity review.

So far the citizen engagement has collected current patient's experience via 230 surveys – based on the national care quality commission's survey which was run in 2010. The commissioners and citizen engagement team has also interviewed 95 mums and dads with recent experience of services by visiting children's centres and sure start centres across east Kent, The engagement team has also held focus groups with some seldom heard communities including young parents and those with learning disabilities. This approach will be expanded upon in the consultation to ensure a wide range of communities are able to actively take part in the consultation process.

In addition the PCT is running an online survey for interested citizens to comment, and we have also held several community road shows for staff and community members. Also the citizen engagement team are visiting a number of family friendly events this summer to discover how local people about the criteria being used to define the options and which should have the highest priority. The importance of ante natal and postnatal care has come through in all of the work, so the steering group options clearly recognise that the community teams will remain in situe and the birthing centres will continue to offer both ante natal and post natal care along with the monitoring and clinical advice for worried mothers during their pregnancy.

Also throughout the engagement the midwifery staff and doctors whilst praised and supported overall, are frequently recognised as being very busy and unable always to devote the time to one to one level of care they might intend.

"I can highly recommend all the staff at William Harvey and my local support network. Everyone has made my labour (despite my an emergency c. section) a positive experience'

'They could do with more staff for better care. It was too long between seeing anyone.'

All of this work and the views collected have been fed into the maternity review and will be formally considered as part of the engagement and consultation process.

6. Options

The review group's view is that the most sustainable solution to the issues identified was to provide a midwife to birth ratio of 1:28 as per "*Safer Childbirth"* recommendations. It is agreed that the continuation of providing birth facilities at Dover Birth Unit, Canterbury Birth Centre and the 2 acute sites without additional investment is not a safe option and is therefore not included as one of the scenarios. A review of current staffing levels and skill mix has been undertaken and by reconsidering the roles of Band 2 staff and incorporating 24 hour ward clerk and administration into this role it has been agreed to convert 18.04 WTE of these posts into Band 3 Maternity Care Assistants. This will reduce the external investment required as including these posts in the midwifery workforce will allow flexibility in matching the appropriate tasks with the required skills and knowledge. The workforce has been modelled using a 90:10 (Midwife:MSW) split as recommended by Birthrate Plus (the only recognised midwifery workforce planning tool supported by the DH), 'Safer Childbirth' (RCOG 2007) and the Kings Fund. These changes will be phased in to allow training and skills development. Appendix 1 shows the workforce and financial modelling of each scenario which is summarised below. It should be noted that in considering the options for sustainable maternity services in East Kent, choices must be made about how resources are spent across the whole health economy. Substantial additional investment in maternity services would inevitably result in other services having to cease.

6.1. Scenario 1

- Maintain all facilities including births at Canterbury Birth Centre, and Dover Birth Unit
- Ensure midwife to birth ratio at QEQM and WHH is 1:28
- Open QEQM co-located Midwifery Led Unit

Indicative additional service costs: £2,126,667

6.2. Scenario 2a

- Maintain all facilities including births at Canterbury Birth Centre. Maintain antenatal and postnatal outpatient services at Dover Birth Unit and cease births on this site
- Ensure midwife to birth ratio at QEQM and WHH is 1:28
- Open QEQM co-located Midwifery Led Unit

Indicative additional service costs: £1,475,241

6.3. Scenario 2b

- Maintain birth facilities at Dover Birth Unit. Maintain antenatal and postnatal outpatient services at Canterbury Birth Centre and cease births on this site
- Ensure midwife to birth ratio at QEQM and WHH is 1:28

- Open QEQM co-located Midwifery Led Unit

Indicative additional service costs: £1,355,320

6.4. Scenario 3

- Maintain all facilities except births at both Dover Birth Unit and Canterbury Birth Centre
- Ensure midwife to birth ratio at QEQM and WHH is 1:28
- Open QEQM co-located Midwifery Led Unit

Indicative additional service costs: £700,468

Scenario 1

Maintain all existing services and open second MLU

Not deliverable with current resources hence current suspension of birth centre and QE MLU not opened

Advantages
- Local services maintained
- Open MLU QEQM
- Meets current normalising birth and choice agenda
- Reduces risk of rising C/S rate in the future
- Potentially aids capacity management by use of postnatal beds at birth centres
- No change of work place for staff

Disadvantages
- Poor estate will need upgrade / replacement
- Demand at the birth centres is reducing year on year
- Significant midwife recruitment required to allow birth to midwife ratio of 28:1
- Services are inefficient and midwifery staffing inflexible and unable effectively to follow patient flow
- Inequitable service as low risk women received the highest level of care
- Impossible to maintain safe services on all areas particularly WHH site
- Significant increase in unit diversions
- High pay costs per delivery on birth centre sites
- Continued risk of unit closures in order to accommodate staffing pressures

Scenario 2a

Maintain antenatal and postnatal services but cease births at Dover Birth Centre

Scenario 2b

Maintain antenatal and postnatal services but cease births at Canterbury Birth Centre

Scenario 3

Maintain antenatal and postnatal services but cease births at both Dover AND Canterbury Birth Centres

Reflects current model of care with one birth centre suspended

Sustainable option

Requires public consultation

Advantages
- Better utilisation of resources
- Access to standalone and co-located Midwifery Led Units maintains choice of birth experience
- Maintenance of local outpatient and day care services
- Potential for increase in home births
- Open MLU QEQM

