HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 14th October, 2011

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 14th October, 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 and 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)	Dr M Eddy and Mr M J Fittock

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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 (Pages 1 - 8)	
5.	Reducing Accident and Emergency Admissions: Part 1 (Pages 9 - 56)	10:00 – 11:20
6.	East Kent Maternity Services Review (Pages 57 - 74)	11:20 – 12:00
7.	Eating Disorders Review (Pages 75 - 80)	12:00 – 12:05
8.	Child and Adolescent Mental Health Services (CAMHS) (Pages 81 - 88)	12:05- 12:10
9.	NHS Financial Sustainability Review: Written Update (Pages 89 - 114)	12:10- 12:15
10.	HOSC and the Local Dimension (Pages 115 - 130)	12:15 – 12:35
11.	Forward Work Programme (Pages 131 - 132)	12:35 – 12:45
12.	Date of next programmed meeting – Friday 25 November 2011 @ 10:00 am	

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

6 October 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, 9 September 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, Mrs E Green, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Cllr J Burden, Cllr R Davison, Cllr Geoffrey Lymer, Cllr M Lyons, Mr M J Fittock, and Mr R Kendall

ALSO PRESENT: Cllr Mrs A Blackmore, Cllr J Cunningham, Mr L B Ridings, MBE, Cllr John Avey, Christine Baker, Shirley Griffiths, Cllr Vince Maple, and Cllr Julie Shaw

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Minutes
(Item 4)

(1) It was noted that the sentence in paragraph 3 on page 2 of the Minutes should read, "…Medway was closer to Maidstone than Darent Valley…".

(2) RESOLVED that, subject to this amendment, the Minutes of the Meeting of 22 July 2011 are recorded and that they be signed by the Chairman.

3. NHS Transition
(Item 5)

Roger Gough (Cabinet Member for Business Strategy, Performance and Health Reform, Kent County Council), Meradin Peachey (Kent Director of Public Health), Hazel Carpenter (Director of Commissioning Development and Transition, NHS Kent and Medway), Tish Gailey (Health Policy Manager, Kent County Council), Lorraine Denoris (Director of Citizen Engagement and Communications, NHS Eastern and Coastal Kent), Dr Mike Parks (Medical Secretary, Kent Local Medical Committee), and Di Tyas (Deputy Clerk, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the item and explained that although the complete picture around the changes to the health sector was incomplete, it was important to take this opportunity to take stock and gain a better understanding of the ongoing changes. A large part of this was to understand the new

language which was developing as time went on with GP Commissioning Consortia (GPCC) now being referred to as Clinical Commissioning Groups (CCG). A number of Members mentioned the plethora of acronyms which needed to be understood. It was observed that the Background Note which formed part of the Agenda was a useful and accessible summary of the changes and the new terms.

(2) The Cabinet Member for Business Strategy, Performance and Health Reform at Kent County Council then provided an overview of the work which had been going on relating to the NHS Transition within Kent. The main element he wished to stress was the growing and positive relationship with the GP community as a whole and the emerging CCGs in particular. This was demonstrated by the fact that all CCGs wish to be represented on the Health and Wellbeing Board, which had been strengthened as a result of the 'pause' earlier this year, rather than delegate their role. County Council had approved the establishment of the Health and Wellbeing Board (HWB) in July and the first formal meeting would take place on 28 September. Precursor meetings earlier this year had looked at the Joint Strategic Needs Assessment (JSNA) which would in the future be produced by the HWB. As a general rule, awareness of it amongst GPs had not been high, but this was being looked at and the JSNA work would also feed into the production by the HWB of the Joint Health and Wellbeing Strategy. It was anticipated that not all work would be carried out at the County HWB level. Dover had also been awarded early implementer HWB status and there was good work being carried out there as well as by locality boards across the County. One ongoing issue was that CCGs tended not to be coterminous with Borough boundaries, with at least one crossing 4 of them. Moving on, he expressed the view that there was a natural and good division of labour between HOSC and the HWB. The Health Overview and Scrutiny Committee (HOSC) would be able to provide necessary challenge to the HWB on key areas such as the success of integrated working. Service reconfiguration had been a core area of HOSC work in the past, and this would continue, but it was possible the HWB would become involved in this also. In answer to a specific question, it was confirmed that the HWB would meet in public.

(3) There was a discussion about the ongoing uncertainty and some Members felt that the final position regarding how the health sector will work in the future will differ from how it is being expressed currently. It was also observed that a lot of the detail will only be known following Royal Assent of the Health and Social Care Bill when guidance was published and made available.

(4) Several common themes ran through the discussion. One was a concern that the proposed new structures would add bureaucracy to the NHS, when what was needed was a reduction. Another was that the changes only increased the importance of the HOSC in maintaining a strategic overview of the entire health economy.

(5) A third was the importance of enabling patient choice and not losing the focus on improving patient pathways, with one Member wondering whether a Select Committee on this latter topic was possible. In answer to a specific question, it was explained that there was no upper limit to the cost of medication, but where two were equally efficacious, then there was an expectation the

cheaper would be prescribed. It was also explained that a team of prescription advisors were available to GPs. More broadly it was explained that GPs had been involved in improving clinical pathways and commissioning for a number of years, and that what was happening now was that GPs were becoming responsible for the budgets. There were also some concrete examples already of how GPs had been moved into decision making positions and how this had improved pathways. One example was the joint working between CCGs and social services which had resulted in a memory clinic within each Borough.

(6) While it was recognised that there may not be many changes to report, the Committee requested that this issue return to the Agenda for the 25 November. The Chairman also mentioned, as a related subject, that he had asked for a discussion paper on HOSC and the local dimension to be prepared for the 14 October meeting.

(7) AGREED that the Committee note the report and further discussion this item at the 25 November meeting.

4. Trauma Services in Kent and Medway
(Item 6)

Nicola Brooks (Head of Medical Services, South East Coast Ambulance Service NHS Foundation Trust), Matthew England (Clinical Quality Manager, South East Coast Ambulance Service NHS Foundation Trust), Dr Marie Beckett (A&E Consultant, East Kent Hospitals NHS University Foundation Trust), Dr Patricia Davies (Dartford, Gravesham and Swanley Clinical Commissioning Group) and Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway) were in attendance for this item.

(1) The Chairman welcomed the Members of Medway Council's Health and Adult Social Care Committee who were present as guests of the Committee. Both Committees had previously examined the proposals but the Kent HOSC wished to follow up on a number of key issues.

(2) There was a broad consensus around some of the main reasons why the trauma network in Kent and Medway needed developing. Nationally there was variation between the survival rates for trauma between hospitals and there was often a lack of appropriate coverage at the weekend. This had led to the development of a national plan and the appointment of a national tsar. However, the staffing requirements to give full coverage and the number of trauma patients in Kent and Medway annually meant it was not possible for every Accident and Emergency Department to contain a Trauma Unit. In the event of an incident, the aim is that patients whose injury was over 15 on the Injury Severity Score (ISS) be taken to a Trauma Unit for stabilisation. Of the 488,189 emergency cases across Kent and Medway in 2010/11, 202 of them, or 0.04%, had an ISS of over 15. Of these, over 50% had been able to be taken to a Major Trauma Centre, mainly King's in London, within 45 minutes. In sum, less than 100 patients a year require stabilisation.

(3) Members asked a number of specific questions. In answer to one it was confirmed that all the designated Accident and Emergency Departments have a majors and a resuscitation room. Another one confirmed that a patient from

Broadstairs would be taken to Medway in the first instance and this was possible within the 45 minute target. Thirdly, it was not regarded as feasible to reverse the services available at Maidstone and Pembury respectively because of all the equipment necessary for a Trauma Unit which would also need to be moved.

(4) Representatives from the South East Coast Ambulance Service explained the process of hot secondary transfer. Trauma was a priority for the service and Critical Care Paramedics would be despatched to an incident. Where there was a procedure which could not be carried out by a paramedic, perhaps involving the airways or a chest drain, then the process would be to take the patient to the nearest Trauma Unit, where the patient would stay on the ambulance trolley, for stabilisation before transfer to a Major Trauma Centre. There were also doctors who volunteered to attend the scenes of incidents and these clinicians were able to provide a range of treatments paramedics could not.

(5) In terms of data and performance monitoring, it was explained that there were robust information technology and monitoring systems in place. Data was shared across the care pathway and assessed against national bench markers.

(6) A number of Members expressed concerns about emergency resilience planning, particularly in the context of the Olympic Games taking place in 2012. The Chairman explained that there was a window of opportunity at the January meeting and NHS colleagues explained that they were more than happy to return with detailed information on this topic at that time.

(7) AGREED that the Committee note the report.

5. East Kent Maternity Services Review
(Item 7)

Dr. Neil Martin (Medical Director, East Kent Hospitals NHS University Foundation Trust), Dr. Sarah Montgomery (GP Clinical Commissioner), Lindsey Stevens, Head of Midwifery, East Kent Hospitals NHS University Foundation Trust), Ann Judges (Maternity Lead, NHS Kent and Medway), 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 thanking the Members of the Informal HOSC Liaison Group which had been established to consider this matter over the summer and those Members who had been able to attend a meeting at Kent and Canterbury Hospital on 17 August. He explained that these three, Nigel Collor, Dan Daley and Roland Tolputt would be asked to begin discussion of this item by providing a brief verbal report on their findings. The Chairman also explained that he had written to the MPs and District and Borough Council Leaders inviting their views on this matter but that it had been short notice and so the fact comments had not been received from all

those who had been written to was no reflection on their interest. One comment from Roger Gale MP expressing support for the conclusions of the Hospitals Trust following a briefing with them was read out by the Chairman.

(2) It was also explained by the Chairman that we were currently in the pre-engagement stage and that the role of the Committee was to challenge the NHS on behalf of Kent residents and ensure their concerns are debated and answered.

(3) The Members of the informal HOSC Liaison Group each thanked colleagues in the NHS for their assistance over the summer and for arranging the informative meeting. A range of points arose from the feedback. Firstly there was a need to understand the broader context within which these changes were being proposed as the location of the existing hospitals was not necessarily ideal in that the Queen Elizabeth the Queen Mother (QEQM) Hospital in Margate had issues around difficulty of access, whereas Folkestone, the largest town in East Kent, had no hospital. The present arrangement of services came out of a reconfiguration 11 years ago and one Member commented that people would need to be assured that any proposals were sustainable in the longer term. It was also recognised that there were important difference between this situation and the reconfiguration of women's and children's services at Maidstone and Tunbridge Wells NHS Trust but that one lesson that needed to be learnt was the importance of ensuring the GP community supported the proposals. One Member reported having spoken to a number of people and there was a strong feeling in favour of the status quo. One Member expressed support for the concept of Alongside Midwifery Led Units as they struck the balance between choice and safety. It was felt that the current ongoing NHS reorganisation might be a good time to look at the tariff for maternity services with a view to ensuring it reflected the true cost of delivering a quality service.

(4) A request was made of the NHS for details of location of birth broken down by postcode of residence.

(5) On the subject of GP involvement, it was stressed by representatives of the NHS that GPs had very little influence over choice of place of birth. This was a decision usually made by mothers with midwives, based on the risk factors present in the mother's medical history. Concerning the review, Dr. Montgomery explained that it was her responsibility to keep GP colleagues informed. This was done through informal weekly meetings and formal monthly clinical commissioning meetings. Kent Local Medical Committee officers have been present at the monthly meetings. GP commissioning groups had seen the same papers as the Committee to comment on and formal support has been received from GP commissioning boards in Ashford, Canterbury and Dover, with informal support being received from elsewhere.

(6) Members raised the issue of whether there was adequate capacity within maternity services, not only in East Kent, and more broadly across the county as a whole. The view was expressed that at first glance it appeared strange to be discussing the possible closure of birthing centres when the number of births was increasing along with a broader growth in population. It was acknowledged by representatives of the NHS that there were issues across

Kent and Medway and that work was being undertaken by NHS Kent and Medway and all providers on a pan-escalation policy across the whole area. Specifically on capacity in East Kent it was explained that the alongside midwifery-led unit at the QEQM with 4 labour beds has yet to open, but that it would, increasing capacity. The alongside midwifery-led unit at the William Harvey Hospital in Ashford currently had 8 beds and delivered around 600 births each year and there were plans to increase this to 1,000 births per annum. Also within William Harvey, there were plans for two additional beds in the consultant-led unit. Concerning the capacity for home births, there was a community midwifery service in place and that would remain. No increase in home births has been seen compared to other years during the temporary closures of Dover and Canterbury. No increase in activity from the Maidstone area to William Harvey had yet been seen, but was under review. Dr Martin explained that the issue of beds was being looked at but that the crux of the capacity issue was the ratio of midwives to births in order to cope with the peaks and troughs of demand and that a £700,000 investment was being sought to raise the ratio from 1:32 to 1:28. It was also explained that there was no midwifery recruitment issue in East Kent, partly due to the location of the University, and two cohorts had been recruited this year.

(7) A range of views was expressed around the question of choice with one Member expressing the view that while capacity might go up, choice would go down under some of the options put forward, with the potential closure of the midwifery-led units in Canterbury and Dover. An alternative perspective was offered by representatives from the NHS in that choice needed to be realistic and affordable and that hospitals with consultant-led units and alongside midwifery-led units offered that choice. The focus of the NHS was on ensuring a safe and sustainable service for the 7,000 women each year who had no choice but to give birth in an obstetric unit.

(8) There was a wide-ranging discussion of a series of connected points around deprivation, access to services, and travelling, exacerbated by the peninsular and coastal nature of the eastern half of the county. While it was accepted that there were pockets of deprivation everywhere, it was acknowledged that in some areas, such as Dover, the lack of access to a car was a particular problem. NHS representatives were keen to stress that ante- and post-natal clinics would still take place at Canterbury and Dover and these accounted for the majority of trips taken during the maternity care pathway and that the majority of women currently already travelled to either Ashford or Margate for birth itself. A number of Members felt there was a need for firmer reassurances about the future of the whole range of women's and children's services as well as more certainty about the long term future of the Buckland Hospital site.

(9) On the subject of the forthcoming public consultation, representatives from the NHS explained that a wide ranging engagement exercise had already been carried out and that the NHS would continue to actively seek the views of mums-to-be, stakeholders and the wider public during what was likely to be a 13-14 week consultation. Social media was being utilised and there was daily communication with the local media as well. Members of the Committee felt that there was a need to be assured that the consultation was going to be a genuine listening exercise and the guests from the NHS were invited back to

the next meeting of the Committee, on 14 October, to discuss more fully the plans for the consultation process, which should have already just commenced.

(10) The offer was made to the Members of the Informal HOSC Liaison Group to continue to be involved in the development of the review prior to this meeting. It was agreed that Mrs Elizabeth Green should join this group.

(11) AGREED that the Committee consider and note the report and that the NHS be invited back to further discuss this topic at the meeting of 14 October.

6. Date of next programmed meeting – Friday 14 October 2011 @ 10:00
(Item 8)

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 October 2011

Subject: Reducing Accident and Emergency Admissions: Part 1.

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1. Background

(a) At the meeting of 10 June, the Committee approved the Forward Work Programme which included a two-part review into reducing attendances at accident and emergency departments. This was further highlighted as a future area of HOSC work in the Committee's report on NHS Financial Sustainability.

(b) The strategic questions which this review will seek to answer are:

- What is the impact of the current levels of attendance at accident and emergency departments on the sustainability of health services across Kent and Medway?
- How can levels of attendance best be reduced?

(c) In order to make the topic manageable, NHS organisations have been invited in two groups as follows:

14 October:

- NHS Kent and Medway
- Kent and Medway NHS and Social Care Partnership Trust
- Kent Community Health NHS Trust
- South East Coast Ambulance Service NHS Foundation Trust

25 November:

- Dartford and Gravesham NHS Trust
- East Kent Hospitals NHS University Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust
- Medway NHS Foundation Trust

(d) Due to the system-wide nature of the subject, it is possible that representatives from Trusts other than those given for a specific date may attend for the other session in support of other colleagues.

(e) The specific questions submitted to the different NHS organisation are appended to this report.

2. Recommendation

That the Committee consider and note the report.

Appendix – Questions from the Committee

Questions for Commissioners

1. Can you provide an outline of the range of urgent and emergency healthcare services available in Kent and Medway?

2. Specifically, what is the definition of 'minor injury' and 'Minor Injuries Unit'?

3. How do people currently access urgent and emergency services and how is this being developed? In particular, how is public awareness of the most appropriate service to access, for example Minor Injuries Unit against Accident and Emergency Department, being raised?

4. Since 2008, broken down by quarter, what have the numbers of attendances at accident and emergency departments been across the Kent and Medway health economy? How many of these have been:
    a. new attendances
    b. emergency readmissions

5. How do these trends compare to those:
    a. across the south east?
    b. nationally?

6. What factors explain this change?

7. Why is it important to reduce attendance at accident and emergency departments?

8. What work is being undertaken currently, and planned for the future, aimed at reducing accident and emergency attendance?

9. What are the main challenges to reducing attendance at accident and emergency departments?

10. How much is spent on urgent and emergency care services across the health economy and how much solely on attendance at accident and emergency departments?

11. What is the place of urgent and emergency care in the QIPP programme across Kent and Medway?

Questions for Kent and Medway NHS and Social Care Partnership Trust

1. Do the current levels of attendance at accident and emergency departments pose any particular challenge for the delivery of mental health services?

2. What is the role of mental health services in reducing attendances at accident and emergency departments?

3. What is the place of urgent and emergency care in your organisation's QIPP programme?

4. From the perspective of the mental health service, what are the main challenges to reducing attendance at accident and emergency departments?

Questions for Kent Community Health NHS Trust

1. Do the current levels of attendance at accident and emergency departments pose any particular challenge for the delivery of community health services?

2. What is the role of community health services in reducing attendances at accident and emergency departments?

3. What is the place of urgent and emergency care in your organisation's QIPP programme?

4. From the perspective of the community health service, what are the main challenges to reducing attendance at accident and emergency departments?

Questions for the Ambulance Service

1. Since 2008, broken down by quarter, how many 999 calls have been received in Kent and Medway by the ambulance service? Specifically, how many of these were:
   a. Category A?
   b. Category B?

2. Since 2008, broken down by quarter, what proportion of emergency calls result in a patient being taken to an accident and emergency department in Kent and Medway?

3. What is the place of urgent and emergency care in your organisation's QIPP programme?

4. From the perspective of the ambulance service, what are the main challenges to reducing attendance at accident and emergency departments?

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

To: Health Overview and Scrutiny Committee, 14 October 2011

Subject: Reducing Accident and Emergency Admissions

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1. Introduction

(a) One of the main drivers in health policy in recent years has been to deliver more care outside of acute hospital settings. A distinction can be made between two kinds of shift:

i. a shift where the same work which would have been carried out in an acute setting is carried out elsewhere, such as outpatient follow-ups by a GP.

ii. a shift where work is provided in other ways forestalling the need for work in acute settings, such as closer monitoring of people with chronic conditions to prevent A&E attendances.[1]

(b) A distinction needs to be made between attendance at accident and emergency (A&E) departments and patients admitted via A&E, but both are important areas of focus.

(c) The QIPP (Quality, Innovation, Productivity and Prevention) is a series of 12 workstreams aimed at making efficiency savings to be reinvested in services. Across the NHS in England as a whole, the QIPP target is to find £20 billion in efficiency saving by the end of 2014/15[2].

(d) The QIPP workstream on urgent care:

i. "aims to maximise the number of instances when the right care is given by the right person at the right place and right time for patients. The workstream starts from a perspective that rather than 'educating' patients about where it is appropriate for them to go, we should focus on designing a simple system that guides them to where they should go;" and

ii. "aims to achieve a 10 percent reduction in the number of patients attending Accident and Emergency with associated reductions in ambulance journeys and admissions."[3]

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[1] World Health Organisation, *United Kingdom (England) Health System Review*, 2011, p.246.
[2] The Department of Health, *Quality Innovation, Productivity and Prevention,* http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm
[3] The Department of Health, *Urgent care,* http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115468

(e) The Department of Health broadly defines urgent and emergency care as "the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly."[4] The following sections provide an overview of the range of services; it is not exhaustive.

2. Accident and Emergency (A&E) Departments

(a) There are three types of A&E department[5]:

Type 1 = A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients

Type 2 = A consultant led single specialty accident and emergency service (e.g. dental).

Type 3 = Other type of A&E/minor injury units (MIUs)/Walk-in Centres, primarily designed for the receiving of accident and emergency patients. An appointment based service (for example an outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example most out of hours services), or a dedicated primary care service (such as GP practice or GP-led health centre) is not a type 3 A&E service even though it may treat a number of patients with minor illness or injury.

(b) Selected key trends for A&E across England:

- Attendances at Type 1 A&E departments are the main source of emergency admissions to hospital[6].
- Emergency admissions rose by 11.8% equalling 1.35 million additional admissions from 2004/05 to 2008/09[7].
- The number of attendances at Type 1 departments grew by 1.2% and the proportion admitted as emergencies grew by 14.3% from 2004/05 to 2008/09[8].

