HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 20th July, 2012

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 20th July, 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 M V Snelling (Chairman), Mr C P Smith (Vice-Chairman), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr K A Ferrin, MBE, Mr L B Ridings, MBE, 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 A Allen, Councillor A Blackmore, 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 - 6)	10:00 – 10:05
5.	Dermatology Services (Pages 7 - 22)	10:05 – 11:05
6.	NHS Transition: Update (Pages 23 - 44)	11:05 – 11:50
7.	Not the Default Option: Responses (Pages 45 - 52)	11:50 – 11:55
8.	Forward Work Programme: Update (Pages 53 - 54)	11:55 – 12:00
9.	Date of next programmed meeting – Friday 7 September 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

12 July 2012

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, 1 June 2012.

PRESENT: Mr M V Snelling (Chairman), Mr C P Smith (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 K Smith, Mr A T Willicombe, Ann Allen, Cllr Mrs A Blackmore, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Cllr J Burden, Cllr J Cunningham, Cllr R Davison and Mr M J Vye

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest

Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting of 13 April 2012 are correctly recorded and that they be signed by the Chairman.

4. Forward Work Programme
(Item 5)

(1) The Chairman drew the Committee's attention to the Forward Work Programme contained within the Agenda pack and explained that it developed ideas put forward at the previous meeting in consultation with the Vice-Chairman and Group spokespersons, assisted by Committee Officers.

(2) One Member made a series of observations about the Committee's involvement with the substantive item of this meeting's Agenda, the East Kent Maternity Services Review. This involvement had lasted 18 months and Members had invested a lot of hours work on this subject. The question was raised as to whether the outcome which was to be achieved justified the time spent and a request made for a review of the process to be undertaken to provide lessons for the future.

(3) The Chairman undertook to work on such a review with Committee Officers.

(4) AGREED that the Committee approve the proposed Forward Work Programme.

5. East Kent Maternity Services Review
(Item 6)

Dr Sarah Montgomery (GP Clinical Commissioner), Lindsey Stevens (Head of Midwifery, East Kent Hospitals NHS University Foundation Trust), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), James Ransom (Lead Commissioner Maternity Services, NHS Kent and Medway), Sara Warner (Assistant Director Citizen Engagement, NHS Kent and Medway), Dr Neil Martin (Medical Director, East Kent Hospitals NHS University Foundation Trust), and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(a) The Chairman introduced the item and explained that the Committee had a combination of written updates and discussions on this item for over a year, along with individual members having got involved in the work between formal meetings. This was in addition to the valuable work of the HOSC Liaison Group. HOSC made no response to the consultation, though individual Members may have, and so has taken more of an overview/assurance role during the entire process. Both the Boards of NHS Kent and Medway and East Kent Hospitals NHS University Foundation Trust have made their decision, namely Option 1 on the consultation paper, and so it is for HOSC to consider this decision and express any further views.

(b) Colleagues attending from the NHS were welcomed and offered the opportunity to explain the decision which had been reached.

(c) NHS representatives began with outlining the four tests which service changes in the NHS had to meet. These tests were clinical evidence, support of GP commissioners, patient choice supported, and wider engagement, including the HOSC. The NHS locally believed that all four tests had been met along with five criteria they had set themselves.

(d) The first of these criteria was quality and safety, particularly in the context of the impact on safety at William Harvey Hospital given the increasing popularity of its birth centre, decreasing use of the standalone midwifery led units and 1.6% year on year increase in the birth rate. Achieving the standard of 1:1 midwife care during labour was non-negotiable. The second criteria was for services to be as accessible as possible so that there was more certainty around accessing hi-tech than lo-tech services. The third criterion was maintenance of choice, with the co-location of midwifery led units with consultant led units providing the optimum choice. Fourthly, the service needed to be sustainable in that it needed to be affordable and match a viable staff reconfiguration. Finally, it needed to ensure the safety of all women who need the service.

(e) NHS representatives explained that the three options in the consultation were developed when all these were put together. All three involved the opening of the midwifery led unit at the Queen Elizabeth the Queen Mother Hospital in Margate, with one option closing the birthing unit at Buckland Hospital, the

other closing the birthing unit at the Kent and Canterbury Hospital. Option 1, involving the closure of both, was approved by the Boards of both NHS Kent and Medway and East Kent Hospitals NHS University Foundation Trust. The public consultation had been wide ranging and the development of the consultation paper involved Members of the Committee. Greenwich University was asked to analyse the consultation results, with the conclusion that the criteria had been met. The emerging Clinical Commissioning Groups also supported Option 1.

(f) The Chairman then invited Mr Martin Vye to speak. Although not a Member of the Committee, Mr Vye had requested the opportunity to speak on this issue. He thanked the Chairman and explained that he was a County Councillor for Canterbury and was a founder member of CHEK (Concern for Health in East Kent). He observed that HOSC had not endorsed any option before, that there had been a lot of discussion and that while he had no problem with the consultation, he asked the Committee to defer making a decision. In support, the argument was given that the direction of travel in maternity services was away from hospitalisation and there was discussion about a home birth review. It had been shown that standalone midwifery led units were not unsafe and that although use had gone down, more could be done to promote their use. The level of use at Maidstone's unit was mentioned. The co-located midwifery led units were presented as the best option but this was not the experience of women at public meetings who spoke of a conveyor belt atmosphere. Option 1 would leave a hole knocked in the services in East Kent. A lot of effort had gone into the consultation, with a majority wishing to keep the standalone midwifery led unit at the Kent and Canterbury Hospital. There were questions around the £700k investment in terms of how much this was as a percentage of the overall budget and whether this investment was revenue or capital. It was also necessary to bear in mind the broader policy development which was taking place with GPs looking to upscale services and so would wish to offer Canterbury as a choice.

(g) NHS representatives responded to the questions arising from Mr Vye's comments and began by explaining that the investment accompanying each Option was over and above that received through the national tariff. The Primary Care Trust already paid the national rate and the additional money was to enable the safety critical ratio of 1:1 midwife to each birth. To ensure the plans were sustainable, the nationally recognised Birthrate+ planning tool was used. It was accepted that a small number, 11, preferred Option 2 over Option 1, but the consultation revealed other figures, such as a high level of support for service change as well as the intention of providing higher levels of care. On the issue of choice the argument was made that already 90% of births took place in consultant led or co-located midwifery led units. There were also clinical restrictions on choice. For example, midwifery led units were not as safe for women giving birth for the first time, with 40% being transferred. Home births were still being maintained and the risks were the same as for standalone midwifery led units.

(h) Members of the Committee made a number of points and comments. A number of comments related to the length and detail of the consultation and engagement process and it was commented that lessons had evidently been learnt from the process of changing women's and children's services in West

Kent. There was a measure of scepticism expressed by some Members as to how likely it was that Option 1 would not be the outcome at the end of the process, but it was also accepted that where safety was the driver and the natural constraints around staffing, Option 1 was the best option in the circumstances, even if there was no ideal Option. Members generally felt that there would be no benefit to deferring making a decision as deferral might bring more information but was unlikely to change the result or the reasoning. It was observed that one other major difference between the situation in East and West Kent was how united the GPs in East Kent were behind the proposals. In response to a specific question it was reported that at both Board meetings the discussion had been detailed and searching, but the decision was unanimous in both cases.

(i) More broadly, one Member expressed the view that this was another stage in the centralisation of services at Margate and Ashford which had been foreseen 20 years previously. This change, as well as the development of trauma services at William Harvey Hospital in Ashford, meant that travel times and accessibility were a real issue. This was a view shared consensually by the Committee. NHS representatives accepted this, but wished to point out that as labour could take 12 hours, there were unlikely to be any fathers driving dangerously to transport their partner to a hospital. A small number of babies were always born before arrival (bba) in a very quick delivery but this would happen however the services were reconfigured. The NHS offered to restart the East Kent Transport Group and/or work with other fora such as Locality Boards.

(j) In response to a specific question about planning capacity for the future, NHS representatives explained that data from colleagues in public health was used.

(k) In response to comments about the value of the consultation, NHS representatives informed the Committee that changes had already been made and others were planned in response to feedback received during the process. Post natal care in particular had been a focus for improvement. Midwifery Care Assistants were being trained to become post-natal specialists. This had the advantage of freeing up midwifery time, and where this change had been introduced, complaints about post-natal care had gone down. Drop in breastfeeding clinics running from 8-8 were also being introduced. It was hoped these changes got rid of the conveyor belt feeling reported by some in the past as well as improve post natal care and services.

(l) Members accepted that the proposals meant safer services for the majority, but that the minority should not be overlooked. One Member commented that in any communications and engagement plan it needed to be stressed that pre and post natal clinics were remaining in their current locations. NHS representatives explained that engagement at the heart of the process thus far and would continue to do so. Rolling out a consistent message was a key part.

(m) The Chairman of the Committee requested the Researcher to the Committee read out a possible recommendation:

- That the Committee note the decision to proceed with Option 1 and accepts the need to secure a safe and sustainable service, and requests an update

report in six months on the work which has been undertaken on improving access and engaging the affected communities and other ancillary issues, in discussion with the HOSC Liaison Group.

(n) Members broadly agreed with the proposed recommendation, but felt nine months would provide enough time to allow a meaningful report to be brought back to HOSC.

(o) NHS representatives were thanked for their attendance and the recommendation approved as amended.

(p) RESOLVED that the Committee note the decision to proceed with Option 1 and accepts the need to secure a safe and sustainable service, and requests an update report in nine months on the work which has been undertaken on improving access and engaging the affected communities and other ancillary issues, in discussion with the HOSC Liaison Group.

6. Date of next programmed meeting – Friday 20 July 2012 @ 10:00 am
(Item 7)

This page is intentionally left blank

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 20 July 2012

Subject: Dermatology Services

---

1. Background

(a) During its discussion on its Forward Work programme on 13 April, the Health Overview and Scrutiny Committee discussed informed related to the Orpington Health Services Project which had been circulated to Members.

(b) Dermatology was identified by Members as one service which was accessed from Orpington Hospital Services by a large number of Kent residents in 2010-11. This suggested there could be value in a wider review of dermatology services in Kent with a view to answering the following strategic question:

- Is access to dermatological services adequate and equitable across Kent?

(c) The questions submitted to NHS Kent and Medway and South London Healthcare Trust are contained in the appendix to this report.

2. Recommendation

That the Committee consider and note the report.