Disadvantages
- Will be seen to disadvantage the area that ceases services for birth
- Inefficient use of available resource
- Possible rise in C/S
- Effect on midwifery staffing through potential increase in home birth
- High pay costs per delivery on birth centre sites
- Continued risk of unit closures in order to accommodate staffing pressures

Advantages
- Ability to open MLU at QEQM
- Better utilisation of physical and staffing resource
- Access to collocated MLU maintains choice of birth experience
- Maintenance of local outpatient and day care services
- Potential for increase in home births
- Improved care on acute sites for high risk women
- Most cost effective option
- Increase service stability, less anxiety for women regarding unit diversions

Disadvantages
- Reduced choice of local birth centre for low risk women in Dover and Canterbury
- Potential higher activity on acute centres as a result of increased transfer rate from co-located MLUs
- Reduction in overall capacity
- Possible rise in C/S rate
- Effect on midwifery staffing through potential increase in home birth

7. Risks to change

The temporary suspension of the one stand alone MLU has been accepted on safety grounds, given the rise in admissions to the neonatal unit. If there is to be a case for permanent closures, this would have to be taken through a formal consultation process. It is recognised that the current position cannot continue and reconfiguration is required to sustain safe services. If consultation was to be delayed, legal advice should be sought as to the legitimacy of the current temporary arrangements.

The evidence which is being gathered through the maternity review has established a strong case to support service change. It is necessary to follow a careful timetable of consultation to avoid legitimate legal challenge.

National policy is clearly based on improving access and choice, whilst ensuring safety and offering high quality of care, these imperatives cannot be ignored. The National Perinatal Epidemiology Unit national 'Birth Place' study is due to be released shortly, and the DH is concerned that all maternity services reconfigurations are coherent with current policy and practice.

The review group must be assured of equity of access and be able to articulate the average transfer time between all units and from all areas. Finally, adequate capacity must be provided within any service reconfiguration to avoid women having to travel outside east Kent to give birth.

7.1 Recommendations

In order to provide appropriate, safe and high quality 1:1 care in established labour, within two locations additional midwifery staff levels to the current establishment are required. The current provision of choice given to women in terms of additional co-located and stand alone midwifery units further increases the gap in staffing.

EKHUFT and the East Kent Maternity Services Review Group would recommend Scenario 3 as the most sustainable option. This facilitates the effective use of maternity staff to open the co-located unit at QEQM and support the acute units. This would require reallocating staff from both the birth centres and investment in more midwives in order to adequately support the co-located midwife led units, obstetric units (labour wards) to deliver a midwife to birth ratio of 1:28 on both sites. Data issued by NHS South East Coast indicates that 40% of east Kent births are normal deliveries. A normal delivery includes all spontaneous births without induction of labour, augmentation, artificial rupture of membrane, epidural or episiotomy.

The Dover and Canterbury Birth Centres would continue to offer all their current day and community services. This includes two consultant clinics at Canterbury weekly; one joint consultant clinic at Dover; various midwifery clinics; day care services on both site and parent education classes. Both areas undertake high volumes of work and this will continue as it is recognised that local services are important to women. Furthermore, there is not the capacity either in space or staff time to undertake this work on the acute sites.

It should be recognised that the criteria for delivery at these stand alone birth centres is the same for home births and this option continues to be available and would be expanded if that was the choice of women in the future.

Appendix 1

JOINT MATERNITY SERVICE REVIEW

Draft Terms of Reference
June 2011

1. Purpose

The purpose of the Joint Review is to continue to deliver and maintain a safe, sustainable model of care for maternity services through a joint approach with commissioners, clinicians and providers for East Kent residents.

In addition this review will further enhance and:-

- improve health and reduce health inequalities;
- improve access to safe services;
- ensure choice of provision and improve access to services ensuring equity across eastern and coastal Kent;
- pursue perfection in the safety and quality of clinical services;
- respond effectively to the diversity and changing demographics of our population;
- deliver value for money.

The work of the Joint Review will contribute to the delivery of the Integrated Strategic Operating Plan (ISOP) and the initiatives set out in the Maternity Commissioning Strategy, ensuring that investments are productive, effective and efficient.

2. Outcomes

- Agreed clinical outcomes.
- Agreed activity levels.
- Agreed level of choice in line with Maternity Matters.
- Agreed sustainable workforce model and plan.
- The Review will have an East Kent focus but will take into consideration the wider implications of capacity across Kent and Medway
- Agreed birth to midwife ratios.
- Agreed communication/public engagement management.
- Agreed/clear funding and costing.
- Agreed service provision through period of review – status quo for service delivery unless evidence of patient safety and quality issue.

