HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 25th November, 2011

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 25th November, 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

Webcasting Notice

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

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

Item	Timings
1. Introduction/Webcasting	
2. Substitutes	

3. Declarations of Interests by Members in items on the Agenda for this meeting.

4. Minutes (Pages 1 - 8)

5. Reducing Accident and Emergency Admissions: Part 2 (Further reports to follow) (Pages 9 - 34) 10:00-11:00

6. Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Partnership (Pages 35 - 54) 11:00 – 11:30

7. NHS Transition: Update (Pages 55 - 60) 11:30 – 12:00

8. Older People's Mental Health Services (Pages 61 - 68)

9. Date of next programmed meeting – Friday 6 January 2012 @ 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

17 November 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, 14 October 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 A T Willicombe, Mr R A Marsh (Substitute for Mr R Tolputt), Cllr J Burden, Cllr R Davison, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Cllr Mrs A Blackmore and Cllr J Cunningham

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Membership
(Item)

The Committee noted the following update to its Membership:

LINk Representatives (2): Dr M Eddy and Mr M Fittock.

3. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting of 9 September 2011 are recorded and that they be signed by the Chairman.

4. Reducing Accident and Emergency Admissions: Part 1
(Item 5)

Dr John Allingham (Medical Secretary, Kent Local Medical Committee), Helen Buckingham (Deputy Chief Executive and Director of Whole System Commissioning, NHS Kent and Medway), Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust), Marion Dinwoodie (Chief Executive, Kent Community Health NHS Trust), Gordon Flack (Director of Finance, Kent Community Health NHS Trust), Dr Mark Jones (GP Clinical Commissioner, C4), Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), and Lesley Strong (Deputy Chief Executive/Director of Operations, Adults, Kent Community Health NHS Trust) were in attendance for this item.

(1) The Chairman introduced the item by explaining that the current meeting was to be the first of two on this wide-ranging subject, with the next one scheduled to take place in November. While there had been some recent media coverage concerning local accident and emergency departments, the Chairman requested that specific questions be postponed until the November meeting, to which representatives of all four Acute Trusts in Kent and Medway had been invited.

(2) The lead representatives present from the NHS organisations attending the meeting gave short overviews of the topic. From the perspective of the commissioners, the urgent care pathway was a clear example of whole system commissioning as it involved primary care, through intermediate care and up to acute services, so that while accident and emergency departments and the ambulance service may be the most visible parts, there were many other services to consider. The importance of taking a whole systems approach was endorsed by the representatives present from primary care, and the community health and ambulance services. The shared goal was for a health system which delivered the right care by the right person in the right place and that a good example of this was the primary angioplasty service based at William Harvey Hospital and covering the whole County. It was noted that it was also important to ensure individual patients moved through the system, seeing different providers, smoothly with no waiting between them.

(3) While many patients would always need admitting to hospital, there was an agreement around the development of alternative pathways to deliver different interventions outside the acute setting. To this end the NHS Pathways assessment system and the Directory of Services were seen as key. This linked in with the coming introduction of the 111 number across England.

(4) A number of Members raised issues around public awareness of the alternatives to accident and emergency departments, such as Minor Injuries Units. It was partly a question about whether or not people knew about the alternatives, and if they did, there were separate questions around whether people understood fully what counted as a ‘minor injury’ and how to access these services, including confusion around opening times. One Member expressed surprise, for example, that a broken limb could be treated in a Minor Injury Unit. There were parallel questions around the effectiveness of some current systems, such as making an appointment with a GP. Where this did not work well, people may end up going to accident and emergency departments in order to be seen by someone. The point was also made that there were services for minor illnesses as well as minor injuries.

(5) Representatives of the NHS explained that these were the kinds of questions that the 111 number was intended to answer. The Ambulance Service and out of hours service provider used the same NHS Pathways system, and this would be used to triage patients using both the 111 and the 999 numbers. The Directory of Services would act as a ‘phone before you go’ service to ensure that a particular service was able to deliver the right service at any given time. However, it was acknowledged that there was a communications challenge to ensure the most appropriate number was used as one important difference was that an ambulance was triggered by the use of the 999 number.

(6) Both services would be available 24/7 and the observation was made that this fitted in with the expectations of patients. It was noted that this would involve the development of effective information systems with the sharing of data between organisations. It was noted that the Connecting for Health and National Programme for IT programmes had been aimed at addressing these issues, and at present the Summary Care Record was being rolled out across the County, at different rates. This was intended to make key aspects of a patient available to all providers of healthcare when appropriate. It was acknowledged that more work needed to be done in this area. The comment was also made that developments in other areas were providing the push for improving the data available around certain services, such as the move away from block contracts for community services.

(7) In answer to a specific question, the Committee was informed that the 111 number would replace the 0845 number currently operated by NHS Direct, but would not replace NHS Direct as an organisation, which was expected to continue as a provider of the 111 service in some areas.

(8) Another specific question related to the cost of translation services within the Kent health economy and representatives from NHS Kent and Medway undertook to collate this information from providers and make it available to the Committee.

(9) From the perspective of the Ambulance Service, the move to paramedic as a graduate career was highlighted as key, as was the development of two specialist kinds of paramedic, both requiring post-graduate qualifications. These were Paramedic Practitioner (PP) and Critical Care Paramedic (CCP). CCPs were able to care for patients over longer distances to enable them to access specialist treatment and PPs were able to work as part of extended primary care and community health teams to deliver care in home and community settings. Pilot schemes involving managing long-term conditions had seen a 15% reduction in attendance at accident and emergency departments.

(10) Kent Community Health NHS Trust (KCHT) put forward the idea that there was a disproportionate amount of NHS resources directed towards the acute sector. As an example, it was explained that last year 77% of occupied bed days related to long-term conditions. Community services were pivotal in enhancing the quality of life of patients where these patients could be better cared for working with GPs in a multi-professional setting. KCHT were also working with social care on the personalisation agenda. Rapid response intermediate care services and effective rehabilitation in community hospitals and other settings were also given as key to reducing accident and emergency admissions, as was the need to reduce the numbers of frequent attendees at accident and emergency.

(11) The importance of primary care as part of the urgent care pathway was also highlighted. Dr Jones, from the C4 Clinical Commissioning Group, pointed to the example of work done locally on falls prevention which had improved the quality of care is residential care settings and contributed to reducing accident and emergency admissions. There was also an important part to be played by effective medicines management. More generally, continuity of care and

access to GP services was viewed as central to reducing accident and emergency admissions. It was stressed that the roles played by self care, primary care, and pharmacies meant that there was more to the urgent care pathway than simply the use of Minor Injury Units in the place of accident and emergency departments.

(12) On the subject of mental health services as part of the urgent care pathways, it was universally agreed that this was an important aspect. Psychiatric liaison services were at different stages of development across Kent, but the point was made that it was important to work with Clinical Commissioning Groups in West Kent in order to establish the right pattern of services and not simply copy across those operating in East Kent Hospitals NHS University Foundation Trust. Kent and Medway NHS and Social Care Partnership Trust also operated Crisis Resolution Home Treatment Teams which acted as gatekeepers to acute services. The important point was also made that patients with mental health care needs could also have physical health admittance needs. Questions were also raised about whether current levels of funding for mental health services were adequate. The Committee requested that an appropriate time be found to examine specifically the issue of the mental health aspects of the urgent care pathway.

(13) A number of Members expressed the view that prevention was the best way to reduce accident and emergency admissions and there was a sense in which the work which was being planned and carried out by the NHS was geared more towards redistributing the workload than solving the problem. For example, admissions related to alcohol could be seen as emergencies but were not necessarily accidental in the sense of being self-inflicted. In response, the importance of prevention was highlighted by representatives from the health sector and it was here that the role of local authorities could play a major role, through licensing activities and the transfer of Public Health functions from the NHS to Kent County Council currently underway.

(14) AGREED that this Committee recommends to the Health and Wellbeing Board that it considers prioritising the issue of reducing accident and emergency admissions as part of their role in coordinating commissioning across health and social care.

5. East Kent Maternity Services Review
(Item 6)

Glynis Alexander (Deputy Director of Communications and Citizen Engagement, NHS Kent and Medway), Dr John Allingham (Medical Secretary, Kent Local Medical Committee), Helen Buckingham (Deputy Chief Executive and Director of Whole System Commissioning, NHS Kent and Medway), Ann Judges, (Maternity Lead, NHS Kent and Medway), Lindsey Stevens (Head of Midwifery, East Kent Hospitals NHS University Foundation Trust) and Sara Warner (Assistant Director Citizen Engagement, NHS Kent and Medway) 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 five Members of the informal HOSC Liaison Group who had continued to work with the NHS in East Kent on the review. He reminded the Committee that the focus for the meeting was on the consultation process itself, and that this had been formally launched that morning. Members had been provided with copies of the full consultation document at the start of the meeting. Demographic information about the ethnicity of mothers in East Kent had also been made available to Members at the start of the meeting in response to a specific request made by a Member of the HOSC Liaison Group.

(2) Those Members of the HOSC Liaison group who were present for the meeting were each given the opportunity to speak first, and all took the chance to thank the NHS for the opportunity to comment on the draft consultation document. One Member felt that more stress could have been given on the retention of ante and post-natal clinics at both Canterbury and Dover. Another Member commented that most suggestions had been incorporated, though another Member regretted that the original Option 1 as presented in the report to HOSC on 9 September was no longer included. In addition, Mr Collor explained that an Overview and Scrutiny Committee at Dover District Council had already met and made recommendations to the NHS, copies of which had been provided to the Chairman of the Committee.

(3) One area of interest to Members was the timing and location of the 8 public events listed in the consultation document and there was concern that the timings and locations would not be sufficient to reach the intended audience. A case was made in particular for an additional meeting in Ramsgate. In response, representatives from the NHS explained that the timings and locations had been discussed with parents and parents-to-be as part of the pre-engagement process. Clinicians were going to be available at all the scheduled public meetings. It was also explained that the NHS would be present at 47 other events and that the consultation process was long enough so that if there was judged to be enough interest, further meetings could be scheduled. They were also happy to respond to invitations from any interested groups. In addition, a wide-ranging advertising and marketing campaign involving the local media had been organised.

(4) The Members of the Committee were also keen to ensure information on the Consultation was made widely available so that everyone who would wish to would have the opportunity. In terms of making the consultation document available, representatives from the NHS explained that 2,000 full versions had been printed, along with 10,000 summary versions. These were to be made available in libraries, children's centres and community centres. 50 copies were also being sent to each GP practice. Dr Allingham observed that the number was about right for his surgery to be able to make a copy available to each expectant mother, but there were larger practices.

(5) Queries were raised over the figures used about births on page 9 of the consultation document as they did not appear to match up. Representatives from the NHS felt that they may represent different time periods, but they also undertook to clarify the figures and make this information available to the Committee.

(6) In response to a number of specific questions, it was explained that there was no national review of maternity service underway, but there were others in the South East Coast region, and a teleconference to share learning between them had been scheduled. In addition, the results of the largest birthplace study in the world had been awaited since August and it was now anticipated in October.

(7) AGREED that the Committee thank the members of the informal HOSC Liaison Group for their valuable work in recent months and that the report be noted.

6. Eating Disorders Review
(Item 7)

AGREED that the Committee note the report.

7. Child and Adolescent Mental Health Services (CAMHS)
(Item 8)

AGREED that the Committee note the report.

8. NHS Financial Sustainability Review: Written Update
(Item 9)

(1) The ongoing importance of the subject of NHS Financial Sustainability was raised by a number of Members, with one reporting particular issues of sustainability in outer London. The idea of returning to the subject at some point next year found favour, as did the idea of receiving regular written updates from the local NHS.

