HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 12th October, 2012

9.30 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 12th October, 2012, at 9.30 am	Ask for:	**Peter Sass**
Council Chamber, Sessions House, County Hall, Maidstone	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 Mrs A Allen, Councillor Mrs A Blackmore, Councillor Mr G Lymer and Councillor Mr M Lyons
LINk Representatives (2):	Dr M Eddy and Mr M J Fittock

Webcasting Notice

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UNRESTRICTED ITEMS

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

Item | Timings

1. Introduction/Webcasting

2. Substitutes

3.	Declarations of Interests by Members in items on the Agenda for this meeting.	
4.	Minutes (Pages 1 - 8)	
5.	Kent and Medway NHS and Social Care Partnership Trust: FT Application (Pages 9 - 26)	9.30 – 10.00
6.	Joint Health and Wellbeing Strategy (Pages 27 - 64)	10.00 – 10.30
7.	East Kent Hospitals University NHS Foundation Trust Clinical Strategy (Pages 65 - 90)	10:30 – 11:30
8.	Trauma Services: Update (Pages 91 - 102)	10:30 – 11:30
9.	The Tunbridge Wells Hospital: One Year On (Pages 103 - 114)	11:30 – 12:30
10.	Date of next programmed meeting – Friday 30 November 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

4 October 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, 7 September 2012.

PRESENT: Mr M V Snelling (Chairman), Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mrs E Green, Mr J F London (Substitute for Mr C P Smith), Mr R A Marsh (Substitute for Mr R E Brookbank), Mr L B Ridings, MBE, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Ann Allen, Cllr Mrs A Blackmore, Cllr M Lyons, Cllr G Lymer and Mr M J Fittock

IN ATTENDANCE: Ms D Fitch (Assistant Democratic Services Manager (Policy Overview))

UNRESTRICTED ITEMS

3. Declaration of Interest
(Item)

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

4. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting held on 20 July 2012 are correctly recorded and that they be signed as by the Chairman.

5. Kent Community Health NHS Trust: FT Application
(Item 5)

Marion Dinwoodie (Chief Executive, Kent Community Health NHS Trust), Lesley Strong (Deputy Chief Executive / Director of Operations Adults, Kent Community Health NHS Trust), Isabel Woodroffe (Head of Governor and Member Recruitment, Kent Community Health NHS Trust), Natalie Yost (Assistant Director, Communications, Engagement and Public Affairs, Kent Community Health NHS Trust) were in attendance for this item.

(1) The Chairman welcomed the representatives from the Kent Community NHS Trust and invited Mrs Dinwoodie to introduce the item.

(2) Mrs Dinwoodie set out the context, their five strategic goals and the consultation process for the Foundations Trust Application and referred to the papers on their journey to become a Foundation Trust which had been circulated with the agenda.

(3) A general question was raised about the impact of Private Finance Initiatives (PFIs) on the finances of local hospitals. Although this did not affect Kent

Community Health NHS Trust directly, it was explained that local PFI hospitals were looking at getting into a stable and mature position and had a 5 year plan to get full money back into the area by year 6.

(4) Members requested some clarification around which properties were run by the Trust. Mrs Dinwoodie confirmed that the Kent Community Health NHS Trust FT ran services in the 12 Community Hospitals around Kent, but that there was not an equitable distribution across the county as they tended to be positioned around the perimeter of the county. These were used as step down facilities from an acute setting. She stated that there needed to be a better balance between this and step up facilities from respite. The future of the community estate was currently being considered and it was likely a new body, The NHS Property Company, would take ownership of them. Most services were provided by the Trust outside of fixed locations, in the community. This contributed to a sense in which community services were like "dark matter" in the health economy in that they held everything together but were not visible. In the future, the Trust would be asset light which would improve its flexibility.

(5) In response to a question about information to patients on about what to expect following an operation with an example given by a Member, Ms Strong stated that the trust would be working on care pathways to ensure that this situation patients were given this information prior to discharge. She undertook to discuss the specific matter further with the Member outside of the meeting. She explained that the normal process was to facilitate discharge into Community Services if appropriate. With long term conditions part of the Trust's work was supporting self management to help the client to manage the condition themselves.

(6) In response to a question on how the difference made by the Trust would be seen on the ground, Mrs Dinwoodie and her colleagues stated that they believed that the Trust engaged with and listened to the patient now, but there will be a greater transparency under the constitution of the Foundation Trust as there will be a membership with Governors drawn from this. The aim was to make services more personalised. So, for example, if a client has a long term condition they would see what opportunities they have if they came to a focus group or engaged and were listened to.