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[4] The Department of Health, *Urgent and emergency care,* http://www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/index.htm

[5] The Department of Health, *Quarterly Monitoring of Accident and Emergency (QMAE), Guidances, FAQs and Simple form,* p.3, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_129783.doc

[6] The Nuffield Trust, *Trends in emergency admissions in England 2004-2009: is greater efficiency breeding inefficiency?*, p.1, http://www.nuffieldtrust.org.uk/publications/trends-emergency-admissions-england-2004-2009.

[7] Ibid., p.1.

[8] Ibid., p.1.

- Across all three types of A&E, there was a 10% increase in attendance from 2004/05 to 2008/09 with the majority of the additional attendances being at Types 2 and 3[9].

- Emergency admissions accounted for around 65% of hospital bed days in 2007/08 which equates to 34 million bed days or 4.75 million emergency admissions[10].

- The majority of attendances at A&E are self-referrals (65.5% in 2009/10) with referrals from GPs and the emergency services at 6.4% and 9.3% respectively (also for 2009/10). Around 25% arrive by ambulance or helicopter.[11]

(c) Modern A&E departments began to evolve from casualty wards across the country in the 1960s, with the first posts in the A&E specialty piloted by the then Department of Health and Social Security in 1972[12]. Issues around long delays within A&E departments led to *The NHS Plan* of 2000, the publication of a ten year strategy, *Reforming Emergency Care* in 2001 and the target of 98% of patients being admitted, discharged or transferred within 4 hours being agreed in January 2004 as part of a five point plan[13].

(d) From 1 April 2011, the 4-hour standard was replaced by a series of clinical quality indicators. The five headline measures are[14]:

- Unplanned re-attendance
- Left without being seen rate
- Total time spent in A&E department
- Time to initial assessment
- Time to treatment

(e) There are three other indicators as supporting measures[15]:

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[9] Ibid. pp.6-7.
[10] The Kings Fund, *Avoiding Hospital Admissions. What does the research evidence say?*, December 2010, p.1, http://www.kingsfund.org.uk/publications/avoiding_hospital.html
[11] NHS Information Centre, *Accident and Emergency Attendances in England (Experimental Statistics) 2009*-10, January 2011, p.15, http://www.ic.nhs.uk/webfiles/publications/004_Hospital_Care/HES/aandeattendance0910/AE_Attendances_in_England_Experimental_statistics_2009-10__v2.pdf
[12] Department of Health, *Transforming Emergency Care in England*, October 2004, p.5, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4091781.pdf
[13] Ibid., pp.16-19.
[14] The Department of Health, *Dear Colleague Letter. Performance Management of NHS A&E Services Using the Clinical Quality Indicators*, June 2011, p.4, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128536.pdf

- Ambulatory care
- Service experience
- Consultant sign-off

3. Ambulance Services

(a) The Ambulance Services across England have developed in a number of ways over the past decade. For example, there has been the development of two types of specialist paramedic. Critical Care Paramedics (CCPs) have received additional training and education in order to enable them to work in the critical care environment, often alongside doctors at the scene, and to undertake intensive care transfers between hospitals. Paramedic Practitioners (PPs) have received additional training and education to give them greater patient assessment skills. They are able to treat many minor injuries and illnesses ('see and treat') in patients' homes and in the community, bypassing the need to be seen in an Accident and Emergency Department[16].

(b) In 2010/11 the ambulance service overall received 8.08 million calls across England, which was a 2.7% increase, with 6.61 million calls (81.8%) resulting in an emergency response arriving at the scene which was a 3% increase on the previous year[17].

(c) *The NHS Plan* of 2000 also led to the target for 75% of Category A calls (life threatening emergencies) to be responded to within 8 minutes[18]. A set of 11 clinical indicators was introduced in April 2011 and the Category B 19 minute target removed[19]. The Category A targets remain[20].

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[15] Department of Health, *A&E Clinical Quality Indicators Implementation Guidance,* p.11, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123055.pdf

[16] South East Coast Ambulance Service NHS Foundation Trust, *Integrated Business Plan 2010-2015*, p.38, http://www.secamb.nhs.uk/about_us/our_vision_and_strategy.aspx

[17] NHS Information Centre, *Ambulance Services England 2010-11*, June 2011, p.4, http://www.ic.nhs.uk/webfiles/publications/Audits%20and%20Performance/Ambulance/Ambulance%20Service%202010_11/Ambulance_Services_England_2010_11.pdf

[18] Department of Health, *Transforming Emergency Care in England*, October 2004, p.12, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4091781.pdf

[19] South East Coast Ambulance Service NHS Foundation Trust, *Clinical Quality Indicators,* http://www.secamb.nhs.uk/about_us/our_performance/response_time_targets/clinical_quality_indicators.aspx

[20] Department of Health, *Reforming urgent and emergency care performance management*, July 2011, http://www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/DH_121239

4. Out of Hours

(a) Out of hours GP services received 8.6 million calls and completed 6.8 million medical assessments across England in 2007/08[21].

(b) In 2000, the Department of Health (DoH) commissioned a review of out-of-hours (OOH) services (referred to as the Carson Review). Its recommendations, combined with *The NHS Plan*, established the foundations for current OOH services[22].

(c) Following the Care Quality Commission's enquiry into Take Care Now, the Department of Health commissioned a report into GP out-of-hours services from Dr David Colin-Thomé, National Clinical Director for Primary Care at the Department of Health, and Professor Steve Field, Chairman of Council, Royal College of General Practitioners which made a number of recommendations[23].

(d) As set out in the NHS White Paper, out of hours services are set to be redefined as part of an integrated 24/7 urgent care service (see below).

5. NHS Direct

(a) NHS Direct has been available nationwide since October 2000[24]. It became an NHS Trust in 2007[25].

(b) It undertook 12.5 million assessments in 2010/11 - 4.5 million calls through to the national 0845 4647 number and 8 million assessments through the online service across England. 55% of assessments were completed by NHS Direct with no need for face to face contact[26].

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[21] The Healthcare Commission, *Not just a matter of time. A review of urgent and emergency care services in England,* September 2008, p.12, http://www.cqc.org.uk/_db/_documents/Not_just_a_matter_of_time_-_A_review_of_urgent_and_emergency_care_services_in_England_200810155901.pdf

[22] National Audit Office, *The Provision of Out-of-Hours Care in England. Full Report,* p.4, May 2006, http://www.nao.org.uk/publications/0506/the_provision_of_out-of-hours.aspx#

[23] Department of Health, *General Practice Out-Of-Hours Services. Project to consider and assess current arrangements,* January 2010, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111893.pdf

[24] NHS Direct, *History*, http://www.nhsdirect.nhs.uk/About/History

[25] NHS Direct, *Annual Report and Accounts 2008/09,* p.41, http://www.nhsdirect.nhs.uk/About/OperatingStatistics/~/media/Files/AnnualReportArchive/AnnualReport_2009.ashx

[26] RCGP Centre for Commissioning, *Guidance for commissioning integrated urgent and emergency care. A 'whole system' approach*, August 2011, p.21, http://commissioning.rcgp.org.uk/wp-content/uploads/2011/09/RCGP-Urgent-Emergency-Commissioning-Guide-v2.pdf

6. Other Primary Care

(a) GP in-hours services (GPs and practice nurses) deal with around 290 million consultations each year, with a growth rate of 3% each year between 1995 and 2006[27].

(b) Pharmacy services dispense c.750 million prescription items each year, and there are 1.8 million visits each day to community pharmacists[28].

(c) A proportion of the work of both GPs and Pharmacists concern urgent and emergency care.

7. Mental Health Services

(a) An estimated 5% of those attending A&E have a primary diagnosis of mental ill health. The largest groups within this are substance abuse and deliberate self-harm.

(b) A further 20-30% of attendees have coexisting physical and psychological problems.

(c) Overall, it has been estimated that around 35% of A&E attendances are alcohol related (including violent assaults, road traffic accidents, mental health emergencies and deliberate self-harm)[29].

(d) There is a range of health services involved in urgent and emergency care for people with mental health problems – including crisis resolution home treatment teams (CRHT) and liaison psychiatry services. CRHT provide treatment at home for those who are acutely unwell but do not require A&E admission[30]. Liaison psychiatry provides psychiatric treatment to patients attending general hospitals, whether they attend out-patient clinics, accident & emergency departments or are admitted to in-patient wards[31].

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[27] Ibid., p.21.
[28] Ibid., p.22.
[29] Department of Health, *Checklist Improving the management of patients with mental ill health in emergency care* settings, September 2004, p.3 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4089197.pdf
[30] Royal College of Psychiatrists, *Acute mental health care: briefing note*, November 2009, p.5, http://www.rcpsych.ac.uk/Docs/Acute%20mental%20health%20care%20briefing%20final%2097-03%20version.doc
[31] Royal College of Psychiatrists, *Faculty of Liaison Psychiatry*, http://www.rcpsych.ac.uk/specialties/faculties/liaison.aspx

8. A 24/7 Urgent Care Service

(a) The NHS White Paper, *Equity and Excellence: Liberating the NHS*, contains the following policy intention:

i. "Develop a coherent 24/7 urgent care service in every area of England that makes sense to patients when they have to make choices about their care. This will incorporate GP out-of-hours services and provide urgent medical care for people registered with a GP elsewhere. We will make care more accessible by introducing, informed by evaluation, a single telephone number for every kind of urgent and social care and by using technology to help people communicate with their clinicians."[32]

(b) The new NHS 111 service is currently being piloted with the intention that it becomes an England-wide non-emergency healthcare service on a three-digit telephone number[33]. It is currently available in County Durham and Darlington, Nottingham City, Lincolnshire and Luton[34]. When rolled out nationally by April 2013, it will replace the NHS Direct number, though NHS Direct is expected to continue, alongside other providers[35]. It will be commissioned locally[36].

[32] Department of Health, *Equity and Excellence: Liberating the* NHS, July 2010, p.18 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

[33] Ofcom, *New 111 non-emergency healthcare phone number confirmed*, December 2009, http://media.ofcom.org.uk/2009/12/18/new-111-non-emergency-healthcare-phone-number-confirmed/

[34] Department of Health, *Press Release: Prime Minister and Health Secretary announce new commitments on 24/7 NHS care*, 1 October 2011, http://mediacentre.dh.gov.uk/2011/10/01/prime-minister-health-secretary-new-commitments-247-nhs-care/

[35] Department of Health, *NHS 111*, November 2010, http://www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/DH_115054

[36] Department of Health, *Dear Colleague Letter. Rolling out the NHS 111 Service,* August 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129104.pdf

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NHS
Kent and Medway

REDUCING ACCIDENT AND EMERGENCY ADMISSIONS

This briefing responds to the specific questions raised. Examples are used rather than attempting to summarise the detailed activity or the wide range of plans within each Clinical Commissioning Group area.

QUESTIONS FOR COMMISSIONERS

1 Can you provide an outline of the range of urgent and emergency healthcare services available in Kent & Medway?

The current arrangements for urgent healthcare are as follows:

A Self care, supported by professional advice:

NHS Direct respond to around 9,000 calls per month in Kent and Medway. Of these around 64% are managed by telephone, 23% are advised to see a primary care clinician, and 13% are advised to attend A&E or call 999.

B Primary Care:

All GP surgeries offer urgent appointments on the day, and home visiting where required. Many have arrangements to enable telephone advice for urgent requests.

The GP out of hours service for Kent (excluding Medway) is provided by South East Health. They manage over 20,000 calls per month. Of these around 75% of patients are advised by telephone, or referred directly to another service. 20% are seen at a base and 6% receive a home visit. The Out of Hours (OOH) services provide access to community nurses and can draw on other services such as social care and palliative care.

An emergency dental service is provided via a central telephone access point for all Kent and Medway. Local commissioning variations apply but the service is available every evening, seven days a week and Saturday, Sunday and Bank Holiday mornings. The caller is taken through a triage process and if applicable is booked into a local dental practice.

Community pharmacies provide a comprehensive range of free advice, mainly seven days a week and often with extended hours. Emergency supply of medication is usually available, especially for regular patients. Most pharmacies also provide additional urgent services such as emergency contraception and minor ailments services as well as a range of health promotion services such as smoking cessation.

C Specific help-lines and direct access for particular conditions:

There are a range of direct access arrangements for patients with particular conditions to enable them to access urgent advice from the team providing their specific care. This includes palliative care patients, those with particular long term conditions such as heart failure and COPD (Chronic Obstructive Pulmonary Disease), and mental health patients.

A number of ' Rapid Access Clinics' are being set up for complex elderly patients with certain acute or chronic conditions which are perceived as urgent by the GP, requiring prompt clinical assessment, diagnosis and treatment, but whose condition does not require hospital admission. These geriatrician-led clinics are supported by a multi-disciplinary team providing specialist assessment and treatment where appropriate (nursing, physiotherapy, occupational therapy, social care and mental health care) both during the clinic and afterwards, to ensure the appropriate on-going management of the client group. Conditions suitable for referral include falls-related injury, certain respiratory, cardiac or musculoskeletal conditions and complicated urinary infections.

Women across Kent and Medway can access midwifery services directly at any point in their pregnancy, it is not necessary to be referred by a GP. This means that from the point that a women thinks she is pregnant, and then throughout her pregnancy and into her postnatal care, she can contact her local midwifery services to arrange to see a midwife. Women can also access emergency obstetric services at any time in their pregnancy should that be necessary.

Paediatric services: Self referring Children and young people across Kent and Medway will be seen, assessed, treated in Minor Injury Units (MIUs), Walk-in Centres (WIC), Emergency Care Centres (ECC) and A&E departments. Those children who need an assessment by a paediatrician will either be seen in A&E by a paediatrician or referred to a short stay paediatric assessment unit where a child can be observed and assessed in a child appropriate setting, before being admitted to a ward or discharge home. GPs and other health professional are able to refer children direct to the assessment units.

Parents of children with long term conditions are advised when to contact specialist services. In some areas this is direct to the paediatric ward, in others it is via A&E. EKHUFT (for east Kent) are aware of these children but prefer that in the first instance they enter hospital via A&E to ensure that the current problem is diagnosed, treated correctly and immediately, particularly during the Out Of Hours period, before the child is admitted to the ward. Medway have a Red Card system that allows the responsible adult or ambulance crew to take the child directly to the ward. Maidstone and Tunbridge Wells NHS Trust (MTW) has a direct access pathway for children to the assessment unit or ward, where appropriate and Darent Valley Hospital has an open passport scheme of children with specific conditions.

People in the care of community mental health services, provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT) are assigned a care co-ordinator in their local team, who they or their carer should call during office hours if they feel they are relapsing or experiencing a mental health crisis. (In the case of the care co-ordinator being absent, they are advised to speak to the on-duty worker.) In the evenings and at weekends, they are advised to speak to the KMPT Crisis Resolution Home Treatment team for their locality.

D Minor injuries and walk in centres

Minor Injuries units for walk in patients are available in the following locations:

- Deal (nurse led)
- Dover (nurse led)
- Edenbridge (nurse led)
- Faversham (nurse led)
- Gravesham (nurse led)
- Sevenoaks (nurse led)
- Sheppey (nurse led)
- Sittingbourne (nurse led)
- Whitstable (nurse led, GP available on site)
- Medway Maritime Hospital (nurse led)

Walk in Centres for walk in patients are available in the following locations:

- Folkestone (nurse led)
- White Horse Practice Northfleet (GP led)
- Gillingham DMC (GP led)

The range of clinical skills and facilities available varies in each area, and are defined in the detail held on the Urgent Care Directory of Services currently supporting 999 and to be developed as described below.

Usage varies from less than 100 patients per month in Faversham to over 1,000 per month in Folkestone.

E Emergency Departments

Emergency departments for walk in patients are at:

- Darent Valley Hospital
- Pembury Hospital
- Maidstone Hospital
- William Harvey Hospital, Ashford
- Queen Elizabeth, the Queen Mother Hospital, Margate
- Medway Hospital

These provide a full range of service for ‘minor’ and ‘major’ emergencies.
Kent and Canterbury Hospital provides a more limited emergency department, Kent and Canterbury Hospital Emergency Care Centre is open 24/7 and a consultant is on call at all times. It provides the majority of services available at an A&E but does not accept Major Trauma or provide surgery. The detail of all symptoms accepted is currently available and live on the Directory of Services attached to *NHS Pathways* triage system. This is in addition to the nurse led MIU on the same site.

For certain serious conditions, the ambulance service will take patients to particular hospitals with the necessary specialist skills required. E.G. those requiring primary angioplasty will be taken to William Harvey Hospital, emergency surgery and orthopaedic patients in the Maidstone area will be taken to Pembury Hospital (or Medway/William Harvey if nearer).

From 1 April it is planned that patients with major trauma will be taken to either the nearest Major Trauma Centre (likely to be Kings College Hospital) if within 45 minutes, or to a designated trauma unit in Kent – planned to be Pembury, Medway and William Harvey hospitals.

F Rapid access clinics

A number of ‘Rapid Access’ clinics are being set up to enable patients to have an urgent assessment and treatment for certain conditions, after assessment by a GP or other healthcare professional. Examples include a DVT (deep vein thrombosis) assessment service in Medway, TIA clinics (transient ischemic attack – mini-stroke) in several hospitals, falls services.

Whilst not providing ‘walk in’ immediate access for self referral, they provide an alternative to A&E when a health professional has assessed the patient. In many cases these are same day or next day and provide a bookable appointment with a relevant specialist nurse, doctor or other clinician.

G Ambulance service

South East Coast Ambulance NHS Foundation Trust provides emergency ambulance services across Kent & Medway. The service is accessed via 999 and a triage system (called *NHS Pathways*) leads the call hander to assess the immediacy of the situation, using nationally established criteria. Where a call is immediately life threatening, then an emergency response is dispatched immediately. Where it may be that an alternative service could meet the patients’ needs, then the system identifies a range of options for the patient, based on our locally defined directory.

The service plans to respond to around 220,000 incidents in Kent & Medway in the year, and currently around 4% are being managed with telephone advice and/or referral.

Around two thirds of 999 calls from the public lead to an ambulance taking the patient to hospital. For the remainder, the crew assess the patient and either provide

reassurance and advice, or arrange some further support e.g. a follow up by the patients own GP.

2 Specifically, what is the definition of 'minor injury' and 'Minor Injuries Unit'?

The NHS Choices website gives a good summary of the role of minor injury units, see appendix A. They do differ dependant on the service commissioned, and the skills and facilities available.

Minor Injury Units come under type 03 in terms of A&E reporting. Below is the definition for type 03 from the NHS Data Dictionary.

03 *Other type of A&E/minor injury ACTIVITY with designated accommodation for the reception of accident and emergency PATIENTS. The department may be doctor led or NURSE led and treats at least minor injuries and illnesses and can be routinely accessed without APPOINTMENT. A SERVICE mainly or entirely APPOINTMENT based (for example a GENERAL PRACTITIONER Practice or Out-Patient Clinic) is excluded even though it may treat a number of PATIENTS with minor illness or injury. Excludes NHS walk-in centres*

3 How do people currently access urgent and emergency services and how is this being developed? In particular, how is public awareness of the most appropriate service to access, for example Minor Injuries Unit against Accident and Emergency Department, being raised?

A number of mechanisms have been used to establish how people make their choices in accessing urgent care.

In Maidstone, research undertaken with patients in A&E and the GP out of hours centre in 2008 showed:

Route to A&E/Out of Hours (OOH) /Decision Making

- Overall, half go direct to A&E/OOH, increasing to 63% amongst A&E patients
- Whereas OOH patients were significantly more likely to seek advice from their GP prior to attendance than A&E patients
- Urgency of response and advice from a third party (after a health professional or friend/family member) are the main drivers behind patients choice to visit A&E/OOH
- The advice received is reported to impact heavily on their decision to attend A&E/OOH with advice from GPs and NHS Direct being key
- However, just under half (42%) said not knowing where else to go impacted their decision and over half said timing of health problem had an impact

Awareness and Knowledge of Alternatives

- Almost all patients felt they made the right decision to attend A&E/OOH, with around a third saying there was no alternative
- A quarter would have preferred to go elsewhere for treatment (usually their own doctor) and two fifths would treat themselves if the same situation repeated itself
- Amongst those with a preference to go to their own doctor, most OOH patients and half of A&E did not do so because the surgery was closed
- Knowledge of GP surgery services seems limited in terms of availability of emergency appointments, out of hours cover and to some extent surgery timing/turn up and wait
- Those attending OOH have better knowledge of GP services
- Knowledge of NHS Direct and MIU/Walk-in Centre is also limited, especially the latter with two-fifths unaware of it.