(2) The Researcher to the Committee was asked to liaise with local NHS organisations with a view to determining the best way in which to achieve this.

(3) AGREED that the Committee note the report.

9. HOSC and the Local Dimension
(Item 10)

(1) The Chairman began by thanking the Officers involved in preparing the report, which was there as a stimulus for discussion with the aim of ensuring that the right forum was found for the right topic, with the example given of issues facing one community hospital against an issue facing the whole community hospital system across the County.

(2) A range of different perspectives were presented on this subject around the development and interpretation of the localism agenda across the County, as well as the balance between needing local mechanisms for various purposes and increasing bureaucratic systems which may use up time but achieve little.

(3) AGREED that the Committee note the report.

10. Forward Work Programme
(Item 11)

(1) The Chairman requested that as well as having an opportunity in the meeting, any further ideas for the Forward Work Programme should be sent to either himself or the Committee Officers.

(2) A specific request was made by Councillor John Cunningham and Mr Mark Fittock that an opportunity be found for two reports on mental health issues produced by LINk and Maidstone Borough Council jointly with Tunbridge Wells Borough Council be brought to the Committee with a view to seeing what progress the local NHS had made against the recommendations contained within each. This was agreed and the Researcher to the Committee asked to liaise with a view to finding the most appropriate juncture for this to be facilitated.

(3) AGREED that the Committee note the report.

11. Date of next programmed meeting – Friday 25 November 2011 @ 10:00 am
(Item 12)

Addendum to Agenda of 14 October 2011:

Item 5, Information from NHS Kent and Medway, p.21 of Agenda, Part b, Paragraph 2, should read:

"… they manage around an average of 15,000 calls from patients per month, rising to over 20,000 in busy months. Of these around 53% of patients are advised by telephone, or referred directly to another service. 35% are seen at a base and 13% receive a home visit…."

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2011

Subject: Reducing Accident and Emergency Admissions: Part 2.

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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 first meeting was held on 14 October. During this meeting it was decided that an additional meeting focusing on the role played by mental health services in this topic should be held and this will be arranged for 2012.

2. Questions

(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?

(e) The specific questions submitted to the Acute Trusts attending today's meeting are appended to this report.

2. Recommendation

That the Committee consider and note the report.

Appendix – Questions from the Committee

Questions for Acute Trusts

1. Since 2008, broken down by quarter, what have the numbers of attendances been at your accident and emergency department(s)?

2. What factors explain this change?

3. What has been the impact of the new Accident and Emergency provisional quality indicators?

4. Specifically, has there been any impact due to the closure of accident and emergency departments in neighbouring areas?

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

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

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

8. How many people arrive at your accident and emergency department(s) by ambulance/helicopter compared to other methods?

9. What information can you provide on the method of discharge from your accident and emergency department(s) (i.e. admitted, referred and so on)?

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

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

To: Health Overview and Scrutiny Committee, 25 November 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.

(d) The changes to the General Medical Services (GMS) contract for 2012/13 agreed between NHS Employers and the General Practitioners Committee (GPC) of the British Medical Association (BMA) including new indicators as part of the Quality Outcomes Framework (QOF) aimed at reducing avoidable accident and emergency attendances[29].

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)[30].

(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

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[27] Ibid., p.21.
[28] Ibid., p.22.
[29] NHS Employers, *Changes to 2012/13 General Medical Services Contract*, 2 November 2011, http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/LatestNews-GMS/Pages/Changesto201213GeneralMedicalServicescontract.aspx
[30] 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

admission[31]. 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[32].

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."[33]

(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[34]. It is currently available in County Durham and Darlington, Nottingham City, Lincolnshire and Luton[35]. When rolled out nationally by April 2013, it will replace the NHS Direct number, though NHS Direct is expected to continue, alongside other providers[36]. It will be commissioned locally[37].

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[31] 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

[32] Royal College of Psychiatrists, *Faculty of Liaison Psychiatry*, http://www.rcpsych.ac.uk/specialties/faculties/liaison.aspx

[33] 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

[34] 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/

[35] 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/

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

[37] 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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Medway NHS
NHS Foundation Trust

Response to Questions posed by the Health Overview and Scrutiny Committee

1. **Since 2008, broken down by quarter, what have the numbers of attendances been at your Accident and Emergency Departments?**

Period	Attendances
Q1 2008/09	21189
Q2 2008/09	20628
Q3 2008/09	20630
Q4 2008/09	20294
Q1 2009/10	21858
Q2 2009/10	21152
Q3 2009/10	21219
Q4 2009/10	20587
Q1 2010/11	22141
Q2 2010/11	22936
Q3 2010/11	21349
Q4 2010/11	21517
Q1 2011/12	22804
Q2 2011/12	22490

2. **What factors explain this change?**

The number of people attending the Emergency Department has increased gradually over recent years, very much in line with other increases seen in the other areas of the hospital.

3. **What has been the impact of the new Accident and Emergency provisional quality indicators?**

Five new indicators were introduced from the beginning of April 2011 to replace the 4 hour access target. The shift in emphasis has been to monitor the time taken before assessment and treatment is started, particularly for patients arriving by ambulance. The Department of Health has, however, now issued revised guidance for this year. Trusts are required to report performance against the 4 hour access target as well as the new indicators, but will only be held to account for the 4 hour access target.

The introduction of new indicators has taken some of the focus away from the achievement of the 4 hour access target and consequently there has been a slight decrease in the percentage of patients discharged within the 4 hour period.

4. **Specifically, has there been any impact due to the closure of Accident and Emergency Departments in neighbouring areas?**

Since the changes made in September in Maidstone, the Trust has seen increases in the number of patients arriving by ambulance (up 12% when compared to 2010 - an average of 10 extra per day) and those patients self presenting (up 8% when compared to 2010 - another 20 patients per day). Not all of this increase is from outside of Medway but the majority is from post codes that would traditionally have been taken or chosen to go to Maidstone.

5. **Why is it important to reduce attendances at Accident and Emergency Departments?**

Up to 300 patients a day attend the Emergency Department at Medway, of which 20% could have been appropriately seen in primary care locations. Medway Community Health operates a same day treatment centre adjacent to the Emergency Department and they will treat around 15% of the attendances.

Non urgent patients still take time to be seen and treated and this can have an impact on waiting times for other patients.

6. **What work is being undertaken currently, and planned for the future, aimed at reducing Accident and Emergency attendance?**

The PCT continues to promote the alternative services that are available as well as having invested in paramedic practitioners to reduce the numbers of patients being brought to hospital by ambulance.

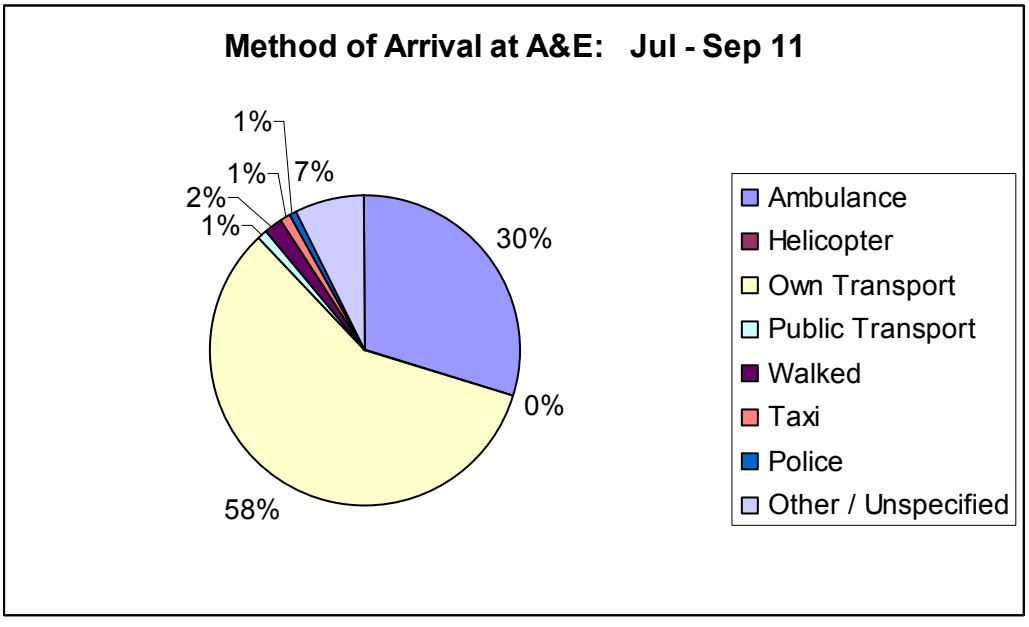
7. **What are the main challenges to reducing attendance at Accident and Emergency Departments?**

Despite the promotion of alternatives the ED is still chosen as it is convenient and with the introduction of the 4 hour access target, patients have some certainty on how long they may have to wait so it is perceived to be more convenient than making an appointment with a GP or visiting a walk in centre, which has a more limited service capability.

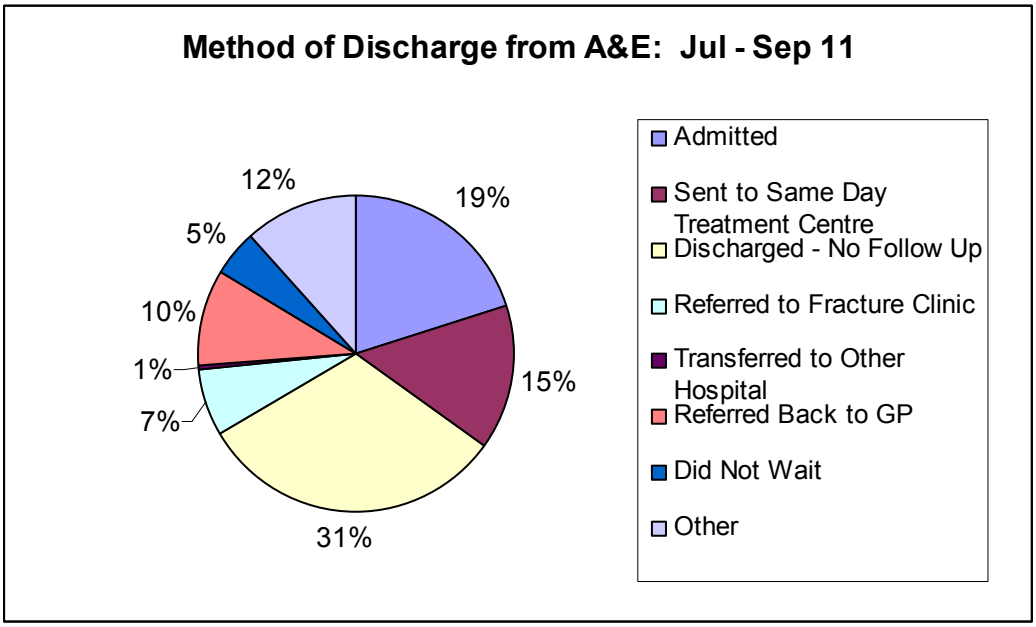
8. **How many people arrive at your Accident and Emergency Department by ambulance/helicopter compared to other methods?**

Period	Ambulance	Helicopter	Own Transport	Public Transport	Walked	Taxi	Police	Other/ Unspecified
Q1 2008/09								
Q2 2008/09	5957	4	12700	262	722	346	125	1788
Q3 2008/09	6621	5	12057	214	613	321	158	1128
Q4 2008/09	6279	7	11956	182	576	288	132	2084
Q1 2009/10	6549	3	13043	195	629	292	146	2484
Q2 2009/10	6643	3	12590	150	514	266	142	2200
Q3 2009/10	7088	2	12234	139	457	313	150	1600
Q4 2009/10	6581	3	12238	142	483	260	149	726
Q1 2010/11	6787	4	13605	141	455	291	178	679
Q2 2010/11	6996	4	13742	164	474	298	175	1083
Q3 2010/11	7115	4	12594	77	422	230	174	733
Q4 2010/11	6794	0	13350	95	378	201	164	534
Q1 2011/12	6943	2	14136	110	374	236	177	826
Q2 2011/12	6707	1	13108	152	460	255	153	1654

* Note: Q1 2008/09 data is not available on Symphony; recorded on REMASS



9. **What information can you provide on the method of discharge from your accident and emergency department (i.e. admitted, referred and so on)?**



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

The Trust is focused on reducing un-necessary admissions to the hospital by working closely with other providers in community and primary care.

