HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 6th January, 2012

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 6th January, 2012, 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

Please note: this meeting may be filmed for live or subsequent broadcast via the Council's internet site – at the start of the meeting the Chairman will confirm if all or part of the meeting is being filmed.

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 - 16)

5. NHS Emergency Resilience and Olympics Planning (Pages 17 - 32)

   Meradin Peachey (Director of Public Health), Matthew Drinkwater (Head of Emergency Preparedness and Response, NHS Kent and Medway), Paul Mullane (Head of Emergency Planning, Response and Resilience, 2012 Olympics Lead, NHS Kent and Medway), Jon Amos (Contingency Planning and Resilience Manager, South East Coast Ambulance Service NHS Foundation Trust), and Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust) are expected to be in attendance for this item.

6. Reducing Accident and Emergency Admissions: Preliminary Findings (Pages 33 - 34)

7. Forward Work Programme (Pages 35 - 36)

8. Date of next programmed meeting – Friday 3 February 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

23 December 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, 25 November 2011.

PRESENT: Mr B R Cope (Vice-Chairman), Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Mr L Christie (Substitute for Mrs E Green), Cllr J Burden, Cllr R Davison, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

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. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting of 14 October 2011 are recorded and that they be signed by the Chairman.

3. Reducing Accident and Emergency Admissions: Part 2
(Item 5)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust), Mark Devlin (Chief Executive, Medway NHS Foundation Trust), Dr Amanda Morrice (Clinical Director of Accident and Emergency, Medway NHS Foundation Trust), Robert Rose (Divisional Director, Urgent Care and Long Term Conditions Division, East Kent Hospitals University NHS Foundation Trust), Chris Green (Principal Information Analyst, East Kent Hospitals University NHS Foundation Trust), Ashley Scarff (Associate Director of Strategy and Planning, Maidstone and Tunbridge Wells NHS Trust), Colette Donnelly (Associate Director of Operations for Emergency Care, Maidstone and Tunbridge Wells NHS Trust) and Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway) were in attendance for this item.

(1) The item was introduced with a reminder that this item built on what had been discussed at the previous meeting, and that the Acute Trusts were all represented today. The mental health dimension of the topic of reducing accident and emergency admissions would be considered in the New Year.

(2) Members noted the useful and detailed information provided but in the case of the multi-site Trusts, more information by site would assist them. Common themes were identified as running through the written information provided and the short opening summaries given by representatives of the four Acute Trusts

across Kent and Medway. It was given as a guiding principle for delivering effective health care that patients be seen by the right person at the right time and in the right place. An estimated figure was given of around 15-20% of patients in accident and emergency departments that could be seen more effectively elsewhere.

(3) Representatives from all Trusts agreed that working with commissioners, other Trusts and social services was important in delivering a sustainable and appropriate reduction in attendances and admissions at accident and emergency departments. Representatives from Maidstone and Tunbridge Wells NHS Trust (MTW) and from East Kent Hospitals University NHS Foundation Trust (EKHUFT) mentioned their participation in an Urgent Care Board and Integrated Care Board respectively which looked to achieve this.

(4) Beyond this, while it was acknowledged that each Trust may require different solutions, there were some changes across the region which also needed to be recognised and taken into account. One of these was the development of major trauma units in three Acute sites across Kent and Medway, at Medway, Ashford and Pembury. While this did not mean any reduction in the number of accident and emergency departments, there were implications for clinical services. For example, this was given as one reason the accident and emergency department at the newly opened Pembury Hospital saw an increase in the number of attendees. If Pembury was where the clinicians able to undertake emergency surgery were located, then ambulances would go there direct. Work was underway with the Ambulance Trust on refining the care pathway. The air ambulance, though dealing with comparatively small numbers of patients, was a valued component in the development of the trauma network. The South East Coast wide procurement to deliver the non-emergency 111 number was seen by the NHS as an important change which would enable patients to be informed and guided correctly as to their choices.

(5) The move to GP led commissioning through Clinical Commissioning Groups was also seen as important. Their knowledge would be vital in helping develop the right services for the population as well as educating patients and changing the nature of the patient mix going to accident and emergency departments. GPs also knew their individual patients' histories, and this was valuable information to utilise in delivering effective treatment. In terms of GPs as service providers, a number of different points were raised. The view was expressed that where the changes to the GP contract meant that GPs could opt out of providing out-of-hours cover, people seeking treatment could turn to their nearest accident and emergency department through not understanding the alternatives. A different perspective was given by a Member who suggested GPs chose to send patients to be admitted via accident and emergency departments when waiting times for elective treatment were too long.

(6) The confusion on the part of the public concerning the alternatives to accident and emergency departments was a theme picked up and emphasised by a number of Members. While a representative from the NHS stressed that minor injury units were often well used and well known in the areas where they were located, there was a valid point made about how people understood 'minor injury' and what services a walk-in-centre offered. One Member suggested

that as a minimum, minor injury units have standardised opening hours across the County.

(7) The importance of the accident and emergency department itself as a venue for signposting people to the appropriate service was also stressed. A number of sites had non-accident and emergency services co-located with the accident and emergency department so that although a patient may present there, it may not be the accident and emergency department which delivers the treatment. For example, Medway NHS Foundation Trust had a same day treatment centre alongside, run by Medway Community Health.

(8) In other areas of Kent and Medway, MTW had made a bid with the Primary Care Trust for four acute physicians for both sites in order to carry our urgent assessments and run a turnaround clinic. There are also signposting services to GP and pharmacy services.