In Eastern and Coastal Kent, feedback was obtained from a pilot that placed a GP in the Emergency Care Centre at the Kent and Canterbury Hospital. The feedback revealed that during the period September 2009 – February 2011 approximately 20% of the patients arriving at the Kent and Canterbury Emergency Care Centre when the GP was on site* were triaged as suitable for a GP consultation in preference to an ECC or MIU consultation. A requirement of the pilot was that the service was not advertised as available but was to identify the number of patients who self referred to an A&E that had symptoms suitable for treatment by a GP

The majority of the patients triaged to the GP for their consultation were asked to complete a survey. The survey is one that is more frequently used to monitor patient satisfaction with their own registered GP service and is used as a national benchmark. The survey for this cohort of patients triaged to the GP at the Kent and Canterbury Emergency Care Centre also included the question: 'Why did you choose to attend a Minor Injuries Unit?'

The responses indicate a mix of reasons

Why did you choose to attend a Minor Injuries Unit'		
Left blank	226	20.3%
Close to home	209	18.8%
Own GP surgery closed	354	31.8%
No GP appointment available	212	19.1%
Other	111	10.0%
Total	1112	100%

And when asked if they would use the service again there was an overwhelmingly positive response with many of the respondents also adding a positive qualitative statement about the service they had received and that they would use the service

again. This is an indication that patients will choose to travel to the site where they will receive the service that they perceive they need.

These themes were also reflected in local results from national patient surveys of people attending A&E.

Building on the information from this, and from national best practice, the communications team has actively promoted the appropriate use of the range of urgent care services through year-round campaigns, starting in 2008/9 and building ever since. These are themed:

- Keep Warm, Keep Well/ look after yourself in a heat wave/how to prevent falls
- Infection control (including Catch It, Bin It, Kill It and norovirus)
- Choose Well
- Seasonal flu

The overall objectives of the campaigns are to encourage people to take measures to protect their own health and wellbeing, and to ensure they have the information they need about the full range of NHS services, to support them in making appropriate choices.

Different communication channels are used to reach different audiences, depending on the campaign and the message – for instance, the main audiences for Choose Well communications (i.e. people who leave A&E without being treated or who are discharged to their GP or on-call GP services) are people aged between 17 and 45. (Source: research carried out by NHS Medway Commissioning and Performance Team).

It is also important to note that a high proportion of people attending A&E (48 per cent) have long term conditions, including mental health conditions

Communications to improve knowledge and understanding of the range of services across Kent and Medway include:

- Booklets with information about GPs offering extended hours sent to every home in Kent and Medway
- Roadside banners encouraging people to use NHS Direct and alternative services displayed outside hospitals / railway stations / supermarkets
- Press releases and social media activity proactively with public health messages / information about services available at MIUs, pharmacies etc
- Press releases and social media activity reactively at times of pressure, asking people to think before they come to A&E
- NHS magazines with Choose Well and other information distributed via a range of outlets including supermarkets, train stations
- Leaflets distributed via a range of outlets, including GP surgeries, pharmacies, children's centres, libraries, acute Trusts, hairdressers, businesses, takeaways
- BT phonebook information
- Adverts in buses, on radio, in local newspapers, on websites

- Information about services and how to use them prominently displayed on PCT websites
- Information sent out to the community via health networks, community publications such as carers' newsletters
- Letters to parents sent out via schools, thanks to support from Kent County Council and Medway Council

This winter we also plan to further develop digital communications, promoting use of the NHS Direct text and Smartphone app, once we are certain that they are robust and 100 per cent accurate.

This is in addition to the seasonal flu campaign, which is focusing on the role of frontline health professionals (such as midwives, district nurses and GPs) in encouraging uptake.

The NHS Choices website and NHS Direct both provide links to search for the nearest service, while NHS Direct has an excellent symptom checker to help guide people as to when they need to access care. These are linked from the PCT website and from the websites of all our local providers.

Despite this information being available, we know from the research described above that there are still many people who would have preferred to use a service other than A&E and we are therefore keen to make access even easier. Communications also forms part of a new cluster project which is reviewing ways of reducing inappropriate A&E attendances across Kent and Medway – please see response to question 8.

4 ***Since 2008, broken down by quarter, what have the numbers of attendances at accident and emergency departments been across the Kent and Medway health economy? How many of these have been:-***

a new attendances
b emergency readmissions

Please refer to appendix B and Q5

5 How do these trends compare to those:

a across the south east?
b nationally?

Please refer to appendix B.

Overall, A&E and Minor Injury Unit activity in the Kent and Medway hospitals increased by 5.2% between 2008/09 and 2010/11. Nationally for Q1 this was approximately 7.8% and in South East Coast 1.9%.

Differentiating between the changes in A&E (type 1) and MIU (type 3) is difficult due to changes in the organisations and in counting. It is also worth noting that changes

outside Kent can impact on the activity at the hospitals. For example, the closure at Queen Mary's Sidcup before Christmas 2010 has led to an increase in Bexley patients using Darent Valley Hospital.
It is not possible to identify the proportion of patients re-attending to A&E in a summary form. However, individual Clinical Commissioning Groups (CCGs) are looking at their patients who re-attend with the aim of identifying any further care which could be given to manage their care better. Weekly reports are produced for GPs in the Maidstone and Malling CCG and for example in one week recently, 2 of the 78 patients had visited A&E 2 or 3 times in the previous 6 months, seven had attended once before but for most, this was the only visit. Practices in the Eastern and Coastal Kent CCGs are provided a report of the most frequent attendees each month to enable them to identify if care could be improved.

6 What factors explain this change?

The increase in attendances is related to a number of factors, including the perception of availability of GP services, the increasing numbers of residents from overseas where A&E is the only option, the increasing population and the increasing life expectancy and the increasing numbers of people with long term conditions. A needs analysis to support the Joint Strategic Needs Assessment is required for urgent care to fully indentify the causes and therefore support the solutions.

Analysis of the types of patients and conditions that present to A&E is being considered by the CCGs. For example in the Maidstone & Malling area, the CCG has very recently identified that around 66% of patients are self presenting to A&E. Of these, the majority of A&E attendances are for patients between the ages of 25-59, and the majority are during the afternoon i.e. within working hours. Soft tissue injuries are the greatest proportion (18.5% of all self referrers). Of these, 56% did not require any treatment.

This analysis is being considered by the CCG, and is also being reviewed for other areas to identify more clearly where services may need to be targeted.

7 Why is it important to reduce attendance at accident and emergency departments?

The accident and emergency departments have the skilled staff and facilities to identify manage patients with a wide range of illness and injury. Some of this can only be managed at the A&E department, but others can be managed in a variety of settings. It is important that the departments have the flexibility and capacity to manage those more serious conditions, rather than having to see patients who had a simple problem.

With good advice and with readily accessible primary care services patients can be managed closer to their home and by those health professionals who are providing their ongoing care. This is especially important for those with long term conditions where the relationship with their primary and community health professionals can mean they are able to stay in their own home.

In the A&E department, the clinicians generally have little prior knowledge of that patient, or their support at home and arranging the services the patient needs can be complex. They therefore may have to admit the patient whilst arranging everything, whereas a patient's own GP and community healthcare professionals may well have everything arranged and can simply advise or amend the treatment.

For those patients experiencing a one-off problem, many travel a considerable distance to the full A&E department, whereas a more local MIU or GP could meet their needs if they were aware and had confidence that the service was appropriate for them.

The cost of an A&E attendance ranges from £52 to £183 depending on the complexity. Patients using their own GP, or out of hours primary care are generally covered by the overall primary care contract. Where additional community services are needed, the cost may be included in the contract or may be additional. Whilst there is still a cost to the NHS of providing the care in this way, it is generally at a significantly lower cost than through a hospital A&E department. Should the patient go on to be admitted, instead of cared for at home, the costs become more significant.

Using an A&E department when the condition could be managed differently is therefore:

- Potentially less convenient for the patient,
- Uses skilled resources and facilities unnecessarily,
- And costs more

This always needs to be balanced with the need to 'get it right first time' and if the care is best provided by an A&E, then the patient should be directed there first.

8 What work is being undertaken currently, and planned for the future, aimed at reducing accident and emergency attendance?

In the immediate short term, a project has been established to review and reduce A&E attendances by utilising the successful 'emergency planning' mechanisms which support the Kent and Medway system at times of particular pressure. This will include a combination of rapid access to key data, better information for patients and the public and some specific work with GPs and other services to improve access.

Existing medium to longer term plans are also being further developed, as indicted in the NHS Kent and Medway integrated plan. These are at several levels:

A Kent & Medway

Across the cluster, the strategic change to the urgent care system is being pursued, through three main changes across Kent & Medway which are interlinked: NHS 111, NHS Pathways and the Directory of Services.

NHS 111 is being introduced nationally from April 2013, and in Kent & Medway, we are looking to start procurement of a provider this autumn.

111 will be a single point of access for patients who have an urgent health need but do not need to call 999 or go to A&E, and cannot contact their GP. It will ensure patients receive the right care, by the right person, at the right place and right time regardless of which point of the health service they access first.

Access to urgent care will be improved and simplified, the quality of the urgent care that patients receive will be improved, and patients' experience of urgent and emergency care will be enhanced. Health outcomes will be improved because patients will get the care that is most appropriate for their needs. 111 will make for more efficient use of emergency services by directing patients who don't need to call 999 or go to A&E to the service that can best treat their needs.

A single procurement will be conducted to implement 111 across this region, with possible flexibility for variations in the service specification in each PCT cluster area to allow for the particular needs of local populations.

Various pilots are already underway, or are soon to be launched, in other parts of the country.

Key messages about 111

- NHS 111 will make it easier for the public to access local health services when they need help quickly. In future if people need to contact the NHS for urgent care there will only be three numbers: 999 for life-threatening emergencies, their GP surgery or 111.

- 111 will improve and simplify access for people to urgent care services, and improve public satisfaction and confidence in their local NHS.

- It will make 999 ambulance services more efficient by reducing the number of non-emergency calls to 999.

- It will help NHS commissioners to ensure services are tuned to meet people's needs.

- 111 is part of a wider programme of improvements to the urgent care system across Kent, Surrey and Sussex to deliver a 24/7 urgent care service that ensures people receive the right care, from the right person, in the right place, at the right time.

- The NHS 111 service will be free to call and will be available 24 hours a day, 365 days a year.

- NHS 111 will provide a clinical assessment at the first point of contact, without the need to call patients back; will direct people to the right NHS service, first time, without the need for them to be re-triaged; and will be able to transfer clinical assessment data to other providers and book appointments for patients where appropriate.

- NHS 111 will work alongside the 999 emergency service and will be able to despatch an ambulance without delay and without the need for the patient to repeat any information.

- Each year in Kent, Surrey and Sussex more than one and a half million people go to A&E. However, many of those patients would be more appropriately treated elsewhere in the health service, in the community or even in their own home. This would give them better health outcomes whilst at the same time making better use of NHS resources.

- Research shows us that people find it difficult to know which bit of the NHS is right for them when they have an urgent need that isn't serious enough to call 999 or go to A&E. People are sometimes confused by the wide range of services on offer, like walk-in centres, minor injuries units and GP led health centres. As a result, many people choose to go to their local A&E by default. We need to change that culture, by making it easier for patients to get to the right care setting first time, regardless of which point of the health service they approach first

Supporting the NHS 111 telephone system will be a clinical triage system, consistent with that already being used for 999 calls by SECAmb, and being piloted by South East Health for GP out of hours calls.

This system (NHS Pathways) is nationally governed with a clinical board led by the Royal College of GPs. It has been in use in the North East Ambulance Service for some years, as well as some GP out of hours services and is now being used in the NHS 111 pilots.

It allows the call handler to identify the immediacy of the problem and also the skills needed to manage the problem. Within the 999 service, it allows an ambulance to be dispatched immediately for life threatening calls, but can also allow advice and referral to other more appropriate services.

These other services are identified through a live 'Directory of Services' (DoS). The PCTs have been working with the urgent care providers in Kent & Medway to ensure that detailed information about the skills available and the conditions that can be managed are captured on the database, which is then searched by the NHS Pathways system to identify as service suitable for the patient.

Commissioners prioritise the order in which the services are shown, e.g. primary care and minor injuries units will come higher up the list than an A&E department. Prioritisation will be confirmed by the Clinical Commissioning Groups for the services

in their area. Only the providers able to offer the service, at the time required, are shown.

The combination of the NHS Pathways and the DoS systems will also provide valuable reports to the commissioners about the services required and not available, or where patients have not accepted the suggestion. This will allow far greater understanding of the use and the gaps in urgent care services.
The role of the Ambulance Service is also developing to enable ambulance crews who attend a patient to be able to assess and identify alternative services, including linking the patient into their GP or community service. KMPT have developed a local protocol with SECAmb (commissioned by the Kent and Medway mental health commissioners) to refer people who identify themselves as existing users of secondary mental health services, direct to the correct KMPT team, subject to a risk assessment carried out by ambulance staff.

More highly trained paramedics 'Paramedic Practitioners' are being deployed to be better able to assess and manage a patient and involve other services to provide the necessary support. This change is being supported by the quality scheme 'CQUINS' and also involves providing information to the patients GP to help improve care, and also following up on the patients experience to make sure the care meets their needs.

Working with KCC we have been introducing telemedicine in Eastern and Coastal Kent and West Kent, as part of the Whole System Demonstrator pilot. We hope to roll this out further. This is expected to improve the management of patients with long term conditions, where monitoring their condition can reduce exacerbations and therefore reduce the need for ambulance and A&E attendances.

Across Kent & Medway, we will be reviewing the range and type of urgent care services available as part of our review of the overall integrated plan. We will be working closely with all our partners and stakeholders, with our shared public heath team and involving patients and public.

B In each Hospital Trust

All the acute hospitals are working on pathways for ambulatory emergency care, either by revising specific pathways or by a more generic approach to managing care when a patient presents themselves and need not be admitted.

In some cases, e.g. cellulitis, this means ensuring the community teams are able to provide the antibiotics and have the skills to administer via an intravenous drip. In other cases the equipment is needed e.g. for a dopplar scan to identify DVT.

We are working with the Trusts to identify the process for identifying less serious cases when they present and either manage them separately, or direct them to a primary care service on site e.g. the same day treatment service at Medway hospital. In each area, work is underway to streamline the access through A&E to admission (where required) or treatment/discharge. The joint work with social care to facilitate

discharge and support re-ablement and independence is also key to the efficient model of urgent care.

Over the last three years, acute psychiatry liaison services have been developed, and as of April 2011, are offered at all the emergency departments in Kent and Medway. These are for people who present at A&E with mental health needs, including those who also have physical conditions needing treatment. The service is provided by psychiatric nurses who assess patients on referral by A&E clinical staff. They may advise on treatment or management, signpost to other support, or refer people into KMPT services. The experience of the psychiatry liaison service to date is that it is highly effective at reducing re-attendances, particularly among those who self-harm.

C In each locality/clinical commissioning group

GPs and other clinicians in each area are reviewing their activity and identifying what may help reduce the need for their patients to attend A&E. Most areas are working through a toolkit to help ensure they can provide a high level of access for patients with urgent needs.

Work with care homes has been targeting those where the numbers of admissions is high. Increased support and better access to nursing, coupled with a proactive approach to care planning has had a significant impact.

End of Life care is a particular sensitive area, where better planning and communication can help a patient be supported at home rather than be admitted via A&E . A range of projects are in place to help.

Our overall approach is to encourage the service to respond to people's need for the right care to be provided at the right place and the right time, first time.

9 What are the main challenges to reducing attendance at accident and emergency departments?

People need to have confidence that the service is available and will meet their needs. Whilst we have a range of options, the only two services perceived as being always available are the A&E departments and the ambulance service.

GP services are also available, in and out of hours, but are often not perceived as being available and getting a same day appointment is not always easy.

Minor injuries departments have varied times and skills available and without certainty, people may choose to go straight to the place they know is there.

The strategic model for urgent access across NHS Kent and Medway is aimed at tackling this uncertainty by co-ordinating a consistent approach. NHS 111 number, supported by a clinically safe triage system and an accurate 'live' Directory of Services, will be coupled with a 'phone before you go' message and backed up by a

more informed commissioning and performance management process. This will go a long way towards having an integrated urgent care system which people can be confident will be able to support them whenever they need it.

10 How much is spent on urgent and emergency care services across the health economy and how much solely on attendance at accident and emergency departments?

Urgent and emergency care is estimated to be around £500million across the Kent and Medway cluster. Of this, around 13% is spent on A&E attendance and by far the largest element is the emergency hospital admission which accounts for some two thirds of urgent and emergency care costs.

The figures below do not include primary care, although GP and community pharmacy provide the majority of all urgent care. Nor is NHS Direct included as this is not currently funded through the local PCT budgets.

The figures attributed to the community services, including minor injuries, community hospitals and other intermediate care services are approximate as most are part of a broader contract for services.

As can be seen below, the current forecast for emergency admissions is slightly below 2010/11 although A&E attendances are higher.

Urgent & Emergency care spend by NHS Kent & Medway	Actual 2010/11				Forecast 2011/12			
	East Kent	West Kent	Medway	All K&M	East Kent	West Kent	Medway	All K&M
GP Out of Hours					6.3	5.2	1.8	13.3
Minor injuries/walk in					2.6	0.9	tbc	3.5
Community Hospitals					9.0	7.1	tbc	16.1
Other intermediate care services					13.1	3.8	tbc	16.9
NHS joint work with Social care					8.4	7.8	tbc	16.2
Emergency Ambulance	25.1	18.2	7.5	50.8	26.0	18.5	7.9	52.5
A&E (98% within K&M)	18.3	17.0	6.2	41.5	18.9	19.1	6.9	44.9
Admissions (70% within K&M)	154.6	142.0	54.2	350.8	152.6	135.4	54.0	342.0
Total	198.0	177.1	68.0	443.1	237.0	197.9	70.6	505.5
% A&E	12%	12%	11%	12%	12%	14%	13%	13%

11 What is the place of urgent and emergency care in the QIPP programme across Kent and Medway?

The acute QIPP programme is built around the philosophy of having the right care in the right place, first time. The programme focuses on NHS 111 and the supporting systems described above to reduce attendances at A&E, and therefore have an impact on admissions. It also includes:

- Supporting patients in their community with primary and self care, where it is appropriate
- Streamlining the care pathways for people who attend A&E and can be followed up in the community
- Minimising the duplication by having a co-ordinated and consistent system

Over the 4 year period £77million is planned to be released through the QIPP programme.

The programme was developed last year in each PCT area, in conjunction with health and social care partners. Projects include:

- Implement NHS Pathways for 999 to reduce ambulance conveyance by use of Directory of Service.
- Implement 111 through NHS Pathways supported by expanded Directory of Service leading to redirection to alternative services, e.g. MIU & OOH.
- Role out programme of 49 Ambulatory Emergency Care pathways.
- Reduction in A&E attendances & admissions through front-end GP provision.
- Implement hospice/ hospital at home services for patients with long term conditions (LTC) and those in need of end of life (EOL) care.
- Introduce single bed bureau across health systems
- Redefine direct admission criteria to community hospitals.
- Roll-out OOH thrombolysis for stroke beyond east Kent.
- Roll-out of a local version of the 'Bolton Dashboard'.
- Implement hub/spoke model level 2 trauma through Critical Care and Trauma networks

Minor injuries units

If you have an illness that is not life threatening, contact your GP surgery first if possible. You can still call your GP outside normal surgery hours, but you will usually be directed to an out-of-hours service. The out-of-hours period is 6.30pm to 8am on weekdays, and all day at weekends and bank holidays.

You can also call NHS Direct on 0845 4647 (or NHS 111 if it's available in your area). They can give you advice or direct you to the best local service to treat your injury. Alternatively, use our symptoms checker to assess your symptoms online and receive personalised advice on the best action to take.

If your injury is not serious, you can get help from a minor injuries unit (MIU), rather than going to an A&E department. This will allow A&E staff to concentrate on people with serious, life-threatening conditions and will save you a potentially long wait.

There are currently 225 minor injuries units in England. MIUs are usually led by nurses and an appointment is not necessary.

Some MIUs and walk-in centres do not have facilities to treat young children. This depends on the capacity, resources or skill levels available at the MIU or walk-in centre. Contact your local MIU or walk-in centre in advance if you are not sure whether you or your child can be treated there. Search for your local MIU.

Minor injuries units can treat:

- *sprains and strains*
- *broken bones*
- *wound infections*
- *minor burns and scalds*
- *minor head injuries*
- *insect and animal bites*
- *minor eye injuries*
- *injuries to the back, shoulder and chest*

If there is not a minor injuries unit in your area, these services will also be provided by an A&E department.