(7) Referring to the FT consultation process, a Member referred to the 12 consultation meetings and assumed that they were linked to District areas and asked what the feedback been like so far and the attendance at consultation meetings. Ms Woodroffe explained that the Trust had also sought feedback at the County Show. The Consultation process did not just start on 30 July 2012 as the Trust already had a large panel of people who they engaged with about services via their engagements team, which is a rich source of feedback. The Trust also sought feedback from these people in August. The Trust had run a radio campaign on a local station which was aimed at young people. The Trust had a small team who went out to all kinds of events with specific groups and they had been out and about in the community. She believed that they had received about 36 written responses but had also captured the responses from meetings that they had attended.

(8) In relation to a question about the financial duty upon a Foundation Trust and the difference between this and the break even duty, Mrs Dinwoodie explained that the financial duty on the Foundation Trust would be rigorous and went further than the break even duty. She explained that as a Foundation Trust they would have to demonstrate to their Board, the Strategic Health Authority, the Department of Health and Monitor, as well as the Committee that they really understood their business. They had to show that what they were going to provide had the certainty of support from various commissioners, including KCC, and that the Foundation Trust's strategy matched commissioners' intentions. Also the Foundation Trust needed to demonstrate a stable commitment over five years. This should enable the Trust to run a more stable organisation year on year than having to achieve annual break even. If the Trust wants to pump prime anything to provide new services they needed to demonstrate how they would make a surplus, they therefore need to have a recurring balance every year.

(9) In relation to a question about the wellbeing of staff, Ms Strong stated that there was a robust Occupational Health service available, and there were policies being developed around for example staff smoking at work. However, lifestyle choices were down to the individual, although it was possible to influence this through work polices.

(10) In relation to assessing community based quality of service Mrs Dinwoodie explained that this would be a matter for Monitor. In the past the Trust had been paid as a block contract and therefore they did not know the true cost of each service. They were now moving to a tariff regime and would therefore be able to see if a service was making a profit or loss. This in turn would help the Trust consider issues of quality and value for money. The Trust also wanted to be able to show what impact they were having with their work to try to get performance and understanding out into the open. She stated that they would keep the Committee informed of progress.

(11) Ms Strong explained in response to a question on the equality of provision that there was a tension between how the Trust made the service locally appropriate, as they had to engage with CCGs, and the risk that the services would develop differently depending on CCG commissioning and local community needs. The aim was for people not to have to go to acute hospitals but to manage their own condition, for example via telehealth. This could work very well at the local level but one size did not fit all.

(12) Mrs Dinwoodie, in response to a question stated that the Trust was getting better at understanding what patients and GPs will want to choose. The Trust was gaining the confidence of patients and partners through, for example, listening to patients and aiming to be responsive. They were getting to the stage of seeing what offer would be in each CCG area. They were trying to get as much sign off and input from CCGs as to what they will want to commission. Expanding the numbers of people appropriately looked after in the community was possible but limited by budgets and what could be afforded.

(13) Mrs Dinwoodie confirmed that there were 19 Community Trusts aspiring to be Foundation Trusts so there was a network, which enabled the Trust to produce benchmarks as well as sharing and learning from best practise.

(14) Mrs Dinwoodie confirmed that the Trust was taking the application to their Board and the Strategic Health Authority in November 2012.

(15) In response to a specific question Ms Woodroffe explained that local people would hold the Foundation Trust to account via the Council of Governors. The Public Governors would be elected by the membership who would be balloted in March 2013 and there were already 20 people who had expressed an interest in becoming a Governor. In November/December a workshop would be held for anyone interested in becoming a Governor. The four Staff Governors would be elected in a similar way. The out of area Governor would be elected from people who did not live in Kent but had accessed the Trust's services. There had been no expressions of interest for out of area Governors but these could be elected over time in the same way as the other Governors. The stakeholder Governors would be elected by their appointing bodies.

(16) In relation to locations for services, Ms Strong explained that work was being carried out to provide services in different ways such as, for example, from Children's Centres. In relation to services for Adults the Trust was looking at co-locating in existing or KCC buildings. She emphasised that the Trust wanted their budget to be spent on staff and services and did not want the expenses of running a large property estate.

(17) Regarding the statement in the paper that the Trust wanted to have "committed" staff, Ms Strong stated that they were going through large scale changes and that this recognised the need to take staff with them. They did this by constantly explaining to staff what was happening and why there was a need to change and do things differently.