(9) In East Kent, EKHUFT has four sites, accident and emergency departments at William Harvey Hospital in Ashford and the Queen Elizabeth the Queen Mother Hospital in Margate, an Emergency Care Centre at Kent and Canterbury Hospital and a Minor Injury Unit at Buckland Hospital in Dover. A consultation with staff is currently underway in order to provide more equal service coverage over weekends compared to that available during the week. In Canterbury, GPs and hospital clinicians worked together in the Emergency Care Centre. At the William Harvey, there was an assessment unit and a short stay unit to which GPs could directly admit people. While admittedly it had been from a low base, direct admittance to the assessment unit by GPs had risen 240%. Direct attendance at the accident and emergency department has reduced 2%. Where there had been an issue with the number of reattendances at Buckland Hospital over the summer, this was due to patients returning to where they had received the initial treatment.

(10) Dartford and Gravesham NHS Trust (DGH) had been impacted by two major developments. Firstly, there had been the closure of the accident and emergency department at Queen Mary's Hospital in Sidcup, the nearest hospital to Darent Valley at 10 miles distance, which happened in two phases; and secondly the decision last year by the community services provider to no longer run the walk-in-centre at Darent Valley which meant the patients there were now included in the Trust's total. The presence of a minor injury unit in Bexley meant that those patients that were directed to DGH were more serious cases and this has meant changes to the physical structure of the accident and emergency department had been undertaken recently. The presence of the innovative White Horse walk-in-centre at Northfleet had led to effective pilot work on the right kind of onwards referrals. In addition, work with local nursing homes on getting GPs to assess elderly patient first had seen a 30% reduction in the number of admissions from nursing homes.

(11) A number of Members and representatives of the NHS made related points around the public health agenda on such issues as alcohol misuse which could have an impact on reducing the number of self-presenters.

(12) The Chairman thanked the Committee's guests for their time and the valuable discussion which had taken place.

(13) AGREED that the Committee note the report.

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

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust) and Mark Devlin (Chief Executive, Medway NHS Foundation Trust), and Dr Amanda Morrice (Clinical Director of Accident and Emergency, Medway NHS Foundation Trust) were in attendance for this item.

(1) Members of the Committee had previously discussed this topic on 22 July 2011 and the Chief Executives of both Trusts began by saying they were glad to have the opportunity to provide another update.

(2) The overall vision for combining the two Trusts was to develop a platform to provide health services to a combined population of around 630,000 and increase the number of specialist services available in Kent and Medway as well as maintaining current services. The broader context was that two medium sized district general hospitals such as Medway NHS Foundation Trust (MFT) and Dartford and Gravesham NHS Trust (DGH) had sustainability issues in the current climate of flat funding and reductions to the tariff coupled with a shift of emphasis towards health services provision in the community and not Acute settings. This meant the Acute sector as a whole had to be smaller but work harder. There was also a national policy drive that all NHS Trusts achieve Foundation Trust status, which MFT had achieved but DGH had not.

(3) A number of Members made related points about the point of devoting effort to merging when there were other priorities, as well as the need to make certain that the merger did not lead to a diminution of the number and range of services currently available. The Chief Executives of both Trusts stressed that the Trusts were not looking to reduce services and focussed on four key services which would remain on both sites. These were consultant led accident and emergency departments, maternity services, children's services and outpatient services. The population base was increasing in north Kent which meant that the services would remain viable. In addition to which any changes to service provision would need to be brought to the Committee. The aim was to repatriate some services currently only available in London. One Member indicated that many people in the area found it easier to access tertiary services in London and the reply was given that this was part of what the current consultative process was looking at. NHS representatives highlighted the need to continue to deliver services safely and indicated the evidence that combining clinical teams lead to more sustainable and effective health care.

(4) It was pointed out that cooperation in delivering services across the two Trusts was already well established. MFT delivered the dermatology and ear, nose and throat (ENT) services at DGH and urology services had been consolidated at MFT so that while services were delivered on both sites, when a patient needed surgery, consultants went to MFT to carry it out.

(5) One Member commented that the report provided by the Trusts was perhaps overly optimistic and requested fuller detail about the savings and efficiencies required. A number of specific points about finances came out during the debate. £30 million in savings were to come from £10 million in new revenue and £20 from savings in areas like reducing length of stay and patients missing appointments. £15 million pounds over 3 years for reinvestment in services were to be found from back office efficiencies from the two Trusts coming together and only having 1 Board, HR department and so on. In response to a specific question it was clarified that pathology did not count as a back office function.

(6) Both Trusts had different estate related issues. The challenge posed by the £24 million maintenance backlog at MFT was highlighted by Members and the plans for better use of what were often quite old buildings conceded by the Chief Executive. Plans to move services into main building and administration offices out were outlined. Darent Valley Hospital was built under the Private Finance Initiative (PFI) scheme and this meant a certain level of ongoing payment was required. The recent closure of services at Queen Mary's hospital in Sidcup meant DGH had no spare capacity with which to undertake private work. The Trust was 1 of 22 included in the McKinsey review commissioned by the Department of health to look at those Trusts for whom the costs of a PFI was likely to be a barrier to achieving Foundation Trust status. It was 1 of 6 out of these 22 which was regarded as being able to make progress through efficiency savings which meant the Trust was receiving support, but no additional money.