Appendix

(a) Questions submitted in advance to NHS Kent and Medway:

1. Please provide an overview of the kind of dermatological services available to patients within Kent and Medway at the following levels of care:

    a. Primary Care

    b. Intermediate Care

    c Secondary Care

    d. Tertiary Care.

2. What are the latest annual figures available for the estimated total number of patients in Kent accessing dermatological services at each of the above levels of service?

3. How many of these patients access services outside of Kent and Medway, where are these services located and what level of services are provided?

4. In addition, what is being done to enable self-care where appropriate?

5. The Committee has been informed that 3,223 people from West Kent attended dermatological services at Orpington Hospital in 2010-11. What work is being done to assess the impact on access to dermatological services for Kent residents as a result of the ongoing Orpington Health Services Project?

6. What work is being done, including work being undertaken with emerging Clinical Commissioning Groups, to develop dermatology services for Kent residents now and for the future?

(b) Questions submitted in advance to South London Healthcare NHS Trust:

1. Can you provide a summary of the Orpington Health Services Project, focussing on the current provision of dermatology services and how the provision of these is likely to change?

2. What work is being undertaken with NHS Commissioners in Kent over the impact of the Orpington Health Services Project on Kent residents accessing dermatology services at Orpington Hospital?

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

To: Health Overview and Scrutiny Committee

Subject: Dermatology Services Background Note

---

1. Introduction

(a) Dermatology is the branch of medicine dealing with the skin and its diseases. Depending on classification, dermatology deals with a complement of between 1,000 and 2,000 diseases.[1]

(b) Key Facts:

- Skin disease is the most prevalent disease in those under the age of 16 and the second most prevalent disease in adults.[2]
- Around 24% of patients presenting to a primary care professional have a skin disease with around 6.1% of these being referred to a specialist.[3]
- Dermatology clinics make up about 5% of specialist outpatient activity.[4]
- There were nearly 4,000 deaths from skin disease in 2005, with 1,817 of these due to malignant melanoma (nearly twice as many as cervical cancer).
- Skin cancer is the most common form of cancer in the UK and malignant melanoma incidence rates in Britain have more than quadrupled since the 1970s.[5]
- In 2005/6 it has been calculated that the total cost for providing care for people with skin disease in England and Wales was £1,819 million. Of this, GP consultations for skin disease cost about £395 million (4.4% of the General Medical Services Budget that year).[6]

---

[1] Centre for Evidence Based Dermatology, University of Nottingham, *Skin Conditions in the UK: a Health Care Needs Assessment*, 2009, p.6, http://www.nottingham.ac.uk/scs/documents/documentsdivisions/documentsdermatology/hcnaskinconditionsuk2009.pdf

[2] NHS Primary Care Commissioning, *Quality Standards for Dermatology*, July, 2011, Foreword, http://www.pcc.nhs.uk/quality-standards-for-dermatology

[3] Ibid., p.104

[4] Ibid

[5] NHS Primary Care Commissioning, *Quality Standards for Dermatology*, July, 2011, Foreword, http://www.pcc.nhs.uk/quality-standards-for-dermatology

[6] Centre for Evidence Based Dermatology, University of Nottingham, *Skin Conditions in the UK: a Health Care Needs Assessment*, 2009, p.28,

2. Services

(a) *Quality Standards for Dermatology* outlined the four levels of care for people with skin condition in the United Kingdom.

Level 1 – Self-Care/Self-Management.

- People manage their own condition, or do so with assistance of friends/family. Information is sourced from books, the internet, patient groups, other media, or community pharmacists.

Level 2 – Generalist Care/Primary Care

- First point of contact with GP, practice nurse, community dermatology nurse or pharmacist with special training in skin problems. GP acts as gatekeeper, referring patient to Level 3 where necessary.

Level 3 (a) - Intermediate Specialist Services/Intermediate Care.

- Specialist outreach services by consultants, dermatology specialist nurses, accredited GPs with a Special Interest (GPwSI) in dermatology, or accredited pharmacist with a special interest (PHwSI) in dermatology.

Level 3 (b) – Specialist Care/Secondary Care.

- Acute hospital setting. Consultant dermatologists, specialist registrars, dermatology specialist nurses, GPwSIs (accredited or in training).

Level 4 – Supra-Specialist Care/Tertiary Care.

- Consultant dermatologists/other care professionals with special skills in management of complex and/rare skin disorders.[7]

---

http://www.nottingham.ac.uk/scs/documents/documentsdivisions/documentsdermatology/hcnaskinconditionsuk2009.pdf

[7] Adapted from: NHS Primary Care Commissioning, *Quality Standards for Dermatology*, July, 2011, pp.48-9, http://www.pcc.nhs.uk/quality-standards-for-dermatology and Centre for Evidence Based Dermatology, University of Nottingham, *Skin Conditions in the UK: a Health Care Needs Assessment*, 2009, p.42, http://www.nottingham.ac.uk/scs/documents/documentsdivisions/documentsdermatology/hcnaskinconditionsuk2009.pdf

Dermatology provision

Please be assured that access to dermatology care within Kent and Medway is equitable to address all care needs. The model for service delivery is slightly different across each area in line with the development work undertaken within the three PCTs.

The west Kent clinical lead for dermatology undertook a clinical review of services in November 2011 and referral guidelines were reviewed by one of the west Kent General Practitioners with Special Interest (GPwSI) in January 2012. Medway reviewed services provision in 2010. Within east Kent a comprehensive review was undertaken in 2010 following a workshop which included patient representation across all localities. As a result the group proposed a new model of care model of care which was tendered through the Any Qualified Provider process.

East Kent

The model is composed of three elements which all work together to form an integrated service model. As a result patients have the choice of provider within a community service at their chosen location. In general the model is designed to support the following pathways:

- One stop assessment, diagnosis and treatment of new patients
- Education and strategies for patients with chronic conditions to support their ability to manage their own condition but with access to fast track review in the event of exacerbation
- Provision of nurse led helpline service for patients

The model was implemented in November 2011 with full implementation in January 2012. Leading up to this we also implemented training for GPs and as we were aware that over 60% of patients referred as a routine case for a pigmented skin lesions did not require treatment, we implemented a diagnostic service where patients have a dermascope image taken before referral. This is then sent to a consultant for review. This has had the following impact for the patients:

- Reduction in length of time between GP review and diagnosis from 13 weeks to 2 weeks
- Reduction in unnecessary visits to hospital when diagnosis is that no treatment is required
- Identification of patients with malignant melanoma who would previously have been referred as a routine patient

In regards to the Orpington model the commissioners are not aware of this service and have not specifically commissioned this provision. However patients have the right to choose as a service provider in line with Choose and Book.

Community Dermatology Providers in Kent

Clinical Commissioning Group (CCG)	Provider responsible	Location of service
Canterbury Group	Whitstable Medical Practice	Estuary View Medical Centre
Canterbury Group	East Kent Hospitals Foundation University Trust	University Medical Centre Bridge Surgery Queen Victoria Memorial Hospital St Anne's Surgery Northgate Surgery Kent & Canterbury Hospital Faversham Health Centre
Canterbury Group	The Practice	Newton Rd Surgery
Ashford	DMC	St Stephens Willesborough Health Centre
Ashford	Concordia	St Stephens
Ashford	Sydenham House Medical Centre	Sydenham House Surgery
Ashford	East Kent Hospitals Foundation University Trust	Willesborough Health centre
Thanet	East Kent Hospitals Foundation University Trust	East Cliff Surgery
Thanet	Concordia	Broadway Medical Centre
Thanet	The Practice	Minster Surgery
South Kent Coast	East Kent Hospitals Foundation University Trust	Deal Hospital Buckland Hospital Royal Victoria Hospital - Folkestone
South Kent Coast	Concordia	St Richard Surgery Oaklands Surgery Dover Medical centre
Swale	Medway NHs Trust	Sittingbourne Hospital Sheppey Community Hospital
Swale	Concordia	Minster Surgery Iwade Surgery
Swale	DMC	Sittingbourne Hospital Sheppey Community Hospital

West Kent

General practitioners have access to teledermatology as the first line service for non-malignant dermatology. The GP receives a diagnosis within 48hrs from first seeing the patient. The teledermatology service has the additional benefit of providing ongoing training and development for GPs leading to more selective referral patterns.

A range of second line provision is available to ensure patient choice and provision closer to home. The second line provision consists of:

- A GPwSI (GP with Special Interest) service located at Lamberhurst Surgery, Tonbridge Cottage Hospital and The Gateway, Tunbridge Wells.
- A consultant-led community service located at Tonbridge Cottage Hospital.
- Secondary care services are provided by Medway Foundation Trust at Maidstone Hospital, Medway Hospital, Sevenoaks Hospital, Darent Valley Hospital and at Borough Green Medical Practice.
- Secondary care provision available at the Princess Royal University Hospital (PRUH) assists with patient choice and provision closer to home.

Light therapy service provision was expanded in April 2011. Prior to this provision was only available at Orpington Hospital. Provision is now available at Benenden Hospital and at King's Hill Medical Centre in West Malling. The commissioners in west Kent are not aware of a particular Orpington model.

West Kent data does not support the statement that over 3000 patients are accessing Orpington hospital for dermatology. The data does show that over 3000 patient attendances take place annually at the South London Healthcare Trust with the majority occurring at the Princess Royal, Farnborough due to its convenient location for Sevenoaks patients. Over 700 attendances have been removed from the South London Healthcare Trust with the restructuring of the light therapy service in 2011 and these appointments are now provided closer to home (as described above).

Dermatology Services – Patient Activity

East Kent:

Between April 11 - March 12

Secondary care
- Inpatients - 4314
- Outpatients - 76831
- Total = 81145

Tertiary
- Inpatients – 242
- Outpatients - 8640
- Total = 8882

Between November 2011- May 2012
- Community providers 1882

West Kent:

Primary Care
- 2,678 patient attendances

Secondary Care
- 25,479 patient attendances

Tertiary Care
- 917 patient attendances

7,415 dermatological attendances took place outside of west Kent – 3,735 attendances were with south London hospitals and 3,680 attendances with other providers across the country including specialist services in tertiary centres.

Dermatology Service Model

East Kent

The model includes 3 elements:

- GP Advice and Guidance Scheme including the dermascope services
- Secondary care element for specialist services that require acute environment.
- Community locality hubs for delivery of remaining service

GP to GP Scheme

GPs are able to refer to the scheme for advice and guidance service which acts as an interface between GPs core practice and consultant assessment.