3. Agreed Evidence

- Detailed sustainable workforce plan and calculations (including work undertaken by University of Kent).
- Activity by site including all sites (including home births), MLU and obstetric delivery areas including, cross boundary. Activity data to include postcodes.
- SUS data and coding.
- Patient experience of temporary closure.
- KPMG clinical review
- FTN benchmarking document.
- Kent and Medway Integrated Operational Plan (QIPP)
- Finance funding and costs.
- Commissioning strategy.
- Public Health data.
- Data around transfers of mothers during delivery
- Midwife to patient ratios re equity of services

4. Membership

The membership of the Joint Review will be made up as follows:-

PCT Role	Member
Interim GP Chair	Dr Sarah Montgomery
Interim GP Chair (nominated deputy)	TBC
Director Sponsor	Hazel Carpenter / Helen Buckingham
GPCC Maternity Commissioner	James Ransom
Citizen Engagement	Sara Warner
Finance/Information	Deborah Bateson / Stewart Town
Communications	Glynis Alexander or substitute
Clinical – Quality & Safety	Debbie Dunn
Public Health	Jonathan Sexton
Locality SCAO reference group	Dr Chee Mah Dr Jessica Crouch Dr Anne Weatherley

EKHUFT Role	Member
Medical Director	Dr Neil Martin
Director of Specialist Services (nominated deputy)	Jane Ely
Assistant Director of Strategic Development & Capital Planning	Anne Neal
Maternity & Obstetric Leads	Lindsey Stevens - Head of Midwifery and Gynae Nursing
Citizen Engagement	Kunie Thomas - Head of Patient Experience
Finance/Information	Dawn Allaway
Communications	Jim Murray - Director of Communications
General Manager Specialist Services Division	Ben Stevens
Consultant obstetrician clinical Lead	Dr Kate Neales

5. Chair

The GP Clinical Commissioner will act as Chair of the Joint Review and will be mandated by NHS Eastern & Coastal Kent's Commissioning Strategy Committee. If the Chair is absent from a meeting or absent temporarily on the grounds of a declared conflict of interest, the Medical Director from East Kent Hospitals University Foundation Trust (EKHUFT) will act as Chair for the duration of the meeting. The Chair will be responsible for ensuring that GPCC leads from each locality (including Maidstone and Medway) are consulted with as part of the Review.

6. Secretary

James Ransom will act as Secretary to the Joint Review.

7. Quorum

The quorum necessary for the transaction of the business shall be the Medical Director from EKHUFT and GP Clinical Commissioner, or their nominated deputies.

A duly convened meeting of the Joint Review at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable, by the Group.

8. Frequency of meetings

The Review Group shall meet as and when required as part of the project plan process.

9. Notice of meetings

Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed and supporting papers, shall be forwarded to each member of the Joint Review and any other person required to attend no later than two weeks before the date of the meeting.

Meetings of the Joint Review other than those regularly scheduled as above, shall be summoned by the chair of the Joint Review.

10. Conduct of meetings

Except as outlined above, meetings of the Steering Group shall be conducted in accordance with the provisions of Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions approved by the Board of NHS Eastern and Coastal Kent and also that of East Kent Hospital University Foundation Trust.

11. Minutes of meetings

The Secretary shall minute the proceedings and resolutions of all meetings of the Joint Review, including recording the names of those present and in attendance.

The minutes of the Project Group's meetings will be reported to NHS Eastern & Coastal Kent's Commissioning Strategy Committee and made available to each GPCC. The minutes will also be made available to the Chief executive of East Kent Hospitals University Foundation Trust.

All decisions made by the Joint Maternity Service Review working group will be ratified by EKHUFT Board, Commissioning Steering Committee (CSC) and Kent and Medway PCT cluster.

12. Review of Terms of Reference

The terms of reference will be reviewed as appropriate by the Joint Review.

Appendix 2 Financial details

Scenario 1

Birth: Midwife Ratio based on 1:28 per Acute Site

Site	No of Births per paper	Staffing			Number of Births per Midwife	Average number of Births per Midwife
		Total Midwives and MSW's (per 2011/12) establishment WTE	Investment in Acute Sites to ensure ration is 1:28 WTE	Total Staff to Deliver Service WTE		
WHH	4208	105.50	44.79	150.29	**28**	
QMH	2729	78.20	19.19	97.39	**28**	
KCH	300	28.80	0.00	28.80	**10**	
BHD	217	23.03	0.00	23.03	**9**	
	7454	**235.53**	**63.98**	**299.51**		**25**

Will ensure that ratio of 1:28 is achieved at Acute Sites and as based on birth rates would allow for the opening of the MLU at QMH

Staffing split 90% : 10% Qualified to Unqualified

Current Staffing			Proposed Staffing			Changes		
Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE
99.50	6.00	105.50	135.26	15.03	150.29	35.76	9.03	44.79
72.22	5.98	78.20	87.65	9.74	97.39	15.43	3.76	19.19
28.48	0.32	28.80	25.92	2.88	28.80	-2.56	2.56	0.00
22.50	0.53	23.03	20.73	2.30	23.03	-1.77	1.77	0.00
222.70	**12.83**	**235.53**	**269.56**	**29.95**	**299.51**	**46.86**	**17.12**	**63.98**
			Indicative Investment in Service Required			**2,056,351**	**70,316**	**2,126,667**

Scenario 2a

Birth : Midwife Ratio based on Staffing Levels with Closure of Dover Birth Centre
Birth : Midwife Ratio based on 1:28 per Acute Site

Site	No of Births per paper	Transfer of Births from BHD	Total Births	Staffing					Number of Births per Midwife	Average number of Births per Midwife
				Total Midwives and MSW's (per 2011/12) establishment WTE	Transfer Staffing from BHD WTE	Total Staffing per proposal to invest WTE	Investment to 1 : 28 WTE	Total Staff to Deliver Service WTE		
WHH	4208	130	4,338	105.50	13.97	119.47	35.53	155.00	**28**	
QMH	2729	87	2,816	78.20	9.06	87.26	13.24	100.50	**28**	
KCH	300	0	300	28.80	0.00	28.80	0.00	28.80	**10**	
BHD	217	-217	0	23.03	-23.03	0.00	0.00	0.00	**0**	
	7454	**0**	**7,454**	**235.53**	**0.00**	**235.53**	**48.77**	**284.30**		**26**