(7) Members raised the question as to whether the process was a foregone conclusion and both Chief Executives outlined the numerous stages which needed to be gone through which meant the outcome was not predetermined. The Co-operation and Competition Panel needed to examine whether the merger was anti-competitive; Monitor had a large role to play as MFT was a Foundation Trust and the Department of Health likewise with regards DGH. In response to a specific question it was confirmed that at present the timeline on p.48 of the Agenda was accurate and on track.

(8) There was also a need to ensure patient and public engagement. It was clarified that the list of organisations on pp.52-54 of the Agenda were voluntary groups and local authorities were also being included. One Member reported that the two Trusts had attended the Gravesham Locality Board that week. There had also been two LINk meetings and Mr. Fittock undertook to provide the questions from LINk to the Trusts to Members of the Committee along with the answers when available. The Trusts' intention was to continue the current widespread consultative exercise until 29 February next year. This would be followed by a stocktaking exercise with the process resuming towards the end of March.

(9) AGREED that the Committee note the report and that representatives from both Trusts be invited to return on this topic at an appropriate future date.

5. NHS Transition: Update

(Item 7)

Roger Gough (Cabinet Member for Business Strategy, Performance and Health Reform, Kent County Council) was in attendance for this item.

(1) Mr. Gough introduced the item by giving a presentation on the main points of the topic. This is attached as an Appendix to the Minutes. The last update had been given to HOSC on 9 September. Since this time there had been two meetings of the Shadow Health and Wellbeing Board (HWB) and this was where a lot of focus had been. Mr. Gough explained that the HWB was to be the local systems leader in health and had the responsibility for overseeing the Joint Strategic Needs Assessment which provided the data to inform the Joint Health and Wellbeing Strategy and beyond this, individual commissioning plans. Work was currently underway to prepare for running the proposed new health system virtually during 2012/13 before the old NHS structures went in April 2013.

(2) Beyond the commissioners, who were represented on the HWB, Mr. Gough also outlined issues around engagement with health service providers as there was a split between the two functions but also a need to draw on clinical advice to redesign care pathways. Kent County Council (KCC) had proposed Pathway Advisory Groups in its response to the Department of Health listening exercise on the proposals earlier this year, and there was also a Clinical Leadership Group set up in Kent to test models of possible HWB/Clinical Commissioning Group (CCG) engagement with providers. There was also a recent KCC initiative, The Kent Health Commission, focused on Dover at present, which looked at how new ways of working could deliver better care. One Member expressed a measure of scepticism around ideas such as the Pathway Advisory Groups and Clinical Leadership Groups which went against the NHS division between commissioner and provider; Mr. Gough explained that similar reservations were expressed during the discussion on relationships with the provider organisations at that week's Shadow Health and Wellbeing Board.

(3) There were a number of ongoing issues which needed further consideration, including ensuring children's services were not overlooked, the appropriate way of dealing with service reconfiguration, the role of scrutiny, and operating in a two-tier authority County.

(4) Members of the Committee picked up on this last aspect and it was pointed out that from the perspective of Locality Boards it was important to know who was in control of the finances. Mr. Gough replied that the CCGs had the largest budgets and were the commissioners of health services, but that it was important not to overlook the role of the NHS Commissioning Board as well as the public health and social services budgets controlled by KCC directly. Mr. Gough stated that a key role for health scrutiny in the future would be holding commissioners and providers to account.

(5) On behalf of the Kent LINk, Dr. Eddy raised a number of specific points about the HealthWatch update made available to Members before the meeting. While Mr. Gough agreed with the principle that it was important to ensure the

future HealthWatch was independent, he did not agree with the stated interpretation of a number of other points.

(6) The number of issues arising from the complexity of the current proposed reforms was made with the suggestion made that one role for HOSC in the future would be to find out who was responsible for any given decision. Mr. Gough stated that past configurations of the NHS had rarely been simple and that the enhanced role for the local authority was a good thing. The HWB, for example, would bring together all the commissioners and so assist in promoting integrated care locally.

(7) Mr. Gough made the offer to return with further updates when the Committee felt it would like to know more.

(8) The Chairman thanked Mr. Gough for his time and valuable contribution.

(9) AGREED that the Committee note the report.

6. Older People's Mental Health Services
(Item 8)

AGREED that the Committee note the report.

7. Date of next programmed meeting – Friday 6 January 2012 @ 10:00 am
(Item 9)

This page is intentionally left blank

HOSC Update

25 November 2011

Roger Gough

Cabinet Member for Business Strategy, Performance & Health Reform

Responsibilities of the Shadow H&WBB

- Shadow H&WBB has met twice (28 September and 23 November)
- Responsibilities include:
  - Joint Strategic Needs Assessment (JSNA)
    Identifies the health priorities of the population
  - Pharmaceutical Needs Assessment (PNA)
    Identify what pharmaceutical services are needed
  - Health and Wellbeing Strategy
    Agreed strategy to address priorities identified by JSNA and PNA
  - Ensuring the commissioning plans of the GPCC, Public Health, and Adult and Childrens' Social Care reflect the priorities of the JSNA and the Health and Wellbeing Strategy
  - Promoting integration and partnership and joined up commissioning plans across the NHS, social care and public health
  - Supporting joint commissioning and pooled budget arrangements where agreed