Secondary care element

Patients with the following conditions are referred into acute care**:**

- Rapid Access referral, diagnosis and treatment.
- Patients who require PUVA treatment
- Suspected connective tissue disorders
- Systemic illness with a rash
- Cutaneous vasculitis

Community service

These are consultant led services based within GP practices or community hospitals. The hubs are situated within larger practices and are supported by an integrated team. The range of providers is set out earlier in this report.

The service accommodates all dermatology patients with the exception of the above. However where patients have been assessed, diagnosed and commenced treatment within secondary care it is expected that on-going treatment is provided within the community service.

West Kent

Teledermatology

This service enables primary care clinicians access to secondary care diagnosis within 48 hours of the patient initially being seen. This means no waiting time for the patient to get a secondary care appointment. Allows the GP to act as a one stop shop for the patients non-malignant dermatology needs. This service has the additional benefit of providing training to the GPs with each of their patients acting as a case study.

Consultant-led community service located at Tonbridge Cottage Hospital

This provides a full dermatology service in a community setting offering choice and providing care closer to home.

GPwSI service located at Lamberhurst Surgery, Tonbridge Cottage Hospital and The Gateway, Tunbridge Wells.

This acts as a step up service for patients that may be beyond the competency of the GP to manage but do not need to access a full secondary care dermatology service. It also acts as a gateway to more complex services such as light therapy.

Secondary care services are provided at Maidstone Hospital, Medway Hospital, Sevenoaks Hospital, Darent Valley hospital and Borough Green Medical Practice.

This provides full secondary care service at multiple sites across west Kent.

Secondary care services at Princess Royal University Hospital.

Offers a full secondary care service and provides patients with an alternative provider to Medway Foundation Trust and therefore supporting patient choice.

SLHT Dermatology services

Dr Stephanie Munn
Clinical lead

Why do we need to change?

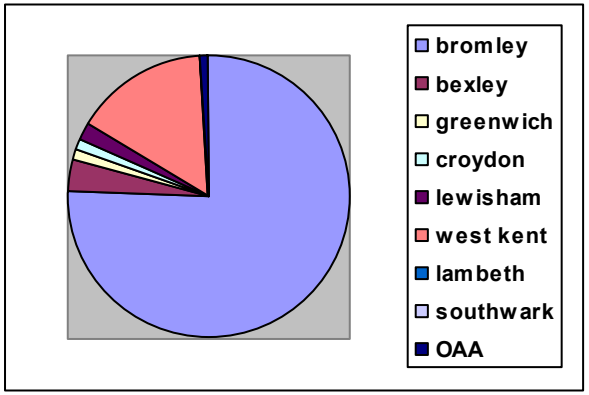
- Current accommodation not fit for purpose
- Commissioning intentions
- Changes in ways of working
- Opportunity to develop high class centre offering specialist treatments

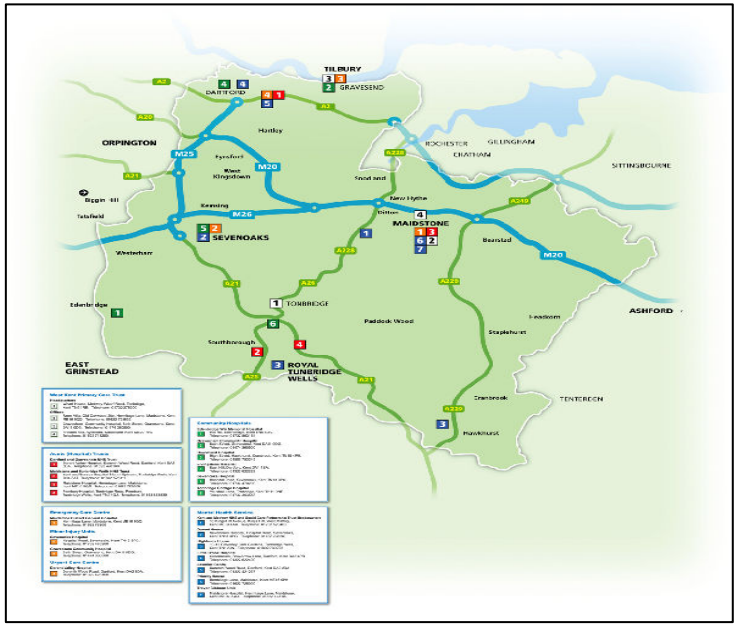
What are we aiming for

- Single Dermatology Hub for SLHT
- Spoke clinics
- Paeds allergy service
- Skin cancer treatments
- Day treatment unit
- Multidisciplinary working
- Cover for acute sites

West Kent dermatology

- None commissioned from SLHT
- Approx 630 news and 900 olds on PbR
- Medway main provider
- Community providers
- Phototherapy bid





Impact of moving Orpington dermatology department to QMS

- Better facilities for patients
- Possibly further to travel for some patients, but quicker road link
- Pooled expertise and multidisciplinary team – more services locally avoiding need to travel to London/East Grinstead for some patients
- Improved patient care

This page is intentionally left blank

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 20 July 2012

Subject: NHS Transition

---

1. Background

(a) The Health Overview and Scrutiny Committee has received periodic updates on the policy developments arising from the publication of the NHS White Paper, *Equity and Excellence: Liberating the NHS.*

(b) The current meeting is a chance to receive a further update and consider the following two strategic questions:

1. How are the policy proposals contained within the Health and Social Care Act 2012 being developed and implemented locally?

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

2. Recommendation

That the Committee consider and note the report.

This page is intentionally left blank

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

To: Health Overview and Scrutiny Committee, 20 July 2012

Subject: NHS Transition Year 2012/13: Background Note

---

1. Introduction.

(a) ***The Health and Social Care Act*** received Royal Assent on 27 March 2012. The intention is for the bulk of the statutory changes to come into effect on 1 April 2013. Although much preparatory work has been undertaken already, many details will only become apparent through the passage of secondary legislation and publication of guidance. Some of these will be preceded by further consultation documents.

(b) This Background Note looks to set out some of the main actions which will be taken over the next year to prepare for the transition.[1] It is not a detailed description of the new landscape.

2. Commissioning.

(a) Local commissioning will be largely the responsibility of ***Clinical Commissioning Groups (CCGs)*** covering a specific geographical area with identified GP member practices. The current estimate is for 212 across England. The size of the CCGs varies from Corby, with 6 practices and 67,800 population, and North, East, West Devon, with 130 practices and 901,200 population.[2]

(b) Maps of the proposed geographical boundaries for Clinical Commissioning Groups across England and South East England are appended to this note.[3]

(c) Most of the emerging CCGs have been established as sub-committees of Primary Care Trust (PCT) clusters with delegated responsibility for around 59% of their future commissioning budgets. This percentage will increase over the year.

(d) Before taking up full statutory powers and responsibilities in April 2013, CCGs need to be authorised by the ***NHS Commissioning Board***

---

[1] Information in this Background Note primarily sourced from: Department of Health, *The Month. March 2012*, http://www.dh.gov.uk/health/category/publications/bulletins/the-month/, except where indicated.

[2] Department of Health, *The Month June 2012*, p.6, http://www.dh.gov.uk/health/2012/06/the-month-55-june-2012/

[3] England map sourced from NHS Commissioning Board, http://www.commissioningboard.nhs.uk/files/2012/07/a3-ccg-proposed-boundaries.pdf; South East England map adapted from NHS Commissioning Board, http://www.commissioningboard.nhs.uk/files/2012/07/south-east.gif

(NCB, or the Board). The first wave of applications by emerging CCGs will occur in July 2012. The intention is for the initial round of assessments of emerging CCGs to be completed by January 2013. Where authorisation is subject to conditions, this will allow time for arrangements to be made.

(e) The NCB is also working with GP leaders on an 'assembly' as a way of effectively engaging all CCGs where joint working is needed. An agreed system will be in place by autumn 2012. A letter setting out further detail about the NHS Commissioning Assembly was published on 4 July 2012.[4]

(f) Most PCT clusters are developing ***commissioning support services (CSSs)*** in order to be able to offer a range of services to CCGs. A number of different models are being developed and a full business case will need to be completed by the end of August with the NCB taking decisions on the hosting of CSSs in October 2012. National offers are also being developed in: major clinical procurement; business support; business intelligence; and communications and engagement. On 14 May it was announced that the development of a national NHS Communications and Engagement Services had stopped and an alternative business model was being developed.[5]

(g) The NHS Commissioning Board was established as a special health authority (SpHA) in October 2011 and is leading the development of the new commissioning system. It will become an Executive Non-Departmental Public Body in October 2012 and begin preparatory work such as authorising CCGs. It will take on full statutory responsibilities in April 2013.

(h) The NCB will be organised into nine national directorates, four sub-national regions (mirroring current Strategic Health Authority (SHA) cluster areas) and a network of 27 Local Area Teams (LATs). There will be 1 LAT coterminous with Kent and Medway.[6] It will directly commission primary care services, specialised NHS services, offender health services, military health services, a number of public health services as well as having a role in emergency planning and quality assurance of NHS services.

(i) The NCB will also host a number of ***clinical networks and senates*** relating to different clinical areas and operating across a range of geographical areas. There will be a total of 12 senates, 1 will cover the

[4] http://www.commissioningboard.nhs.uk/files/2012/07/nhs-commissioning-assembly.pdf
[5] NHS Commissioning Board, *Commissioning Support Services: Outcome of Checkpoint 2*, 14 May 2012, http://www.commissioningboard.nhs.uk/2012/05/14/outcome-of-checkpoint-2/ See also, *Commissioning Support Bulletin Issue 3,* 9 July 2012, http://www.commissioningboard.nhs.uk/2012/07/09/cs-bulletin-issue3/
[6] NHS Commissioning Board: Local area teams, 20 June 2012, https://www.wp.dh.gov.uk/commissioningboard/files/2012/06/lat-senates-pack.pdf

South East Coast area, including Kent and Medway.[7] These will connect with the development of ***academic health science networks (AHSNs)*** and local education training boards (see section 7).

(j) On 4 July 2012, a consultation paper on the draft mandate for the NHS Commissioning Board was launched the same day as the Secretary of State for Health's Annual Report.[8,9] Under the Health and Social Care Act 2012, the Secretary of State will be required to publish an annual report each year (the duty formally comes in 1 April 2013). The Secretary of State will also set out a multi-year mandate for the NHS Commissioning Board; this will be refreshed annually.

3. Provision.

(a) As of the end of June 2012, there were 144 ***Foundation Trusts (FTs)***. The intention is that all NHS Trusts will become Foundation Trusts either in their own right, as part of an existing FT, or in another organisational form by April 2014.