Will ensure that ratio of 1:28 is achieved at Acute Sites and as based on birth rates would allow for the opening of the MLU at QMH
Assumes transfer of all staff at BHD on the assumption that a Day Care Centre will still provided at Dover Site (no different from offering service in Community by Community Midwives)

Staffing split 90% : 10% Qualified to Unqualified

Current Staffing			Proposed Staffing			Changes		
Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE
99.50	6.00	105.50	139.50	15.50	155.00	40.00	9.50	49.50
72.22	5.98	78.20	90.45	10.05	100.50	18.23	4.07	22.30
28.48	0.32	28.80	25.92	2.88	28.80	-2.56	2.56	0.00
22.50	0.53	23.03	0.00	0.00	0.00	-22.50	-0.53	-23.03
222.70	**12.83**	**235.53**	**255.87**	**28.43**	**284.30**	**33.17**	**15.60**	**48.77**
			Indicative Investment in Service Required			**1,411,172**	**64,069**	**1,475,241**

Scenario 2b

Birth : Midwife Ratio based on Staffing Levels with closure of Canterbury Birth Centre
Birth : Midwife Ratio based on 1:28 per Acute Site

Site	No of Births per paper	Transfer of Births	Total Births	Staffing					Number of Births per Midwife	Average number of Births per Midwife
				Total Midwives and MSW's (per 2011/12) establishment WTE	Transfer Staffing from KCH WTE	Total Staffing per proposal to invest WTE	Investment to 1 : 28 WTE	Total Staff to Deliver Service WTE		
WHH	4208	180	4,388	105.50	17.47	122.97	33.82	156.79	**28**	
QMH	2729	120	2,849	78.20	11.33	89.53	12.15	101.68	**28**	
KCH	300	-300	0	28.80	-28.80	0.00	0.00	0.00	**0**	
BHD	217	0	217	23.03	0.00	23.03	0.00	23.03	**9**	
	7454	**0**	**7,454**	**235.53**	**0.00**	**235.53**	**45.97**	**281.50**		**26**

Will ensure that ratio of 1:28 is achieved at Acute Sites and as based on birth rates would allow for the opening of the MLU at QMH
Assumes transfer of all staff at KCH on the assumption that a Day Care Centre will still provided at Dover Site (no different from offering service in Community by Community Midwives)

Staffing split 90% : 10% Qualified to Unqualified

Current Staffing			Proposed Staffing			Changes		
Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE
99.50	6.00	105.50	141.11	15.68	156.79	41.61	9.68	51.29
72.22	5.98	78.20	91.51	10.17	101.68	19.29	4.19	23.48
28.48	0.32	28.80	0.00	0.00	0.00	-28.48	-0.32	-28.80
22.50	0.53	23.03	20.73	2.30	23.03	-1.77	1.77	0.00
222.70	**12.83**	**235.53**	**253.35**	**28.15**	**281.50**	**30.65**	**15.32**	**45.97**
			Indicative Investment in Service Required			**1,292,401**	**62,919**	**1,355,320**

Scenario 3
Birth : Midwife Ratio based on Staffing Levels with the Closure of both Birth Centres plus opening of MLU and close 2 of birth centres
Birth : Midwife Ratio based on 1:28 per Acute Site

Site	No of Births per paper	Transfer of Births	Total Births	Staffing					Number of Births per Midwife	Average number of Births per Midwife
				Total Midwives and MSW's (per 2011/12) establishment WTE	Transfer Staffing from BHD/KCH WTE	Total Staffing per proposal to invest WTE	Transfer Staffing from KCH	Total Staff to Deliver Service WTE		
WHH	4208	310	4,518	105.50	31.44	136.94	24.56	161.50	**28**	
QMH	2729	207	2,936	78.20	20.39	98.59	6.12	104.71	**28**	
KCH	300	-300	0	28.80	-28.80	0.00	0.00	0.00	**0**	
BHD	217	-217	0	23.03	-23.03	0.00	0.00	0.00	**0**	
	7454	**0**	**7,454**	**235.53**	**0.00**	**235.53**	**30.68**	**266.21**		**28**

Will ensure that ratio of 1:28 is achieved at Acute Sites and as based on birth rates would allow for the opening of the MLU at QMH
Assumes transfer of all staff at KCH & BHD on the assumption that a Day Care Centre will still provided at Dover Site (no different from offering service in Community by Community Midwives)

Staffing split 90% : 10% Qualified to Unqualified

Current Staffing			Proposed Staffing			Changes		
Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE	Qualified Staffing WTE	Unqualified Staffing WTE	Total WTE
99.50	6.00	105.50	145.35	16.15	161.50	45.85	10.15	56.00
72.22	5.98	78.20	94.24	10.47	104.71	22.02	4.49	26.51
28.48	0.32	28.80	0.00	0.00	0.00	-28.48	-0.32	-28.80
22.50	0.53	23.03	0.00	0.00	0.00	-22.50	-0.53	-23.03
222.70	**12.83**	**235.53**	**239.59**	**26.62**	**266.21**	**16.89**	**13.79**	**30.68**
			Indicative Investment in Service Required			**643,828**	**56,640**	**700,468**