Minor injuries units cannot treat:

- *chest pain*
- *breathing difficulties*

- *major injuries*
- *problems usually dealt with by a GP*
- *stomach pains*
- *gynaecological problems*
- *pregnancy problems*
- *allergic reactions*
- *overdoses*
- *alcohol-related problems*
- *conditions likely to require hospital admission*
- *mental health problems*

Appendix B

Type 1 and Type 3 A&E First Attendances 2008-09 to 2011-12 Quarter 1

Source - Unify QMAE Data Return

Type 1 Attendances

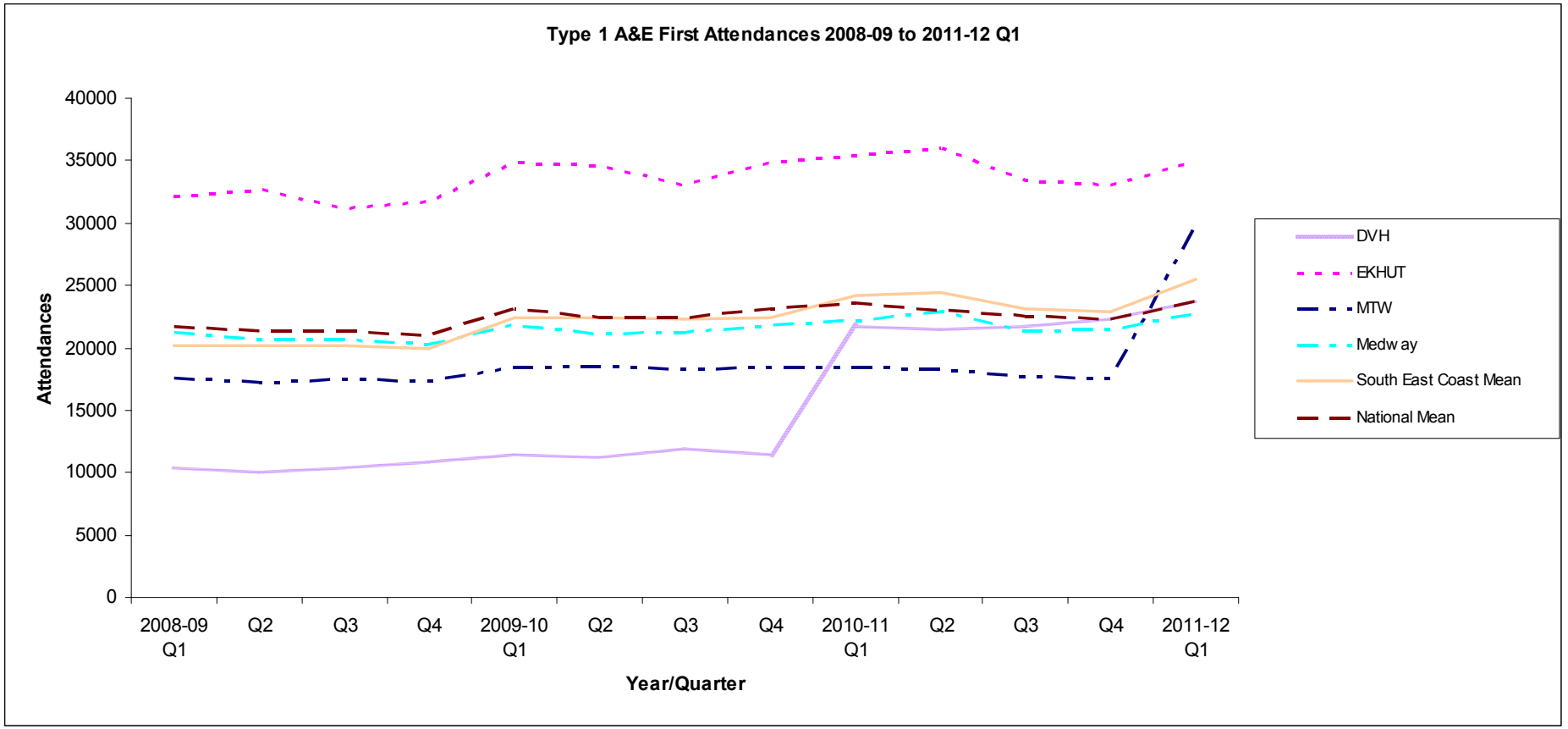
	2008-09 Q1	Q2	Q3	Q4	2009-10 Q1	Q2	Q3	Q4	2010-11 Q1	Q2	Q3	Q4	2011-12 Q1
DVH	10353	10003	10385	10908	11438	11260	11963	11438	21733	21479	21720	22331	23744
EKHUT	32099	32636	31201	31768	34808	34610	33014	34808	35415	35991	33436	33051	34957
MTW	17636	17253	17488	17344	18391	18532	18322	18391	18428	18299	17684	17639	29677
Medway	21189	20628	20630	20294	21858	21152	21219	21858	22141	22936	21349	21517	22803
South East Coast Mean	20183	20168	20198	19978	22455	22371	22340	22455	24143	24368	23135	22938	25451
National Mean	21714	21341	21306	20981	23181	22423	22441	23181	23586	22975	22514	22353	23767

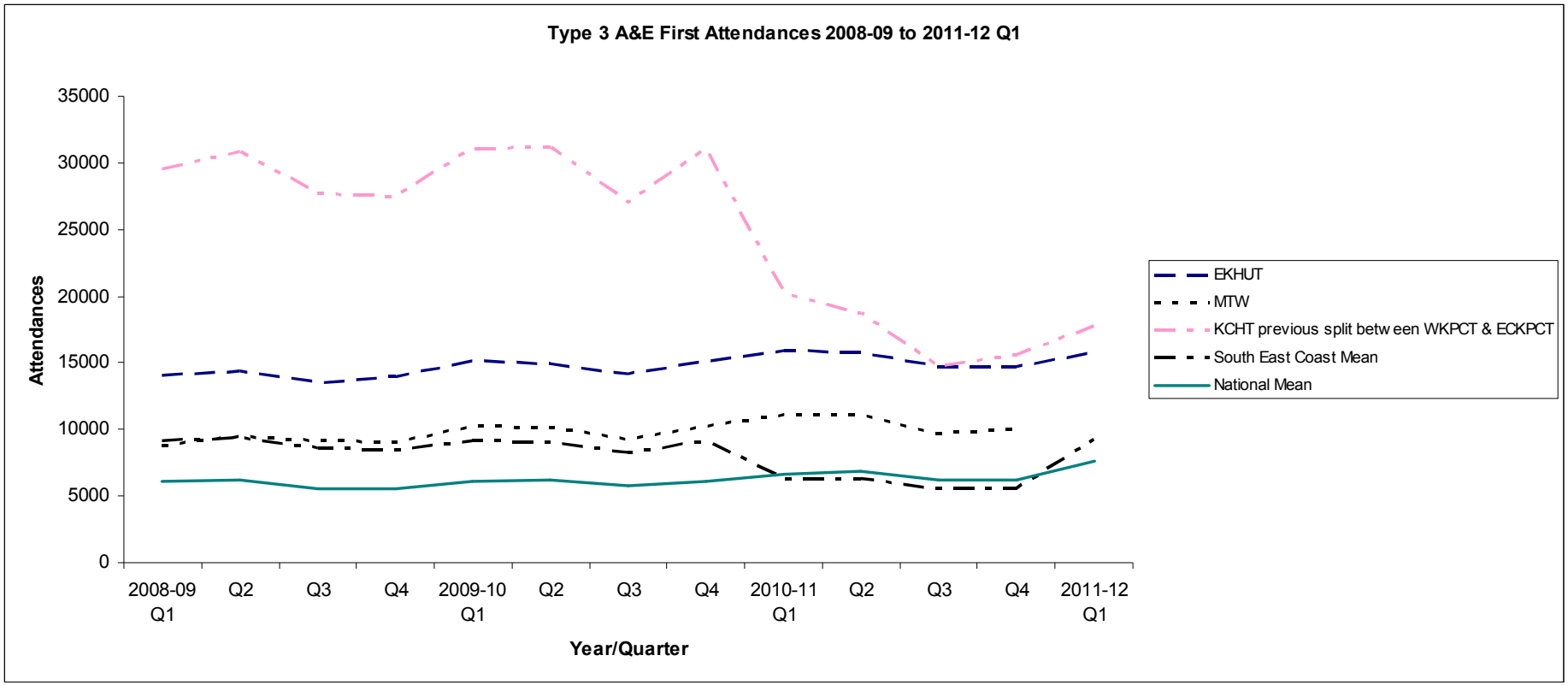
Type 3 Attendances

	2008-09 Q1	Q2	Q3	Q4	2009-10 Q1	Q2	Q3	Q4	2010-11 Q1	Q2	Q3	Q4	2011-12 Q1
EKHUT	14105	14381	13574	14006	15132	14929	14166	15132	15887	15783	14672	14772	15835
MTW	8864	9525	9111	9079	10233	10186	9265	10233	11174	11087	9673	9992	
EKCPCT	11632	12849	10965	11231	12385	12447	10710	12385	11924	10315	8238	8657	
WKPCT	17935	17993	16703	16237	18717	18774	16324	18717	8231	8417	6517	6985	
KCHT previous split between WKPCT & ECKPCT	29567	30842	27668	27468	31102	31221	27034	31102	20155	18732	14755	15642	17721
South East Coast Mean	9115	9403	8629	8555	9145	9001	8264	9145	6364	6303	5587	5557	9295
National Mean	6135	6201	5604	5574	6155	6253	5829	6155	6700	6853	6196	6221	7583

Minor Injury Units attached to A&E Departments. This may also explain the non-return of Type 3 attendances in Q1 2011-12 at MTW

West Kent PCT ceasing reporting of figures to Urgent Care Centre


Type 1 A&E First Attendances 2008-09 to 2011-12 Q1
Attendances
40000
35000
30000
25000
20000
15000
10000
5000
0
2008-09 Q1
Q2
Q3
Q4
2009-10 Q1
Q2
Q3
Q4
2010-11 Q1
Q2
Q3
Q4
2011-12 Q1
Year/Quarter
DVH
EKHUT
MTW
Medway
South East Coast Mean
National Mean


Type 3 A&E First Attendances 2008-09 to 2011-12 Q1
Attendances
35000
30000
25000
20000
15000
10000
5000
0
2008-09 Q1
Q2
Q3
Q4
2009-10 Q1
Q2
Q3
Q4
2010-11 Q1
Q2
Q3
Q4
2011-12 Q1
Year/Quarter
EKHUT
MTW
KCHT previous split between WKPCT & ECKPCT
South East Coast Mean
National Mean

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South East Coast Ambulance Service NHS Foundation Trust

Emergency and Urgent Care in Kent and Medway for Kent HOSC

What does SECAmb do?

South East Coast Ambulance Service NHS Foundation Trust is an innovative, patient focused healthcare organisation providing emergency, urgent and non-emergency care.

The Trust responds to 999 calls from the public and urgent calls from healthcare professionals in Kent, Surrey and Sussex, and areas within North East Hampshire and Berkshire. Across the region the Trust provides specialist neonatal transfer services, in Kent and Sussex we also provide non-emergency patient transport services.

The Trust was formed in July 2006, following the merger of Kent Ambulance Service NHS Trust, Surrey Ambulance Service NHS Trust and Sussex Ambulance Service NHS Trust. It was one of the first ambulance services to become a Foundation Trust in March 2011.

The new organisation has established a strong track record of improving patient care through the adoption of innovative clinical practices and equipment, the development of specialist clinical roles and the implementation of new technologies and systems; all aimed at improving the quality of care the Trust provides to improve patient outcomes, safety and experience

The Trust's annual turnover is approximately £160 million. The Trust employs over 3100 members of staff of which approximately 85% are operational, either as front-line staff (including Patient Transport Services) or within the three Emergency Dispatch Centres (EDCs) which receive calls and dispatch the necessary resources, with the other staff (15%) providing support services and management functions.

The Trust operates from approximately 65 sites located across the area we serve.

Services

The Trust provides a range of services to ensure that we respond to the needs of the patients, healthcare professionals and emergency services within the communities we serve. The services are organised into four main categories Accident and Emergency Services, Patient Transport Services, Commercial Services and Emergency Preparedness.

Accident and Emergency Service

The patients we care for range from the critically ill and injured, to those with minor healthcare needs that can be treated at home or in the community. Calls are received in our Emergency Dispatch Centres via the 999 system, and triaged in accordance with NHS Pathways to determine the most appropriate response based on clinical need. Once a call has been triaged it is categorised as follows:

- *Category A* – Life threatening conditions where speed of response may be critical in saving life or improving outcome for the patient
- *Category C* – Non life-threatening conditions that may require a non-emergency ambulance or be appropriate for referral to an alternative care pathway

We currently provide three different services within our A&E service:

- *Hear & Treat* – a call that is triaged via NHS Pathways and either managed by the initial call taker or where advice is provided by a clinically trained member of staff, this may include identification of and referral to an alternative care pathway.
- *See & Treat* – a clinician attends and provides treatment to the patient, but there is no requirement to transport the patient to a healthcare facility.
- *See, Treat & Convey* - as with *See & Treat*, the clinician attends and provides treatment to the patient, however, there is the need to transport the patient to a healthcare facility for further treatment.

In line with national trends, A&E activity is increasing year on year. Analysis of trends relating to population, epidemiology and healthcare confirm that demand for ambulance services is likely to continue to rise in line with recent trends and highlights increasing demand for our A&E services.

Patient Transport Service (PTS)

Non-emergency patient transport services provide transport for the movement of patients to and from NHS facilities including the transportation of ambulant, wheelchair bound and stretcher patients. The types of journeys undertaken include inpatient admissions, transport for out-patients and day patients to NHS facilities and non urgent transfers between hospitals and discharges from hospitals to home.

The Trust currently provides two different PTS services

- *High Acuity PTS* - when the patient may require some degree of clinical care during transportation.
- *Low Acuity PTS* – when patients will not require clinical care during transportation.

Commercial Services

These include providing a custody service for the police, services for public events, advising insurance companies, training and education.

The Private Ambulance Service currently provides First Aid, pre-hospital emergency cover to a range of public events across Surrey, Sussex and Kent and surrounding areas, with the capability to provide Health and Safety Executive approved First Aiders, technician crews, registered nurses, paramedic practitioners and the paramedic Cycle Response Unit. By attending events we are able to deal with injuries and illnesses on scene and ensure patients are discharged to appropriate follow-on care, preventing acute services becoming overwhelmed as a result of large public gatherings.

The Private Ambulance Service undertakes both private and NHS patient transfer work.

Emergency Preparedness

The Trust is classified as a Category 1 responder under the terms of the Civil Contingencies Act 2004, and as such we have six statutory duties:

1. Assess local risks and use this to inform emergency planning;
2. Put in place emergency plans;
3. Put in place Business Continuity arrangements;
4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
5. Share information with other local responders to enhance co-ordination;
6. Co-operate with other local responders to enhance co-ordination and efficiency.

What is the impact of the current levels of attendance at accident and emergency departments on the sustainability of health services across Kent and Medway?

The current levels of attendance at A&E compromise acute Trusts' ability to deliver against agreed ambulance turnaround times. Agreements are in place that each patient will he "handed over" to the A&E department within 15 minutes. When activity is at its peak within A&E acute Trusts do not deliver against this agreement and significant delays occur. This then compromises SECAmb's ability to respond to emergency calls thus reducing the quality of service.

How can levels of attendance best be reduced?

Paramedic Practitioners working with GPs

Paramedic practitioners (PPs) are making a big difference for 999 callers with urgent or primary care needs. PPs undertake additional education which is supported by the RCGP and this equips them to promote more care in the patients' home. In particular, patients with long term conditions can be dealt with by PPs in collaboration with the patients GP and other community specialists to ensure that they only attend hospital if necessary. Often, exacerbations of Long Term Conditions (LTCs) present very acutely, but can be managed appropriately without the need to go to A&E.

PPs can be the GPs eyes and ears in the community. PPs work closely with practices in many parts of SECAmb, and this promotes the relationship between the Trust and primary care and also benefits the PPs education and experience to deal with the urgent care.

Our goal is to develop a network of surgeries across the region to which PPs are "tethered" for their ongoing post qualification primary/urgent care education and

development. There are many benefits for surgeries who have these relationships already, such as broadening the multidisciplinary team and gaining more insight into emergency care in their areas.

Surgeries registered with the Deanery to provide GP training can also host PP training. PPs all undertake 8 weeks of training in a surgery prior to full qualification and the surgeries who have provided this up to now have reported very positive experiences.

By increasing the number of PPs working in Kent and Medway we can reduce the number of patients conveyed to A&E.

There are currently 60 Paramedic Practitioners across Kent and Medway, providing 24/7 rota coverage in key operational locations. Moving forward with the Front Loaded Service Model development, the roll out will focus on creating an establishment of PPs which is proportionate to the demand profile in each operational area. There will be 300 PPs in total across SECAmb.

Increase use of GP pathway

Local agreements within Medway and West Kent have been put in place to facilitate the transfer of care from ambulance clinicians to GPs and GP out of hours where it is thought a conveyance to A&E is not necessary. This could be rolled out into East Kent and increased in West Kent. In Medway approximately 120-150 patients per month are not conveyed to A&E as a result of the GP pathway. It is anticipated that approximately 200 patients will not be conveyed in West Kent, subject to approval of a business case.

Implement services to better manage falls

Both ambulance and A&E data suggest that falls are one of the main reasons that patients access health care services in an emergency situation. If patients that have had multiple falls were managed differently there would most likely be a reduction in the number of calls/ A&E attendances for this reason.

A business case is being developed in West Kent to introduce a service that would manage falls referrals to appropriate services in order to prevent falls and the complications that come with them.

Increase the availability of alternative services to ambulance clinicians

South East Coast now has a well-developed Directory of Service (DoS) which holds detailed clinical profiles, opening times, and address details for the majority of services that could manage patients accessing emergency and urgent services. Whilst it holds information about A&E services it also holds details for alternative services that can be accessed. All services have been prioritised by commissioners so that it is clear for people accessing the DoS which services should be recommended first. If ambulance crews had access to this information they would be able to reduce the number of patients being conveyed to A&E.

Increase the number of Hear and Treat calls for 999

NHS Pathways, a sophisticated triage software, has been in operation within our emergency call centres since April 2011; this has resulted in a move from 1% of 999 calls being dealt with at the point of call (Hear and Treat) to 5%. With further refinements SECAmb believe the Hear and Treat rate may increase further.

Use NHS Pathways to triage patients before they register at A&E

NHS Pathways is being used in Blackpool to triage patients before they are permitted to register with the A&E reception. The aim is to utilise alternative services so that A&E is a last resort. Further information can be found on the Connecting for Health website.

Introduce 111

The introduction of 111 may result in a reduction in A&E attendances. Data from the North East where the ambulance service is delivering the 111 service has seen a decrease in A&E attendances. PCTs are commissioning 111 with a view to it being operational during 2012/3.