(b) Those Trusts which are not yet FTs are having their performance assessed against milestones set out in Tripartite Formal Agreements (TFAs) agreed between the Trust, SHA, and Department of Health.

(c) The ***NHS Trust Development Authority (NTDA)*** will be established as a Special Health Authority in June 2012 to be able to take on the responsibility for overseeing NHS Trusts from April 2013.[10]

(d) By September 2012, patients will be able to choose from ***Any Qualified Provider (AQP)*** in at least three locally selected community and/or mental health services. In Kent and Medway, the following services were selected: diagnostic tests closer to home, musculo-skeletal services for back and neck pain and primary care psychological therapies for adults.[11]

(e) To qualify as providers under AQP, there is a national qualification process where prospective providers must show they can meet NHS quality and other standards. Prices are fixed with national or local tariffs.

(f) From 2013/14, the NCB and CCGs will determine which services to open up to AQP.

---

[7] Ibid.
[8] Department of Health, *Consultation on new care objectives for improving health and healthcare*, 4 July 2012, http://www.dh.gov.uk/health/2012/07/consultation-objectives/
[9] Department of Health, Secretary of State's Annual Report 2011/12, 4 July 2012, http://www.dh.gov.uk/health/files/2012/07/Secretary-of-State's-Annual-Report-2011-2012.pdf
[10] See NHS Trust Development Authority website for further information, http://www.ntda.nhs.uk/about/
[11] NHS Kent and Medway Cluster Board Minutes, 28 September 2011, Item 8, http://www.westkentpct.nhs.uk/PCT_Board_Meetings/28_September_2011/index.html

(g) The Health and Social Care Act sets out a framework for the regulation of the healthcare sector. One of the key features is joint working between ***Monitor***, the ***Care Quality Commission (CQC)*** and NCB.

4. Health and Wellbeing Boards.

(a) Most upper tier and unitary authority areas have established a ***Health and Wellbeing Board (HWB)*** in shadow form. HWBs will bring together elected representatives, CCGs, social care, public health, HealthWatch and others (including the NCB where appropriate). It will take on its statutory role formally from 1 April 2013.

5. HealthWatch.

(a) ***HealthWatch England (HWE)*** will begin operating from October 2012 and will be a statutory committee of the CQC. Local ***HealthWatch (HW)*** will be commissioned by the upper tier/unitary authority to operate from April 2013. HW will support public involvement in the commissioning and provision of local health services. It may also provide NHS complaints advocacy services if commissioned. A range of different models are being developed.

6. Public Health.

(a) ***Public Health England (PHE)*** will be established as an executive agency of the Department of Health (DH) and will have the three key business functions of delivering a nationwide health protection service, supporting local public health services and supporting the public in making healthier choices. It will take on its full statutory role from April 2013. Duncan Selbie, currently Chief Executive of Brighton & Sussex University Hospitals NHS Trust, was named chief executive designate on 5 April 2012.[12] Mr Selbie took up his role in July 2012 and a *Vision for Public Health* was published on 6 July.[13]

(b) PHE will have a national office and four regional sectors to match those of the NCB. It will also have local units to support local authorities.

(c) From April 2013, upper tier and unitary authorities will have a ring fenced grant in order to undertake their new public health functions. Aside from being required to provide a small number of mandatory services, ***local authorities*** will be able to set their own priorities but are required to have regard to the Public Health Outcomes Framework. Work has been undertaken on estimating future funding for local authority public health functions: of £5.2 billion estimated NHS spend on public health services in 2012/13, £2.2 billion will be spent on services which fall under future local authority responsibilities. Recommendations from the ***Advisory Committee on Resource***

[12] http://mediacentre.dh.gov.uk/2012/04/05/duncan-selbie-chief-exec-designate-phe/
[13] Department of Health, http://healthandcare.dh.gov.uk/vision-phe/

Allocation (ACRA) about how future allocations will be determined, and details of the actual allocations local authorities will receive in 2013/14, will be published by the end of the year.[14]

(d) ***Directors of Public Health*** will have chief officer status in the local authority and will be appointed by local authorities acting jointly with PHE. They will produce an annual report on the health of the local population.

7. Education and Training.

(a) ***Health Education England (HEE)*** will be established as a special health authority in June 2012, taking on some functions in October 2012 and assuming full operational responsibility from 1 April 2013. It will plan for the medium and long term development of the healthcare workforce. It will also provide oversight for the work of the ***local education and training boards (LETBs).*** Shadow LETBs will be set up as SHA committees from April 2012 in preparation for authorisation by HEE from October 2012.

8. Health Research.

(a) ***The Health Research Authority (HRA)*** was established as a special health authority in December 2011. Its organisational form will develop in 2012/13 (becoming a non-departmental public body) and it will take on further functions from April 2013. It is responsible for protecting and promoting the interest of patients and the public in health research.

9. Workforce.

(a) Much in the way of movement of people between organisations has already occurred and the overall aim is for all affected staff to know their futures by December 2012.

(b) During May and June 2012, very senior management appointments will be made to the NHS Commissioning Board Authority and commissioning support services. From July to December the remaining phases will be completed.

10. Informatics.

(a) From April 2013 (and following the ending of the National Programme for IT (NPfIT)), NHS Connecting for Health will be replaced with a new delivery function to ensure that though providers will be able to purchase and implement their own IT solutions, there will be standards set by the NCB or Secretary of State to ensure health and social care

[14] An update on public health funding for local authorities was published on 14 June, http://www.dh.gov.uk/health/2012/06/ph-funding-la/

information can be shared securely. This delivery function may be housed in the ***Health and Social Care Information Centre.***

(b) An information strategy was published by the Department of Health on 21 May 2012.[15]

11. Property and Estates.

(a) The intention to create ***NHS Property Services Ltd*** as a company wholly owned by the Secretary of State was set out in January 2012. It will take ownership and manage those parts of the existing PCT estate which does not transfer to NHS providers. Details are to be worked out in the coming months.

12. Shared Services.

(a) Shared services for new national organisations - NCB, PHE, NTDA, HEE and LETBs - are being developed in preparation for April 2013: finance and accounting; human resources and payroll; procurement; and communications.

13. Emergency Resilience.

(a) Existing organisations remain responsible for emergency preparedness, resilience and response (EPRR) during the transition year. There will be a revised system placing clear duties on the NCB and NHS funded organisations implemented by April 2013 and will include the development of ***local health resilience partnerships (LHRPs).***

14. Quality and Safety.

(a) The ***National Quality Board (NQB)*** is a multi-stakeholder board set up to champion quality across the NHS. It set out requirements for SHAs and PCTs to produce handover documents for their successor organisations. A series of further guides on maintaining quality through the transition will also be produced.

(b) In May 2012, the NQB published *How To: Maintain Quality during the Transition: preparing for handover*. This focussed on setting out details for the preparation of handover documents on quality. PCT Clusters are to submit these to their SHA Cluster by 23 June 2012, with the SHA Clusters submitting their own by 30 June 2012. These documents are to be updated and sent to the relevant successor organisations, who will receive them formally at their first public meetings.[16]

[15] http://www.dh.gov.uk/health/2012/05/information-strategy/
[16] Department of Health, National Quality Board, 17 May 2012, *How To: Maintain Quality during the Transition: Preparing for handover*, http://www.dh.gov.uk/health/files/2012/05/Preparing-for-Handover.pdf

(c) On behalf of the NQB, the National Quality Team is working on how the new system will respond to the lessons of Mid Staffordshire and a report will be produced setting out the roles and responsibilities with regards to quality from April 2013. The forthcoming report of the ***public inquiry into Mid Staffordshire***, led by Robert Francis, will contain recommendations that all NHS boards will need to consider.

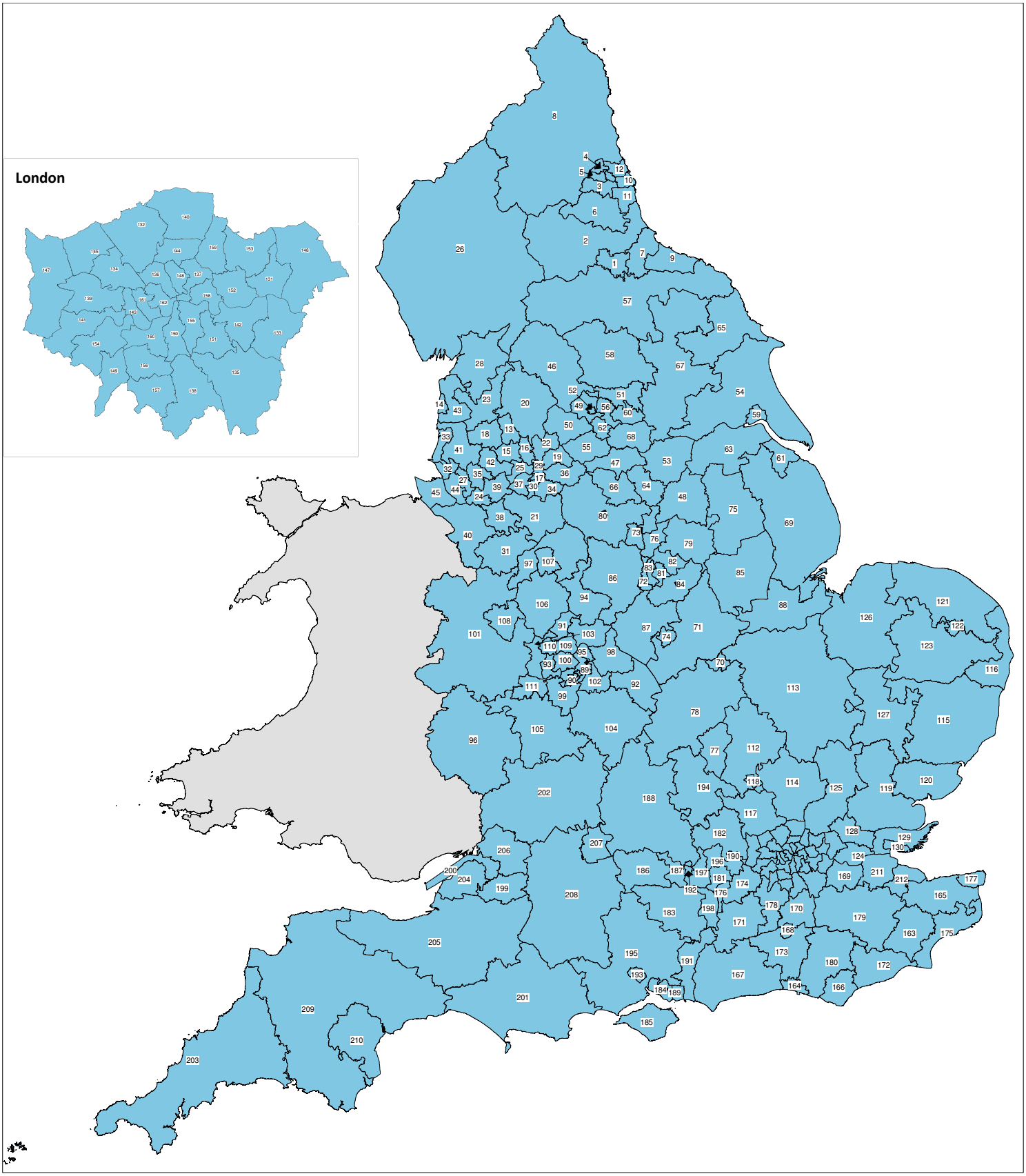
15. Planning for 2013/14

(a) In the autumn of 2012, the NCB and DH will agree the first mandate setting out the expectation for the NHS for 2013/14. The NCB will then issue allocations and planning guidance for 2013/14 to CCGs. As noted above, a consultation on the draft mandate was launched on 4 July 2012.