Shadow H&WBB- Progress Update

- Priorities and feedback from the July Workshop:
  - Greater integration of health and social care services
  - Dementia and carers (to include an integrated model and accessible care pathways)
  - CAMHS
  - Addressing health inequalities
  - Ensuring equity of health provision across Kent for everybody
  - More investment in community and primary care by 5% p.a. shift in funding

- JSNA for Kent – getting the product right. The draft JSNA will inform HWBS and CCGs' commissioning plans
  - Diagnostics - What are the problems and gaps in provision?
  - What does the evidence tell us about what works?
  - What does the patient experience tell us?
  - Recommendations and priorities
  - JSNA January 2012

Shadow H&WBB – Progress Update

- Towards a HWB Strategy
  - JSNA Kent wide priorities (taking account of local priorities where they are important but differ from Kent)
  - High level mapping of existing resources
  - Vision for what the health of the population will look like in future years
  - Setting out key directions for major initiatives e.g change in pathways
  - Implementation plan for delivering the vision
  - Strategy in place by April 2012

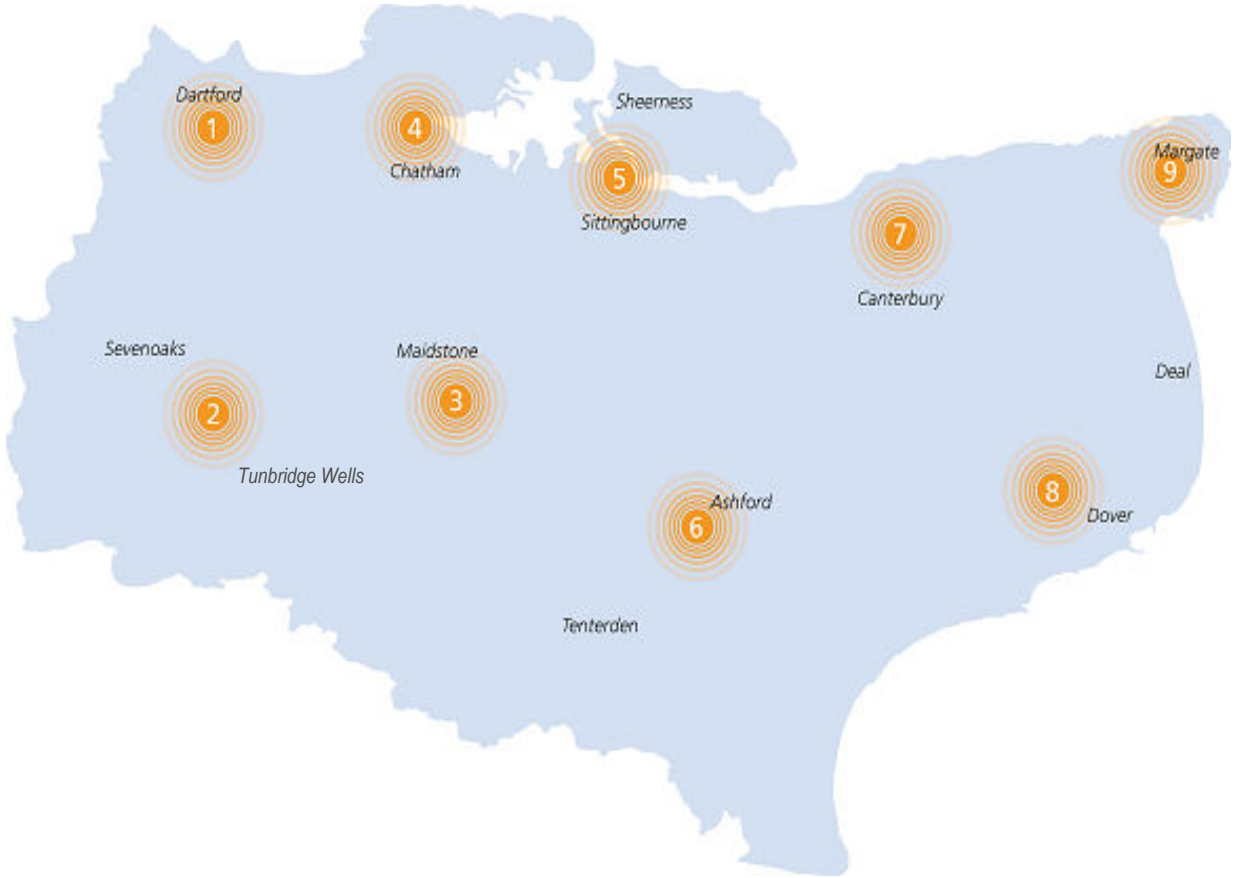
- Developing provider relationships
  - KCC proposed Pathway Advisory Groups
  - Clinical Leadership Group to test model of HWB/CCG engagement with providers

- The Kent Health Commission - “The art of the possible”
  - Dover as key focus
  - Involvement of Dover DC, GPs and local MP
  - First meeting held on 17 November
  - Interim report by Christmas

CCG Authorisation Process

- Initial development phase commenced October 2011
- Earliest applications for authorisation to be received summer 2012
- CCGs could be established from October 2012
- CCGs won't take on commissioning responsibility of their PCT cluster until 1st April 2013
- Final decision for authorisation will rest with NHSCB and relevant legal powers for this will commence July – October 2012

Clinical Commissioning Groups in Kent and Medway



1) **Dartford Gravesham and Swanley Clinical Commissioning Group** – Pathfinder – 1st Cohort
2) **West Kent and Weald Clinical Commissioning Group** Pathfinder – 4th Cohort
3) **Maidstone Malling Clinical Commissioning Group** -Pathfinder – 2nd Cohort
4) **Medway Clinical Commissioning Group** – 5th Cohort
5) **Swale Clinical Commissioning Group**
6) **Ashford Clinical Commissioning Group** - Pathfinder – 5th Cohort
7) **C4 Canterbury Clinical Commissioning Group / Whitstable Clinical Commissioning Practice –** Pathfinders 2nd Cohort
8) **South Kent Coast Clinical Commissioning Group** – Pathfinder – 2nd Cohort
9) **Thanet Clinical Commissioning Group/ Eastcliff Clinical Commissioning Practice** - Pathfinders 2nd Cohort

What Common Issues are emerging from Early Implementers?