East Kent Hospitals University NHS
NHS Foundation Trust

Nick Chard
Chairman
Health Overview and Scrutiny Committee
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Our Ref: SB/RR/KM/jc

14 November 2011

From the Chief Executive: Stuart Bain

Dear Nick

Health Overview and Scrutiny Committee meeting – 25 November 2011

Thank you for your letter of 2 September 2011, inviting me to contribute to the Committee's understanding of reducing accident and emergency admissions.

You will find attached to this letter responses to the questions which you kindly attached as an appendix to your original letter to me.

Unfortunately I am unable to attend your Committee in person as we have a Board of Directors meeting on 25 November, however, I have asked Robert Rose, Divisional Director, Urgent Care and Long Term Conditions Division, to attending on behalf of our Trust together with Karen Miles, Programme Manager, Emergency Care Chris Green, Principal Information Analyst also in attendance. Once you have had the opportunity to reflect on the information I have provided, I would be more than happy to furnish more information as required.

My team is looking forward to seeing you and other Committee members on 25 November 2011.

Yours sincerely

Stuart Bain
Chief Executive

Putting patients first

Responses to your key questions

1. Since 2008, broken down by quarter, what have the numbers of attendances been at your Accident & Emergency Department(s)?

A breakdown of attendances for each of the Accident & Emergency Departments at the William Harvey Hospital, Ashford and Queen Elizabeth the Queen Mother Hospital, Margate is attached as Appendix 1.

I will also take this opportunity to provide a further breakdown of attendance at the Emergency Care Centre, Kent and Canterbury Hospital, Canterbury and the Minor Injuries Unit, Buckland Hospital, Dover for your information.

Appendix 1 shows that the number of attendances at our Emergency Departments in East Kent has remained consistent over the past two years. However, the first quarter of this calendar year shows varying degrees of growth/decline.

2. What factors explain this change?

Traditionally, there has been a 4% year on year increase in attendances at the emergency departments. This is in part due to demographic changes. I am also conscious of housing development around Ashford. With the planned developments over the next 5 years it is expected that Emergency Department attendances will rise.

More recently, members will note there has been a reduction in attendances at the Accident & Emergency Departments at the William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital. We believe this is due to proactive intervention by PCT and GP commissioning colleagues with more patients being seen within primary care. For example, the development of the Estuary View Medical Centre has, between 1st July 2011 and 30th September seen 4010 patients attend that unit. This is equivalent to an average of 43 patients per day. Historically these patients would have attended the Emergency Care Centre at the Kent and Canterbury Hospital or The Queen Elizabeth Hospital. It also reflects the opportunity for direct referrals by GP's to the Assessment Units at William Harvey Hospital, Queen Elizabeth Queen Mother Hospital and Kent & Canterbury Hospital.

3. What has been the impact of the Accident & Emergency provisional quality indicators?

Eight Clinical Quality Indicators were introduced on 1 April 2011 by the Department of Health, to ensure compliance with the broad range of performance across the emergency floor. Initially, it was proposed that five Clinical Quality Indicators were tracked on a monthly basis by Monitor within the first quarter. This was to enable Trusts to set up robust mechanisms for ensuring compliance.

A decision was taken between the Department of Health & Monitor on 4th August 2011 to use the '(4 hour) time in department' Indicator for performance monitoring.

We have consistently taken the view that we would wish to adhere to all Clinical Quality Indicators as originally described and have used these as an opportunity to drive performance and continued improvement in patient services across the board.

Attached at Appendix 2 are the eight National Clinical Quality Indicators which apply to Emergency Departments.

Appendix 3 is the performance report that we use to monitor Accident & Emergency Department performance.

4. Specifically, has there been any impact due to the closure of Accident & Emergency departments in neighbouring areas?

We have noted the change in service provision at Maidstone Hospital on 21st September 2011.

Thus far we have noted minimal impact in terms of additional attendances, which are most likely to occur at the William Harvey Hospital, Ashford. Appendix 4 shows the increase in attendances from the Maidstone area that may possibly have attended the Maidstone Hospital. Based on the analysis shown at Appendix 4, we would expect to see, on average, an additional 9 patients a day likely to require 3 beds. This would predominantly occur at the William Harvey Hospital, although a minority may go to Kent & Canterbury Hospital.

An illustration of the changes in flow which we anticipate could materialise from change in the service model at Maidstone Hospital is also shown.

5. Why is it important to reduce attendance at Accident & Emergency Departments?

It is important that patients are seen and treated by the most appropriate healthcare team and within an appropriate environment, thereby ensuring patients receive treatment in the right place at the right time.

6. What work is being undertaken currently, and planned for the future, aimed at reducing Accident & Emergency attendance?

We are working closely with our colleagues in primary care to develop an Integrated Urgent Care Centre attached to the Emergency Care Centre at Kent and Canterbury Hospital, Canterbury. We see this as an opportunity to appropriately stream patients who traditionally have arrived at that site back into primary care, rather than be seen in a more acute environment and potentially be seen by acute (hospital) medical staff.

At the William Harvey Hospital, Ashford we have, with the agreement of the Integrated Care Board of the East Kent NHS partners, introduced an Assessment Unit to which General Practitioners can directly refer. In response we have seen a 2% reduction in attendances at the William Harvey Hospital and 5% reduction in admissions via Accident & Emergency. Conversely, as would be expected there has been an increase in direct referrals to the Assessment Unit.

7. What are the main challenges to reducing attendance at Accident & Emergency Departments?

We see the main challenge to reducing attendance at the Accident & Emergency Departments as being one of patient awareness and understanding of the role of Emergency Departments and appropriate streaming of patients that could be seen by primary care into primary care.

In response we have been working closely with primary care colleagues to raise awareness of Ambulatory Care and other pathways including those that would arise from the introduction of 111, so that primary care colleagues can provide support to patients who need to be seen within an acute hospital environment.

Appendix 3 illustrates that we are experiencing a high level of unplanned re-attendances. From the analysis that we have undertaken, we have seen there are a number of patients who have been initially attending for relatively minor injuries. Subsequently some of these patients have re-attended because there is confusion, and on occasion, lack of resource with a primary care provider. We are working closely with primary care and PCT colleagues to ensure re-routing of patients can take place by patients being more appropriately informed as they attend GP surgeries for example.

8. How many people arrive at your Accident & Emergency Department(s) by ambulance/helicopter compared to other methods?

Studying the profile of patients and their method of arrival, it can be seen that since April 2011, there has been no significant change in the proportion of patients that arrive via ambulance, or air ambulance. However, as we can see from the table below, the proportion differs dependent on the site.

	BHD		KCH			QEH			WHH		
	Other	Ambulance	Other	Ambulance	Helicopter	Other	Ambulance	Helicopter	Other	Ambulance	Helicopter
Apr-11	1525	10	3059	1016		4139	1696		3711	1993	7
May-11	1580	5	3085	1071		4399	1810	1	3999	2011	4
Jun-11	1388	5	2905	1044	1	4040	1777	2	3778	1992	3
Jul-11	1492	9	2919	1031		4170	1874	1	3987	2124	3
Aug-11	1303	6	2916	1060		3914	1904	1	3900	2093	1
Sep-11	1267	16	2824	1079		3856	1789		3900	2042	4
Oct-11	1228	7	3043	1180		3970	1850	3	3894	2095	1

9. What information can you provide on the method of discharge from your Accident & Emergency Department(s) (i.e. admitted, referred and so on)?

A breakdown of the flow of patients once they have been seen by Accident & Emergency staff is shown at Appendix 5. Appendix 5 shows that there is seasonal variation in the proportion of patients who are admitted after an Emergency Department attendance. This can be attributed to the increase in the population of East Kent, during the summer months either on vacation, or passing through the area. As with the aforementioned site variation, this is also the case with admissions through the Emergency Department.

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

Urgent and Emergency Care is high on the Trust's QIPP agenda, focussing on improving patient pathways to release capacity and costs with associated reduction in income due to left shifting the length of stay to zero and short stay (ie less than 3 days) rather than longer length of stays.

The Trust has worked with the Emergency Care Intensive Support Team and set up 3 work streams to deal with specific areas of Urgent and Emergency Care. The programme works across primary and secondary care as well as Social Services. The 3 work streams are as follows:

1. Urgent & Emergency Model of Assessment and Care
2. Ambulatory Emergency Care & Short Stay
3. Integrated Discharge and Transfer of Care

Each work-stream has Quality Indicators comprising aim statements, measures and balancing metrics designed to ensure that improvements and redesign initiatives meet both quality and productivity standards and targets.

List of Appendices

Question	Details of appendix	Appendix Number
No. 1	A breakdown of attendances at departments.	Appendix 1
No. 3	The eight Clinical Quality Indicators that this Trust has been adhering to.	Appendix 2
No. 3	Performance report that is used to monitor Accident & Emergency Department performance.	Appendix 3
No. 4	This shows the increase in attendances from the Maidstone area that we would previously have anticipated would have attended Maidstone Hospital.	Appendix 4
No. 9	A breakdown of the flow of patients once they have been seen by Accident & Emergency staff.	Appendix 5