(b) CCGs will take the lead on planning for 2013/14 in the second half of 2012/13. The NCB will support CCGs in this and agree plans for those services it will commission directly. The NTDA will oversee NHS Trust plans.

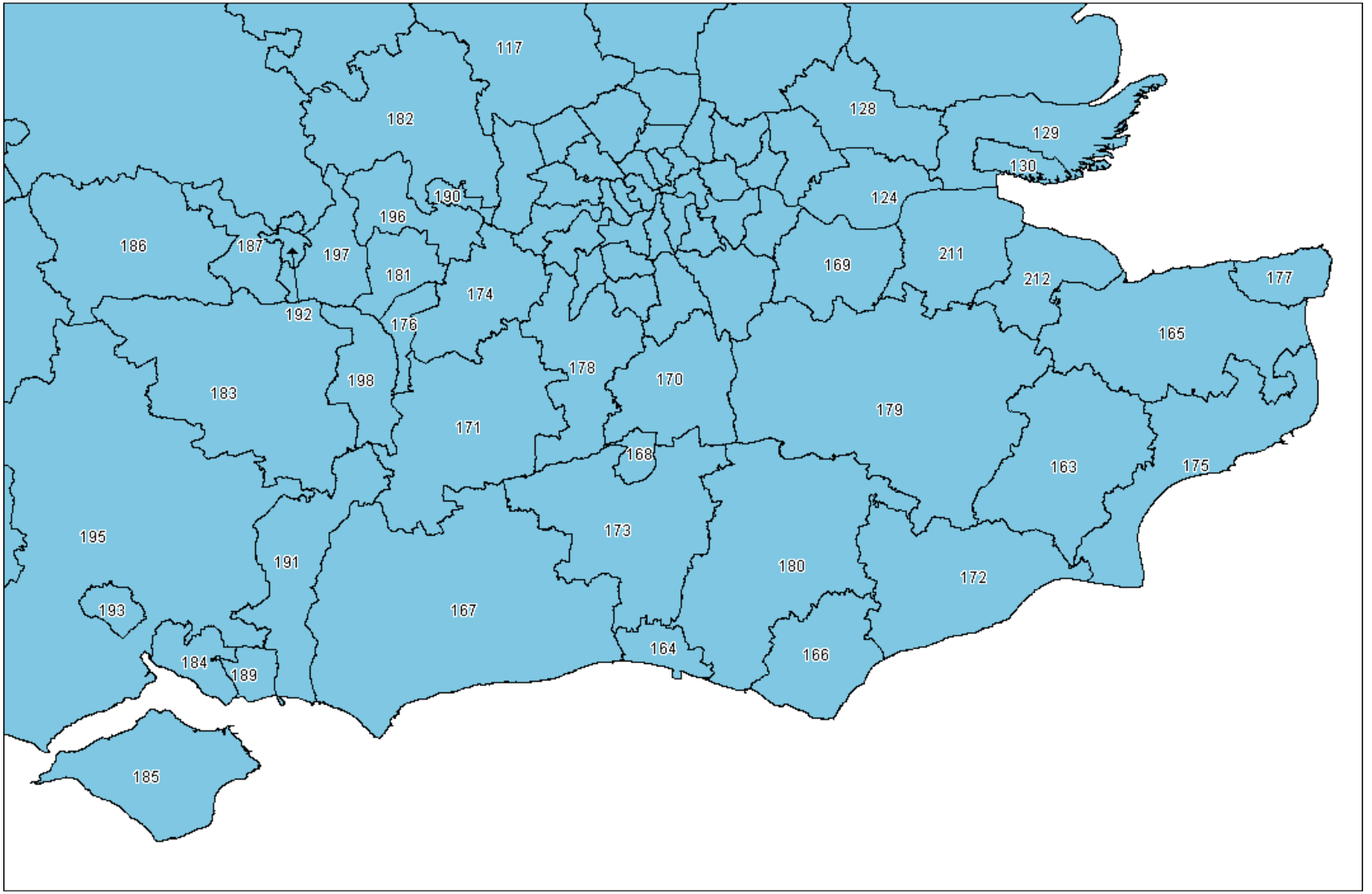
(c) SHA and PCT clusters remain accountable up to and including 31 March 2013.

This page is intentionally left blank


London

CCG code	CCG Name
00C	1. NHS Darlington CCG
00D	2. NHS Durham Dales, Easington and Sedgefield CCG
00F	3. NHS Gateshead CCG
00G	4. NHS Newcastle North and East CCG
00H	5. NHS Newcastle West CCG
00J	6. NHS North Durham CCG
00K	7. NHS Hartlepool and Stockton-on-Tees CCG
00L	8. NHS Northumberland CCG
00M	9. NHS South Tees CCG
00N	10. NHS South Tyneside CCG
00P	11. NHS Sunderland CCG
99C	12. NHS North Tyneside CCG
00Q	13. NHS Blackburn with Darwen CCG
00R	14. NHS Blackpool CCG
00T	15. NHS Bolton CCG
00V	16. NHS Bury CCG
00W	17. NHS Central Manchester CCG
00X	18. NHS Chorley and South Ribble CCG
00Y	19. NHS Oldham CCG
01A	20. NHS East Lancashire CCG
01C	21. NHS Eastern Cheshire CCG
01D	22. NHS Heywood, Middleton & Rochdale CCG
01E	23. NHS Greater Preston CCG
01F	24. NHS Halton CCG
01G	25. NHS Salford CCG
01H	26. NHS Cumbria CCG
01J	27. NHS Knowsley CCG
01K	28. NHS Lancashire North CCG
01M	29. NHS North Manchester CCG
01N	30. NHS South Manchester CCG
01R	31. NHS South Cheshire CCG
01T	32. NHS South Sefton CCG
01V	33. NHS Southport and Formby CCG
01W	34. NHS Stockport CCG
01X	35. NHS St Helens CCG
01Y	36. NHS Tameside and Glossop CCG
02A	37. NHS Trafford CCG
02D	38. NHS Vale Royal CCG
02E	39. NHS Warrington CCG
02F	40. NHS West Cheshire CCG
02G	41. NHS West Lancashire CCG
02H	42. NHS Wigan Borough CCG
02M	43. NHS Fylde & Wyre CCG
99A	44. NHS Liverpool CCG
12F	45. NHS Wirral CCG
02N	46. NHS Airedale, Wharfedale and Craven CCG
02P	47. NHS Barnsley CCG
02Q	48. NHS Bassetlaw CCG
02R	49. NHS Bradford Districts CCG
02T	50. NHS Calderdale CCG
02V	51. NHS Leeds North CCG
02W	52. NHS Bradford City CCG
02X	53. NHS Doncaster CCG
02Y	54. NHS East Riding of Yorkshire CCG
03A	55. NHS Greater Huddersfield CCG
03C	56. NHS Leeds West CCG
03D	57. NHS Hambleton, Richmondshire and Whitby CCG
03E	58. NHS Harrogate and Rural District CCG
03F	59. NHS Hull CCG
03G	60. NHS Leeds South and East CCG
03H	61. NHS North East Lincolnshire CCG
03J	62. NHS North Kirklees CCG
03K	63. NHS North Lincolnshire CCG
03L	64. NHS Rotherham CCG
03M	65. NHS Scarborough and Ryedale CCG
03N	66. NHS Sheffield CCG
03Q	67. NHS Vale of York CCG
03R	68. NHS Wakefield CCG
03T	69. NHS Lincolnshire East CCG
03V	70. NHS Corby CCG
03W	71. NHS East Leicestershire and Rutland CCG
03X	72. NHS Erewash CCG
03Y	73. NHS Hardwick CCG
04C	74. NHS Leicester City CCG
04D	75. NHS Lincolnshire West CCG
04E	76. NHS Mansfield & Ashfield CCG
04F	77. NHS Milton Keynes CCG
04G	78. NHS Nene CCG
04H	79. NHS Newark & Sherwood CCG
04J	80. NHS North Derbyshire CCG
04K	81. NHS Nottingham City CCG
04L	82. NHS Nottingham North & East CCG
04M	83. NHS Nottingham West CCG
04N	84. NHS Principia - Rushcliffe CCG
04Q	85. NHS South West Lincolnshire CCG
04R	86. NHS Southern Derbyshire CCG
04V	87. NHS West Leicestershire CCG
99D	88. NHS South Lincolnshire CCG
04W	89. NHS Birmingham Cross City CCG
04X	90. NHS Birmingham South and Central CCG
04Y	91. NHS Cannock Chase CCG
05A	92. NHS Coventry and Rugby CCG
05C	93. NHS Dudley CCG
05D	94. NHS East Staffordshire CCG
05E	95. NHS North East Birmingham CCG
05F	96. NHS Herefordshire CCG
05G	97. NHS North Staffordshire CCG
05H	98. NHS Warwickshire North CCG
05J	99. NHS Redditch and Bromsgrove CCG
05L	100. NHS Sandwell and West Birmingham CCG
05N	101. NHS Shropshire CCG
05P	102. NHS Solihull CCG
05Q	103. NHS South East Staffs and Seisdon Peninsular CCG
05R	104. NHS South Warwickshire CCG
05T	105. NHS South Worcestershire CCG
05V	106. NHS Stafford and Surrounds CCG
05W	107. NHS Stoke on Trent CCG
05X	108. NHS Telford & Wrekin CCG
05Y	109. NHS Walsall CCG
06A	110. NHS Wolverhampton CCG
06D	111. NHS Wyre Forest CCG
06F	112. NHS Bedfordshire CCG
06H	113. NHS Cambridgeshire and Peterborough CCG
06K	114. NHS East and North Hertfordshire CCG
06L	115. NHS Ipswich and East Suffolk CCG
06M	116. NHS Great Yarmouth & Waveney CCG
06N	117. NHS Herts Valleys CCG
06P	118. NHS Luton CCG
06Q	119. NHS Mid Essex CCG
06T	120. NHS North East Essex CCG
06V	121. NHS North Norfolk CCG
06W	122. NHS Norwich CCG
06Y	123. NHS South Norfolk CCG
07G	124. NHS Thurrock CCG
07H	125. NHS West Essex CCG
07J	126. NHS West Norfolk CCG
07K	127. NHS West Suffolk CCG
99E	128. NHS Basildon and Brentwood CCG
99F	129. NHS Castle Point, Rayleigh and Rochford CCG
99G	130. NHS Southend CCG
07L	131. NHS Barking & Dagenham CCG
07M	132. NHS Barnet CCG
07N	133. NHS Bexley CCG
07P	134. NHS Brent CCG
07Q	135. NHS Bromley CCG
07R	136. NHS Camden CCG
07T	137. NHS City and Hackney CCG
07V	138. NHS Croydon CCG
07W	139. NHS Ealing CCG
07X	140. NHS Enfield CCG
07Y	141. NHS Hounslow CCG
08A	142. NHS Greenwich CCG
08C	143. NHS Hammersmith and Fulham CCG
08D	144. NHS Haringey CCG
08E	145. NHS Harrow CCG
08F	146. NHS Havering CCG
08G	147. NHS Hillingdon CCG
08H	148. NHS Islington CCG
08J	149. NHS Kingston CCG
08K	150. NHS Lambeth CCG
08L	151. NHS Lewisham CCG
08M	152. NHS Newham CCG
08N	153. NHS Redbridge CCG
08P	154. NHS Richmond CCG
08Q	155. NHS Southwark CCG
08R	156. NHS Merton CCG
08T	157. NHS Sutton CCG
08V	158. NHS Tower Hamlets CCG
08W	159. NHS Waltham Forest CCG
08X	160. NHS Wandsworth CCG
08Y	161. NHS West London (K&C & QPP) CCG
09A	162. NHS Central London (Westminster) CCG
09C	163. NHS Ashford CCG
09D	164. NHS Brighton & Hove CCG
09E	165. NHS Canterbury and Coastal CCG
09F	166. NHS Eastbourne, Hailsham and Seaford CCG
09G	167. NHS Coastal West Sussex CCG
09H	168. NHS Crawley CCG
09J	169. NHS Dartford, Gravesham and Swanley CCG
09L	170. NHS Esydoc CCG
09N	171. NHS Guildford and Waverley CCG
09P	172. NHS Hastings & Rother CCG
09X	173. NHS Horsham and Mid Sussex CCG
09Y	174. NHS North West Surrey CCG
10A	175. NHS South Kent Coast CCG
10C	176. NHS Surrey Heath CCG
10E	177. NHS Thanet CCG
99H	178. NHS DEEMMS CCG
99J	179. NHS West Kent CCG
99K	180. NHS High Weald Lewes Havens CCG
10G	181. NHS Bracknell and Ascot CCG
10H	182. NHS Chiltern CCG
10J	183. NHS North Hampshire CCG
10K	184. NHS Fareham and Gosport CCG
10L	185. NHS Isle of Wight CCG
10M	186. NHS Newbury and District CCG
10N	187. NHS North & West Reading CCG
10Q	188. NHS Oxfordshire CCG
10R	189. NHS Portsmouth CCG
10T	190. NHS Slough CCG
10V	191. NHS South Eastern Hampshire CCG
10W	192. NHS South Reading CCG
10X	193. NHS Southampton CCG
10Y	194. NHS Aylesbury Vale CCG
11A	195. NHS West Hampshire CCG
11C	196. NHS Windsor, Ascot and Maidenhead CCG
11D	197. NHS Wokingham CCG
99M	198. NHS North East Hampshire and Farnham CCG
11E	199. NHS Bath and North East Somerset CCG
11H	200. NHS Bristol CCG
11J	201. NHS Dorset CCG
11M	202. NHS Gloucestershire CCG
11N	203. NHS Kernow CCG
11T	204. NHS North Somerset CCG
11X	205. NHS Somerset CCG
12A	206. NHS South Gloucestershire CCG
12D	207. NHS Swindon CCG
99N	208. NHS Wiltshire CCG
99P	209. NHS North, East, West Devon CCG
99Q	210. NHS South Devon and Torbay CCG
09W	211. NHS Medway CCG
10D	212. NHS Swale CCG