- Children, Young People and Families
- Mental Health/Dementia
- Frail Elderly
- Health Improvement (promotion and prevention)
- Tackling health inequalities (building on Marmot)
- Service reconfiguration
- HWBs relationship with Scrutiny Committees
- 2 tier authorities
- Healthwatch /public engagement
- JSNA/Joint Health and Wellbeing Strategy

Questions

- What is the best way of keeping HOSC updated on progress from each H&WBB?
- What should the relationship be between HOSC, H&WBB and Local HealthWatch in the future?
- How should the H&WBB be scrutinised?
- How does this link with Locality Boards?

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 January 2012

Subject: NHS Emergency Resilience and Olympics Planning

---

1. Background

(a) At the meeting of 14 October 2011, the Committee requested the opportunity to explore the topic of NHS Emergency Resilience and Olympics Planning.

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

1 How robust is NHS emergency resilience planning and preparedness in Kent?

2 What specific NHS plans exist to prepare for the 2012 Olympic and Paralympic Games?

(c) The specific questions submitted to the different NHS organisation are below. The first question relates specifically to the first strategic question above, and the second to the second, with the third relating to both equally:

1

a What are the main features of NHS strategic major incident response plans in Kent?

b How are these plans produced, developed and tested?

c What are the main challenges to effective resilience planning by the NHS in Kent?

2

a What is the expected impact of the Olympic and Paralympic Games on Kent's health services' ability to deliver services as usual?

b What milestones and planning assumptions are Kent's health services working towards in preparing for the Games?

c What are the resource implications for delivering health services during the Games and how will these be managed?

d What are the key issues facing Kent's health services in planning for the Games over the remaining months prior to the Games?

3 With regards both emergency resilience and Olympics planning, what features are unique to Kent contrast to other areas of the country?

2. Recommendation

That the Committee consider and note the report.

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

To: Health Overview and Scrutiny Committee

Subject: NHS Emergency Resilience and Olympics Planning: Background Note.

---

1. Introduction

(a) An 'emergency' is defined by the Civil Contingencies Act 2004 as:

- An event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK[1].

(b) Within the NHS the term 'major incident' is in general use, defined as:

- Any occurrence that present serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations[2].

(c) 'Beyond a Major Incident' refers to incidents threatening severe disruption to health and social care that exceed the collective local capacity of the NHS.

(d) Three levels of major incident are categorised[3]:

- Level 1/Major – More patients need to be dealt with, faster and with fewer resources than usual. E.g. multi-vehicle crashes.

- Level 2/Mass – Affects hundreds of people or persistent disruption over many days. E.g. closure of a major facility through fire or contamination.

- Level 3/Catastrophic – Severe disruption to health and social care along with other functions such as water and power exceeding local collective NHS capabilities.

---

[1] Department of Health, *The NHS Emergency Planning Guidance* 2005*,* 12 October 2005, p.11, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4121236.pdf

[2] Ibid., pp.12-13.

[3] Ibid. p.14; NHS South East Coast, *Major Incident Plan*, June 2009, p.10, http://www.southeastcoast.nhs.uk/Downloads/Emergency%20planning/Major%20Incident%20Plan.pdf

- In addition, pre-planned major events such as sporting fixtures may require planning and a response.

2. Emergency Preparedness in the NHS

(a) The service-wide objective for emergency preparedness in the NHS is:

- To ensure that the NHS is capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries[4].

(b) Local Resilience Forums (LRFs), based on police force areas, are the main mechanism for multi-agency co-operation at the local level, between category 1 responders. The LRF is a statutory process rather than a statutory body[5]. The difference between a Category 1 and Category 2 responder is as follows[6]:

- Category 1 responder. A person or body listed in Part 1 of Schedule 1 to the Civil Contingencies Act. These bodies are likely to be at the core of the response to most emergencies. As such, they are subject to the full range of civil protection duties in the Act. Includes: the NHS, local authorities, police forces, and the fire and rescue authorities, amongst others.

- Category 2 responder. A person or body listed in Part 3 of Schedule 1 to the Civil Contingencies Act. These are co-operating responders who are less likely to be involved in the heart of multi-agency planning work, but will be heavily involved in preparing for incidents affecting their sectors. The Act requires them to co-operate and share information with other Category 1 and 2 responders. Includes: utilities, railway operators and ports, amongst others.

(c) The NHS is a Category 1 responder. Among NHS Trusts, the ambulance services "have a distinct place within the multi-agency civil protection effort. As one of the emergency services, they are at the vanguard of emergency response."[7] The Cabinet Office guidelines

[4] Department of Health, *The NHS Emergency Planning Guidance* 2005*,* 12 October 2005, p.18, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4121236.pdf

[5] Cabinet Office, *Emergency Preparedness. Guidance on Part 1 of the Civil Contingencies Act 2004, its associated Regulations and non-statutory arrangements*, p.10, http://www.cabinetoffice.gov.uk/sites/default/files/resources/emergprepfinal.pdf

[6] Ibid., pp.19-23, 216.