Appendix 3

Diversion of units – further details

Current maternity bed capacity in EKHUFT

WHH

10 labour beds and 4 beds for induction of labour and triage
29 postnatal/antenatal beds

Singleton Midwifery led unit

6 labour /postnatal beds
2 pool rooms

QEQM

9 labour beds and 3 induction of labour beds
21 postnatal/antenatal beds

MLU (not used at present time)

4 labour/postnatal beds

CBC

2 labour beds
5 labour/postnatal beds

DFBC

3 labour beds
8 postnatal beds

Diversion of a unit is always undertaken in close liaison with all sites and only ever authorised by a midwifery manager. There is a comprehensive guideline that managers follow and includes notification of all sites, hospital managers and ambulance control. It is fortunate that EKHUFT have the benefit of two acute sites and hence women are always able to access maternity care within the trust when one site is diverted. To date it has not been necessary to close both sites simultaneously. Midwifery managers and the co-ordinating labour ward midwifery staff maintain close communication throughout the time a unit is on divert and the unit is opened as soon a possible so that women are not disrupted for any longer than is necessary.

All women are advised of the possibility of unit diversions both verbally by their community midwife and this is reinforced in the patient information leaflet 'Your birth, Your choice'

Although diversion of birth site is disruptive and can cause significant anxiety to women, there have been no adverse incidents arising as a result of a unit diversion. On review of maternity statistics it is clear that the number of babies born before arrival (BBA is recorded as such if the woman delivers on route to the hospital or prior to the arrival of a midwife to the home) have not increased. In the period 2009/10 there was 50 BBAs and in 2010/11 there were 42.

In 2010 there were 27 diversions as follows:

Unit	Reason	Diversions
CBC	Staffing	2
DFBC	Staffing	1
MLU	Staffing	2
QEQM	Capacity	18
WHH	Capacity	4
Total		**27**
Total number of women requiring transfer		**18**

To date in 2011 there have been 26 diversions as follows:

Unit	Reason	Diversions
CBC	Suspended	0
DFBC	Staffing	1
MLU	Staffing	15
QEQM	Capacity	9
WHH	Capacity	1
Total		**26**
Total number of women requiring transfer		**9**

As can be seen there has been an increase in the requirement to divert birth sites although the need to divert because of capacity appears to be fairly consistent. This is unlikely to continue to be the case for two reasons

1. The local birth rate continues to rise.

2. In September the acute labour ward at Maidstone will close and will be replaced with a midwifery led service similar to that provided in the birth centres in Canterbury and Dover. It is likely that women, both those who are high risk and those who prefer the option of a co-located birth centre, who live in the South of Maidstone will choose to come to the WHH for birth. In the past estimates have been made of approximately 500 women who will choose the WHH. This remains unclear at this time and there is the thought that many women will travel to Pembury for birth because the excellent facilities there (all single rooms and the ability for partners to stay).

The above alongside the possibility of changes in services and removal of one or both birth centres as a result of the maternity review need to be considered. What is clear from the bed occupancy data below any increase in numbers of births on either site will have a further impact on capacity.

Detailed analysis of bed occupancy is collated via the information team which demonstrates the following:

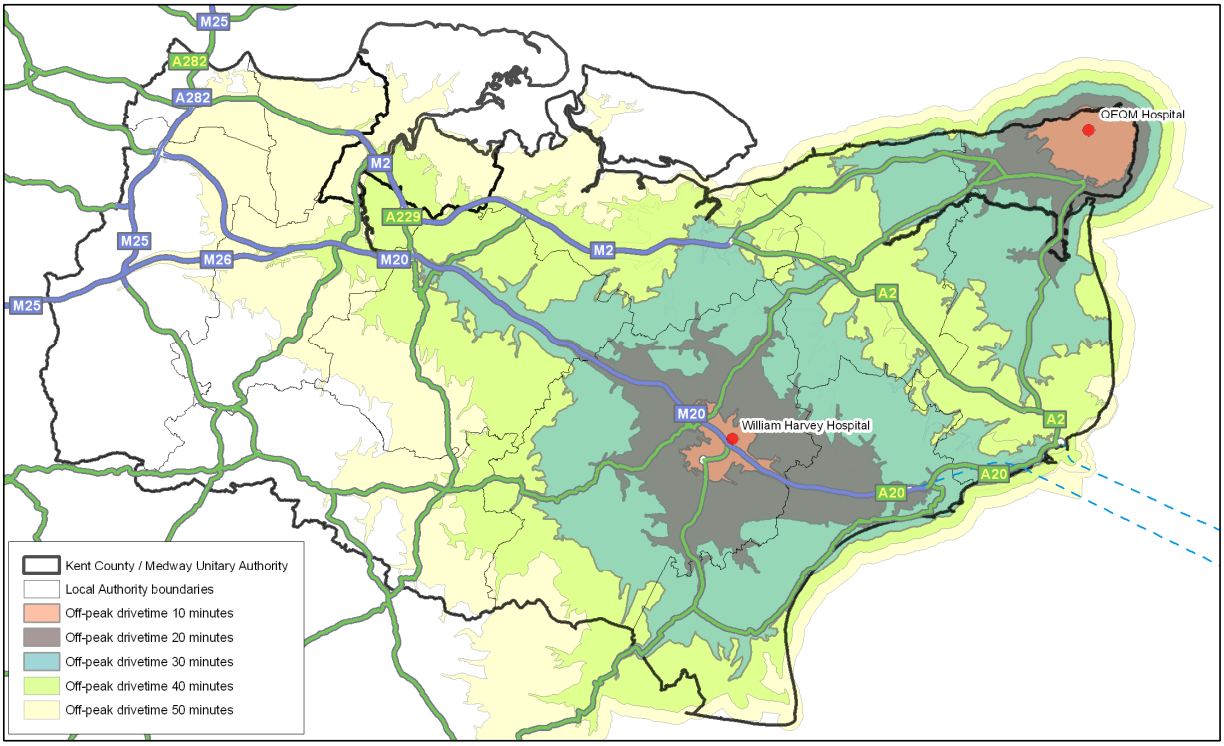
Year Summary 2010/11 Bed Occupancy	
Unit	**Percentage**
CBC	19. 91% (suspended from January)
DFBC	22.15% (suspended from October 2010 to January 2011)
MLU	41.18%
QEQM	**91.28%**
WHH	**89.09%**