Clinical Commissioning Groups in South East England – Proposed Geographical Boundaries



This page is intentionally left blank

NHS
Kent and Medway

NHS Transition - update

1. Introduction

(a) On the 9th September 2011 the Kent Health and Overview Committee were provided with an update from the Kent and Medway PCT Cluster on the approach to delivering the reforms.
(b) The early paper described the systems and processes in place to ensure the successful establishment of the new commissioning architecture such that it can accelerate the improvements in health and healthcare outcomes for the population of Kent and Medway.
(c) This update and briefing paper will describe the progress through application of the programme and will confirm the new architecture and measures are in place to ensure the continuity and quality of care for the residents of Kent.

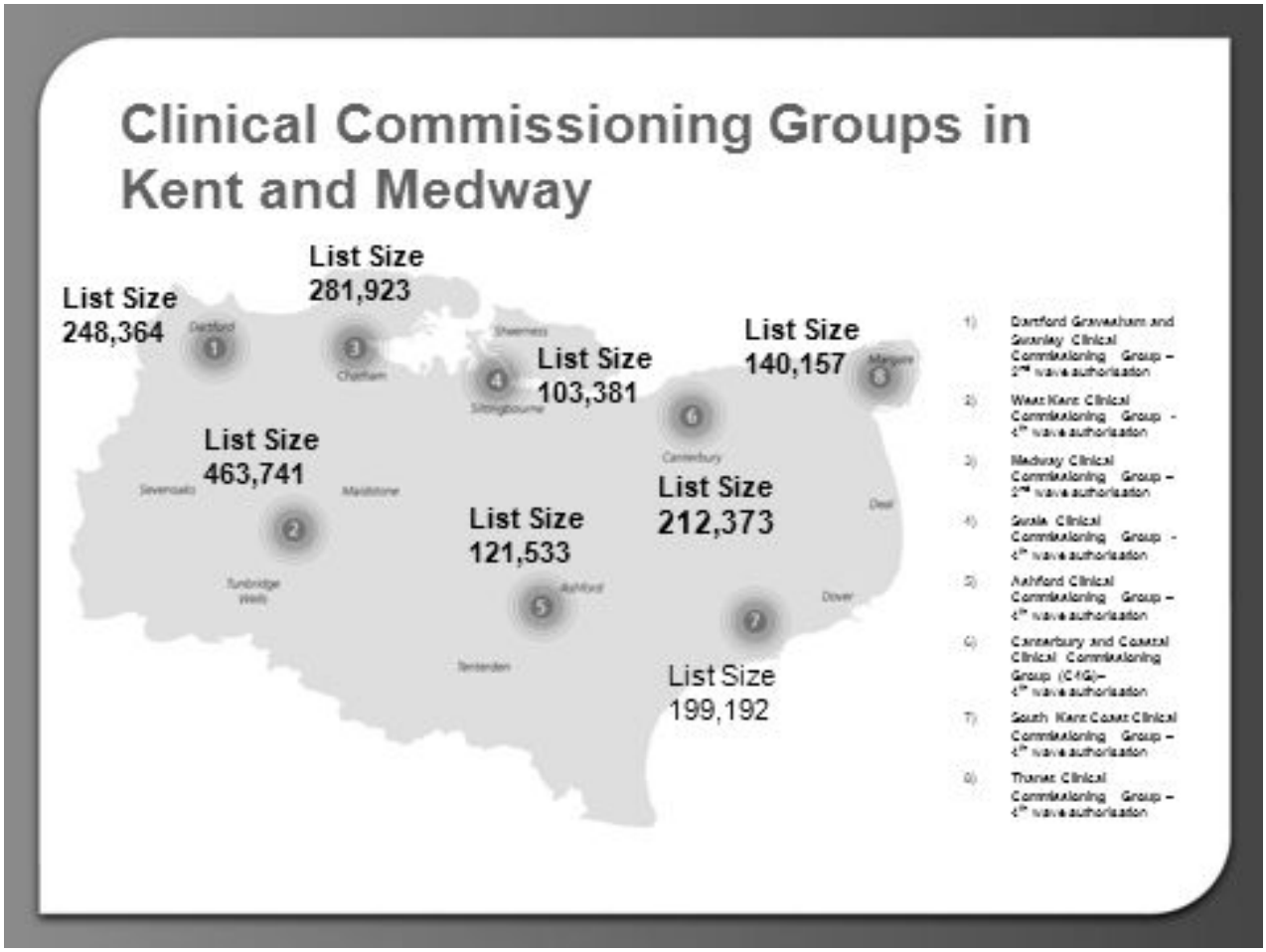
2. Clinical Commissioning Groups (CCGs)

(a) The Kent and Medway Cluster has been supporting the development of eight CCGs across Kent and Medway. Since September 2011 the Kent and Medway PCT Cluster has worked with the emergent CCGs to address the following key priorities:

September 2011	Formal constitution of the Commissioning Development and Transition Committee as a subcommittee of the PCT Cluster Board to oversee transition and reform programme.
October 2011	Commence alignment of PCT cluster staff to CCGs to shift commissioning delivery
November 2011	Completion of a national configuration risk assessment to help CCGs understand whether their current proposed arrangements were likely to meet the criteria defined in the Health and Social Care Bill.
December 2011	Confirmation of the eight emergent CCGs and the membership profile (table 1)
January 2012	The completion and submission of emergent CCG organisation development plans. CCG Leads participate in the shadow Kent Health and Wellbeing Board meeting

February 12	Kent and Medway Cluster hosted a simulation based, whole system event called 'Testing the Circuits'. The purpose was to test out how the new structures and processes for health and social care and wellbeing will operate, identify any potential risks and establish what further development work might need to be undertaken to address them.
March 12	The cluster confirmed the Scheme of Delegation through a Memorandum of Understanding whereby a percentage of the commissioning budget is delegated to each CCG. It included the setting up of all eight CCGs as sub committees of the current Cluster board from April 2012 to April 2013.
April 2012	An authorisation readiness review is undertaken in partnership with the SHA. CCG committees confirm their commissioning intentions as part of the Annual Operating Plan and commence detailed planning of delivery of commissioning intentions for 2012/13. CCG Clinical Leads begin to describe the services and functions that would be bought from commissioning support services.
May 2012	National decision on the authorisation wave applications with confirmation that Dartford Gravesham and Swanley and Medway CCGs would make authorisation applications for wave 2 (September 2012) and West Kent, Ashford, Swale, Canterbury and Coastal, Thanet and South Kent Coast would make applications for wave 4 (November 2012). Development and implementation of CCG constitutions and governance arrangements, including elections and recruitment of board members
June 2011	CCGs commence recruitment to senior officer posts of Accountable Officer and Chief Financial Officers

Table 1



(b) Over the last ten months clinical leads and their board membership have continued to develop the principle of the governing body through practice membership. In addition the clinical leads have been developing relationships with local authority partners to understand the key priorities for their community.