[7] Ibid., p.20.

state that the local NHS should look to having a single representative in the LRF process in addition to the ambulance service[8].

3. 2012 Olympic and Paralympic Games

(a) A number of events are being hosted in the region – Olympic Road Cycling Race and Olympic Cycling Time Trial Race in Surrey and Paralympic road cycling at and around Brands Hatch[9]. As well as a residential training camp for visiting Olympic teams, there will be an athletes' village at the Royal Holloway College in Egham[10]. There will also be a number of related events occurring across the region.

(b) The 2012 Olympic Torch will stop off at Dover and Maidstone[11].

4. NHS Operating Framework

(a) *The Operating Framework for the NHS in England 2012/13* contained the following paragraph about "Emergency preparedness."[12]

- "Emergency preparedness, resilience and response across the NHS continues to be a core function of the NHS, required in line with the Civil Contingencies Act 2004. Accountability arrangements should be clear at all times throughout the transition and organisations must continue to test and review their arrangements. All NHS organisations are required to maintain a good standard of preparedness to respond safely and effectively to a full spectrum of threats, hazards and disruptive events, such as pandemic flu, mass casualty, potential terrorist incidents, severe weather, chemical, biological, radiological and nuclear incidents, fuel and supplies disruption, public health incidents and the 2012 Olympic and Paralympic Games. PCT commissioners must also ensure that they maintain the current capability and capacity of existing Hazardous Area Response Teams (HARTs) in ambulance trusts."

---

[8] Ibid., p.20.
[9] Go Surrey, http://www.gosurrey.info/about-us/news/
[10] NHS South East Coast, *NHS 2012 Olympic and Paralympic Planning and Preparation – update and SEC Planning Pack*, 28 September 2011, http://www.southeastcoast.nhs.uk/Downloads/Board%20Papers/28%20September%202011/75-11%20-%20NHS%202012%20Olympic%20and%20Paralympic%20Planning.pdf
[11] Kent County Council, http://www.kent.gov.uk/news_and_events/news_archive/2011/may_2011/olympic_torch_comes_to_kent.aspx
[12] Department of Health, *The Operating Framework for the NHS in England 2012/13*, 24 November 2011, p.21, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf

This page is intentionally left blank

NHS
Kent and Medway

KCC Health Overview and Scrutiny Meeting – 6 January 2012

Question 1	**How robust is NHS emergency resilience planning and preparedness in Kent?**
Answer to Question 1	Under the Civil Contingences Act 2004 (CCA) and the NHS Emergency Planning Guidance and underpinning material 2005 all NHS Trusts are required to prepare major incident response plans, business continuity plans. In additional all NHS Trusts are required to produce and issue specific plans for threats such as pandemic flu and Heatwave. As the lead government department for NHS Emergency Planning the Department of Health requires Strategic Health Authorities to provide assurance that these plans are in place, tested and fit for purpose. On behalf of the Strategic Health Authority the PCT Cluster conducts annual assurance surgeries which ensure the requirements of the Civil Contingences Act and the NHS guidance have been met. This process has demonstrated that each NHS Trust in Kent has exceeded the

	guidance to have plans in place and tested as required of the guidance. All NHS Trusts in the County are fully engaged with the Kent Resilience Forum which includes the emergency services and KCC amongst other partners. The forum is a platform for the statutory agencies to plan and exercise together ensuring the emergency response in Kent is fully intergraded.
Question 2	**What specific NHS plans exist to prepare for the 2012 Olympic and Paralympic Games?**
Answer to Question 2	The Kent Resilience Forum has a sub group dedicated to planning for the impact of the Olympics in Kent. With the full engagement of the NHS this group has produced a framework and plans which will be tested in a series of exercises in the run up to the Olympics.
Question 1a	**What are the main features of NHS Strategic Major Incident Response Plans in Kent?**
Answer to Question 1a	**Below is an extract from the introduction of the NHS Kent & Medway Strategic Major Incident Response Plan** **Scope of the Plan** 1. The Plan outlines the Strategic Major Incident response for the Kent and Medway PCT Cluster. 2. Tactical emergency response plans and operational procedures have been produced by NHS Provider Trusts to support these arrangements. 3. The Plan is split into two parts. Part One is the General Strategic Response Plan for the Kent and Medway PCT Cluster, including definitions and plan administration. Part

Two details site and hazard specific activation and response procedures. Though the two parts should be used in conjunction with each other, part two is designed to be useable by responders as a series of independent working documents, for use in specific Major Incident responses.

4. The plan recognises the importance of maintaining the continuity of the routine business of both the organisation and the NHS during and after a Major Incident. This is achieved through the creation of business continuity plans and specific contingency emergency plans.