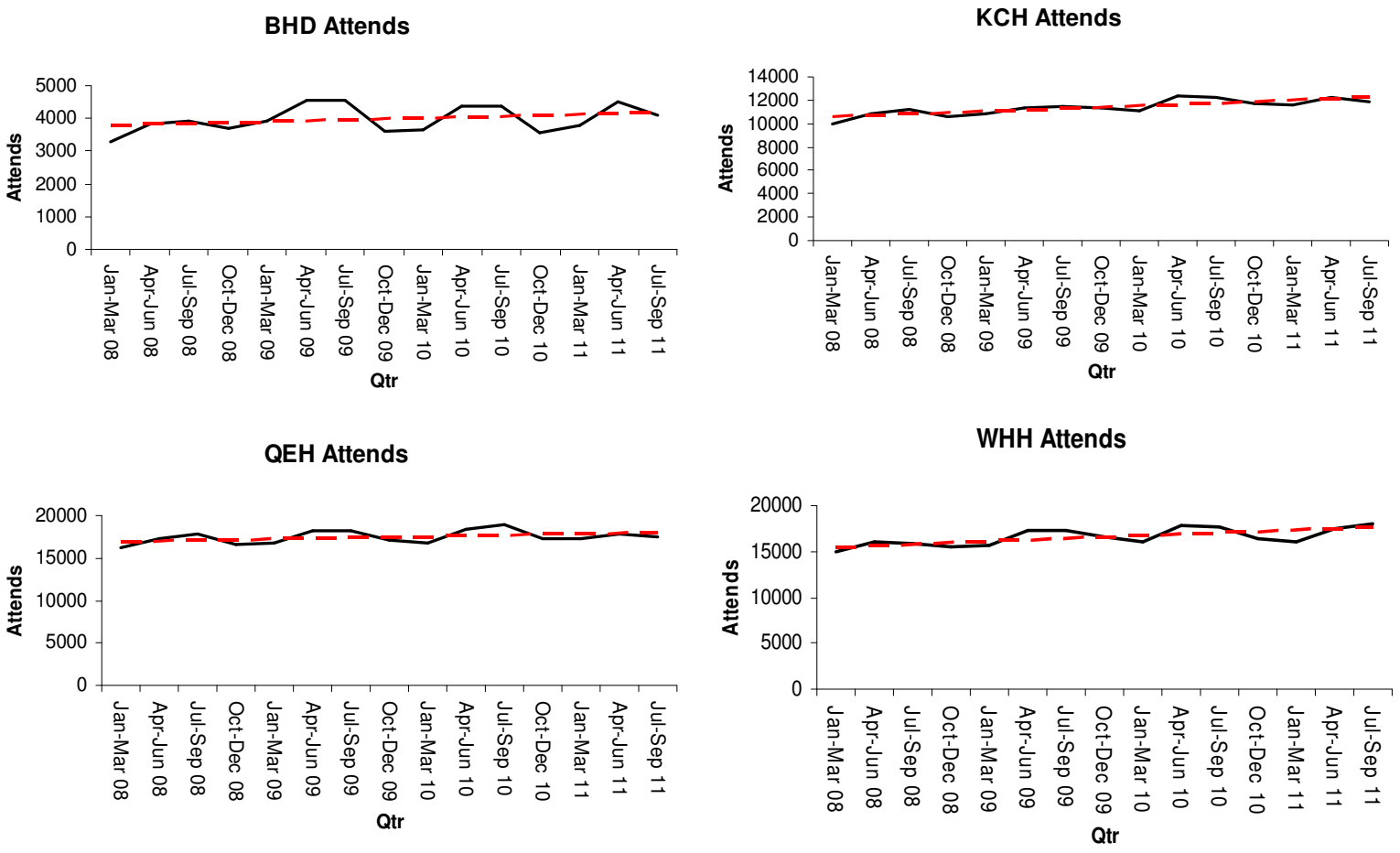
Appendix 1 - A breakdown of attendances at Departments

As can be seen from the graphs below there remains a consistent number of attendances in the Emergency Departments across the services provided by East Kent Hospitals. However, if we focus upon the first three quarters of this calendar year we can see from the below table that there have been varying degrees of growth/decline.

Table 1 – growth

	BHD	KCH	QEH	WHH
Jan-Sep 10	12386	35690	54118	51580
Jan-Sep 11	12372	35572	52716	51648
Growth	-0.11%	-0.33%	-2.59%	0.13%

Emergency Department



Graph set 1 – Emergency department attendances

Graphs show - Dotted line as the trend
Unbroken line as the actual performance.

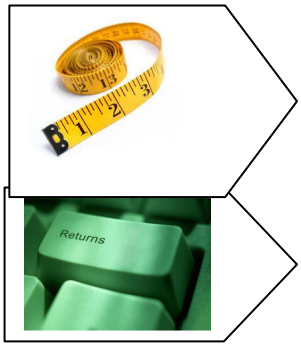
Appendix 2 - The eight Clinical Quality Indicators that this Trust has been adhering to.

Arrival to Nurse Assessment	15 MINUTES	Initial Assessment (IA) Tracking Step

Arrival to Treatment Commenced When competent decision maker commences assessment or treatment	60 MINUTES	D1S Tracking Step

Total Time in A&E from Arrival to Discharge	4 HOURS	Discharge Tracking Step

Consultant Sign Off for High Risk Patients Must be seen by a senior doctor*.	-Adults over 17 years with non traumatic chest pain. -Febrile children less than 1 year. -Patients re-attending with same condition within 72 hours of discharge from A&E.	6 Monthly Audits (College of Emergency Medicine)



Patient Experience Audit	Productive Ward handheld audit tool to be given to patients to complete whilst in the department	Audit information to be presented monthly
Unplanned Re-attendance	Less than 5% of ALL A&E Attenders	Audit of patients booked in under Code

Left without being seen	Less than 5% of ALL A&E Attenders	Information collected from discharge code. DNW – Did not wait
Ambulatory Care -DVT -CELLULITIS	% of patients with a diagnosis of DVT or cellulitis	Clinical coding upon discharge

Appendix 3 - Performance report that is used to monitor Accident & Emergency Department performance.- Trust Summary

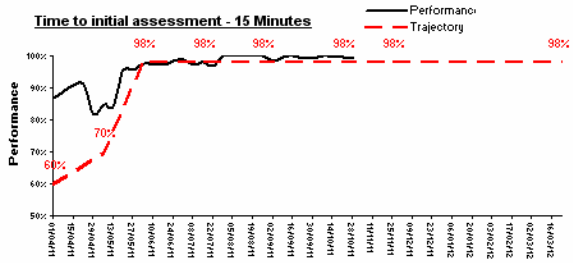
AE Clinical Quality Indicators 2011-12

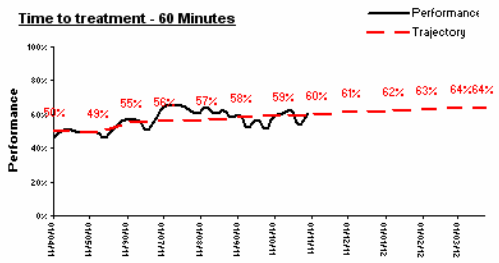
East Kent Hospitals University NHS
NHS Foundation Trust

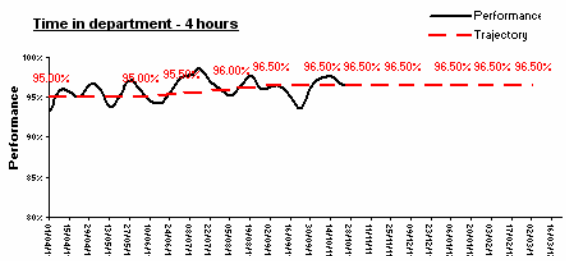
Site: Trust ← Please use the drop down menu to change site

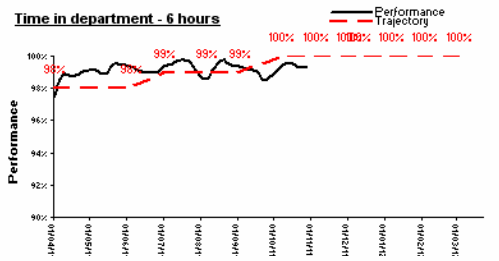
For commentary on indicators please click here

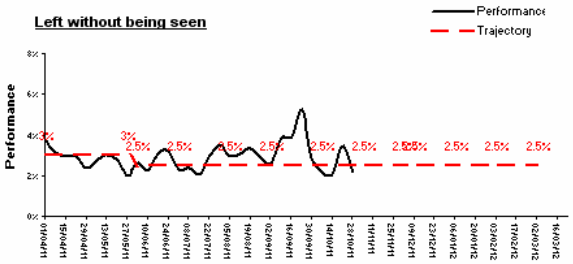
	Last 4 weeks performance (Week ending)					Last 4 months performance					Quarterly Performance		
	16-Oct	23-Oct	30-Oct	06-Nov		Jul-11	Aug-11	Sep-11	Oct-11		Q1	Q2	Q3
Ambulance Patients	1116	1146	1108	1102		4976	5008	4861	5080		14448	14845	
: within 15 minutes	1114	1141	1102	1095		4865	5002	4835	5048		13181	14702	
Performance	99.82%	99.56%	99.46%	99.36%		97.77%	99.88%	99.47%	99.37%		91.23%	99.04%	
95th Percentile (mins)	4	3	4	4		4	4	4	3		45	4	
National Standard	15	15	15	15		15	15	15	15		15	15	
Time to treatment	3857	3661	3671	3658		17048	16579	16419	16964		51175	50046	
: within 60 minutes	2340	2271	1962	2217		10804	10209	9178	9771		26312	30191	
Performance	60.67%	62.03%	53.45%	60.61%		63.37%	61.58%	55.90%	57.60%		51.42%	60.33%	
Median - 51st Percentile (mins	45	44	54	45		39	45	51	49		58	44	
National Standard	60	60	60	60		60	60	60	61		60	60	
Time in department	3874	3658	3636	3696		17326	16777	16430	16978		51207	50533	
: within 4 hours	3775	3571	3514	3563		16921	16142	15703	16386		48770	48766	
Performance	97.44%	97.62%	96.64%	96.40%		97.66%	96.22%	95.58%	96.51%		95.24%	96.50%	
95th Percentile (mins)	238	239	239	239		237	239	240	239		240	239	
National Standard	240	240	240	240		240	240	240	241		240	240	
Time in department	3874	3658	3636	3696		17326	16777	16430	16978		51207	50533	
: within 6 hours	25	16	25	25		17256	16640	16287	16833		50647	50183	
Performance	0.65%	0.44%	0.69%	0.68%		99.60%	99.18%	99.13%	99.15%		98.91%	99.31%	
National Standard	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	
Left without being seen	2.15%	2.05%	3.49%	2.19%		2.53%	2.60%	3.18%	3.56%		2.78%	3.11%	
National Standard	5.00%	5.00%	5.00%	5.00%		5.00%	5.00%	5.00%	5.00%		5.00%	5.00%	
Unplanned Reattedances	7.78%	7.05%	8.06%	7.55%		8.53%	6.37%	7.09%	7.13%		8.51%	6.86%	
National Standard	5.00%	5.00%	5.00%	5.00%		5.00%	5.00%	5.00%	5.00%		5.00%	5.00%	

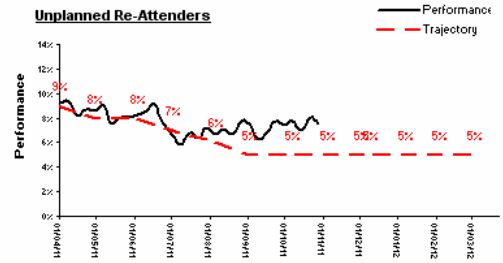












Appendix 4 Attendances from Maidstone area.

Appendix 4 shows the increase in attendances from the Maidstone area that may possibly have attended the Maidstone Hospital.

Information relating to the GP Practices which are the closest to EKHUFT has been looked at in terms of number of emergency admissions. Through the analysis work we calculated the number of Emergency Department attendances that would be generated on a daily basis.

	Emergency Admissions - April 2011
ST LUKES MEDICAL CENTRE	38
DR SINHA GC	11
BEARSTED	81
MOTE	79
BREWER STREET	62
LENHAM	20
THE COLLEGE PRACTICE	105
NORTHUMBERLAND	46
WALLIS AVENUE	36
LANGLEY	19

Average Emergency Admissions April 2011	17
Additional admissions from above (15% expected) to EKHUFT	2.6
Additional ED Attends	9

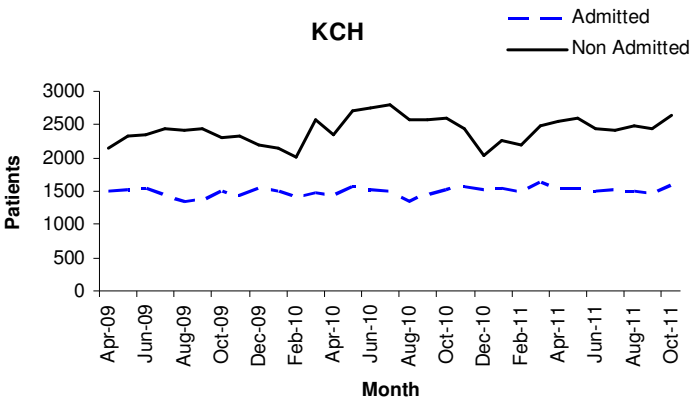
We would expect to see, on average, an additional 9 patients a day. This would predominantly occur at The William Harvey Hospital, although a minority may go to Kent & Canterbury Hospital.