(c) Each CCG has identified clinicians to work closely with health providers to agree contract terms and now meet regularly with providers to consider performance and quality of care based on those contract terms. These individual performance meetings form part of the overall assessment of healthcare delivery and performance which are summarised at the Integrated Care Board.

(d) Current work is focussing on the collaboration of Kent and Medway clinical leads to consider the strategic view of current investment and outcomes to inform the development of the next iteration of the annual operating plans. The intention is that this early work will inform the Kent and the Medway strategic health and wellbeing strategies.

(e) A further 'Testing the Circuits' whole system event is planned for October which will concentrate on the provider perspective in

negotiating the new commissioning landscape and specific relationships between public health, CCGs and the health and wellbeing boards.

(f) All CCGs are working toward full authorisation without conditions; Medway CCG and Dartford, Gravesham and Swanley CCG are in wave 2 and have a detailed programme of work and evidence that will demonstrate competence and clear track record at submission in September 2012. The remaining CCGs are also preparing detailed plans that will ensure full authorisation.

Commissioning Support Services

(a) The Kent and Medway Cluster Board has confirmed the intention to establish a commissioning support service to be named Kent and Medway Commissioning Support (KMCS).

(b) The KMCS has submitted their outline business case to the Department of Health Business Development Unit which successfully passed checkpoint 2. Work is underway to prepare a full business case through a due diligence assurance process. Teams are currently describing their detailed offer of services for CCGs and other potential customers.

(c) An interim management team has been appointed and the outcome of the national recruitment process for the Managing Director role is awaited.

(d) Teams are working closely with CCGs to maintain the current delivery plan. Specific projects are being supported within CCG localities to underpin the delivery of the QIPP programmes.

NHS Commissioning Board

(a) The Department of Health and shadow Commissioning Board have been working with SHA and PCT Cluster to agree the final arrangements for NHS Commissioning Board (NHSCB) local area teams (LAT). There will be 27 local area teams, with local staff of the operations directorate working from a number of office bases across their geographical area.

- North of England: 9 local area teams
- London: 3 local area teams
- Midlands and East: 8 local area teams
- South of England: 7 local area teams (table 2)

(b) All LATs will have the same core functions around; CCG development and assurance; emergency planning, resilience and response; quality and safety; partnerships; configuration and system oversight. All LATs will take on direct commissioning responsibilities for GP services,

dental services, pharmacy and certain aspects of optical services, in addition:

- 10 local area teams will lead on specialised commissioning
- A smaller number of local areas teams will carry out the direct commissioning of other services such as military and prison health;
- The model for the commissioning of NHS public health services and interventions is still to be finalised.

(c) Through June – July 2012: the NHSCB will commence recruitment to the very senior manager (VSM) posts. From July - December 2012 the recruitment to direct reports of the local area team directors will take place.

(d) **Clinical Senates -** The formation of clinical senates has been agreed and there will be a total of 12 senates covering England. They will be made up of a range of clinicians and professionals from health, including public health and social care alongside patients, public and others, as appropriate. The NHSCB is working with clinicians and stakeholders on the exact makeup of clinical senates.

(e) **Primary Care –** A national Primary Care Single Operating Model has been released which describes the system by which the NHS will use the £12.6bn it spends on commissioning primary care to secure the best possible outcomes.

(f) The local, regional and national teams will work in one single system and the local element of the system includes people working in the local area teams of the NHSCB, CCGs, local authorities and health and wellbeing boards.

(g) The local primary care team are currently working with all CCGs to develop existing mechanisms that assess quality and performance across primary care.

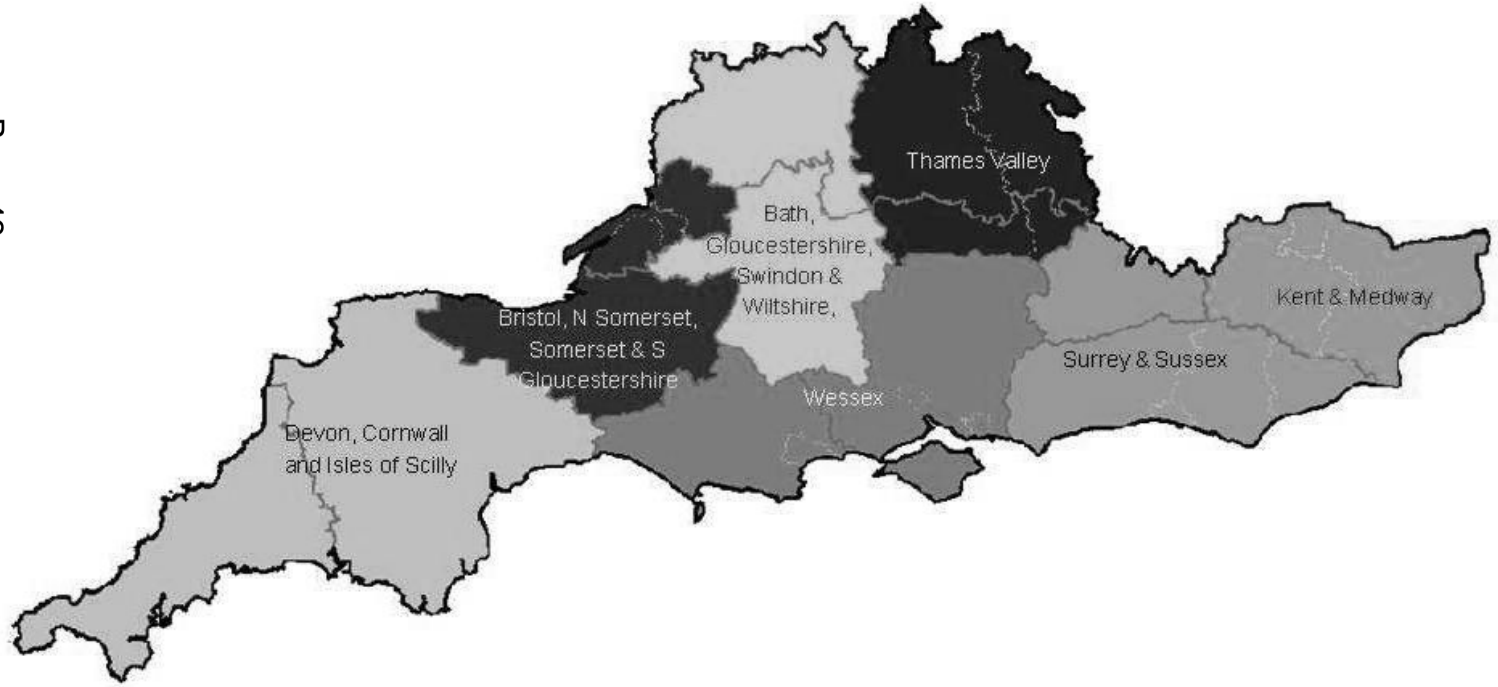
Public Health

(a) Local authorities will be responsible for commissioning or providing most public health services locally. The budgets to pay for these services will be transferred from PCTs to local authorities from April 2013. These budgets will be ring-fenced and include the costs of the public health workforce that will transfer to local authorities. Local authorities will also be required to provide public health advice, expertise and intelligence to CCGs. The costs of providing this service will be met from within the same overall ring-fenced budgets transferred to local authorities.

Table 2
Clinical Senate Geography – South of England

South of England

South of England	Popn (1,000s)	CCGs	HWBs
Bath, Gloucestershire, Swindon and Wiltshire	1411	4	4
Bristol, N Somerset, Somerset and S Gloucestershire	1413	4	4
Devon, Cornwall and Isles of Scilly	1652	3	5
Kent and Medway	1662	8	2
Surrey and Sussex	2640	12	4
Thames Valley	1985	10	8
Wessex	2550	9	7
Total	13313	50	34



(b) The NHS Commissioning Board is likely to commission the following public health services on behalf of the Secretary of State:

- Routine screening programmes (cancer and non-cancer)
- National immunisation programmes
- Public health services for children aged 0 – 5 years (until 2015)
- Child Health Information Systems
- Public health services for those in prison or custody
- Sexual Assault Referral Centres (SARCs)

(c) The public health transition plans for Kent and Medway have been submitted to SHA. The feedback letter reported that Transition plans were rated 'green'

(d) In relation to public health people transition, HR joint working groups have met and scheduled monthly meetings to track progress toward specific milestones with revised structures being consulted on during June and July 2012

(e) Work is underway to review contracts for transfer to local authorities; systems are in place to ensure information governance principles remain in place.

This page is intentionally left blank

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 20 July 2012

Subject: *Not the Default Option*: Formal Responses

---

1. Background

(a) On 9 March 2012, the Health Overview and Scrutiny Committee approved the report of its review into reducing A&E attendances: *Not the Default Option.* This was then sent to all NHS Trusts in Kent and Medway requesting a response once full consideration had been undertaken of the key findings and recommendations.

(b) The full responses received to date are attached.

2. Recommendation

That the Committee consider and note the report.

This page is intentionally left blank

"Not the Default Option"
A review into levels of attendance at Accident and Emergency Departments

East Kent Hospitals University NHS Foundation Trust welcomes the above report, produced for Kent County Council's Health Overview and Scrutiny Committee.

The report summarises well, many of the key issues around attendances at Accident and Emergency Departments across Kent and Medway.