Search of relevant literature would suggest that bed utilisation of more than 80-85% is likely to cause service failure (Sylvester, K; NHS Institute). Both acute sites are frequently working beyond capacity.

Travel times between the two main hospitals

Off Peak Drivetimes for William Harvey and QEQM Hospitals

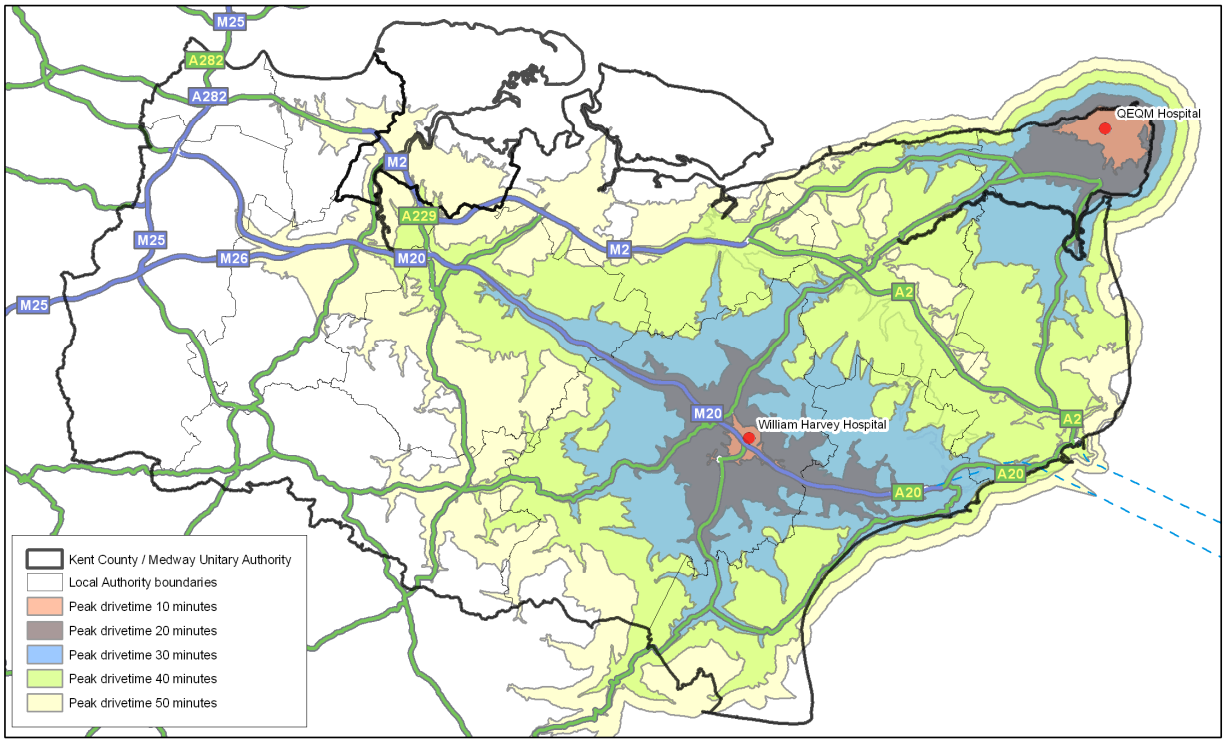
Kent & Medway Public Health Observatory



 Produced by Kent and Medway Public Health Observatory (KO) 13th Jluy 2011

Peak Time Drivetimes for William Harvey and QEQM Hospitals

Kent & Medway Public Health Observatory



 Produced by Kent and Medway Public Health Observatory (KO) 13th Jluy 2011

NHS
Kent and Medway

Maternity Review Communications and Citizen Engagement strategy

Background

East Kent Hospitals University NHS Foundation Trust currently offers a wide range of choice of maternity care for women.

- Choice for place of birth includes home birth
- Birth in a stand alone birth centre at either Canterbury or Dover (one temporary closure on safety)
- A co-located midwifery led unit at William Harvey (Singleton unit)
- Two consultant-led maternity units at William Harvey (WHH) and Queen Elizabeth Queen Mother (QEQM)

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

In 2010, it became apparent that maintaining services in this manner was becoming increasingly challenging in terms of staff resources, maintaining safety on all sites and provision of an equitable service.