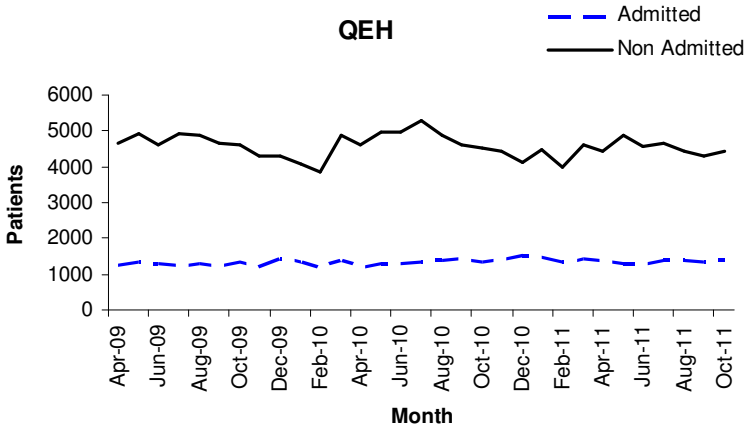
Appendix 5 - A breakdown of the flow of patients once they have been seen by Accident and Emergency staff

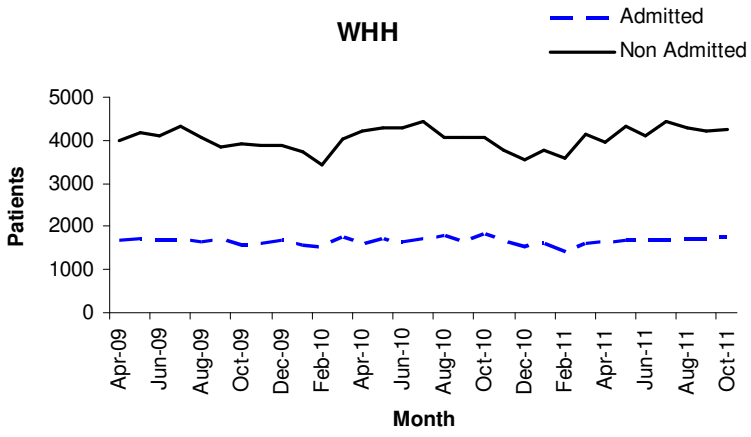
It can be seen from the graph set out below that since 2008 there has been little variation in the flow of patients, being those who go on to be admitted or discharged home. However, there is seasonal variation in this due to the increase in population during the summer months. This can most notably be seen at the Kent & Canterbury site.

If the graphs below are plotted on a daily basis, the seasonal variation is more pronounced.

Graphs - Top line – non admitted Bottom line - admitted







	KCH		QEH		WHH	
	Admitted	Non Admitted	Admitted	Non Admitted	Admitted	Non Admitted
Q1 0910	4563	6829	3905	14220	5074	12272
Q2 0910	4141	7288	3770	14450	5038	12201
Q3 0910	4470	6824	3959	13174	4846	11664
Q4 0910	4376	6733	3927	12828	4862	11199
Q1 1011	4513	7819	3858	14574	4970	12812
Q2 1011	4320	7929	4130	14801	5156	12581
Q3 1011	4611	7091	4280	13046	5040	11392
Q4 1011	4647	6931	4284	13082	4616	11467
Q1 1112	4592	7589	3998	13872	5000	12402
Q2 1112	4474	7357	4084	13409	5085	12958

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Item 6: Dartford and Gravesham NHS Trust and Medway Foundation Trust: Developing Partnership.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2011

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

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1. Background

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

(b) This topic was further pursued at the meeting of 22 July 2011 with the understanding that the Trusts would return at an appropriate time in the future.

(c) The specific questions which have been asked of both Trusts in advance of this meeting are as follows:

1. What decisions have been made since July regarding the proposed integration of Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust?

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

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

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

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

2. Recommendation

That the Committee note the report.

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

To: Health Overview and Scrutiny Committee, 25 November 2011

Subject: Foundation Trust Status

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1. Foundation Trusts (FTs)

(a) Foundation Trusts are independent public benefit organisations but remain part of the NHS. They are accountable to Parliament as well as the local community. They have a duty to engage with their local community and encourage local residents, staff and service users to become members. Members can stand for election to the council of governors.

(b) The council of governors is drawn from various constituencies, with members either elected or appointed by that constituency. It works with the board of directors, which has the responsibility for day-to-day running of the FT.[1]

(c) The current Health and Social Care Bill progressing through Parliament proposes a number of changes to FTs. There will be an increase in autonomy – the private patient income cap will be repealed, legislation on organisational change will be completed and there will be increased transparency around financial assistance from the Secretary of State.

(d) The role of FT governors and directors will be clarified and there will be a requirement to hold board meetings in public.[2]

(e) As things currently stand, there are a number of differences between NHS Trust and NHS Foundation Trust status. One of the areas of difference is around financial duties:

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

2. FTs are not statutorily required to break even, but must achieve the financial position set out in their financial plan. One main

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[1] Monitor, *Current practice in NHS foundation trust member recruitment and engagement,* 2011, http://www.monitor-nhsft.gov.uk/sites/default/files/Current%20practice%20in%20foundatio...ecruitment%20and%20engagement.pdf

[2] Department of Health, *Provider regulation to support innovative and efficient services – The Health and Social Care Bill*, October 2011, http://healthandcare.dh.gov.uk/files/2011/10/B2-Provider-regulation-to-support-innovative-and-efficient-services.pdf

measure of an FT's financial performance is EBITDA (earnings before interest, tax, depreciation and amortisation).[3]

2. The Foundation Trust Pipeline

(a) The first FTs were created in 2004. There is an expectation that all NHS Trusts will become Foundation Trusts (or part of an FT) by 1 April 2014 and NHS Trust legislation would be repealed (meaning non-FT NHS Trusts will not exist). However, the rigid deadline has been removed to allow flexibility. Monitor will maintain its oversight role of Foundation Trusts until 2016, or two years following authorisation.

(b) Since October 2010, the Department of Health has been developing new processes to assist aspirant Trusts towards authorisation.[4] The completion of a 'tripartite formal agreement' (TFA) for each Trust has been a core element of this with the TFA summarising the main issues "relevant to each trust's plans to go forward to foundation status."[5] Any issues were put into four categories[6]:

- Financial;
- Quality and Performance;
- Governance and leadership; and
- Strategic issues.

(c) A Trust Development Authority will be established to take over the Strategic Health Authority role of overseeing non-FT Trusts once SHAs are abolished on 1 April 2013.[7]

(d) As of 1 November 2011, there are 140 FTs. Across England, this accounts for 57% of acute, 73% of mental health and 27% of ambulance trusts.[8]

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[3] Academy of Medical Royal Colleges and Audit Commission, *A Guide to Finance for Hospital Doctors*, July 2009, p.23, http://www.audit-commission.gov.uk/health/audit/financialmgmt/hospitaldoctors/Pages/hospitaldoctors9jul2009.aspx

[4] National Audit Office, *Achievement of foundation trust status by NHS hospital trusts*, Full report p.6, 13 October 2011, http://www.nao.org.uk/publications/1012/foundation_trusts.aspx

[5] Health Service Journal, *Letter from Matthew Kershaw, Director of Provider Delivery, Department of Health*, 10 November 2011, p.18.

[6] National Audit Office, *Achievement of foundation trust status by NHS hospital trusts*, Full report p.21, 13 October 2011, http://www.nao.org.uk/publications/1012/foundation_trusts.aspx. Links to all the TFAs can be found at: Department of Health, *Foundation Trusts: Tripartite Formal Agreements*, http://healthandcare.dh.gov.uk/foundation-trusts-tripartite-formal-agreements

[7] Department of Health, *Timetable for change, http://healthandcare.dh.gov.uk/timetable-for-change*

[8] Monitor, *140th foundation trust authorised by Monitor*, 1 November 2011, http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/latest-press-releases/140th-foundation-trust-authorised-monitor

(e) Across the South East Coast region, 50% of Trusts have been authorised as Foundation Trusts.[9]

(e) In Kent and Medway, the Foundation Trusts are currently:

- East Kent Hospitals NHS University Foundation Trust;
- Medway NHS Foundation Trust; and
- South East Coast Ambulance Service NHS Foundation Trust

3. Monitor

(a) Monitor is the independent regulator of NHS Foundation Trusts and is directly accountable to Parliament.

(b) The three main strands to its work are currently:

1. Assessing the readiness of Trusts to become FTs;
2. Ensuring FTs comply with their terms of authorisation and that they are well governed and financial robust;
3. Supporting FT development.[10]

(c) A number of changes to the role of Monitor have been proposed as a result of the NHS White Paper, *Equity and Excellence: Liberating the NHS*, and the passage of the Health and Social Care Bill through Parliament. It will become the sector regulator for health (and potentially for social care at a later date), licensing providers of NHS services and carrying out functions in the following three areas:

1. Regulating prices;
2. Enabling integration and protecting against anti-competitive behaviour; and
3. Supporting service continuity.[11]

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[9] NHS South East Coast, *Provider Development Update*, Board Papers 28 September 2011, http://www.southeastcoast.nhs.uk/Downloads/Board%20Papers/28%20September%202011/71-11%201%20Provider%20Development%20update%20Sept%202011.pdf

[10] Monitor, *What we do*, http://www.monitor-nhsft.gov.uk/home/about-monitor/what-we-do

[11] Monitor, *The Health and Social Care Bill: Monitor's Evolving Role*, 10 October 2011, http://www.monitor-nhsft.gov.uk/sites/default/files/The%20Health%20and%20Social%20Care%20Bill%20-%20Monitor's%20evolving%20role%20[Information%20sheet]%2010%20October%202011.pdf.pdf

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Ref: HOSCNovember2011.doc

Dartford and Gravesham NHS Trust

Medway NHS Foundation Trust

16th November 2011

Mr Nick Chard
Members Suite
Sessions House
County Hall
Maidstone
KENT
ME141XQ

Dear Nick,

Re: Health Overview and Scrutiny Committee Meeting – 25th November 2011

Further to your invitation for us to attend the above meeting, please find the answers to your questions below.

1) What decisions have been made since July regarding the proposed integration of Dartford & Gravesham NHS Trust and Medway NHS Foundation Trust?

The Trust Boards of both Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust considered whether the proposed integration of the Trusts could be feasible in September 2011, after receiving a detailed feasibility study. Criteria were developed, to support Board members in both organisations to carefully consider whether the integration has the potential to succeed. These were:

1. Do both Boards agree that the integration shows sufficient tangible benefits to patients and the public?

2. Is the agreed clinical strategy for the integrated organisation acceptable to both Trust Boards and formally supported by commissioners?

3. Does the Long Term Financial Model (LTFM) of the integrated organisation achieve the risk ratings for Foundation Trusts (as determined by Monitor)?

4. Do both Boards agree that the outline post integration plan shows how to achieve the required financial benefits, the clinical strategy and the benefits to patients and the public?

The criteria required each Trust Board to scrutinise the integrated clinical, estates and back office strategies; the provision of formal support from commissioners for the integrated clinical strategy; the combined Long Term Financial Model of the new organisation and the outline for the plan to manage the process of integration.

During separate Trust Board meetings in September, a unanimous decision was made, by both Trust Boards to proceed towards integration.