Questions for the Ambulance Service

1. **Since 2008, broken down by quarter, how many 999 calls have been received in Kent and Medway by the ambulance service? Specifically, how many of these were:**
    a. **Category A?**
    b. **Category B?**

Figure 1: Total 999 calls in Kent and Medway by quarter

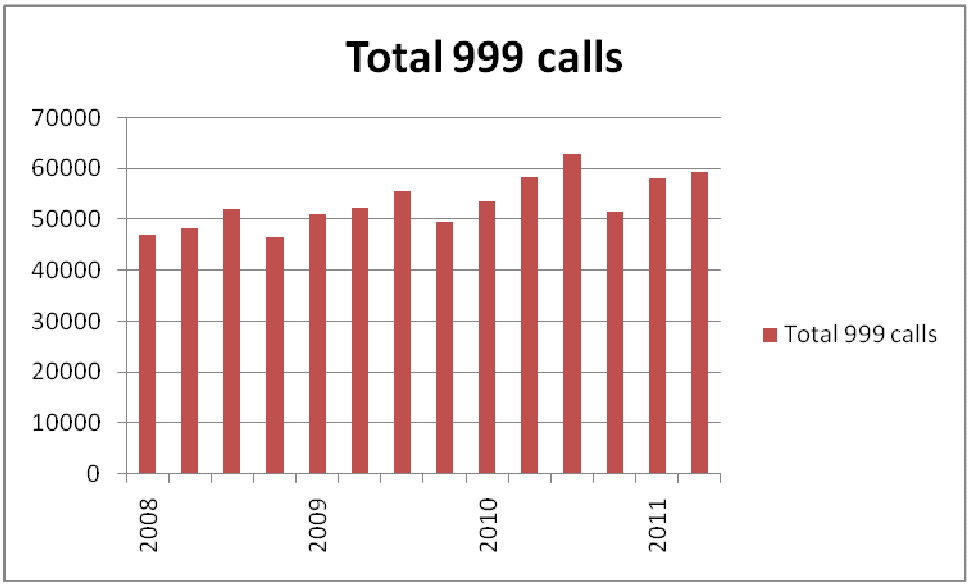
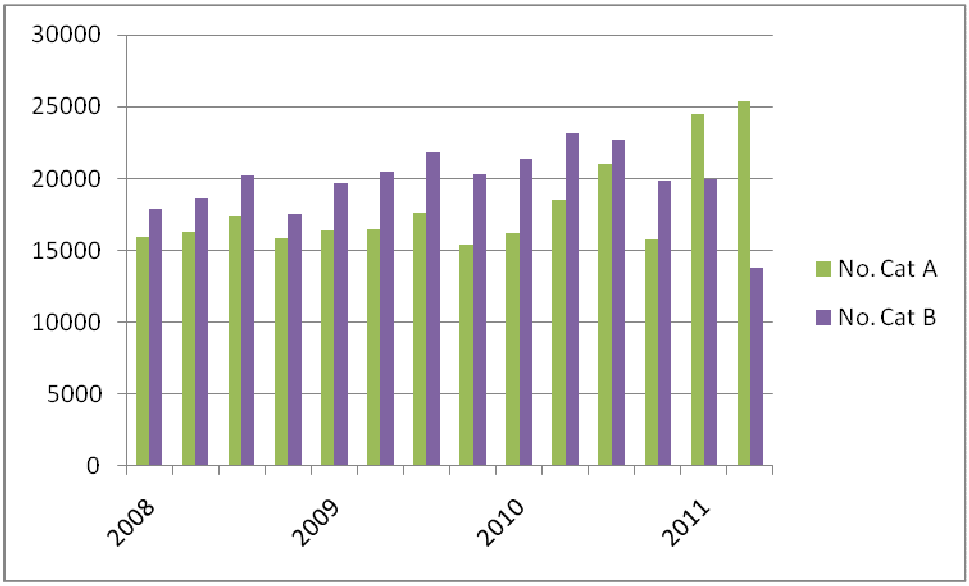
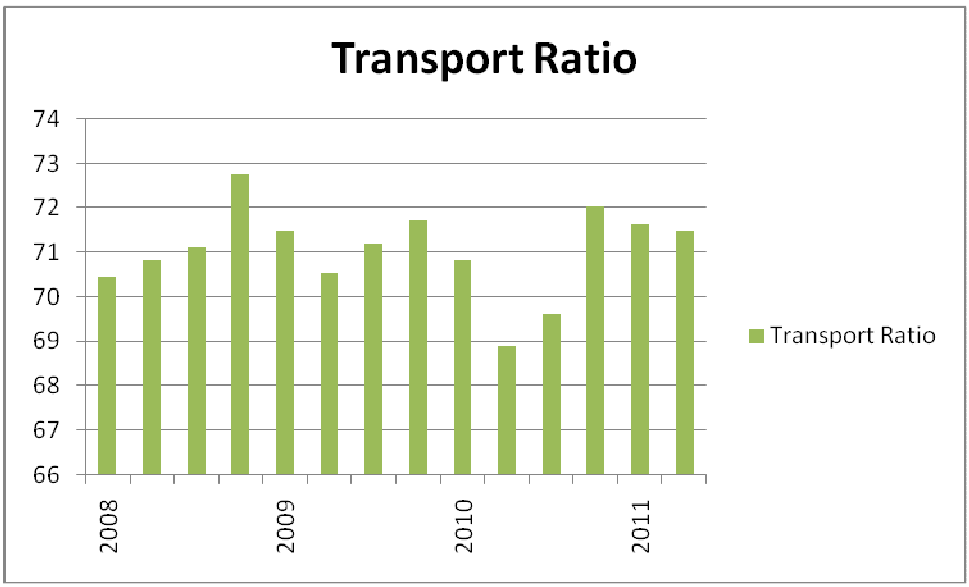


Figure 2: Total Cat A and B calls in Kent and Medway by Quarter



2. **Since 2008, broken down by quarter, what proportion of emergency calls result in a patient being taken to an accident and emergency department in Kent and Medway?**

Figure 3: % of 999 calls that result in a transport (this will also include a proportion of transports to MIUs)



3. **What is the place of urgent and emergency care in your organisations QIPP programme?**

The PP scheme described above is a key workstream which aims to provide increased clinical skill and leadership. This will contribute to delivering a reduction in “managed”* conveyance from the current level to 62% YTD at year end, and further reduced to 54% by 2015. This part of the Trust’s CQUIN plan.

(* - managed conveyance are the journeys to hospital excluding hospital transfers and Drs admissions)

The introduction of NHS Pathways into the Emergency control rooms was also a key QIPP programme that has now been delivered.

4. **From the perspective of the ambulance service what are the main challenges to reducing the attendance at accident and emergency departments?**

Patients often attend A&E as they do not know what other services are available. Data would suggest that many people attend A&E when it is convenient for them so by increasing the hours of GPs, making alternative service more well known and by introducing 111 to help people navigate their way around the system pressures on A&E should be alleviated.

Author:

Anouska Adamson-Parks

Head of External Service Developments

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Kent Community Health NHS
NHS Trust

Health Overview and Scrutiny Committee Meeting -14th October
Reducing Accident and Emergency Admissions

Kent Community Health NHS Trust is a newly formed organisation on 1st April 2011 formed from the merger of community services from West Kent and East Kent and Coastal PCTs.

The Trust's annual turnover is approximately £200 million. The Trust employs 5,458 members of staff of which approximately 85% are in clinical services. The services operate from a range of sites across the county.

The Trust provides a range of community based services which cover:

- Health and wellbeing to ensure people remain in good health e.g. smoking cessation
- Children and young peoples universal services e.g. health visiting, school nursing and services for children with specialist needs e.g. speech and language therapists, community medical paediatric service
- Patients with long term conditions with the aim of sustaining their quality of life e.g. district nurses, community matrons, therapy services
- Rehabilitation and rapid access services e.g. therapists, rapid response, community hospitals
- Specialist services such as dental, diabetic services, minor injury and illness services

These services all contribute to reducing the need for patients to attend Accident and emergency department and to avoid emergency admissions to acute hospitals. The Trust as a whole made **3,279,389** contacts with people in 2010 /2011.

1. ***Do the current levels of attendance at Accident and emergency departments pose any particular challenge for the delivery of community health services ?***

The levels of people attending A&E do not directly pose a particular issue for community health provision. However, we are commissioned to provide admission avoidance services that are not always understood nor utilised effectively and we would like to hone the ability in our contract to do more.

The advent of the national 111 number will involve the use of algorithms to determine the pathway for a patient and this should drive the use of alternative care pathways which will then begin to impact on the use of community health services. This requires a good directory of services to describe the options to redirect patients to services in a community setting.

We actively promote our services, encouraging referrals and are an essential part of the care closer to home agenda. We support all initiatives that are designed to deliver admissions avoidance and earlier discharge facilitation and rehabilitation activity where it is safe and appropriate.

2. ***What is the role of community health services in reducing attendances at accident and emergency departments***

A significant number of patients who attend A&E and are admitted are suffering from a long term condition. Kent Community Health Trust is actively working with partners to join up care for this group of patients with the aim of maintaining their health and managing their symptoms to prevent the need for them to attend hospital. The introduction of integrated personal health budget pilot in Kent will explore what impact this has on an individual in managing their own condition.

The use of assistive technology (telehealth) is now key in our management of appropriate patients with long term conditions. This initiative, together with KCC has proved to be invaluable, firstly for patients and their carers, not only promoting confidence, independence and understanding of the management of their condition but also an early indicator of an impending exacerbation or crisis. An individual management plan is in place for patients and is activated to ensure that their emerging symptoms are managed together with the GP and sometimes their hospital consultant, therefore averting a possible admission. This has shown a reduction in admissions, GP visits and also the need to attend for out patient appointments in some instances.

In addition, we have recently been implementing a risk predictor tool that when patient level data is run through the computer software it can provide a prediction of risk of attendance at accident and emergency. This allows a targeted approach to managing the patient's condition through early intervention. It can also provide evidence that interventions made by

community health services have an impact reducing the need for patients to attend accident and emergency departments

Rapid response services provide a 2 hour or less response to any patient that requires nursing, social care and therapeutic interventions to prevent a hospital admission where it is safe to manage the patient in their own home. This can be for conditions such as chest infections, urinary infections and falls.

Kent Community Health Trust has been working with the ambulance service paramedic practitioners (PP) to identify those patients who could safely remain in their own home. The PP will assess patients and call upon community and other services to support the patient rather than transfer them to hospital.

If the team deem it is not appropriate or safe for the patient to be managed at home they can 'step up' the patent into a bed either in a community hospital, integrated care centre or care home (where there are commissioned short term beds). It is always the team's aim to restore the patient to their former ability or to a level of independence and return them back to their home as soon as possible.

Community hospitals, integrated care centres and short term commissioned beds in care homes play a key role in admissions avoidance through the option to 'step up' patients from the community (their home) directly to a bed in a community setting (if it is safe to do so), providing nursing and medical care in a therapy, with the aim to again to get the patient home as soon as is possible to their own home.

At present the split between transfers to the community hospitals from acute trusts and the stepping up of patients from the community is approximately 75% / 25%. We would be keen to work with the wider health and social care economy to increase the ratio of patients stepped up to community hospitals and other community beds from home to prevent admission to acute hospitals where possible.

Minor injury /illness services are provided by Kent Community Health Trust and see and treat a large number of people per year across the minor injury units (MIU). In 2010/11 there were 94,460 attendances at the MIU centres. At present units in the West of Kent do not provide minor illness treatments but this is planned for a start towards the end of the year following discussions with commissioners. The conversion rate (the numbers of patients sent onto acute hospitals from the units) is relatively low.

Discharge multi professional facilitation teams actively case find patients for early supported discharge, working on acute hospital sites across Kent together with social care. Community based services then continue

rehabilitation, recuperation or longer term support either in the patients own home, community bed or care homes.

A programme which delivers redesign of patient pathways where, traditionally, patients would have to stay in hospital was a collaboration between Community health services in Kent, GP's, social care, and East Kent Hospitals University NHS foundation Trust. These include treatment of conditions such as, deep vein thrombosis, pulmonary embolus and cellulites management, delivering intravenous therapy and anti-coagulation (blood thinning) treatments in the patients own home. A survey of those patients, who received their treatment at home, as part of this programme, was found to be positive.

Patient Examples:

New Care Home Pathways:
Patient A resides in a residential care home and had a fall in their room. The patient had not bumped their head and did not appear to have any bony injury. They had a small abrasion on the small of their back which appeared to suggest they had slipped to the floor while trying to sit in an armchair. This was not the first fall and previously the care home would have dialled 999 and the patient would have been taken to A and E for review.
With the new care pathway developed with the care homes, KCC, SECAMB and KCHT the patient was reviewed in the care home by a paramedic and the Rapid Response senior nurse on duty.
Following a full assessment and agreement that the patient did not require transfer to A and E, the patient was put into bed by the team.
Rapid Response agreed to provide additional monitoring of the patient for the next few days to support the care home in keeping the patient there. In addition, Rapid Response then sent out a therapist to undertake a full falls prevention assessment and provided the patient and the care home staff with strategies to try and prevent future falls and a new walking aid that met their needs.

Long Term Condition management:
Patient B is housebound with a diagnosis of Chronic Obstructive Airways Disease. He has an oxygen condenser and requires regular review. They receive 2 care package visits per day. He had a history of dialling 999 when they were anxious, short of breathe and of being taken to A and E for assessment and usually ending up being admitted for between 3 days and 2 weeks.
To improve this patient's management programme and reduce potential admissions to hospital the GP practice set up a multi disciplinary team (MDT) meeting which included the community matron, care manager and practice nurse. The outcome was an agreement to assess the patient's suitability for telehealth monitoring, then once installed to ask the community matron to review the patient's readings daily and so provide assurance to the patient as well as allow proactive review of medication and early warning of infection or exacerbation.
The GP is given regular readings of the patient and meets the Community Matron as required to ensure the patients readings remain within acceptable levels. It has also enabled the care manager to flex social care support to ensure the patient remains at home.
Before this MDT approach to this patient was initiated he was dialling 999 an average of 3 times a month. This has now dramatically decreased and this summer they have attended A and E just once which was appropriate and following a chest X-ray and a short course of intensive treatment the patient returned home to the care of the community matron.

3.What is the place of urgent and emergency care in your organisations QIPP programme ?

The QIPP programme sits with Clinical Commissioners and therefore we would expect to be contributing to the programme through collaboration in the development and delivery of redesigned care pathways to assist in meeting the urgent and emergency care QIPP programme.

This would relate to the proactive management of patients with long term conditions, through the use of the predictive tool as described earlier (this is a software tool that can be used to identify people via GP practice registers who are at risk of admission to hospital) so that people and be assessed by health and social care services in order to promote health and well being and ensure appropriate case management.

End of life care and dementia will also be areas that Kent Community Health Trust together with social care and mental health services can make an impact on reducing avoidable admissions to hospital and allowing more people to die at home.

We believe that the delivery of the QIPP programme and urgent care management can be achieved through the proposed Integrated Health and Social Care Service model. This brings together primary care (GP practices), community nursing, social care, rehabilitation, rapid response, enablement and mental health services into what can be described as neighbourhood (locality) teams. The team will be accessed via a local single point of referral for health and social care, aiming to deliver the following outcomes:

- Reduction in occupied bed days (average)
- Reduction in emergency bed days for over 65's and over 75's
- Reduction in delayed transfers of care
- Reduction in readmissions

In addition the following is hoped to be achieved:

- Reduction in emergency admissions for end of life care
- Reduction in admissions to care homes –nursing and residential

4. From the perspective of the community health service, what are the main challenges to reducing attendance at accident and emergency departments ?

Patients will attend A&E if they do not know what alternative services are available and the challenge for Kent Community Health Trust is to raise awareness of these alternatives and provide an easy access point.

There is still, despite efforts, a lack of a whole system approach to the management of urgent care demand, some of which relates to the lack of use of alternative care pathways. Our services are largely reactive as a result and are dependant on others who are likely to see the patient first for example; paramedics, GP's and A&E staff. Despite the provision of minor injury / illness units (which are well utilised) people still choose to attend major A&E departments. This is the patient's personal choice.

Challenges also include the lack of commissioning decisions relating to development of new / revised pathways that require the disinvestment in acute services and reinvestment in alternative community service provision. However, we are working with East Kent Hospitals University NHS Foundation Trust to explore opportunities relating to possible sub contract arrangements in some areas of provision. An example is increased intravenous therapy treatments.

There is also a lack of a single co-ordination point via a single telephone access number service for managing redirection of patients who can be safely cared for in a community setting locally. This is contributing to the way patients are still being transported to Accident and Emergency departments rather than utilising alternatives through a robust process. Kent Community Health Trust has been looking into possible options to propose a potential solution. It may be possible to collaborate with others to provide such a service and support a reduction in readmissions.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 October 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. The Members of this informal HOSC Liaison Group were Nigel Collor, Dan Daley, Michael Lyons and Roland Tolputt.

(c) Members of this informal HOSC Liaison Group reported back to the Committee when it further considered this subject on 9 September 2011. It was also decided that Elizabeth Green should join this Group, which would continue to liaise with the NHS on the subject.

(d) It was also agreed that the NHS be invited back to further discuss this topic at the meeting of 14 October when the focus would be on the consultation process.

2. Recommendation

That the Committee consider and note the report.

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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

Version: 5
Date: 29.8.2011
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

Maternity Review – Patient Distribution Analysis
Current Provision

This report graphically presents the current flow of patients into the four birth centres in East Kent.

The report covers:

- Current patient flows,
- Proportion of affected patients,

Primary data source: Euroking Maternity Database,

Reporting period: **August 2009 to July 2010**

This period of time was chosen due to the changes in service during 2010/11. The time period accounts for the most recent 12 month period when all four of our birthing locations were open. Due to the reporting period, the data detailed within the report will not match exactly to those detailed within the maternity review documentation.

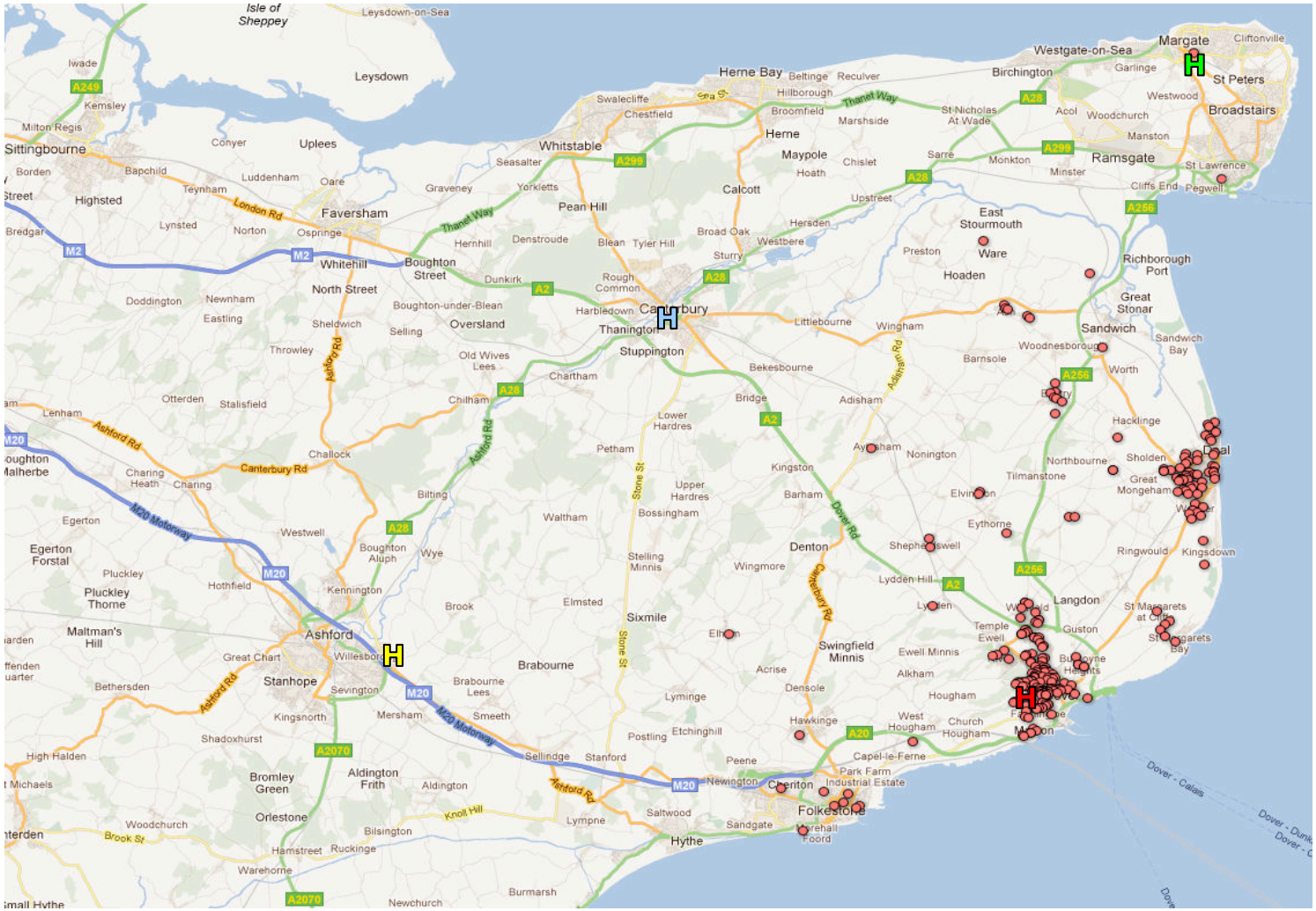
We have kept the same colour scheme throughout the report.