The reason for this is thought to be two-fold. Firstly, a rise in the birth rate to 7,454 – with more parents choosing to use Ashford's co-located Singleton Unit at the William Harvey for the reasons of safety and reassurance, while birth rates at the stand alone midwife-led units have decreased year on year. Secondly, having the distribution of staff spread across four sites means those high risk, high volume units at the acute sites are under pressure, trying to maintain a sufficiently high level of one to one care for mothers and babies. Hence the decision was taken to temporarily cease deliveries at one stand alone MLU (first Dover and subsequently Kent and Canterbury) and reassign those staff to the WHH to focus on the unit with the highest volume of patients. The instigation of the review was to look at the way to maintain safe and effective services going forward. The PCT and Trust have formed a joint steering group to conduct the review with representation from the clinical commissioning groups, chaired by GP, Dr. Sarah Montgomery

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Author: Sara Warner

Business case

Births across EKHUFT had increased year on year up to 2008/09, and showed a 1.6 per cent increase from 2009/10 to 2010/11. Coupled with the increase, there has been an overall shift in activity levels.

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

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 per cent 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 (eg further pain relief such as epidural).

To achieve the enhanced staffing levels required to maintain safe services at WHH, 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.

In January 2011 the PCT and Trust instigated a maternity review to ensure east Kent would continue to deliver safe, equitable maternity services in east Kent. The temporary closure at Dover finished and it re-opened in January, instead Canterbury MLU was temporarily closed. To prevent further confusion and risk to parents this will continue until the end of the review.

Objectives

- Enable a robust two-way dialogue between the partner organisations and their staff, patients, GPs, stakeholders and the local population. Ensuring a transparent and well informed debate about the issues faced, and that any decisions taken are informed by both local opinion and clinical/workforce evidence that meets section 242 and 244 requirements.

Objectives
• GP clinical leads, and GPs are recognised as key stakeholders and have ongoing briefings and information on maternity review and progress made on evidence, national policy and practice, any potential service changes needed for a safe, sustainable service model and the impact it will have on their localities and their patients, and so complying with David Nicholson's four tests for strategic decision making around service change. • Enable members of the local community to become involved in, and are able to influence, the maternity review. Working with Maternity Services Liaison Committee as champions, and using contacts in children's centres and Sure Start centres or Young Active Parents' groups, to ensure conversations are had with parents where they are comfortable. • Ensure all NHS staff have access to adequate information about the maternity plans, and feel part of the process and listened to and that maternity staff in particular are able to lead the discussion. Working closely with midwifes to ensure they are actively involved and able to lead debate and reassure parents as to the temporary measures taken. • Reach out to quiet, seldom heard communities of interest, and use a range of mechanisms to reach as broad an audience as possible. Focus groups with YAP groups, parents of children with learning disabilities, fathers, etc. • Robust patient experience evidence is important strand of evidence to include in the review, review evidence collected for maternity strategy 2008. Use national survey evidence 2010, collect recent patient experience from those who have used services whilst temporary closures in place to quantify impact if any. Ensure parents with recent experience of pathway have plenty of opportunities to contribute their experience and views to influence the shaping of services. • Build close working relationships between partner organisations, patients, carers, public and stakeholders by providing information and support through established mechanisms such as Health Matters Reference Group, Virtual Panel, Foundation Trust governors, FT members and volunteers, PALS and LINKs, finding means for them to be involved. • Ensure stakeholders such as the Strategic Health Authority, MPs and Health Overview and Scrutiny Committees and LA partners are kept up to date with maternity developments and are able to influence plans. • Develop appropriate joint reporting, monitoring and communicating mechanism for communications and engagement activities

Objectives
with accountability to deliver on targets.

Key message
▪ This review will help us to deliver a key part of our Integrated Strategic and Operational Plan to provide better health services and outcomes for the people we serve. ▪ Our ambition for maternity and neonatal care is to ensure comprehensive, accessible and flexible services that respond to the clinical and social needs of women and their families at every stage of maternity and newborn care, and maximises the use of our skilled workforce within our fixed resources. ▪ The safety of mothers and their babies is our number one priority. The safety of the 7,000 babies born in east Kent each year will always be at the heart of any decision we make about how we design and deliver services. ▪ A rising birth rate across east Kent means the current pattern of provision is not sustainable. ▪ An increasing number of parents are choosing to give birth at William Harvey in Ashford alongside a decrease in parents choosing to give birth in Canterbury, Dover and Margate. ▪ The NHS needs to understand better the emerging pattern of choice so we can plan our services more appropriately. ▪ The review will ensure we have the right numbers and mix of teams of experienced midwives and doctors, in the right places to continue to provide a first-class and safe service for mothers and babies in east Kent. ▪ Our aim is to ensure one to one care for all mothers in established labour. ▪ No decision has been made to permanently close any of the birthing or maternity units in east Kent. ▪ The final decision will take into account local opinions alongside the latest clinical evidence, staff resources and the budget available in

Key message
these challenging economic times.