The Integration Feasibility Test document can be found from page 22 (Attachment 4) of Dartford and Gravesham NHS Trust's September Board papers: www.dvh.nhs.uk/about-us/trustmanagement/trust-board/trust-board-minutes-agendas

2) What are the implications for the range and location of health care services delivered at both sites?

Our approach to developing service strategies in the current economic and policy context is two-fold: safeguarding services and developing services.

Safeguarding the range of services provided

The purpose of integration is to safeguard services and build on the range and quality of services already offered to local people. We do not intend to reduce services – as by way of example, both hospitals will continue to provide full Consultant led A&E, maternity, children's, acute medicine, elderly and outpatients services.

We are aware of the need to fully consult with the public in cases where major service changes are anticipated. There are no plans to diminish the range of services provided at either local hospital or to centrally locate services at one hospital site or other. The clinical strategy seeks to "level up" the quality of services provided across both hospital sites. The integrated Trust has ambitious plans to significantly improve the quality of services provided to the population of North Kent and we believe that it will be easier to do this as an integrated entity. This will be achieved, in part, by integrating the teams of consultants and specialist nurses providing the services.

The strategy also seeks to develop the range of services provided so that local people can access more specialised services at their local hospital should they choose to do so, rather than travel long distances to London.

The development of specialist services

Some specialist services require a certain size of population to be sustainable. This is because clinicians need to perform a minimum number of

procedures each year to maintain professional standards and quality outcomes. It is generally accepted that a minimum population base of 500,000 is required to maintain a full range of general hospital services. The integrated organisation would serve a population of 630,000 in the first instance (however, population estimates for North Kent show that number rising) and therefore services will be both viable and sustainable, both clinically and financially, across the North Kent health economy.

We are already working in partnership in a number of areas, such as ear, nose and throat services, urology and dermatology and our staff provide services across both hospital sites and in the local community. Formalising this relationship will realise benefits across a wider range of clinical services.

Whilst the integration would enable our clinicians to maintain their specialist skills it would also provide the flexibility to develop them further and therefore increase the range of specialist services provided in the combined organisation. Some services for which patients have to currently travel to tertiary centres in London for treatment, for instance nephrology, can be developed locally. It will also mean that the new organisation will retain and attract the very best clinicians in its key clinical leadership roles.

Such highly specialised services are accessed by a small number of patients, and the services are developed by highly specialised clinicians, often utilising cutting edge technology and expensive equipment. To achieve economies of scale, both in the purchase of specialised equipment and the availability of highly trained clinicians, decisions to locate these services on one site might need to be made. It is anticipated that, as an integrated organisation, there will be more opportunity to further develop such services.

This is currently the case in urology that followed national guidance in improving clinical outcomes which led to each hospital site offering different regional services – Darent Valley currently provides a kidney stone service using a laser and Medway Maritime currently provides a complex cancer centre. However, in both instances patients are seen in their local hospital's outpatient setting when referred by their GP.

It is not anticipated that there will be an immediate increase in the range of services, specialist services will take time to develop. The first tranche of services developed will be those currently referred to London centres.

<u>Location</u>

We want to take every opportunity to assure residents within our local communities that we are listening to and have heard their concerns. In the vast majority of cases, our patients will continue to access services at their local hospital in the same way that they have always done.

In summary, clinicians are continuing to develop their visions and service plans for the services they lead and we expect these to be finalised in the Spring 2012. They are passionate about providing excellent services to the

local population and we would be pleased to share the detail of these with you in 2012.

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

The timeline in Appendix 1 outlines the formal transactions process that the Trusts are required to undertake.

The Competition and Cooperation Panel (CCP) will undertake an assessment to understand the impact that the integration will have on patient choice and competition in the health market. They will recommend integration if they believe that the benefits to patients and the taxpayer outweigh the loss in choice of organisational provider.

Both Trust Boards will commission independent **due diligence** reports regarding clinical, financial, estates, workforce and legal issues. The purpose of the due diligence reports will be to provide assurance separately for each Trust Board that there are no material issues that they are not aware of that would preclude or be a surprise to them following the integration.

Dartford & Gravesham NHS Trust must submit a **business case to the Strategic Health Authority** (SHA) who will submit it to the Transactions Panel of the Department of Health. The Secretary of State will be advised by the Transactions Panel whether to give formal approval via Parliament to dissolve Dartford & Gravesham NHS Trust as a legal entity.

At the same time, Medway NHS Foundation Trust must submit an **integrated business plan to Monitor**, the Foundation Trust regulator. Monitor will undertake an assessment which will scrutinise the information presented in the business case. Monitor will advise Medway NHS Foundation Trust Board of a risk rating based on this assessment of the new organisation which it will use as part of its decision to integrate.

Dartford and Gravesham NHS Trust Board and Medway NHS Foundation Trust Board will then independently make a formal decision based on the advice received from the CCP, Transactions Panel and Monitor. **This formal decision is anticipated to be taken in July 2011.**

Based on our current timeframes, and subject to the relevant approval processes, the new organisation is anticipated to become a single legal entity on the **1st August 2012.**

4) What are the biggest challenges to achieving a successful outcome?

This is a complex process and there are a number of factors which could impact upon a successful integration and we are working hard to mitigate those risks. Some of the biggest challenges include:

a) Failure to respond to the concerns of the public, patients and our stakeholders, such as GP commissioners:

We are working closely and in partnership with key stakeholders and we plan a significant period of public engagement plan, split into 2 phases. Phase 1, which is already underway, will focus on hearing the views of the general public and our patients, ensuring that views, concerns and suggestions are fairly considered and built into our business plan wherever possible. It will end on 29th February 2012, in order to build in time for views to influence our business case. Phase 2 will take place after the business plan has been submitted to the relevant approval bodies, and it will focus on ensuring that implementation plans address the concerns that are raised.

We are developing a close working relationship with LINks and have already had 2 successful, well attended public meetings in Northfleet and Gillingham. A series of further meetings with local community and patient groups are also planned. We also plan to visit key local areas, such as shopping centres and will be producing information booklets and feedback forms, to capture the views of the wider community. A summary of our public engagement plan, including a list of organisations which we have already contacted, can be found in Appendix 2.

We have been in close contact with GP Commissioners throughout the feasibility study process and now during the development of more detailed plans. We also plan ongoing communications with GPs through existing newsletters and inviting their feedback.

b) Operational and financial performance dips due to the distraction of the changes that will be associated with the protracted integration process:

A number of decisions have been deliberately taken to ensure that this does not happen. This has so far included the establishment of a director level Transition Team, responsible for the development and delivery of the programme. They are a step removed from managing the operational performance of either Trust. This means that executive directors can continue to focus on operational delivery.

c) Failure to engage our staff, particularly our clinicians:

We know that our workforce are key to any successful integration and that without the input and engagement of our doctors and nurses particularly, we will not be able to realise the potential benefits of the integration. Clinical Directors across both Trusts are driving forward this agenda, focusing on the development of

coherent integration plans, deriving the key benefits as well as ensuring that safety remains paramount.

We are developing plans to ensure that we retain our talented workforce during this time of change and transition, and as such, we will work with our trade union partners to ensure they are fully engaged with the integration plans and process.

Our staff engagement plan mirrors our public engagement plan with two phases of engagement, firstly gathering their views to inform our plans and secondly helping with implementation of those plans.

d) An inability to integrate the differing cultures of each hospital:

Naturally, the integration of different organisational cultures will be critical to the achievement of the vision and aims of the proposed integration between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust. Too often, cultural considerations are not given enough emphasis during integrations, and this is cited as the most common reason why mergers fail to make their planned benefits. We are therefore actively building an organisational development plan that aligns the vision and values of the new organisation with all of the strategies, policies, processes, behaviours that are being produced as part of the overall integration plan.

Each hospital has areas that function better than at the other, impacting on quality of care provided and patient experience. It would not be acceptable for each hospital to stay as they are, when they could learn from the other and improve. The integration aims to improve the quality of care across the two hospitals. Where one is better than the other in a specific area, the quality of care will be "levelled up", resulting in consistently high quality of care at both hospitals.

Failure to build a constructive culture and to level up quality of care would mean that benefits identified in the feasibility study would not be realised.

5) Does the existence of a Private Finance Initiative scheme at Darent Valley pose any particular challenges?

The existence of a PFI scheme at Darent Valley ensures that the quality of the physical environment is sustained as a result of the payments made to maintain the facility. However, the challenge for organisations funding PFI schemes is ensuring the estate is optimally utilised and the rigidity of making estates related payments reduces the choice of decisions in allocation of budgets to other areas. There is a particular issue that the PFI presents in

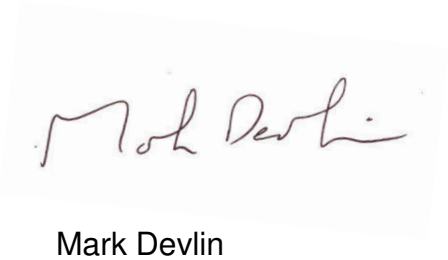
relation to achieving the required metrics and risk ratings used by Monitor to assess Foundation Trust Hospitals. These standards have been fully met as part of the Long Term Financial modelling work that has been undertaken. This was noted earlier as a key criterion of the feasibility study with which both Trust Boards used to make their decision to proceed to the next stage of the transaction.

The PFI scheme has been the subject of questions during our engagement with the public to date. We feel that it is important to make some specific points:

a) Dartford and Gravesham NHS Trust has always met its financial obligations related to this loan. There is no reason to suggest that an integrated organisation could not do the same.
b) One of the conditions of the PFI agreement is that the quality of the estate is maintained at "B" standard. This means that the fabric of the building must be maintained at a "nearly new" standard, in comparison to Medway NHS Foundation Trust which has in excess of £24m backlog maintenance.
c) Financial due diligence will be essential for the integration to proceed and this means that the assumptions made, which demonstrate that the PFI is affordable to the integrated Trust, will be rigorously and independently tested.

We look forward to attending the HOSC meeting on the 25th November. Should members have any questions in the meantime, do not hesitate to contact us.

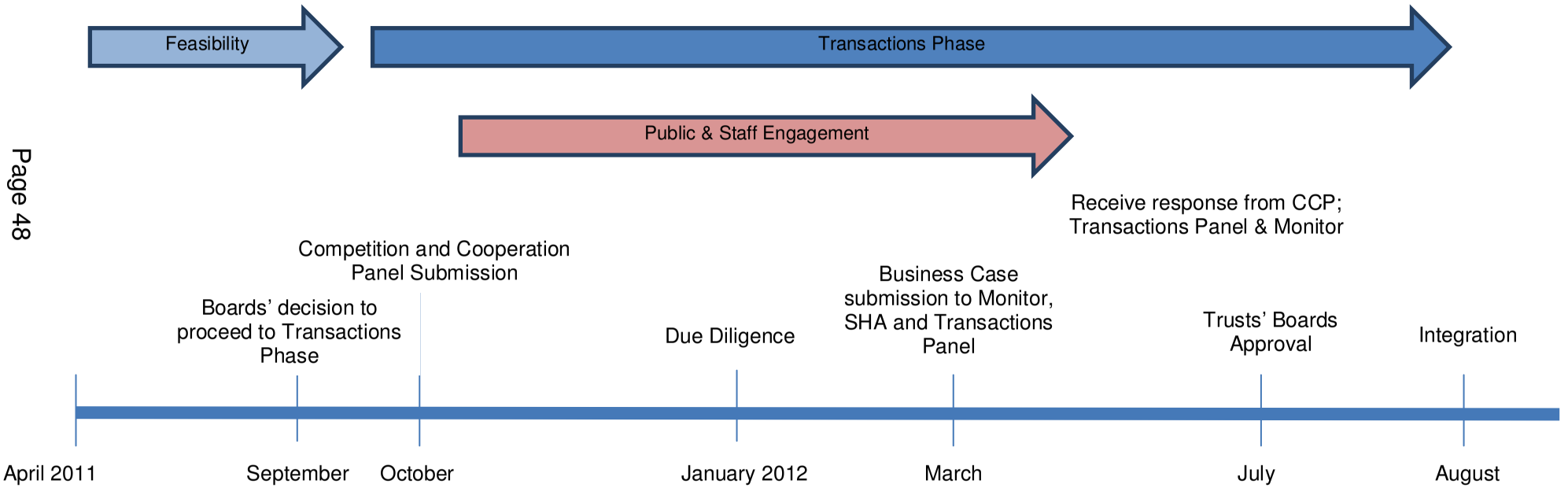
Yours sincerely



Mark Devlin

Susan Acott

APPENDIX 1: Proposed Integration Timeline: Dartford & Gravesham NHS Trust and Medway NHS Foundation Trust



APPENDIX 2: Public and patient communications and engagement summary

Introduction

We want our local communities and members of our organisations to be involved in the development of our plans to integrate Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust. We have developed a communications strategy which details our intended approach. This briefing note aims to give HOSC members a summary of the activities undertaken to date and our plans to involve patients, members and the public over the coming months, to the point of integration.