Dover Family Birth Centre – Red

Canterbury Birth Centre – Blue

William Harvey Hospital – Yellow

Queen Elizabeth the Queen Mother Hospital – Green



Dover Family Birth Centre

Midwife Led Births	248
Consultant Led Births	0
Number of Births	248
% of Total Births	3%

Fig 1.1 - Patients postcodes shown in colour

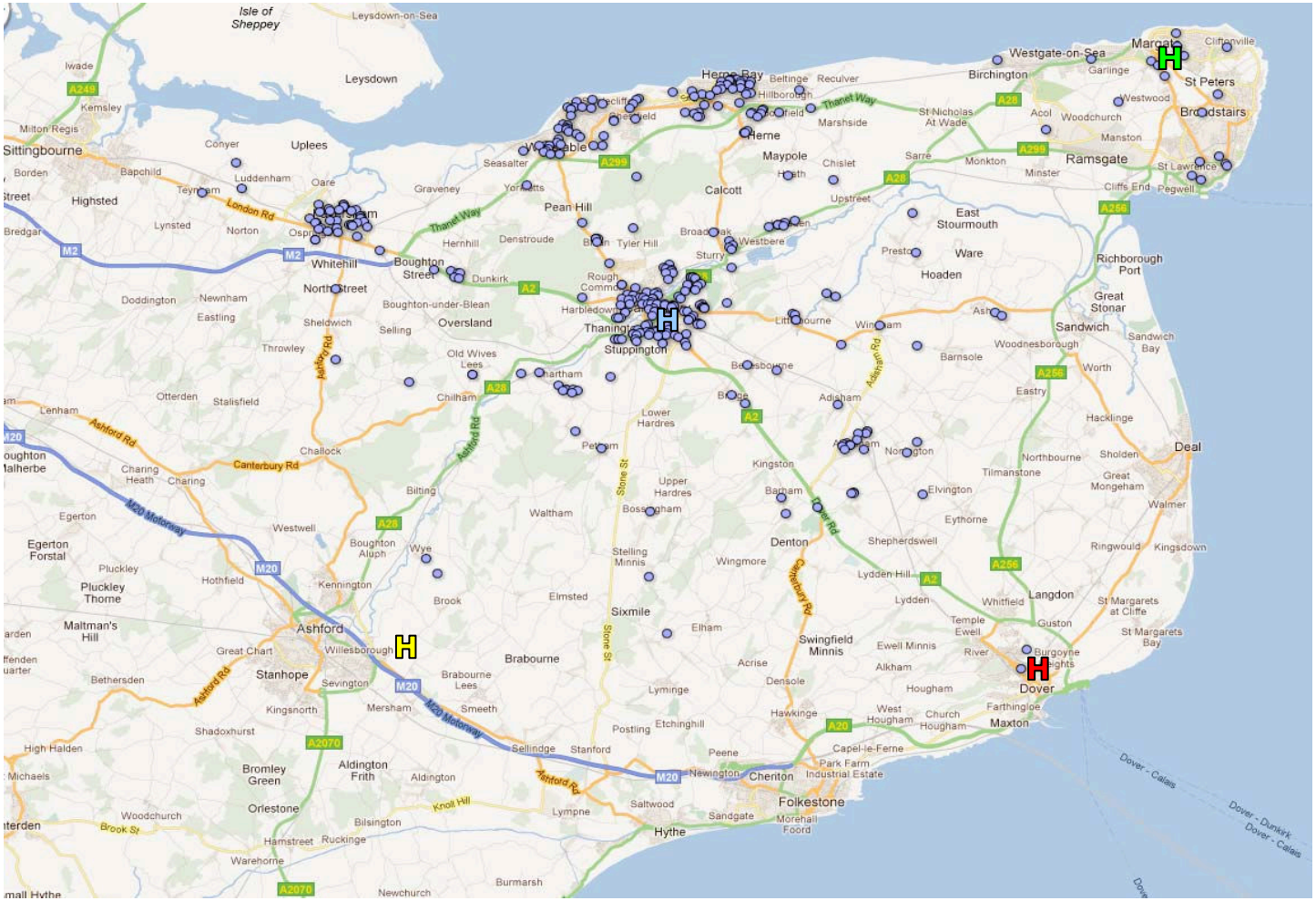


Fig 1.2 - Patients postcodes shown in colour

Canterbury Birth Centre

Midwife Led Births	360
Consultant Led Births	0
Number of Births	360
% of Total Births	5%

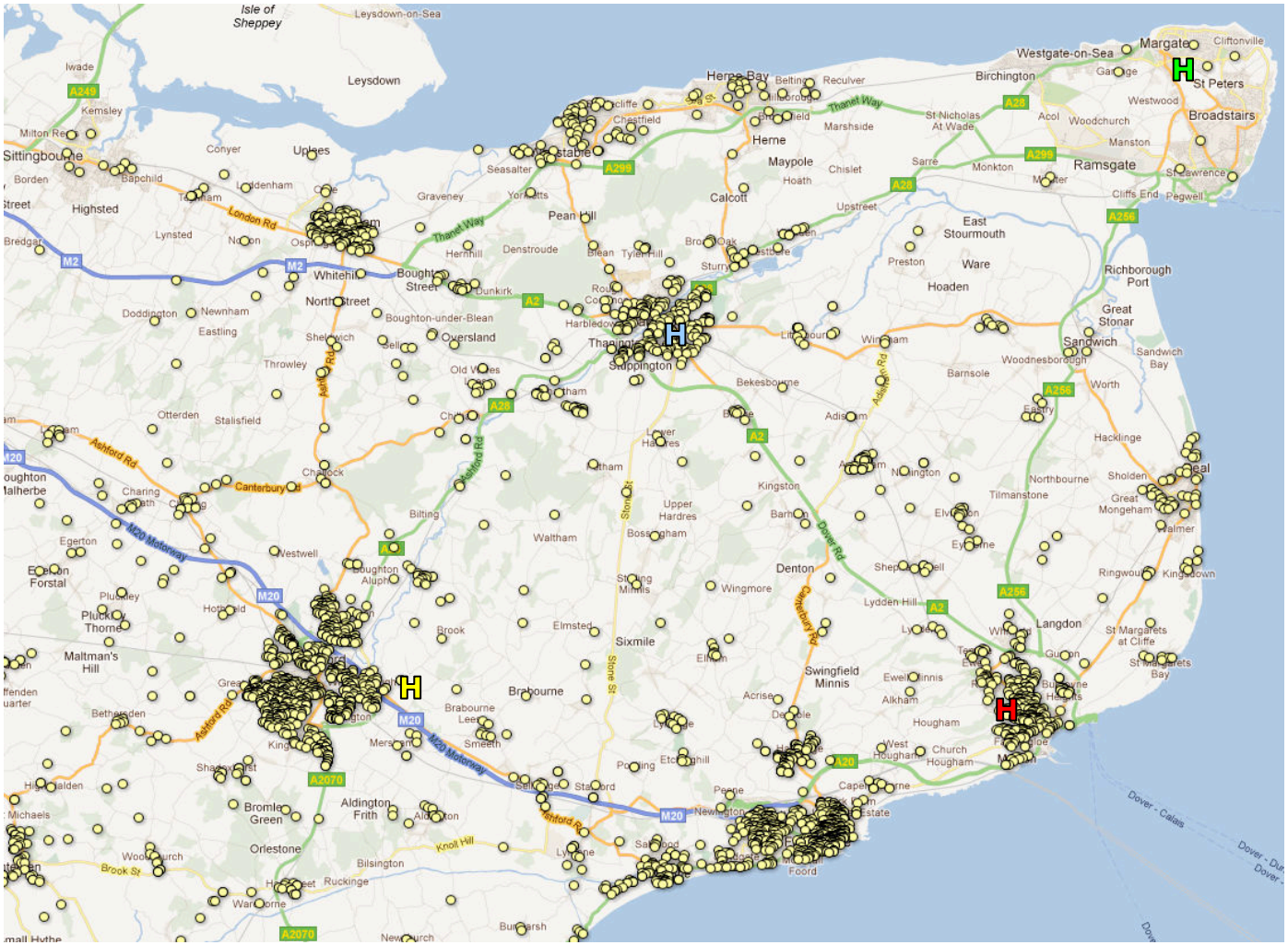


Fig 1.3 - Patients postcodes shown in colour

William Harvey Hospital

Midwife Led Births	899
Consultant Led Births	3050
Number of Births	3949
% of Total Births	54%

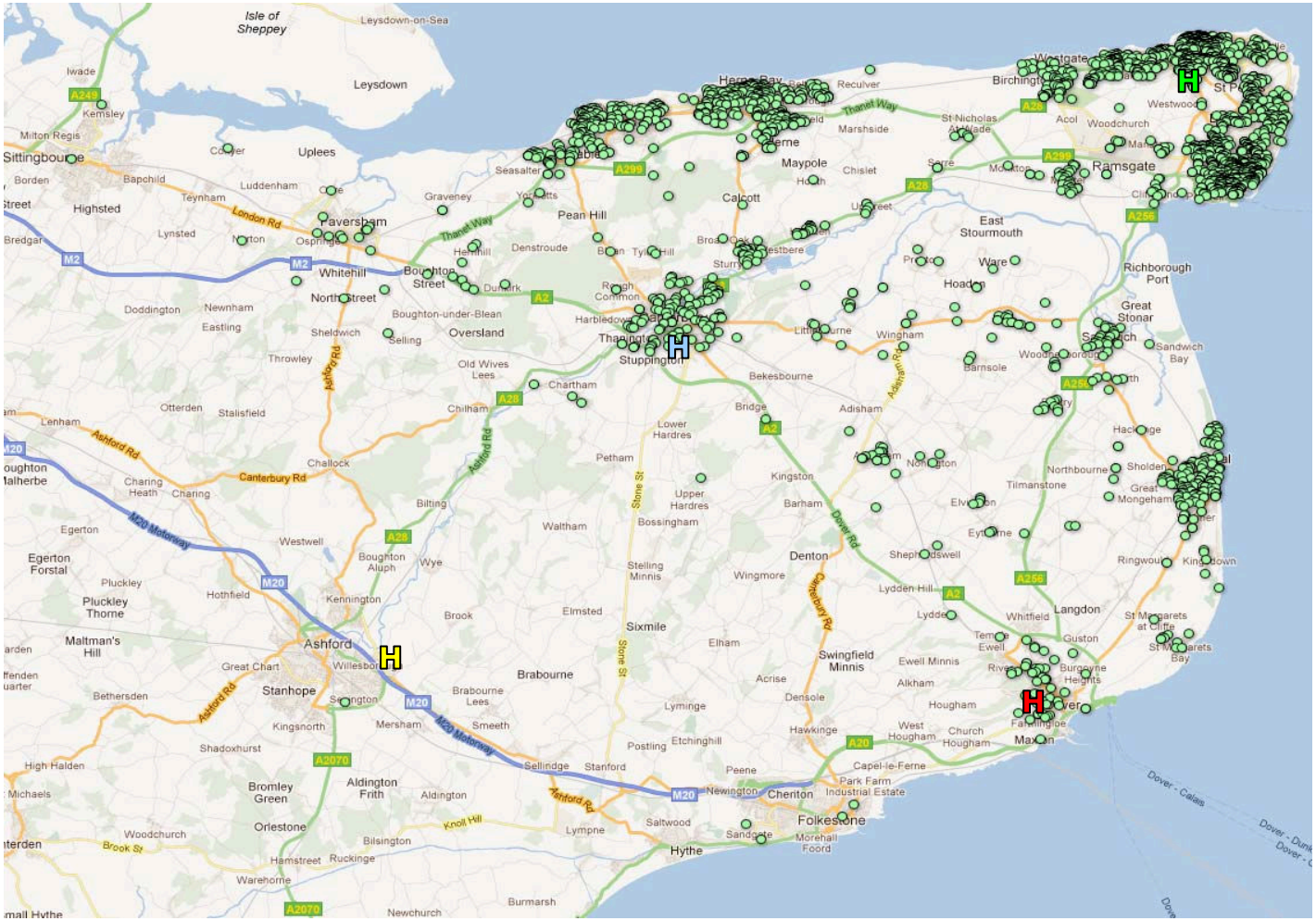


Fig 1.4 - Patients postcodes shown in colour

Queen Elizabeth the Queen Mother Hospital

Midwife Led Births	0
Consultant Led Births	2703
Number of Births	2703
% of Total Births	37%

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 October 2011

Subject: Eating Disorder Services Review

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1. Background

(a) Attached is a briefing note from NHS Kent and Medway setting out the work to date on the eating disorder services review currently underway across the Kent and Medway PCT Cluster (NHS Kent and Medway).

(b) Due to the review covering the whole of Kent and Medway, there may be the opportunity to receive further information on the review in conjunction with Members of Medway Council's Health and Adult Social Care Overview and Scrutiny Committee.

2. Recommendation

That the Committee note the report.

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NHS
Kent and Medway

PURPOSE OF THIS PAPER

This paper seeks to introduce the Health Overview and Scrutiny committee to the work to date on the Eating Disorder Service review currently under way across Kent and Medway PCT Cluster (NHS Kent and Medway). Due to the nature of the project being cross PCT boundaries, we would request consideration be given as to how Kent and Medway HOSC's will form a joint HOSC or working group in order to consider the draft options appraisal, when prepared, for service change.

INTRODUCTION

Kent and Medway NHS and Social Care Partnership Trust are the main providers of services to people with eating disorders in Kent and Medway. Inpatient treatment is provided at the Red House in Maidstone, which also offers Outpatient treatment and a Day programme. Outpatient treatment for the population of East Kent is provided by a small team working out of a number of locations in the area. From April 2010-March 2011, the service saw just over 1,700 patients. In March 2011 there were 32 admissions, 15 for Eastern and Coastal Kent, 7 for Medway and 11 for West Kent.

There are 4 Primary Care Specialist Nurses who offer Early Intervention on eating disorders in East Kent, Dartford and Medway; there is no specialist nurse in Maidstone. Tertiary care for complex cases, where interventional feeding if necessary is administered via a nasogastric tube, is provided out of area by Cygnet Hospital and Maudsley Hospital.

The following table sets out the services according to current location (NB. these services are available to *all* residents in Kent and Medway, irrespective of where they live):

	Primary Care Liaison	Outpatient	Inpatient treatment	NG feeding
West Kent	√ (in D,G&S)	√	√	x
East Kent	√	√	x	x
Medway	√	x	x	x

The Kent and Medway Specialist Mental Health commissioners are committed to providing an accessible, high quality Eating Disorders Service (EDS). They recognise that the current service is inadequate in clinical and financial terms: there is disparity across the county in terms of access to services, very long waiting lists and an disproportionate amount of funding being spent on out of area placements. Conducting a draft options appraisal has allowed the stakeholder steering group to focus on a more effective use of the resources in order to provide a quicker, more responsive Eating Disorders Service for the population of Kent and Medway.

CONTEXT

In order to understand the current model of care, the information below gives an overview of service provision across Kent and Medway.

Primary Care Liaison Service:

- This service is made up of (4) Primary Care Specialist Nurses in East Kent (2), Medway (1) and Dartford, Gravesham and Swanley (1), who work out of their respective localities with referrals from primary care, aged 14 upwards who have recent onset eating disorders or difficulties, for early intervention. There is no Primary Care Specialist Nurse in Maidstone.
- The overall capacity of this service is 40 patients
- From January - December 2010 the service saw 78 patients

Outpatient service.

- This service holds a caseload of patients with severe eating disorders, referred from secondary care and who are treated in the community
- The service is based at the Red House (for patients in West Kent) and in various localities in East Kent.
- This service has a capacity of approximately 60 patients.
- Between April 2010 and February 2011 the service was provided to 154? patients.

Day Programme:

- This service is for patients who require intensive treatment but whose condition can be managed effectively through the Day programme
- This service is based at the Red House
- This service has a capacity of 4 patients.
- In 2010-2011 the service was provided to 22 patients.

Inpatient provision:

- This service is for acute cases of patients with chronic and often enduring eating disorders
- This service is based at Red House
- This service has a capacity of 6 patients
- In 2010-2011 the service saw 22 patients

Inpatient provision with interventional feeding:

- Some complex cases patients require intensive tertiary care treatment involving nasogastric feeding. Currently patients in Kent and Medway who require this treatment are sent out of area to Cygnet Hospital. Cygnet Hospital Ealing is a specialist inpatient services for severely ill patients. Treatment includes therapy, nutritional counselling, group support and complementary therapies; average length of stay is a minimum of 6 months.
- In 2010-2011, 14 patients were sent to Cygnet and 1 to the Maudsley (7 for complex needs, 3 due to lack of beds at the Red House, 2 for NG feeding and 1 for unmanageable behaviour)

COMMISSIONING OBJECTIVES

The objective to **identify a model of care that will enable timely access to a good quality Eating Disorders Service for the population of Kent and Medway.** Improving access to high quality, responsive, community-based, Primary Care Specialist Nurses is a key component of this objective.

PROGRESS TO DATE

In February 2011 an options appraisal of the service was commissioned. On February 11 2011 a stakeholder steering group meeting of service users, carers, healthcare professionals and providers was held to initiate discussions about the options appraisal.

From February to May 2011, the project lead contacted staff, providers, GP's, staff and services users to generate a list of options for the service. A carer's questionnaire has been undertaken across Kent and Medway to gather initial insight into patient experience of the service. During this pre consultation stage, the project lead interviewed staff and attended a sufferers group to meet directly with patients. Telephone interviews with a small sample of service users was also undertaken.

Feedback from pre consultation work indicates that the issue is substantive for a small number of patients. Early engagement shows that patients are supportive of the general direction of travel. The main issues arising from a patient perspective was the waiting times for treatment, and an inequality in access to the service across the region. Patients felt that more education for primary care practitioners was needed to ease speedy referral to the service, with more support needed in the community.

In May, a draft options appraisal was circulated to the stakeholder steering group in order to discuss and debate the options and the criteria. Following this feedback and the findings from the pre consultation work, the options were amended and a financial analysis undertaken in order to assess the feasibility of the options.

NEXT STEPS

Good progress has been made to date, but more work needs to be done with support from the emerging Clinical Commissioning Groups across Kent and Medway, and with service users and carers before a finalised options paper can be presented.

It is anticipated that members of HOSC will be invited to attend, another stakeholder meeting as observers. The purpose of this will be for both Medway and Kent HOSC to better understand the case for change, and the complexity and sensitivity of issues surrounding the service, before they consider the case for change.

Following consideration of the substantial variation form it is expected that both Medway and Kent HOSCs will need to form a joint committee, or hold joint meetings to consider the Kent and Medway wide service, before moving into a formal consultation process.

This has initially been raised with both committees to consider how best this should be taken forward.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 October 2011

Subject: Child and Adolescent Mental Health Services (CAMHS)

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1. Background

(a) At the meeting of the Specialist Children's Services Policy Overview and Scrutiny Committee on 28 September 2011 a request was made that the progress report on the development of Child and Adolescent Mental Health Services (CAMHS) within Kent and Medway be made available to the Health Overview and Scrutiny Committee.

(b) This report is attached. Further progress reports may be made available in the future.

2. Recommendations

That the Committee note the report.

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By:	Jenny Whittle, Cabinet Member, Specialist Children's Services
	Malcolm Newsam, Interim Corporate Director, Families and Social Care
	Lorraine Goodsell, Director Child Health Commissioning
To:	Specialist Children's Services Policy Overview and Scrutiny Committee – 28 September 2011
Subject:	**CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) – A PROGRESS REPORT ON THE DEVELOPMENT OF THE SERVICE**
Classification:	Unrestricted

Summary:	The purpose of this report is to inform and update Members about the progress on the joint commissioning of emotional wellbeing and CAMHS services within Kent and Medway.

Introduction

1. (1) Kent County Council agreed at Cabinet on the 18 July 2011 to:

- the joint commissioning with NHS Kent and Medway of an Integrated Community CAMHS
- the alignment of the current Kent County CAMHS funding with the PCT and
- proceed to the procurement stage the Emotional Wellbeing Services through the Early Intervention and Prevention Multiple Supplier Framework Contract.

(2) NHS Kent and Medway agreed on the 20 July to re-commission current NHS primary and specialist CAMHS services into an Integrated Community CAMHS model. There is also approval to commission these services within an aligned budget and pathway of services with KCC. The model varies slightly in Medway in line with local provision but the whole model is aligned and designed to deliver an improved pathway of care, quicker access to appropriate mental health interventions and improved outcomes for children, young people and their families.

The development of the service model

2. (1) Significant evidence has identified the need for a system redesign of services in Kent. Consultation has taken place with a number of other Local Authorities that have pioneered the development of a Community CAMHS model. A model for Kent has been developed drawing on the learning from consultation with clinicians and patients across Kent, and from best practice nationally.

(2) The Community CAMHS model integrates the provision of primary and specialist mental health services. A single access point enables responsive triage into the most appropriate intervention. It enables faster access to services and interventions appropriate to need.

(3) The key integrated Community CAMHS Model (see Appendix 1) aims to:

- Ensure children and young people are as healthy as possible
- Focus on prevention, early diagnosis and early intervention to sustain health, wellbeing and independence
- Deliver support as locally as possible
- Provide the most effective treatment and cure
- Provide the right, high quality support for children and young people
- Make best use of resources and provide value for money
- Ensure children, young people and families have a say and influence
- Improve the interface between primary and specialist services and emotional wellbeing
- Improve the transition from child to adult services (18+)

Timetable for procurement

3. (1) The key dates in the procurement timeline for the Emotional Wellbeing (led by KCC) and the Community CAMHS (led by NHS Kent and Medway) are shown in Appendix 2. Further details on progress against this timeline will be provided at the meeting.

(2) Emotional Wellbeing Services will be procured against the Early Intervention and Prevention Multiple Supplier Framework Contract, an outcomes based framework. KCC are the lead agency for this part of the procurement process. There are three 'lots' as follows:

- Lot 1 Emotional Wellbeing Services in educational settings
- Lot 2 Emotional Wellbeing Services in community settings
- Lot 3 Emotional Wellbeing Services to parents, carers and families

(3) The Community CAMHS will be provided by specialist CAMHS professionals and will be a single service integrating Tier 2 (Targeted) and Tier 3 (Specialist) into a Community CAMHS model. NHS Kent and Medway is the lead agency for this part of the procurement process. The service model is a single triage/assessment system that is incorporated within an overall CAMHS care pathway and served by a multi-disciplinary CAMHS team and will align with the Emotional Wellbeing Services for children and young people.

(4) Medway will continue to commission its Emotional Wellbeing Services (Tier 2) and primary health through its current arrangements. Nevertheless, the vision, outcomes and objectives that Medway aim to achieve through this procurement are the same as those for Kent and as described in the Community CAMHS model.

(5) Evaluation of tenders will involve all commissioning partners, and will also include participation by young people who have had experience of mental health services.

(6) Both procurements are aligned as far as possible. Notification of award of contract will be earlier for the Emotional Wellbeing services (February). It is anticipated contract start date will be 1st April 2012. Current service providers have been advised that services from the 1st April will be procured against the multiple supplier framework.