Target audiences

Target audience

- General public including parents and parents-to-be
- Community and voluntary support groups (National Childbirth Trust etc)
- Staff at PCT and EKHUFT particularly in midwifery, obstetrics and gynae, paediatrics
- GPs
- Maternity Services Liaison Committee
- Campaign groups, for example CHEK
- MPs, HOSC, councils
- Media
- Health Matters Reference Group and Kent LINk
- FT Governors, members, league of friends, volunteers
- NHS organisations SHA, Department of Health, neighbouring PCTs and Trusts
- Local Medical Committee, Local Dental Committee etc; royal colleges

Methods

1. General public
    - Your Health magazine
    - Media through press release, letters to editor,
    - Direct mail
    - Events – community roadshows, family events/playdays etc
    - Websites – PCT and ECKHFT; Mumsnet and Netmums

Target audiences

- Social media – Facebook and Twitter
- Virtual panel
- LINk

2. Women and their families due to give birth during review
   - Advice available through NHS midwives, PALs at EKHUFT and PCT
   - Information in GP surgeries, children's and Surestart centres, Mother and baby clinics

3. Staff working in the in EKHUFT particular midwifery, obstetrics, gynae
   - Work through EKHFT and its regular mechanisms
   - staff online survey
   - focus groups/roadshows

4. Maternity Services Liaison Committee (potential champions to help test papers/questionnaires, organise discussions, publicise through Facebook)
   - Regular meeting, monthly briefing

5. Other NHS staff
   - Utilise existing mechanisms in PCT and community provider, for example intranet, GP/independent contractor website and weekly e-bulletins.

6. GPs
   - GP briefings through GP bulletin, clinical representatives briefing their Clinical Commissioning Groups, clinical leads' regular development sessions, primarily regular updates to east Kent Commissioning Committee; letter from GP chair etc
   - Protected learning events; GP trainee programme
   - Individual visits to CCG meetings; LMC etc

7. Other NHS organisations/DH/SHA
   - Monthly stakeholder briefing

Target audiences

- Individual meetings

8. MPs, KCC
   - Monthly stakeholder briefing
   - Face-to-face meetings

9. HOSC Members
   - Regular monthly meeting written briefing, clinical leads and commissioners attend to provide detail

10. Other councillors
    - Monthly stakeholder brief, district overview and scrutiny committees, stakeholder events

11. Media
    - Regular press briefings
    - Regular press releases for any new developments
    - Instant rebuttal of any factually incorrect information

12. FT governors, members, leagues of friends, volunteers
    - Via EKHUFT mechanisms, stakeholder events, roadshows etc.

13. Community and Support groups (eg National Childbirth Trust, YAPs, BME groups etc)
    - Publish stakeholder brief
    - Update via infrastructure newsletter articles/letters
    - Attending meetings to brief as invited

14. HMRG/LINK
    - Potential partnership with LINk offering assistance
    - Brief at quarterly meetings
    - Monthly update through websites, e-bulletin, LINk newsletter

Target audiences

Budget
£50,000 including independent analysis, communication materials, surveys, postage, engagement events, publicity, public meetings

Methods

- Review current evidence: maternity strategy, focus groups for integrated plan and national maternity survey
- Interview parents who have recent experience of services
- Online survey of public with recent experience of services
- Online survey/hard copy NHS staff
- Focus groups seldom heard, YAPs, parents of children with learning disabilities, fathers, Gurhka families , eastern European migrant communities
- Roadshows drop in events: wider public parents, stakeholders
- Attend meetings of voluntary and community sector to brief and discuss issues
- Attend family friendly events: teddy bear picnics, play days etc wider community who may not use other services
- Public meetings in localities to debate evidence and consider any changes with stakeholders and public
- Stakeholder workshops – option appraisal
- Film mother and midwife views to stimulate debate online and use at meetings if spokespeople not available

Key spokespeople

With clinical backgrounds

- Lindsey Stevens – Head of Midwifery at EKHUFT
- Dr Sarah Montgomery – GP clinical lead for maternity review

Methods

- Dr. Neil Martin – Medical Director, EKHUFT
- Dr. Kate Neale – Consultant Obstetrician, EKHUFT
- Dr. Anne Weatherly – C4 representation
- Dr. Chee Mah – Deal Consortium representation
- Dr. Jessica Crouch – Ashford CCG
- Jill Blackman (Practice Manager, The Surgery Sun Lane, Shepway)

NHS Kent and Medway Commissioners

- Helen Buckingham – Director Lead for Commissioning Maternity NHS Kent and Medway
- James Ransom - Lead Commissioner for Maternity ECKPCT
- Anne Judges, Project Lead

Timescales

Jan – March, plan and agree terms of partnership scope of review
April – August, pre consultation engagement, review current evidence,
Autumn formal consultation
Analysis of response, final formal evidence submission* recommend independent analysis
Decision in New Year ratified by both Boards

Evaluation

Ongoing during process of different aspects; test surveys with patients and staff,
MSLC – act as reference group and test for plans, delivery and publicising

Evaluation
Build into independent analysis briefing to assess reach of review and range of responses received.

Risks
• Border areas have recently reviewed maternity – in West Kent and East Sussex – concerning changes to maternity provision. Local campaigns may restart or cause confusion with east Kent issues • Heightened level of interest due to above, both local and national coverage e.g. recent Panorama programme on maternity care • Adversarial campaigns due to locality/site issues • Tight timescale and resources to deliver effectively • Partnership working requires additional time and planning