We are keen to reassure HOSC members that we do not propose changes to either local hospital which would diminish its contribution as a significant provider of hospital services to the local community and we do not plan to reduce the range of services offered to local residents, accessed through their local hospitals. We do propose to develop some services that are not currently available locally and it is possible that these may only be developed on one site, to take advantage of economies of scale. We believe that the plans to engage with the public, patients and our members is proportionate to the scale of change that they will experience from the way that they access the services that we provide.

If, at any point in the future, we plan to make major service changes, we are committed to meeting our statutory obligations and enter into a phase of full public consultation.

Our plans – an overview

We have had a communications and engagement strategy in place since the establishment of the programme, designed to ensure that key stakeholders are kept informed throughout the process. Our public engagement plan supports the overarching strategy and ensures that patients and the public are not only kept informed, but also have the opportunity to get involved and influence our plans. Both the strategy and plan focus on on-going engagement and partnership working.

We plan to work closely and in partnership with key stakeholders to engage with patients and the public over the next six months, in two phases. Phase 1, which is already underway, will focus on hearing the views of the general public and our patients, ensuring that views, concerns and suggestions are fairly considered and built into our business plan wherever possible. It will end on 29th February 2012, in order to build in time for views to influence our business case. Phase 2 will take place after the business plan has been submitted to the relevant approval bodies, and it will focus on ensuring that implementation plans address the issues that are raised.

Engagement so far

We have over 10,000 members between the two Trusts. They have been informed of progress to date and we plan to ask members to share their views of our plans. We have also worked with the media and used our websites to publicise the decision to

draw up more detailed plans following the feasibility study outcome. We have a dedicated email address (bettercaretogether@nhs.net) and telephone number, through which members of the public can contact us, ask questions, make suggestions and comment on our plans.

We aim to work in partnership with local community groups and associations to generate considered and detailed engagement and ensure we hear from all sections of the local community. We have worked with LINks to deliver two public meetings, held in our local communities in recent weeks, attended by 130 people. We shared our plans to date, answered questions, invited debate and discussion through the use of round table exercises. The debate on the challenges and benefits of the integration has led to a series of questions, which the Trusts are committed to responding to and publishing on our websites in due course.

We have contacted over 150 local community groups, forums, charities and organisations to invite them to get involved and see how we can work more closely with them to inform and engage with their members and networks (please see the full list below). We are now following up interest from a number of groups, including:

- Bluewater Community Forum
- Dartford Elders Forum
- Alzheimer's Society
- Kent Association for the Blind
- Rural Age Concern Darent Valley
- Age UK North West Kent
- Metro Centre
- Parkinsons Disease Society - South East
- Medway Hindu Community Centre
- African Caribbean Forum – Gravesham
- Medway Heart Care Support Group

We will be working with these organisations, and others, to ensure that they are kept informed of our plans and progress and have opportunities to give feedback. This will be through a variety of mechanisms, including presentations, Q&As and capturing feedback at their meetings and forums, information and feedback booklets and regular email updates.

Future plans for engagement

We are committed to building our relationship with community groups, forums and charities and will continue to have a focus on partnership working with these organisations.

We are also planning to use a number of other communications and engagement mechanisms to ensure patients and the public are kept informed and can have their say. These include:

- Events for members and the public across the area specifically on the integration and on-going members updates.
- The information booklet, with a feedback form included, will be distributed to public locations across the area, including libraries.
- Regular updates will be posted on our websites, with an online feedback form.
- Noticeboards will be established at both hospitals, with updates and feedback forms.
- A roadshow, visiting central areas such as shopping centres, with materials to distribute.
- Using social media, such as Facebook and Twitter to ensure our younger population is engaged with.

Getting involved

We welcome any ideas for further community groups, forums and charities to contact, to ensure that both the public's and our service users' views are heard and can influence the development of our plans.

Other stakeholders

This summary only covers public, patient and member engagement. We have also planned communications and engagement for our other key stakeholders, which include our staff, GP commissioners, PCT cluster staff, GPs, MPs and unions and would be pleased to provide HOSC members with more information on the 25th November, should this be useful.

Full list of organisations contacted

121 Youth Befriending
Abbeyfield Society Ltd
Action with Communities in Rural Kent
Advocacy Kent
African Caribbean Forum Gravesham
Age Concern Chatham
Age Concern Darent Valley
Age Concern Gillingham
Age Concern Gravesend
Age Concern Medway Ltd
Age Concern Northfleet
Age Concern Sheppey
Age Concern Swanscombe & Greenhithe
All Saints Community Project
Alzheimers & Dementia Support Services
Alzheimer's Society
Ash-Cum-Ridley Parish Council
Kent Autistic Trust
Spiritual Assembly of the Bahàìs of Gillingham
Bangladesh Welfare Association
Bangladeshi Trust
Bean Parish Council
Beat
Kent Association for the Blind
Bluewater Community Forum
Blythswood Care
BME Carers: Princes Carers Trust
BME Womens Network/ BME Youth Forum
Brompton Barracks
CARE Kent
Care4
Carers First
Carers Kent
Carers' Relief Service
Carers Relief Service (Dartford & Gravesham)
Carers Support Scheme
Carers UK
Caring Hands in the Community
CASE Kent
Catch 22 Housing
Centre for Independent Living in Kent
Cerebral Palsy Care
The Challenging Behaviour Foundation
Chart Sutton Parish Council
Churches Together in Medway
Citizens Advice Medway
The City of Rochester Round Table no.56
Cobham Parish Council
Connexions Kent and Medway
Coxheath Parish Council
Crossroads West Kent
CVS
Czech/Slovak Society
Darenth Parish Council
Dartford Elders Forum
Dartford, Gravesham and Swanley MIND
Dementia Carers Friendship Group
Eastern European Forum
Ellenor Foundation and Lions Hospice
Emmaus Medway
Epilepsy Action
Ethnic Minority Project Workers
Every Family Matters
Eynsford Parish Council
Fairbridge in Kent
Farningham Parish Council
Fibromyalgia Support Group Medway
First Steps Drop in Centre
Gillingham Youth for Christ
Goldenhar Support Group
HACO (Health Action Charity Organisation)
Hands and Gillingham Volunteer Centre
Hands Rochester Volunteer Bureau
Hartley Parish Council
Heart of Kent Hospice
HI Kent
Hindu Association
Home Start North West Kent
Housing 21
Invicta Advocacy Network

KC Addiction
Kent and Sussex Alternative ME
Kent and Youth Community
Kent Association for Spina Bifida & Hydricephalus
Kent Association for the Blind
Kent Autistic
Kent Children's Fund
Kent Council for Voluntary Youth Service
Kent Energy Centre
Kent Equality Cohesion Council
Kent Volunteers
Kent West Dyslexia Association
Kent Youth
Living Well Centre
Macintyre Charity
Macmillan Cancer Support (Medway Committee)
Marie Stopes
MCCH Employment and Vocational service
Medway Access Group
Medway Asthma Self Help (MASH)
Medway Cyrenians
Medway Ethnic Minority Forum
Medway Heart Care Support Group
Medway Hindu Community Centre
Medway Inter Faith Action
Medway Older People's Partnership
Medway Parents and Carers Forum
Medway Pensioners' Forum
Medway Youth Parliament
Melville & Brompton Community Association
MeRGe (Medway Residents Group)
Metro Centre
MOAT Homes
Motor Neurone Disease Association - Mid Kent Branch
Multiple Sclerosis Society - Medway Branch
Narcotics Anonymous Kent
North Kent Council for Interfaith Relations
North Kent Women's Aid
North West Kent CVS
Parents Plus
Parkinsons Disease Society - Maidstone and Gravesend
Parkinsons Disease Society - Medway Towns
Parkinsons Disease Society - South East
Parkwood Youth Centre
Participate By Right! Kent Children's Fund Network
Pathway Project
Paula Carr Diabetes
Platform 51 - girls and women at heart
Pre-School Learning Alliance (South Division)
Princes Royal Trust Medway Carers' Centre
Quest School for Autistic Children
Rainer
Ramgarhia Darbar
Relate
Religious Society of Friends
Rethink
Richard Watts Charity
Royal Association for Deaf People
Russian Mother & Toddler Group
Salvation Army in Chatham
Salvation Army in Gillingham
Shaw Trust
Singalong Group
Single Parent Support Group
Skillnet Group
South East Faith Forum
Spadework
The Kent Association for Spina Bifida and Hydrocephalus
Sri Guru Ravidass Sabha
St Nicholas Day Care Centre
St Philip & St James' Church Community Office
The Stroke Association
Sunlight Development Trust
Sure Start Centres
Sussex and Kent ME
The National Autistic Society
The Tomorrow's Child Trust
Voice 4 Kent
VoiceAbility
Voluntary Action within Kent

Volunteer Centre - Dartford
Volunteer Centre - Gravesham
Volunteer Centre - Swanley
Volunteering in the NHS
VSU Youth in Action
The Walter Brice Centre
WEDGE (Women on the Edge of their Community)
Welcome Day Centre (EMSCA)
West Kent College
West Kent Extra
West Kent Housing Association
West Kent Mediation
West Kent YMCA
Winter Warmers Society
Word on the Street
Ying Tao Chinese Association

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2011

Subject: NHS Transition.

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1. Background

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

(b) While accepting that the situation is still developing, Members of the Committee agreed at the meeting of 9 September 2011, when this topic was last considered, that they would appreciate a further update at this current meeting.

(c) The second formal meeting of the Health and Wellbeing Board (Shadow) is scheduled for 23 November 2011, so there will be a short presentation given for this item to ensure the information provided to the Committee is as current as possible.

(d) The two strategic questions which have been asked by the Committee are:

1. How are the policy proposals associated with the current Health and Social Care Bill being developed and implemented locally?

2. How is continuity to the care people receive being ensured during the transition?

2. Recommendation

That the Committee note the report.

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

To: Health Overview and Scrutiny Committee, 25 November 2011

Subject: NHS Transition: Update[1].

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1. Introduction

(a) The current proposals for reforming the health sector were originally set out in the NHS White Paper, *Equity and Excellence: Liberating the NHS*[2], and a suite of associated documents.

(b) Following a consultation process, the Health and Social Care Bill[3] began its process through Parliament to give effect to the proposals.