We welcome the recommendations described in the report and offer the following responses to HOSC members for the meeting in July 2012:

Recommendation 1

The patient journey should be seamless, with no duplication of diagnostic tests, or better communication with patients of why tests are being carried out. We ask the commissioners and providers to report back to the Committee with details of what work is being undertaken to assess the scale of the problem and achieve this.

We provide GPs with direct access to diagnostic examinations. This approach is consistent with ensuring that patients are given access to early diagnostics, ensuring faster treatment pathways and better health outcomes for patients in our community.

The ability to scan patients before being referred to the secondary provider enables GPs to discuss the outcome the scan with the patient and agree their on going treatment, which may be management via the GP surgery or onward referral to a specialist service in one of our hospitals.

This approach is also coherent with the government's white paper (and now bill) - Equity and Excellence: Liberating the NHS, as well as many other health initiatives including; 6 week diagnostic waits; the Cancer Reform Strategy and TIA & Stroke management.

We take pride in the early implementation of these initiatives for patients that require early use of diagnostics to support better outcomes. For example, the daily TIA service ensures that patients are seen at the clinic and have an MRI scan on the same day. Supporting early treatment of these patients and potentially avoiding a future stroke.

Our Pathology services provide a 24 hour turnaround time for blood results. GPs access the results electronically via an IT system, Dart OCM. Our pathology staff are available to discuss interpretation and offer support to the GP. This process ensures the patient is referred to a specific pathway of care, which may be provided in the primary or acute setting.

There is daily dialogue between the operational staff and key diagnostic services to ensure that internal standards for investigations are maintained with minimal duplication of requesting tests. As part of our drive to improve services, a number of patient pathways are being reviewed from 'end to end' to identify areas where requests for diagnostic tests have been duplicated. Where this is found to be the case, the required improvements will be put in place.

In relation to the need to improve communication with patients of the reason why diagnostic tests are being carried out, we recognise this as a definite need for all healthcare providers.

Our healthcare professionals are required to clearly explain to patients why diagnostic tests are required. The results of a recent CQ Audit demonstrate that communication to patients is not always optimal. The CQ Audit also highlighted issues with our outpatient clinics where we acknowledge that some physicians do not always explain to patients clearly enough why diagnostic tests are required. In response, we have developed an action plan which documents changes that need to take place to ensure communication between the clinician and patient is improved.

We intend to introduce a telephone helpline for patients who attend an outpatient appointment. If a patient is concerned or unsure about the information they have been given during their consultation with the doctor they can use the helpline to ask for further clarification, including help with understanding why diagnostics tests are required. The patient's query will be directed to the appropriate area to ensure the correct response is given.

We will continue to monitor its performance in this area through the use of patient surveys so that we can be assured of improving communication with our patients.

Recommendation 2

Lack of awareness or confusion around the alternatives to accident and emergency mean turning to A&E is often the simplest and most rational choice, even where it is not the most appropriate one. Commissioners and providers should produce a joint communication plan to simplify the choice of GP out-of-hours services, minor injuries units, walk-in-centres and other alternatives and improve public understanding.

We are working closely with partners and commissioners in exploring ways to reduce attendances at A&E departments through the Integrated Urgent Care Board (IUCB). We would support the IUCB in developing a joint communication plan to simplify the choice of alternative providers and to improve public understanding of service provision.

Recommendation 3

Following from the above recommendation, the Committee asks that commissioners and providers explore the appropriateness and viability of introducing standardised opening hours around a clearly understood set of services across all the minor injury units in Kent.

We provide 24 hour, 7 day A&E services from the William Harvey Hospital in Ashford and from Queen Elizabeth The Queen Mother Hospital in Margate. We also provide 24 hour, 7 day Emergency Care services from Kent and Canterbury Hospital, Canterbury. All three sites have co-located 24 hour Minor Injuries Units attached to them.

We also provide a Minor Injuries Unit service from Buckland Hospital in Dover. The MIU at Buckland Hospital, Dover is open from 0900hrs to 1900hrs Monday to Friday and 1000hrs to 1800hrs on weekends and bank holidays. We have profiled these opening hours to match patient needs based on a review of attendances.

Recommendation 4

We ask the commissioners to provide further information on the costs per case for those patients seen at a walk-in centre or minor injuries unit compared to those seen at A&E departments.

We believe that our Commissioners are best placed to respond to this recommendation.

We are of the view that patients should attend the most appropriate facility and that healthcare providers should respond effectively and efficiently to the patient's condition. We will continue to work with commissioners through the IUCB in reviewing the provision of walk-in centres, MIUs and A&E departments.

Recommendation 5

The Committee congratulates the work done so far in developing Liaison Psychiatry services and asks that commissioners and providers work together to ensure the successes are consolidated and the service fully rolled out across the county.

We are involved in discussions regarding the further development of Liaison Psychiatry services but recognise that this is a service area which the Kent and Medway NHS and Social Care Partnership Trust leads on behalf of Commissioners.

Recommendation 6

The role of GPs in ensuring the goal of each person receiving the most appropriate treatment at the right time is achieved cannot be underestimated. We ask NHS Kent and Medway to provide assurances that all of the emerging Clinical Commissioning Groups are leading on the work to develop the urgent and emergency care pathway.

We continue to work with GPs and CCGs in developing integrated healthcare services on behalf of our patients.

Recommendation 7

The rollout of 111 is a great opportunity accompanied by great risks. There is only one chance to introduce it properly. The Committee requests that the commissioners of the service and relevant providers involve the HOSC and other key stakeholders early on in the development of the communication and implementation strategies.

We value the involvement of the HOSC with this issue and undertake to work with our partners with the implementation of 111, including communicating plans as service change is indicated. We recognise that our commissioners are best placed to lead on this recommendation.

Recommendation 8

The creation of the Health and Wellbeing Board and transfer of substantial public health responsibilities to local government provides a golden opportunity to develop integrated preventive health plans and we ask the Health and Wellbeing to prioritise work which will reduce the number of people entering the urgent and emergency care pathway in the first place.

We are members of the Integrated Planned Care and Long Term Conditions Board which has been established in Kent and Medway. One of the aims of this Board is to examine how A&E attendances could be reduced for patients with long term conditions.

We are also keen to work with CCGs to explore further ways of reducing A&E attendances by providing increased levels of care closer to the patients' home through the increased use of telemedicine and tele-health and through the improved provision of ambulatory care, for example.

Recommendation 9

The HOSC requests that NHS Kent and Medway produce a written report for the Committee by the end of the year detailing what success has been achieved in reducing attendance at A&E and what plans have been agreed with the NHS provider Trusts in order to further meet the challenge.

We believe that NHS Kent and Medway should take the lead on this recommendation.

Kent Community Health NHS
NHS Trust

Chairman and Chief Executive's Office
The Oast
Unit D, Hermitage Court
Hermitage Lane
Barming
Maidstone
Kent ME16 9NT
Tel. 01622.221903
e:mail: marion.dinwoodie@kentcht.nhs.uk
Web: www.kentcht.nhs.uk

Date: 11 July 2012

Dear Chairman,

Kent Community Health NHS Trust welcomes the committee's report "Not the default option" and is working with NHS Kent and Medway and the emerging Clinical Commissioning Groups to respond to the recommendations and contribute to the report which has been requested by the end of this year.

We work closely with our commissioners on the development of alternatives to A&E and on services which prevent people from having to go to hospital in an emergency or unnecessarily. Our preventative services promote good health; people are supported to manage their health in the community, especially those with long-term conditions and we are working increasingly closely with GPs, so that patients are assessed and their needs identified, and addressed, at an early stage so they stay healthier for longer.

We are working closely with KCC to develop integrated health and social care teams to deliver care which meets individual patients' needs and we are developing a multi-skilled workforce able to carry out a range of interventions.

Our specialist services for children focus on children who are seriously ill and families with high levels of need; meeting the needs of vulnerable adolescents and ensuring early support for disabled children, young people and their families. All of these services contribute to preventing ill health, avoiding emergency admission to hospital and support people who do need to go into hospital to leave earlier.

The services available at our seven Minor Injury Units, and their opening hours, are developed to respond to the needs of the local population and are kept under review. Information about them is available on our newly launched website and online Directory of Services www.kentcht.nhs.uk which provides patients and commissioners with consistent details and a search function for community health services where you live.

The Directory of Services also has:

- A patient information library with our patient leaflets in downloadable format
- Surveys for patients to tell us about their experiences of our services
- Patients can also rate services and leave comments
- Information about the Trust including board papers, reports and publications.

Yours sincerely,

Marion Dinwoodie
Chief Executive

This page is intentionally left blank

Item 8: Forward Work Programme: Update.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 20 July 2012

Subject: Forward Work Programme: Update.

---

1. Forward Work Programme.

(a) At its meeting of 1 June, the Committee approved its Forward Work Programme, subject to any changes which may be required to respond to issues as they developed.

(b) A revised Forward Work Programme for the rest of 2012 is set out below:

- 7 September

1. Kent Community Health NHS Trust: FT Application.

2. Kent and Medway NHS and Social Care Partnership Trust: FT Application.

3. Older People's Mental Health Services in East Kent: Update.

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

- 12 October

1. East Kent Hospitals Clinical Strategy: Update.

2. Trauma Network: Update.

- 30 November

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

2. Patient Transport Services.

(c) As was discussed at the HOSC meeting of 13 April, there is a need to retain as much flexibility as possible in the forward work programme in order to deal appropriately with issues which may arise within the health economy. The exact scheduling of some of the items listed above may vary.

2. Kent and Medway NHS Joint Overview and Scrutiny Committee: Adult Inpatient Mental Health Services Review.

(a) At the meeting of 9 March 2012, the Committee agreed that the proposed review into adult inpatient mental health services constituted a 'substantial variation' of service. Medway Council's Health and Adult Social Care Overview and Scrutiny Committee made the same decision at its meeting of 27 March.

(b) As explained at the meeting of 9 March, this means that this subject will be considered by the Kent and Medway NHS Joint Overview and Scrutiny Committee.

(c) This Joint Committee with Medway Council was established at the meeting of the County Council of 25 March 2004. The arrangements were updated at County Council on 14 September 2006.[1]

(d) The Joint Committee consists of 12 Members: 8 from Kent County Council and 4 from Medway Council.

(e) The first meeting of this Committee took place on 3 July 2012.

3. Recommendation

That the Committee consider and note the report.

[1] http://democracy.kent.gov.uk/Data/County%20Council/20060914/Agenda/sep06-item7.pdf