(7) Notification to the successful bidders for Community CAMHS will be 29 March 2012 and there will be a period of mobilisation from 1 May 2012 until full service starts 3 September 2012. At the end of August 2011 the current CAMHS providers received exit letters providing them with one year's notice of termination of the current contract.

Recommendations:

4. (1) Members of the Specialist Children's Services Policy Overview and Scrutiny Committee are asked to **NOTE** the progress so far with regard to the re-commissioning of an Integrated Community Child and Adolescent Mental Health Service for Kent and a Tier 3 CAMH Service for Medway which will facilitate the commissioning of the pathway of services across the community.

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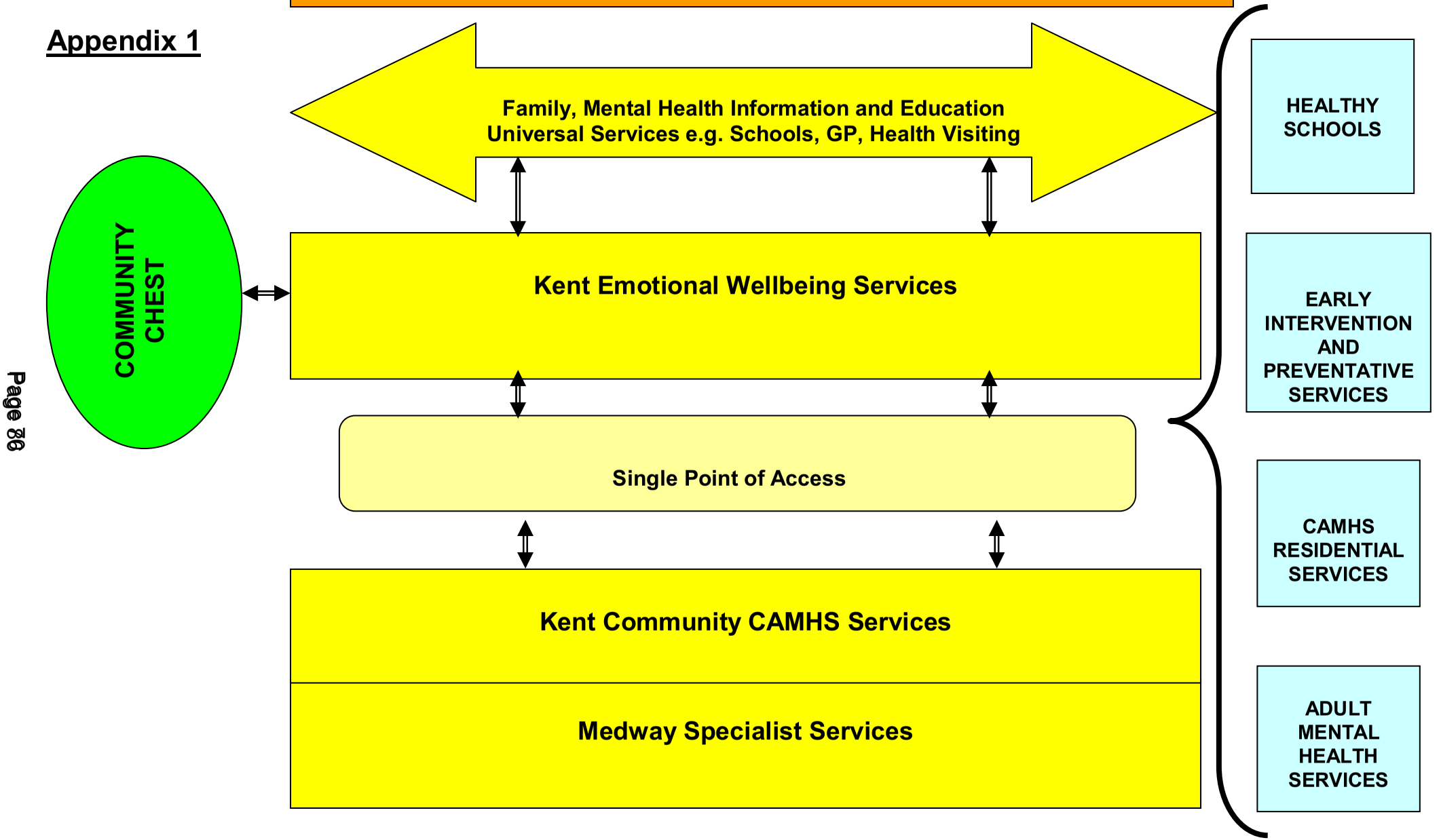
Background Documents:

- Joint Commissioning of Integrated Community Child and Adolescence Mental Health Services – report to Cabinet 18 July 2011
- Child and Adolescent Mental Health Services (report by NHS Kent and Medway) – Report to NHS Kent and Medway Cluster Board 20 July 2011

INTEGRATED COMMUNITY CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Appendix 1



APPENDIX 2

PROCUREMENT TIMELINE (Key Dates)

Milestones – Emotional Wellbeing (Part of EIP Framework)	***Date***	***Milestones Community CAMHS***	***Date***
EOI published on the South East Business Portal	18th July 2011	Advert and MOI published (via e-Sourcing portal)	1 August 2011
Closing Date for EOI	22nd August 2011	PQQ published (via e-Sourcing portal)	3 August 2011
Invitation to Tender (ITT) issued to EOI via ProContract	22nd/23rd August 2011	Bidder Information Event	17 August 2011
Deadline for receipt of ITT	26th September 2011	Deadline for receipt of Conflict of Interest	2 September 2011
Evaluation of ITT via ProContract	September / October 2011	Deadline for receipt of Declaration of Consent	
Confirm successful tenders for inclusion on the Emotional Wellbeing Category of the multiple supplier framework	1st November 2011	Deadline for receipt of Declaration of Completion	
DMT / Cabinet Approval	November 2011	Deadline for receipt of PQQ submissions	
Notify tenderers of decision (Includes standstill period)		Completion of PQQ evaluation	16 September 2011
Mini-Competition ITT Published	December 2011	Bidders notified (via e-Sourcing portal)	19 September 2011
Deadline for receipt of mini competition	January 2012	Invitation To Tender (ITT) issued to qualifying bidders	4 November 2011
Evaluation of mini competition	January 2012	Deadline for receipt of ITT bids	14 December 2011
Providers notified	February 2012	Evaluate bids	December/January 2012
Contract Start	1st April 2012	Confirm preferred bidder	30 January2012
		PCT Cluster board approval	28.March 2012
		Notify bidders of decision	29 March 2012
		Standstill period & contract negotiation	April 2012
		Publish contract (start up)	01 May 2012
		(Full) Service start target date	03 September 2012

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 October 2011

Subject: NHS Financial Sustainability: Key Issues and Recommendations. Written Responses.

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1. Background

(a) At the meetings of 15 March, 19 April, and 10 June the Committee considered the subject of NHS Financial Sustainability in depth. A report was produced as a result of this work and approved by the Committee on 22 July 2011.

(b) Copies of the report were subsequently sent to all the NHS Trusts in Kent and Medway, along with the Health and Wellbeing Board (Shadow) and the Secretary of State for Health.

(c) A copy of the Committee's report and the responses which have been provided so far are attached.

2. Recommendations

That the Committee note the report.

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NHS Financial Sustainability

Key Issues and Recommendations

Health Overview and Scrutiny Committee,
Kent County Council
July 2011

Part 1 - Introduction

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

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

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

(b) The Committee held three formal meetings on the subject and heard from the following organisations:

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

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

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

Part 2 - Key Issues

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

1. Allocations v. Need

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

2. Short term v. Long term planning

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

3. National v. Local targets

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

4. Localism v. Post code lottery

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

5. Providers v. Commissioners

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

6. Competition v. Collaboration.

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

7. Repatriation v. Centralisation of services

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

8. Transition planning v. Continuity of care

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

(b) Although the focus of the Committee's enquiry was the health economy across Kent, most of the key issues outlined above could apply to most, perhaps all, areas of England. What should not be forgotten is that Kent has its own individual set of circumstances, such as being in part peninsular and having a number of separate population centres to which people look for core services. This makes delivering financial sustainability across the Kent health economy uniquely challenging.

Part 3 - Recommendations

To Department of Health

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

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

To Kent and Medway PCT Cluster

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

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

To all NHS Trusts in Kent and Medway

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

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

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

To Shadow Health and Wellbeing Board

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

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

To HOSC

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

Appendix – HOSC Minutes on NHS Financial Sustainability

1. 25 March 2011

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. A free standing large consortium;

2. A large consortium with a locality structure; and

3. Small consortia forming a federation.

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

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

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

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

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

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

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

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

2. 19 April 2011

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust), Stuart Bain (Chief Executive, East Kent Hospitals NHS University Foundation Trust), Colin Gentile (Interim Director of Finance, Maidstone and Tunbridge Wells NHS Trust) and Patrick Johnson (Director of Operations/Deputy Chief Executive, Medway NHS Foundation Trust) were in attendance for this item.

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

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

(3) Medway NHS Foundation Trust echoed the interest in a partnership between it and Dartford and Gravesham NHS Trust, though this was a change from the view a year ago. However, the proviso was made that while a merger would save money, particularly in back office costs, it would not completely offset the financial pressures. Medway NHS Foundation Trust had to make 7% efficiency savings. This was challenging, but the national decision for no pay inflation helped produce a seven figure saving. Reducing the number of bed days at the hospital was a key driver for the current year with different initiatives being pursued to realise this, such as nurses being able to discharge patients and providing the capacity to care for twenty patients in their own homes; the latter policy was going to expand to cover Swale and non-medical patients, neither of which were included in the scheme at present. Following questions from Members, further detail was provided on the scheme for allowing nurses to discharge patients which was due to be implemented in a month's time. It was explained that there was not the capacity at the Trust to enable patients

to be seen by consultants each day, but if the requirements set by the consultant for discharge were met, then the appropriate nurse would have the ability to approve discharge to prevent patients staying in hospital longer than necessary. This point was supported by East Kent Hospitals NHS University Foundation Trust arguing that keeping patients in hospital longer than necessary increased the clinical risks of infection.

(4) Several Members expressed broad approval for the potential of merging Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust, as long as the levels of service provision remained the same at both sites. It was explained that the populations served by both meant this was not likely. The two Trusts were invited to return to the 22 July meeting of the Committee in order to explore the merger potential further.

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

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

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

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

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

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

(11) The actual cost to the NHS of patients receiving treatment under the tariff varied from Trust to Trust because of the Market Forces Factor. Treatment in London was more expensive than in Kent, so the point was made that if patients either chose to go to London, or needed to be referred there, that was an additional cost to the commissioners in Kent and a loss to the providers. For this reason, establishing services locally which were otherwise only available in London, a process known as repatriation, was reported as being a double win. Looking locally, one Member of the Committee made the observation that the two Acute Trusts in West Kent had the highest Market Forces Factors in Kent and Medway, but that NHS West Kent had the lowest per capita PCT allocation. To this was added the point made by East Kent

Hospitals NHS University Foundation Trust that the Market Forces Factor for the Trust had got lower, though it had increased for the others in Kent and Medway. This meant the Trust was receiving less income for each service provided and needed to improve efficiencies even more to keep up. The Trust representative also noted that staff costs were nationally set in most cases.

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

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

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

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

(16) Clarification was sought on the policy that Acute Trusts were financially responsible for readmissions and it was explained that the policy only

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

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

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

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

(20) The specific issue was raised that, whilst the care received may be very good, customer care for patients entering the system and between appointments needed to be looked at so that patients had certainty about who they were going to see and when. East Kent Hospitals NHS University Foundation Trust conceded cancelled outpatient appointments were a struggle and there was a cost involved in remaking appointments. The Trust was moving to a full booking system, where all the appointments for a patient on a pathway could be made in advance, though this did require capacity in the system.

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

3. 10 June 2011

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

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

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

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

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

(5) On the subject of the Minor Injuries Unit at Sheerness it was explained that this was only a temporary closure on safety grounds and that it

was back open 9am to 9pm Monday to Friday and would be open at the weekend again soon. More broadly on the subject of community hospitals, it was explained that the whole of community services support the work the community hospitals undertake, rather than the hospitals causing funds to be diverted from elsewhere.

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

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

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

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

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

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

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

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

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

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

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

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Dartford and Gravesham NHS
NHS Trust

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23rd August 2011

Dear Tristan

Re: NHS Financial Sustainability – Key issues and recommendations

Thank you for sending me the above report and for inviting Dartford and Gravesham NHS Trust to the HOSC itself.

Firstly, at this time of great transition and financial challenge, it is important that the local authority is fully aware of the impact this could have on its resident population and involves itself in the dialogue and the scrutiny of what is being planned from a health perspective.

With regard to the detail in the report, I thought it was very helpful and picked up the key issues. From a public health perspective, the issue of the allocations formula is important. Your report picked up on the fact that West Kent only received £1,499 per person. Dartford and Gravesham is much poorer that the rest of West Kent and the life expectancy is significantly less in some wards. It is a distinct disadvantage to be a poorer district in an overly affluent area and commissioners must work to mitigate the problems which arise from this situation. I think the HOSC should be duly mindful of this fact.

On a matter of factual accuracy, you have appended the minutes on NHS Financial Sustainability. On page 11 under item 4, I think this should read positively. Based on the size of populations, it is likely that the services people regularly need will be provided on both the Darent Valley and Medway sites.

Once again, thanks for the report.

Yours sincerely

Susan Acott
Chief Executive

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NHS
Kent and Medway

Response to Kent County Council HOSC report and recommendations on NHS Financial Sustainability

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

Response to recommendation 3
HOSC Members have been provided with an update on latest developments with respect to transition planning at their meeting on 9 September. Members will of course be informed of any changes at future meetings and this topic has been scheduled into the future work programme for HOSC.

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

Response to recommendation 4
Clinical Commissioning Groups are scheduled to be accountable organisations from 1 April 2013. In order to assure there is no legacy debt, for 2011/12 the PCT Cluster will continue to monitor financial performance on a monthly basis at both the cluster and individual PCT levels. All three PCTs are currently forecasting surpluses of between £1m and £9m. The PCT Cluster is aware of the risks attached to these forecasts, and has mitigation plans in place to deal with them.

For 2012/13, the PCT Cluster, together with Clinical Commissioning Group leads, will produce an Annual Integrated Plan (AIP), which will again be drawn up at a cluster, PCT and CCG level. The AIP will be based upon guidance and assumptions included in the NHS Operating Framework for 2012/13, as well as local plans and commissioning intentions. The objective will be to set a balanced Plan – in agreement with CCGs - in order that any risks of indebtedness are minimised. As with 2011/12, performance against this Plan will be closely monitored on a monthly basis, and corrective action will be taken as necessary.

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

Response to recommendation 5
Ann Sutton Chief Executive of NHS Kent and Medway has recently met with the provider Chief Executives and they are committed to presenting a joint picture of service changes and developments within the whole NHS system through continuing dialogue and shared aims, which will in turn ensure greater clarity over specific work programmes and proposed

timescales. It will also be essential to involve Clinical Commissioning Group leaders in these discussions from the outset with a view to developing a more co-ordinated planning and reporting approach.

Recommendation 6 - Develop Local Pricing. *While we recognise the fine details around currencies and tariffs might not engage the imagination of the wider public that easily, this review has made it clear how important these details are. While the Payments by Results tariff is fairly well established in the Acute Sector, the development of currencies and tariffs in other areas is only slowly developing. Due to their technical nature, the Committee has no specific recommendations to make as to the form they should take. However, we ask all relevant organisations to consider how these should best be taken forward locally.*

Response to recommendation 6
It is understood that there may be guidance on introducing national tariffs for some mental health services in the forthcoming NHS Operating Framework for 2012/13. In addition the cluster has indicated to Community Trust colleagues that it would wish to continue the process of agreeing local tariffs for local services. It should be noted that services such as physiotherapy are already contracted on a cost per cost basis.

NHS Financial Sustainability

Key Issues and Recommendations

Medway NHS Foundation Trust

Introduction

As part of the Health Overview and Scrutiny Committee of Kent County Council's report on NHS Financial Sustainability, several recommendations were made for consideration by the NHS and organisations specifically. This short report looks at the two specific recommendations made relating to Medway NHS Foundation Trust.

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

Response:
Medway NHS Foundation Trust has regular discussions with its commissioners about possible changes to service delivery. Previously these had been exclusively with PCTs but more frequently now and in the future, this includes GP commissioning leads.

Medway's service development strategy is one of looking to provide more specialised services for the local population of Medway and surrounding areas. The Trust has developed several examples of this over the last twelve months increasing the range of services we provide. These include the new Neurosciences unit where patients can have specialist treatment undertaken on site, where previously they would have had to travel to London. For example, we provide multiple sclerosis drug infusions, removing the need for some patients to make 13 trips a year to London.

Develop Local Pricing
While we recognise the fine details around currencies and tariffs might not engage the imagination of the wider public that easily, this review has made it clear how important these details are. While the Payments by Results tariff is fairly well established in the Acute Sector, the development of currencies and tariffs in other areas is only slowly developing. Due to their technical nature, the Committee has no specific recommendations to make as to the form they should take. However, we ask all relevant organisations to consider how these should best be taken forward locally.

Response:
As the report notes, the Payments by Results tariff is fairly well established in the Acute sector and covers the majority of activity that the Trust undertakes. The National Operating Framework, published on an annual basis by the Department of Health, highlights the areas of further development either in terms of currencies or in terms of prices that NHS Trusts should be working towards implementing. Medway discusses with it commissioners those areas that both parties would wish to develop in terms of a further implementation of the Payment by Results ethos.

The Trust is keen to operate in a cost per case way across the total range of its contractual agreements with not just its commissioners, but also with other providers so that payments are reflective of the cost of the activity undertaken and not simply on a "block" basis.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 October 2011

Subject: HOSC and the Local Dimension

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1. Introduction

(a) The remit of the Health Overview and Scrutiny Committee is to review and scrutinise any matter relating to the planning, provision and operation of health and social care services in the area of the Committee's Local Authority. Within the area covered by the remit of the Kent HOSC are 12 Borough, City, or District Councils, each with important, and sometimes distinct, health issues which the HOSC could legitimately consider.

(b) One of the main challenges for the HOSC to consider is how to balance the necessary focus on the strategic issues which affect the whole of the County with the need to make certain the local dimension is captured and important issues not neglected. Key to this is ensuring that the priority health issues across the County are raised and considered in the right forum at the right time. This is in line with the policy direction of national and local government in recent years with the increased emphasis on local engagement and decision making.

2. Current Practice

(a) There are a number of ways in which the HOSC already works to capture the local dimension, including:

1. Alongside 12 County Members with constituencies across the authority, HOSC has 4 Borough, City, or District Councillors on the Committee. It has also been the practice of this Committee to allow any interested Councillor to participate in the debates and raise issues.

2. HOSC has increased capacity by allowing for the establishment of informal HOSC Liaison Groups to consider issues in more detail outside of formal meetings. The informal nature of the Groups allows for Borough, City, or District Councillors who are not Members of HOSC to participate in them.

3. Communications with key stakeholders has been enhanced through the introduction of periodic HOSC Notes.

4. There are 2 LINk non-voting Members of HOSC who are able to bring forward issues.

3. Key Questions and Considerations

(a) Moving beyond this, there are a number of key questions for the Committee to consider:

1. How can HOSC be kept aware of the health issues of concern at the Borough, City, and District level?

2. How can HOSC best keep Borough, City, and District Councils informed of the work it is carrying out?

3. Which health topics are best scrutinised at countywide HOSC level, and which would benefit from being scrutinised more locally?

(b) These questions need to be discussed against the background of the changes arising from the NHS White Paper, including:

1. The establishment of a number of Clinical Commissioning Groups which will largely take over the role of the current Kent and Medway wide PCT Cluster. There are 8 across Kent at present and a number of these are likely to cross one or more Borough, City, or District boundary.

2. The establishment of the Health and Wellbeing Board as a Committee of the Council and the role it will carry out.

3. The transfer of public health functions from the NHS to KCC.

4. The transition from the Kent LINk to HealthWatch.

5. Developments within local government, such as Locality Boards.

6. The broader changes to the way the health economy functions which may have an impact on the way in which HOSC carries out its role.

(c) Any suggestions as to how HOSC can best capture the local dimension will also need to bear in mind the four principles which underpin the Protocol for Health Overview and Scrutiny within the KCC Constitution.

(d) These four principles are[1]:

1. Overview and Scrutiny should focus on supporting the improvement of health services to Kent residents.

[1] p.94, http://democracy.kent.gov.uk/mgConvert2PDF.aspx?ID=18603

2. Overview and Scrutiny should minimise the additional administrative burdens on local authorities or NHS bodies.

3. Overview and Scrutiny agendas need to be developed jointly by the local authorities and the NHS bodies.

4. Overview and Scrutiny needs to operate at different levels within Kent.

4. Recommendation

The Committee is asked to discuss and note the report.