Aim / Objectives of the Plan

1. The aim of the plan is to provide a coordinated, countywide, strategic NHS response to a Major Incident.

2. Specific objectives of the plan are:

- To ensure that arrangements are in place to respond effectively at a strategic level to any Major Incident, regardless of cause, in a planned and co-ordinated manner.
- To minimise the disruption to health and social care services
- To maintain effective communication with other health organisations and partner agencies
- To effectively manage and support health and social care providers to ensure optimum care and assistance is delivered to those affected by the incident
- To bring about a quick return to normal levels of

	functioning • To comply with requirements stipulated by the NHS Emergency Planning Guidance (2005) and the CCA (2004
Question 1b	**How are these plans produced, developed and Tested?**
Answer to Question 1b	Each NHS Trust produces a plan which is signed of by the Board and are tested in accordance with the NHS Guidance. Communications exercises are carried out every six months, a tabletop every year and a live exercise every three years. Post incident and post exercises reports are seen by the board.
Question 1c	**What are the main challenges to effective resilience planning by the NHS in Kent?**
Answer to Question 1c	In addition to the assurance process conducted internally the NHS enjoys a productive and positive relationship with all of our statutory partners through the KRF. We are confident that we will respond fully to any emergency that may arise in the County alongside our partners.
Question 2a	**What is the expected impact of the Olympic and Paralympic Games on Kent's health services' ability to deliver services as usual?**
Answer to Question 2a	Due to the planning process that the NHS is engaged with internally and with our partners within the KRF we have every confidence that there will be no discernable difference in the provision of NHS services from the point of view of our patients.
Question 2b	**What milestones and planning assumptions are Kent's health services working towards in preparing for the games?**

Answer to Question 2b	The NHS is working to the national planning assumptions as circulated by LOCOG and the DH. Specifically for Kent we are participating in the planning for the Olympic Torch Relay and the live events in the County.
Question 2c	**What are the resource implications for delivery health services during the Games and how will these be managed?**
Answer to Question 2c	Based on the data provided by the Public Health Observatory relating to the healthcare provision at previous Olympic games it is not anticipated that there will be any implications during the Games time that cannot be dealt with through normal operating procedures. The NHS has well rehearsed procedures for providing treatment to foreign nationals. It is not anticipated that there will be any problems presented by staff absence.
Question 2d	**What are the key issues facing Kent's health services in planning for the games over the remaining months prior to the games?**
Answer to Question 2d	All Kent Trusts are resourced for and engaged with all relevant planning platforms. We are confident in our ability to meet the planning demands between now and July 2012. We also have systems and process which will ensure that all staff are aware of any extraordinary activity that may be required before during or after the Olympic Games.
Question 3	**With regards both emergency resilience and Olympics planning, what features are unique to Kent contrast to other areas of the country?**
Answer to Question 3	Kent is the gateway to Europe. We have reviewed our specific response plans the Channel Tunnel and the Port of

	Dover and are fully engaged with the development of a plan for Ebbsfleet International. Kent is a major arterial route to the Olympics for domestic and foreign visitors to the Games, however, the NHS is confident that our well rehearsed plans and procedures place us in a strong position to deal with these challenges should the need arise.

KCC Health Overview and Scrutiny Meeting – 6 January 2012

Question 1	**How robust is NHS emergency resilience planning and preparedness in Kent?**
Answer to Question 1	South East Coast Ambulance Service (SECAmb) has legal responsibilities in this area defined by the Civil Contingencies Act (2004). Our compliance with these in addition to Department of Health guidance is regularly assured by the Strategic Health Authority. This assurance, coupled with joint working with health and other partners through the Kent Resilience Fora (KRF) ensures good internal and inter-agency resilience. Further assurance is provided through regular testing and exercising of single agency and inter-agency plans. These regular test specific capabilities and specific threats and risks against local and national priorities.
Question 1a	**What are the main features of NHS Strategic Major Incident Response Plans in Kent?**
Answer to Question 1a	Please refer to the separate submission made by NHS Kent and Medway.
Question 1b	**How are these plans produced, developed and Tested?**
Answer to Question 1b	Whilst SECAmb is consulted as a partner in this process and engages in regular inter-agency exercising which includes the testing of this plan I would refer you to the separate submission made by NHS Kent and Medway for the details of this process.
Question 1c	**What are the main challenges to effective resilience planning by the NHS in Kent?**
Answer to	Changes to the resilience structure both with the abolition of

Question 1c	regional government offices and the on-going changes within the health community are providing new challenges. Through a successful history of and on-going commitment to working closely with partner agencies and ensuring internal resilience within the health resilience community we are confident that we can both meet the challenges and make the best of these changes.
Question 2	**What specific NHS plans exist to prepare for the 2012 Olympic and Paralympic Games?**
Answer to Question 2	As well as engagement in KRF sub groups with a specific focus on the Olympic and Paralympic period and close working with event organisers for the Paralympic Cycling and Torch Relay events, SECAmb has an internal project board which meets on a monthly basis. This group reports to the Trust Risk Management Committee and provides regular briefings to the Board. The current focus within Kent, and nationally, is on ensuring a broad range of capabilities are available and tested to respond to a wide range of scenarios. At a strategic inter-agency level within Kent the focus is on building a framework which builds on embedded best practice. As planning continues over the next few months these capabilities will be dovetailed with the framework and operational plans to ensure an appropriate response to any scenario at any venue in Kent whether Olympic related or not.
Question 2a	**What is the expected impact of the Olympic and Paralympic Games on Kent's health services' ability to deliver services as usual?**
Answer to Question 2a	Though the period of the Games will by no means be business as usual, our planning builds on business as usual processes, experience from previous Games and other large events such as Tour de France as well as almost 2 years