(c) On April 6th the Government announced a 'pause' in the legislative process, to accommodate a two-month listening exercise. A group of patient representatives, doctors and nurses and other health professionals were brought together to conduct the listening exercise and report back to Government. The Forum reported back to the Government on 13 June 2011[4] and a Command Paper containing the Government's response was published on 20 June 2011[5].

(d) The NHS Future Forum has been asked to continue its work, looking at the following four themes:

1. Improving information for service users and professionals;
2. Joining up services;
3. Improving health and wellbeing; and
4. Education and training.

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[1] The Background Note supplements the one contained in the HOSC Agenda for 9 September 2011, http://democracy.kent.gov.uk/mgConvert2PDF.aspx?ID=18818

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

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

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

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

(e) The Health and Social Care Bill has subsequently recommenced its passage through Parliament. Having left the House of Commons, it is currently being considered by the House of Lords.

(f) As with previous health legislation, the detail of a number of the Government proposals will follow Royal Assent in the form of guidance and secondary legislation. The power to bring in other changes already exists.

2. Summary Transition Timeline[6]

Planned date	Commitment
October 2011	• NHS Commissioning Board established in shadow form as a special health authority • SHA cluster arrangements in place – NHS South East Coast has clustered with NHS South Central and NHS South West to form NHS South of England[7]. • By October 2011, PCT clusters are expected to identify three or more community or mental health services in which to implement patient choice of Any Qualified Provider in 2012/13
During 2012	• Health Education England and the NHS Trust Development Authority are established as Special Health Authorities, but in shadow form, without full functions
April 2012	• The next step in extending the choice of Any Qualified Provider, which will be phased in gradually
By October 2012	• NHS Commissioning Board is established as an independent statutory body, but initially only carries out limited functions – in particular, establishing and authorising clinical commissioning groups
October 2012	• Monitor starts to take on its new regulatory functions • HealthWatch England and local HealthWatch are established

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

[7] NHS South East Coast, 3 October 2011, http://www.southeastcoast.nhs.uk/News%20&%20Events/nhs-south-of-england-launched.htm

April 2013	• SHAs and PCTs are abolished and the NHS Commissioning Board takes on its full functions • Health Education England takes over SHAs' responsibilities for education and training • The NHS Trust Development Authority takes over SHA responsibilities for the FT pipeline and for the overall governance of NHS Trusts • Public Health England is established • A full system of clinical commissioning groups is established. But the NHS Commissioning Board will not authorise groups to take on their responsibilities until they are ready.
April 2014	• The expectation is that the remaining NHS trusts will be authorised as foundation trusts by April 2014. But if any trust is not ready, it will continue to work towards FT status under new management arrangements.
April 2016	• Monitor's transitional powers of oversight over foundation trusts will be reviewed (except for newly authorised FTs, where Monitor's oversight will continue until two years after the authorisation date if that is later).

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2011

Subject: Older People's Mental Health Services.

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1. Background

NHS Kent and Medway have requested the opportunity to provide the Committee with some preliminary papers on this subject with a view to returning at the appropriate time in 2012.

2. Recommendation

That the Committee note the report.

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Kent and Medway

Mental Health Services review

Purpose of this paper

This paper seeks to introduce the Health Overview and Scrutiny Committee to work being planned to services for people with mental health needs, including dementia, across Kent and Medway.

Changes to mental health services over recent years mean that effective treatment at home is now much more widely available.

However, there is scope for further improving care at home for people with dementia, and care close to home for people with eating disorders.

Kent and Medway Partnership Trust is working with mental health commissioners at NHS Kent and Medway to develop a long-term clinical strategy for secondary care for adults of working age. This is supported by proposed improvements to primary care mental health services.

We anticipate there will be a need for public consultation in 2012 on three areas of care:

- Improvements to older people's mental health services to enable more people with dementia to be looked after at home (introductory paper attached)
- Changes to Eating Disorder services to enable a more local and equitable service (following on from the paper dated 16/9/2011)
- Potential changes to specialist acute Psychiatric Intensive Care Unit (PICU) and inpatient services for adults under 65 in an acute phase of mental illness, to reflect improvements to services, both in and out of hospital over recent years, which enable early intervention in illness, much more treatment at home, and earlier supported discharge from hospital.

The planning for Older People's Mental Health affects only east Kent. However, the other two affect the whole of Kent and Medway. We would request that Kent and Medway HOSCs jointly consider the clinical cases for change; any options appraisals and consultation plans, when developed.

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NHS

Kent and Medway

Improving Outcomes for People with Dementia in east Kent

Purpose of Paper

This paper provides Members with a first briefing of a number of proposed changes to services in east Kent which will increase access to community support for people with dementia and their carers and has the aim of delivering care as close to home as possible and reducing the need for a hospital admission.

The proposals outlined in the paper are consistent with the National Dementia Strategy and the work being undertaken by Kent County Council's Dementia Select Committee.

Introduction

Dementia is one of the main causes of disability in later life it has a huge impact on capacity for independent living. Dementia is estimated to cost £17 billion per year in the United Kingdom. It is predicted that there will be a doubling, possibly trebling of the number of people who have dementia in the UK over the next 30 years. Dementia costs the health and social care economy more than cancer, heart disease and stroke combined. (Dementia UK: Full report, Alzheimer's Society, 2007, London)

Dementia has a devastating impact on those affected and their family carers. Because of the human impact, the growing numbers and increasing costs, dementia presents a significant and urgent challenge for both health and social care.

This increasing demand is set in the context of a health and social care community which is seeing its resources increasingly under pressure. There is therefore the need to find opportunities to drive up productivity in the services available in addition to looking to improve quality outcomes for individuals by lengthening the time people maintain their independence so delaying and reducing the need for health and social care intervention.

It is estimated that there are currently 9,200 people in east Kent with dementia. This is expected to rise to 15,300 by 2026 with the greatest increase occurring in the over 85 age range. This will mean that a significant number of people with dementia will be frail older people who are also likely to have one or a more physical illnesses or disabilities, eg arthritis, diabetes, etc.

Approximately two thirds of people with dementia live in the community, with or without a carer and one third live in care homes. In the survey, "Support, Stay, Save" (Alzheimer's Society, 2011), 83% of carers and people with dementia said that being able to live in their own home was very important to the person with dementia.

Familiar environment, familiar carers and established daily routines are critical in supporting a person with dementia to keep their independence and to help them to be happy and free from stress or anxiety. Hospital wards in particular are busy clinical environments with lots of different people and set ward routines and procedures. Removing someone with dementia from their familiar environment, whether this is their home or a care home, very often increases their confusion and their levels of anxiety both of which have a direct effect on their wellbeing and their recovery. People with dementia are also much more likely to be discharged to a care home following a hospital admission rather than return to their own home as they are likely to lose some of their independence or ability to do things for themselves and are not given the opportunity to undergo a period of rehabilitation.

Our vision in east Kent is:

- To ensure that people with dementia receive timely diagnosis and support that promotes their independence and helps them to 'live well' with dementia, and that all services and support are provided to the highest possible standards; promoting dignity, choice and respect.
- To increase awareness of dementia, improve early detection and diagnosis and support people to live well with dementia.
- To ensure that there is sufficient capacity in community based services so that people with dementia and their carers are well supported and independence is maximised for as long as possible

Current Service Provision and Performance

The Kent and Medway Partnership Trust (KMPT) is currently the main NHS provider of dementia services in Kent and Medway and provide the following inpatient and community services in east Kent.

	District					
	Ashford	Canterbury	Dover	Shepway	Swale	Thanet
Acute and Assessment Beds	20 beds (WHH site)	30 beds (St Martin's site)	No beds located within these localities.			26 beds (QEQM site)
Community Services	Each district has a community mental health team for older people (CMHTOP) which also includes a Home Treatment Service whose aims are to keep people in their own homes and avoid hospital admission where possible and to help facilitate discharge.					

In comparison to west Kent and Medway there is a higher ratio of mental health in patient beds for older people in east Kent:

	East Kent	**West Kent**	**Medway**
Population	**748,000**	**680,000**	**272,000**
Number of beds (NB both organic and functional beds)	76	32	10
Beds per 10,000 pop	1.01	0.47	0.36

The introduction of the home treatment service in 2007/08 and improvements in the admission and discharge processes within KMPT has meant that performance data

for this financial year has shown occupancy rates of between 84-87% (target 85-90%). This has resulted in a number of vacant beds across all units. As a first step towards the delivery of an enhanced community model, it is proposed to consolidate the vacant inpatient beds to reflect the current activity and usage of the beds which has been sustained for a considerable period. This will mean that 15 beds, (Edmund ward, St Martin's), will remain out of use. This will also allow staff to be redeployed across the remaining wards enhancing the staffing levels on these wards and therefore reduce the need for agency and bank staff. The consolidation of these vacant beds on the Canterbury site will not have any direct impact on patient's access as a service will be retained on all of the three existing sites. Of course if it can be evidenced that this process is impacting on other parts of the health or social care system, consideration will be given to reinstating these beds.

The inpatient wards on the St Martin's site, although refurbished a number of years ago, offer a less than optimal inpatient environment. Also, planning permission was only granted for a temporary period. This adds to the argument for identifying alternatives for service delivery.

Re-focussing the Balance of Service Delivery

This paper provides an overview of the proposed next steps towards re-balancing the focus of service delivery by increasing resources for community support, and refocusing the capacity of inpatient staff and services. It is anticipated that the initiatives outlined below, will enable more people to be supported at home (whether their own home or a care home) and reduce reliance on acute inpatient care.

The three core elements in the delivery of this strategy are:

- **Dementia Crisis services.** Implementation of a 24/7 crisis response for people with dementia and their carers that supports home treatment and therefore avoids inappropriate hospital admission. This will be modelled on the service already provided in west Kent which provides support to people with dementia and their carers. The service provides support to service users and carers where an emergency response is needed, which could be to the service user or to the carer where the caring situation has broken down. The provision of this service will reduce hospital admissions, enhance management of crises and improve outcomes for service users and carers, including unnecessary admissions to both mental health and acute trust hospital services.
- **Enhanced Home Treatment Services** (HTS) for people with dementia. This service provides specialist mental health intensive care for people with dementia and their carers at the point where the care situation is breaking down or to promote timely discharge from acute mental health inpatient services to the most enabling care environment. Overall the services improve the quality of living for the service users, their family and paid carers. The proposal is to revise service eligibility criteria to enable urgent and emergency referrals to be responded to by a local HTS and will provide follow up support where the crisis service has been called out. The service will also provide improved and targeted support for residential and nursing care home providers.
- **Reconfiguration of OPMH Acute service.** The introduction of the above services will also allow for a review of the function, number and location of

inpatient beds for older people with mental health needs, to ensure optimum use of beds and ensure home treatment is considered as a first option wherever this is considered to be appropriate.

Engagement and Consultation

A stakeholder steering group has been established to oversee the implementation of the crisis service and the enhanced home treatment service. Early planning for the crisis service has been influenced by work with staff, service users, carers and the voluntary sector.

It is acknowledged that any significant changes to inpatient provision will require a period of formal consultation. If these plans are approved by the relevant committees and boards, this will commence in the New Year.

In advance of the formal consultation, work will be undertaken to develop the options for the proposed inpatient reconfiguration which will be to be used in the formal consultation process. These options will be developed in conjunction with all relevant stakeholders including service users and carers. HOSC members are invited to be part of this process.

These options will be shared with the Health Overview and Scrutiny Committee once they have been fully worked up. In the interim, Members are invited to undertake 'fact finding' visits if this would be helpful to find out more about how the current home treatment services work and to see the existing inpatient services. To arrange this or to be part of the options appraisal process, please liaise with Su Brown or Sara Warner at NHS Kent and Medway.