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Sevenoaks District Health and Wellbeing Board

Tuesday 3rd May 2011 2pm – 4pm at Sevenoaks District Council

Present:

Lesley Bowles (Chair)	Sevenoaks District Council	lesley.bowles@sevenoaks.gov.uk
Hayley Baldock (HBa)	Sevenoaks District Council	hayley.baldock@sevenoaks.gov.uk
Philip Gilbert (PG)	Sevenoaks District Council	philip.gilbert@sevenoaks.gov.uk
Steve Plater (SP)	Senior Action Forum	steve.keiko@tiscali.co.uk
Terry Hall (TH)	NHS West Kent	terryhall@nhs.net
Lucy Rumbellow (LR)	NHS West Kent	lucy.rumbellow@nhs.net
Athene Fenn (AF)	Sevenoaks MENCAP	athenefenn@hotmail.com
Elizabeth Davies (ED)	Swanley Town Council	EDavies@swanley.org.uk
Heather Brightwell (HBri)	West Kent Extra	heather.brightwell@wkha.org.uk
Rosie Mather (RM)	Family Action	rosie.mather@family-action.org.uk
Jill Roberts (JR)	Sevenoaks Area Mind	jill.roberts@sevenoaksareamind.org.uk
Faiza Khan (FK)	NHS West Kent	faiza.khan@wkpct.nhs.uk
Amy Filmer (AF)	Voluntary Action for West Kent	Amy.filmer@vawk.org.uk
Fiona Watkins (FW)	Voluntary Action for West Kent	Fiona.watkins@vawk.org.uk

Apologies:

Rev. Mark Griffin	Churches Together
Christine Lane	Edenbridge Town Council
Adam Perry	Sencio Community Leisure
Mark Whyman	Sencio Community Leisure
Julie Hoad	Hartley Parish Council

No	Item	Action
1	**Welcome & Introductions**	
2	**Minutes of the last meeting** All agreed accuracy of minutes of last meeting. **Matters arising:** • Work on the BME Task and Finish Group is currently on hold, while the Mosaic system is set up countywide, it is hoped that this will make it easier to gather the information needed. • HBri yet to input the Boomerang figures into the Community Plan Monitoring. • Minibus Update: LB reports that the Voluntary Sector's response to the plans to spread the minibuses across the district was amazingly positive. Most voluntary organisations got the minibuses they wanted and some are already running their programmes. Compaid are now running in the District offering a similar service to the SDC minibus service. • ED to look at who is currently unhappy with the minibuses and what can be done about it. • AF brought up the issue of KCC removing transport for those with learning difficulties, JR and FW wondered if a partnership could be organised between VAWK and Sevenoaks Area Mind to help cover this.	HBri ED
3	**Sevenoaks District Senior Action Forum (SDSAF) Update** • The SDSAF held open meetings in spring of the 2010 to discuss the possibility of setting up an older peoples forum for the district. A steering group was set up and the forum launched on Older Persons Day (1st	

	October 2010) with roughly fifty to sixty people. This has since risen to about 150 with the main goal still being to further publicise the events and the opportunities they can offer. • SP would like to raise a task and finish group about Older People's internet access and computer classes. JR recommended the 'Get Britain Online' centre which cover this, and RM suggested contacting Grandparents Plus, who might be interested in helping. FW also interested in helping. • HBa to work with FW and SP to write an article for October In Shape to coincide with Older People's Day about computer courses for Older People.	HBa
4	**Sevenoaks District Action Plan 2010/2011 Quarterly Update** • HBa explained the Health and Wellbeing Board End of Year Report and outlined the targets that need to be reviewed. • New West Kent Extra projects to be added to the Community Plan. • Targets for Postural Stability to be reviewed for 2011/2012 • MEND target for the year includes 50 families. • Targets for Healthy Schools and Enhanced Status Schools to be reviewed for 2011/2012 • Targets for Smoking to be reviewed, possibly to based on prevalence in the future. • Pharmacies to be included in sexual health data, including emergency contraception, Chlamydia screening and other long term issues. • Targets for alcohol misuse services to be reviewed, more Identification and Brief Advice (IBA) support to be offered. • Targets for Disability Fitness Activities to be reviewed, to maybe include MENCAP's classes, Person Centred Planning's classes, Sevenoaks Mind's classes, St. John's Sports Awareness Classes, and Allotment Gardening Projects. (HBa to discuss with SP) • Target for 'Increase Adult Participation in Exercise' to be split to better reflect individual organisations work. • Target for 'Awareness Raising Workshops about Mental Health' to be reviewed to include Sevenoaks Mind, MENCAP and Alzheimers Information. • TH would like to know how Change 4 Life fits into the figures, HBa to ask Anne Brazier.	HBa HBa
5	**Choosing Health Projects Update** • HBa reported on the year end statistics for Sevenoaks District Council's Healthy Living Projects for the year. (see attachment) • GP referrals continue to increase with 50 for the year to date. • HBa is continuing to work on corporate membership at Sencio for those who complete a Why Weight programme. • Health Walks continue to be a success.	Attachment
6	**NHS West Kent Update** • TH updated the Health and Wellbeing Board about the current state of the NHS reforms. The NHS have currently paused at the strategic level for a listening exercise on the reforms, although planning continues at regional and local level. • PCT's across West Kent, East Kent and Medway are now merging together under one executive board. • Budgets for the year have remained the same, the only deductions	

	coming from underspend and step down funding from the previous year. • AF to discuss with Health Checks for those with Learning Difficulties with HBa	AF/HBa
7	**Any Other Business** FW let everyone know that Volunteer Week is 1st to 7th of July, and that Brighter Futures has been extended. JR reported that Sevenoaks Mind have redesigned their website, and now have a twitter feed that they are keen to publicise. TH would like someone from the Community Safety Partnership to attend the next HAWB meeting, as it has been some time since someone attended. LB to invite Kelly Webb to the next HAWB meeting. HBa to confirm the locations of Southeastern Water's new compulsory meters. FK would like to know if any work has been done on Traveller communities in the district. This information will probably come from the BME/Mosaic Task and Finish Group. **All members to please bring any information they have on Traveller communities to the next meeting.**	LB HBa **All**
7	**Details of future meetings** Further dates for 2011/12 (all to be held in the Conference Room, Sevenoaks District Council, Argyle Road, Sevenoaks): Tuesday 3rd May 2011: 2 – 4pm Wednesday 20th July 2011: 2 – 4pm Wednesday 19th October 2011: 2 ─ 4 pm (Note: Revised Date) Wednesday 18th January 2012: 10am – 12pm	

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Sevenoaks District Health & Wellbeing Board

Venue: Conference Room, Sevenoaks District Council Offices, Argyle Road, Sevenoaks, TN13 1HG

2 – 4pm, Wednesday 20th July 2011

A G E N D A

1. Welcome, introductions and apologies

2. Minutes of the last meeting and matters arising:
   - Boomerang figures added into the new 2011/12 Action Plan – HBri/HBa
   - To explore further details of people who may be unhappy with new minibus service – ED
   - In Shape article for October 2011 to promote It courses for older people – Hba
   - Review and amend new 2011/12 Action Plan targets and actions – Hba
   - Explore Health Checks for adults with Learning Difficulties – AF/HBa
   - Rep from CSP to attend next meeting – LB
   - Confirmation of Compulsory Water Meters location – Hba
   - Bring details of work with Traveller communities to the next meeting - All

3. Community Safety Update – Maxine Quinton, Community Safety Assistant

4. 2012 Paralympic Road Cycling Event – District Opportunities – Hayley Baldock

5. Discussion regarding work with Gypsy and Traveller Communities - All

6. H&WB Action Plan 2011/12
   - Quarterly updates and yearly targets

7. NHS West Kent updates (TH)
   - 2011/12 Forward Planning Update
   - National restructuring Update

8. Any other business

9. Dates and time of future meetings, all held in the Conference Room, Sevenoaks District Council offices, Argyle Road, Sevenoaks:

   - **Wednesday 19th October 2011: 2 – 4pm**
   - Wednesday 18th January 2012: 10am – 12pm

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Health & Wellbeing Board Proposals

Engaging Local Voluntary and Community Groups
First Stage in Consultation: Sharing Information

Agenda

Monday 12 September at 6.15pm,
Council Chamber, Dover District Council, White Cliffs Business Park, Dover CT16 3PJ
Refreshments will be available from 5.45pm

- In Dover we are working hard as only one of three district councils nationally to be an early implementer of health and wellbeing boards.
- The arrangements are part of the **Health and Social Care Bill 2011** to integrate health and social care. These new boards are *not* to be confused with the existing *Dover Health and Wellbeing Partnership Group*.
- This meeting is an opportunity to share information and understand how best to engage with the voluntary and community sector. It is *not* a funding opportunity for individual organisations.

6.15pm 1. **Welcome and Introductions**
- Cllr Pat Heath, Portfolio for Portfolio Holder for Health, Well-Being and Public Protection

6.20pm 2. **Health and Wellbeing Boards – our opportunity for change**
- Sheila Pitt, Locality Director; Dover, Deal and Shepway, Eastern and Coastal Kent NHS
- Caroline Davis, Business Strategy, Kent County Council

6.40pm 3. **Local Development of Health and Wellbeing Boards in Kent and the Dover District**
Kent County Council:
- Cllr Roger Gough - Cabinet Member for Business Strategy, Performance and Health
- Cllr Graham Gibbens - Cabinet Member for Adult Social Care and Public Health

Dover District Council:
- Cllr Sue Chandler, Deputy Leader and Portfolio for Community, Housing and Youth

7.00pm 4. **LINk's transition to local HealthWatch**
- Roger Kendall, Healthwatch
- Tish Gailey, Health Policy Manager, Kent County Council

The Health and Social Care Bill, which reached its final examination by the House of Commons and which will go to Committee Stage in The House of Lords, amongst many other changes abolishes Local Involvement Networks such as Kent LINk and will create a local HealthWatch for the whole of Kent and every other similar local authority in England. This presentation will explain this in greater detail.

7.15pm 5. **Question & Answer Session: Panel Members**
Questions will be invited from the audience

8.45pm 6. **Summary**
Cllr Roger Gough (KCC) and Cllr Sue Chandler (DDC)

9.00pm 7. **Meeting close**

Information Hand-out packs will be available at the meeting and on-line.
On-line consultation: Give us your views: please see **www.dover.gov.uk/health__wellbeing.aspx**
Follow-up Event: Wednesday 02 November 2011: book your place by emailing: **healthandwellbeing@dover.gov.uk**

DOVER DISTRICT COUNCIL

Health and Wellbeing Boards
Engaging Local Voluntary and Community Groups 12 September 2011

Agenda Item 2: Health and Wellbeing Boards – our opportunity for change

EASTERN AND COASTAL KENT NHS

Changes to commissioning in the NHS – what it means for us

One of the main functions of Primary Care Trusts is to commission a range of health and social care services that meet the health needs of the population. Following the National Health Service Reforms that are in progress this function will transfer to groups of GPs that will be known as Clinical Commissioning Groups. Some commissioning functions will also transfer to a newly developed National Commissioning Board. The split between which functions go where are to be based around criteria such as the critical mass of patients required to sustain a service, so an example would be very specialist high cost low volume activity such as organ transplants would be commissioned at the national level.

The biggest change to commissioning is that the local clinical community, led by a number of local doctors, will be the decision makers, determining where and how the budget will be spent.

The current reform is taking place at a time of huge financial challenge for health services. Although budgets will not be cut there will be little or no growth funding (an allowance that covers the cost of inflation) from now on. Inflation will continue, so even to maintain the current level of service will cost more in the coming years. Therefore, if we do not change both the way we buy services and the way they are delivered there will not be enough money to maintain the current level of service across the NHS, never mind making new investment. The demand on services is also rising for people over 60 as the population numbers in this age bracket increase. It is well understood that people over 60 have greater incidence of disease and therefore require more access to healthcare services.

It is therefore essential that the future commissioned services are the right ones.

The Health and Wellbeing Board will contribute to and oversee the development of the clinical commissioning group's commissioning intentions and plans. This is welcomed by the GPs involved as it will enable them to ensure that there is effective community and voluntary sector engagement in the development of their plans, together with the appropriate links to the public health agenda, in a greater holistic way than ever before.

There will be a statutory responsibility to ensure that wider views are sought from members of the locality we serve.

Health and Wellbeing Boards
Engaging Local Voluntary and Community Groups 12 September 2011
Agenda Item 2: Health and Wellbeing Boards – our opportunity for change

KENT COUNTY COUNCIL

What does the Health and Social Care Bill mean for Local Government?

Key new responsibilities for Local Government

Health and Wellbeing Boards (HWBs) – County Councils will be required to set up a HWB, which will be a statutory committee. 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.

Joint Strategic Needs Assessment - Local authorities and Clinical Commissioning Groups 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 JHWS. 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.

Scrutiny - 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.

HealthWatch – The Local Involvement Networks (LINks) will transform into local HealthWatch. They will be commissioned and funded by County Councils 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 County Council will be able to commission HealthWatch to provide advice and information to people about health and social care.

Public Health - A separate Public Health White Paper, Health Lives, Healthy People, was published by the Department of Health on 30 November 2010. Local health improvement functions will transfer to local government, along with ring-fenced funding. Local Government will be accountable to Public Health England for spending the grant. It will be separate from the current funding of local authority functions with public health implications, such as leisure.

Directors of Public Health will be employed by Kent County Council and jointly appointed by Kent County Council 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.

Health and Wellbeing Boards
Engaging Local Voluntary and Community Groups 12 September 2011

Agenda Item 3
Local Development of Health and Wellbeing Boards in Kent and the Dover District

KENT COUNTY COUNCIL

FRQUENTLY ASKED QUESTIONS

1. ***What is Kent County Councils involvement in the Health and Wellbeing Board?***

Answer:

The proposed law (not expected to become law until the Spring 2012) prescribes that it is the County Council in the case of Kent which must establish a Health and Wellbeing Board (HWB).

However, the County Council is very keen to explore with its District Council colleagues how working with the doctors who are forming themselves into Clinical Commissioning Groups, Kent LINk – which is the patient and public representative body (soon to be transformed into Local Health-watch) and other partners can assist in the role of the Health and Wellbeing Board locally. The County Council were very pleased that Dover were already some way towards developing a pilot and were very happy to support their bid to become an early implementer.

2. ***What is the role of the Countywide Health and Wellbeing Board?***

Answer:

The countywide Health and Wellbeing Board by law will:-

- have a strong role in promoting joint commissioning and integrating service provision;
- It can also be the vehicle for commissioning certain services.;
- The County Council and Clinical Commissioning Groups(CCG) will have a responsibility to produce a Joint Strategic Needs Assessment (JSNA). This will be developed through the Health and Wellbeing Board;
- The County Council and Clinical Commissioning Groups 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.;and
- The HWB will be required to involve the public in the production of the JSNA and JHWS; and
- The CCG will involve the HWB as they develop their commissioning plans. There is an expectation that they will be in line with the JHWBS.

3. **Can the decisions of the Health and Wellbeing board be scrutinised?**

Answer:

Yes decisions of the HWB can be held to account trough the Councils scrutiny arrangements.

4. Is the *membership of the Countywide Health and Wellbeing Board prescribed?*

Answer:

To a large extent yes it is. For example the HWB will comprise of:-

- Kent County Council:
    - The Leader of Kent County Council and/or their nominee*
    - Cabinet Member for Adult Social Care & Public Health
    - Cabinet Member for Business Strategy, Performance & Health Reform
    - Cabinet Member for Specialist Children's Services
    - Corporate Director for Families and Social Services*
    - Director of Public Health*

- GP Consortia: up to a maximum of one representative from each consortium or to be determined by the GPC leads*
- HealthWatch/Link*
- Three elected Members representing the Kent District/Borough/City Councils (nominated through the Kent Forum which comprises the Leaders of all the Borough/District Councils in Kent and the Chairman of the Kent and Medway Fire and Rescue Authority)
- Primary Care Trust Cluster Chief Executive (until 2013)
- NHS Commissioning Board*

* denotes statutory member

5. *Has the Countywide Health and Wellbeing Board met yet?*

Answer:

Yes it has but in a 'shadow form'. Partners have worked together to develop a mutual understanding on what the proposed law may mean for each organisation and how this might be developed to provide the best health and wellbeing outcomes for the residents of Kent. The next meeting of the Board which will have more formality is on 28 September 2011.

6. So how in the voluntary sector can we become involved?

Answer:

Both Kent County Council and Dover District Council welcome your attendance this evening as a basis at a local level to start a dialogue with the voluntary and community sector in moving forward with this important and challenging agenda.

Health and Wellbeing Boards
Engaging Local Voluntary and Community Groups 12 September 2011

Agenda Item 3
Local Development of Health and Wellbeing Boards in Kent and the Dover District

Cllr Sue Chandler, DDC Deputy Leader and Portfolio for Community, Housing and Youth

- At Dover District Council we have been fortunate enough to be able to build a good working relationship with local GP's as the health reforms have progressed through Parliament.

- We support the idea of Health and Well-being Boards and placing some democratic accountability in to the system, as outlined by the Health and Social Care Bill.

- However, the Council has been keen from the start to be fully involved in helping to make joined-up local decisions about the health of our residents, against an overarching need and understanding of greater commissioning power across the whole Kent area.

- To achieve this, when the Government invited local authorities to bid for early implementer status for health and well-being boards, we supported the Kent County Council bid, and vice versa. We were both successful and, as a district council, we are only one of three in the country to be awarded this status. We are therefore leading the way and being followed by the Department of Health and other local authorities to identify good practice and any learning opportunities.

- The general idea of having a Dover District Health and Well-being Board is to identify, at the appropriate level, district-wide and neighbourhood-level health needs, priorities and gaps in service provision. The Board can then work to address these through locally determined solutions, in partnership with the County Council and Clinical Commissioning Groups. Thus complementing the County's strategic effort and ensuring there is no duplication of resources.

- For this to work, we need good relationships with all partners and stakeholders to ensure we capture the right information about our districts health needs and the required level of service provision.

- Shadow local Health and Well-being Boards are anticipated to be formally in place by April 2013.

- We expect the strategic, overarching framework will see the County level Health and Well-being Board cover a menu of health services that affect our district. We will work together to ensure we meet our resident's health needs and health outcomes are improved.

- As a local council, we can draw a holistic health approach together, looking at other services such as housing, leisure, air quality and environment services, all of which impact on the health and well-being of residents. At the same time, providing a supportive and enabling partnership for the GP's and other health professionals as they go through a transitional change in the way we work and deliver services.

- We hold and gather a huge amount of information about our district and our residents that we can feed into the process. However, we know voluntary and community groups hold a lot more, and we are therefore keen to have this sector represented on the local Board. Other members of the Board will include DDC, KCC, GP representatives on the Clinical Commissioning Group, Public Health, Adult Social Services, Children's Partnership representatives. We then plan to invite professional expertise as necessary to the meetings.

- We hope the local Health and Well-being Board will be established as a sub-committee of the county Health and Wellbeing Board and will provide a platform for partnership working to improve people's health and well-being, through agreeing priorities and working with the Clinical Commissioning Group as they develop the commissioning plans across the district.

DOVER DISTRICT COUNCIL

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 14 October 2011

Subject: Forward Work Programme

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1. Introduction.

(a) At the meeting of 10 June, Members agreed the Forward Work Programme for the Health Overview and Scrutiny Committee to the end of this year.

(b) During the course of subsequent meeting, this Forward Work programme was updated with further items: NHS Transition at the meeting of 25 November and NHS Emergency Resilience and Olympics Planning at the meeting of 6 January 2012.

(c) Agreed topics for considerations at meetings up to 6 January along with suggestions for possible topics beyond this date are set out below.

2. Proposed Forward Work Programme.

(a) 25 November 2011

i. Reducing Accident and Emergency Admissions: Part 2.

ii. Medway and Darent Valley Merger Update.

iii. NHS Transition - Moving Towards 2013.

(b) 6 January 2012

i. NHS Emergency Resilience and Olympics Planning

(c) 3 February 2012

i. East Kent Maternity Services Review

(d) Meeting dates for the rest of 2012.

- 9 March
- 13 April
- 1 June
- 20 July

- 7 September
- 12 October
- 30 November

3. Joint working with Medway:

(a) There is the possibility that the local NHS will be carrying out a review on one or more areas of mental health services across Kent and Medway which will require the establishment of a formal Joint HOSC or some alternative method of joint working depending on the nature of the review.

4. Possible subjects for 2012:

(a) Suggested topics:

i. Reducing Accident and Emergency Admissions: Further Evidence.

ii. Neurology

iii. NHS Financial Sustainability: Update on Local Progress

iv. Acute Cancer Services

(b) It has also been suggested that a half-day workshop/conference be arranged around the theme of "One Year to Go" and build on the work HOSC has already carried out on the NHS Transition. This could potentially take place on 13 April 2012 instead of the scheduled HOSC Meeting.

5. Recommendation

Members are asked to approve the proposed Forward Work Programme.