	internal and inter-agency impact assessment and planning. Subject to the fulfilment of an outstanding funding bid to the Department of Health we are confident that mechanisms are in place to ensure that services are delivered as usual.
Question 2b	**What milestones and planning assumptions are Kent's health services working towards in preparing for the games?**
Answer to Question 2b	Externally a number of national and local resilience planning assumptions are in place for Games time. SECAmb is actively engaged in reviewing these in light of emerging intelligence and national changes. A number of external milestones provided by event organisers for the Paralympic cycling and Torch Relay events as well as internal project milestones are being used to measure progress, which is currently on track.
Question 2c	**What are the resource implications for delivery health services during the Games and how will these be managed?**
Answer to Question 2c	Ambulance services in the United Kingdom have a commitment to support a programme of National Pre-Planned Aid. This includes a commitment of 28 staff from across SECAmb for 3 weeks over the Olympics and around 15 staff for the Paralympics. These staff are drawn from across all 3 counties. In addition to this SECAmb has an, in principle, agreement to provide ambulance services to Olympic and Paralympic events occurring across the South East. In order to meet both of these requirements a leave restriction of 15% has been agreed for all areas of the Trust during the Olympics. This equates to approximately 50 operational members of staff and also increases the number of support staff to help with co-ordination functions. We are confident that this provides us with sufficient capacity to meet our existing demands and also our specific Games time resource

	demands.
Question 2d	**What are the key issues facing Kent's health services in planning for the games over the remaining months prior to the games?**
Answer to Question 2d	Though much of our internal planning is based upon regular communication to internal and external stakeholders we will need to ensure that this is increased significantly in the run up to the games so that all staff and external partners are aware of Games specific information. This work is underway and has a number of defined milestones within our Olympic project plan. Engagement is also taking place, through Visit Kent, with Games time training camps to ensure clarity of patient access to care for visiting athletes and in concert with Strategic Health Authorities to provide appropriate media messaging to international and UK visitors.
Question 3	**With regards both emergency resilience and Olympics planning, what features are unique to Kent contrast to other areas of the country?**
Answer to Question 3	Kent has a number of large transport hubs which are key access points for the Games. Well established relationships are being built upon to ensure appropriate support to increases in business as usual traffic and to understand any differences which may be required for incident response at these hubs during Games time. Kent is also a relatively late addition to the sporting venues, with Brands Hatch being one of the last venues announced. Again existing knowledge and relationships both at LOCOG and with local partners have allowed this planning to progress at the required pace to be on track for summer 2012.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 January 2012

Subject: Reducing Accident and Emergency Admissions: Preliminary Findings.

---

1. Background

(a) In the first part of 2011, the Health Overview and Scrutiny Committee of Kent County Council held a series of meetings into *NHS Financial Sustainability.* In the resulting report, the Committee undertook to carry out a series of further whole systems reviews focussing on some of the key areas impacting financial sustainability across the Kent health economy.

(b) On 14 October and 25 November, the HOSC began to carry out the first of these reviews, *Reducing Accident and Emergency Departments.* A third meeting, concentrating on mental health services, will take place early in 2012.

(c) 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?

(d) While recognising that the Committee has not completed its review, the appendix to this report sets out a number of draft preliminary findings.

2. Recommendation

That the Committee note the report.

Appendix

Reducing Accident and Emergency Admissions Review - Preliminary Findings.

1. All Trusts have acknowledged openly that reducing accident and emergency admissions is a major challenge for the health economy but that all sectors are committed to tackling it together.

2. There is more to how the NHS responds to urgent and emergency health care needs than accident and emergency departments and 999 ambulance calls – although these are, and will remain, very important.

3. However, while a sustainable reduction in the numbers attending accident and emergency departments and being admitted to hospital subsequently will require a range of different services and providers across the whole pathway, there is a need to ensure simplicity of access for patients.

4. The introduction of the non-emergency 111 number could be crucial to the above point and will need to be communicated effectively to the public.

5. A careful distinction needs to be made between systemic factors affecting the whole health economy, such as changes to the tariff, and local factors, such as the closure of services in neighbouring areas, in order to recommend appropriate solutions.

6. There needs to be a common understanding across the health economy over practicalities such as opening times of minor injury units and the services offered.

7. Any patient requiring urgent care shouldn't notice any difference when moving from one organisation to another, such as from a minor injuries unit to an A&E department, and different providers need to share information more efficiently and effectively.

8. The importance of the preventive health agenda and the role of the local authority through public health and the Health and Wellbeing Board cannot be underestimated.

9. The biggest challenge could be changing the culture that the accident and emergency department is the automatic default option for the public to choose.

10. Health commissioners, providers and scrutiny will need to monitor closely the way proposals around trauma networks, non-emergency numbers and so on develop in terms of effectiveness and unintended consequences.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 January 2012

Subject: Forward Work Programme

---

1. **Proposed Forward Work Programme.**

(a) 3 February 2012

i. Improving Outcomes for People with Dementia in East Kent.

ii. Reducing Accident and Emergency Admissions: Part 3: Mental Health Services.

iii. East Kent Hospitals NHS University Foundation Trust Clinical Strategy.

iii. East Kent Maternity Services Review: Written Update.

(b) 9 March

i. Partnership between Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust.

(c) 13 April

i. East Kent Maternity Services Review.

(d) Meeting dates for the rest of 2012.

- 1 June
- 20 July
- 7 September
- 12 October
- 30 November

2. Joint working with Medway:

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

3. Recommendation

That the Committee approve the proposed Forward Work Programme.