(18) In relation to a question on achieving financial balance Mrs Dinwoodie explained that there was a need to have a stable service which was in control of its revenue year on year and its targets to save year on year. In relation to savings she explained that for many years they had shaved budgets but now there was a need to redesign services and to work across boundaries, this was a huge thing to get right. Regarding the Acute Trusts, they had 70% of beds occupied by people with long term conditions; this was a drain on the health economy.

(4) The Chairman stated that there was an additional subject that he wished to raise with Mrs Dinwoodie. This was stroke services at Tonbridge Cottage Hospital. Mr Daley referred to this matter and the question of what consultation the Trust had carried out with this Committee prior to the changes being implemented. He reminded Health Service colleagues that where there was a proposed change of service provision the Committee should be informed so that they could decide if it was a significant service reconfiguration and how it might wish to be involved or consulted.

(5) Mrs Dinwoodie explained that when the consultation was undertaken for the new Pembury Hospital part of the change was that the ward for stroke

rehabilitation would not be within the acute hospital and that it would go to a community unit in Sevenoaks. There was subsequently a view that would be better placed at the Tonbridge Cottage Hospital, the PCT Board therefore made this decision. Ms Strong confirmed that there were still community beds at Tonbridge Cottage Hospital and others had been re provided over West Kent. Discussions were underway with local CCGs to look at increasing the number of community beds at Tonbridge but these were at an early stage. She gave an undertaking that the Trust would bring any proposed changes to services to this Committee at an early stage.

(6) The Chairman emphasised that the Committee should be informed of any proposed service changes at an early stage and if the Committee decided that they were a substantial variation then it would need to be fully involved.

(7) RESOLVED that the guests be thanked for their contributions and that the Committee looks forward to receiving further updates in the future.

6. Vascular Services
(Item 6)

Nicky Bentley, Associate Director (South of England Specialised Commissioning Group, NHS Kent and Medway) was in attendance for this item.

(1) The Chairman introduced the item and explained that it was for the Committee to consider whether the changes were a substantial variation. Medway Council's Health and Adult Social Care Overview and Scrutiny Committee had considered this and asked for further information before deciding whether this was a substantial variation. If both Health Overview and Scrutiny Committees decided that this was a substantial variation then it would be considered at a Joint Health Overview and Scrutiny Committee.

(2) Ms Benton presented the paper on the Kent and Medway NHS vascular review which included an outline of the proposal with reasons for the changes and the timescale. The Trust had to report to the Strategic Health Authority by the next financial year that they had a plan in place.

(3) Members expressed their appreciation to the Trust for coming to the Committee at this early stage; they welcomed the review and the holistic and long term approach taken. The comment was made that it would be helpful to know the costings and estimated savings from these proposals. Confirmation was sought that this review was more to do with clinical excellence than achieving savings. Ms Benton explained that the proposal was related to Consultant training and Junior Doctors, there was a need for a critical mass of expertise for this service and she did not believe that it was possible to achieve this on two sites.

(4) Information was sought on the impact that travelling a greater distance for surgery would have on the outcome for the patient. Ms Benton stated that this was not available yet but that they would need to have this information for the review.

(5) Responding to a question about screening it was confirmed that it was already in place in GP surgeries in Canterbury. It was reported that this had been very successful and was being rolled out across Kent and Medway.

(6) As only data for 2011/12 had been supplied, a Member asked if this was indicative of previous years. Ms Benton explained that data was available for previous years and would be supplied for as part of the full review.

(7) Ms Benton confirmed that patients would still have the option of being treated at Kings College Hospital.

(8) In relation to a question on the impact of the European Working Time Directive on achieving 24/7 cover, Ms Benton stated that part of the impact was physically having the right number of people, with the right skills in the right place at the right time.

(9) RESOLVED that:

(1) the Committee considers that the proposed changes to Vascular Services are a substantial variation and that, subject to the view of Medway Council, further consideration will be given to them by either the Kent Health Overview and Scrutiny Committee or the Joint Health Overview and Scrutiny Committee with Medway Council, and

(2) an item on the impact of the European Working Time Directive be added to the work programme for this Committee.

7. Older People's Mental Health Services in East Kent
(Item 7)

Evelyn White (Associate Director Integrated Commissioning, NHS Kent and Medway), Linda Caldwell (Senior Commissioning Manager Carers and Older People East Kent, NHS Kent and Medway), Dr Kanagasooriam (GP Commissioning Lead for Older Peoples Mental Health), Dr Karen White (Executive Medical Director), Dr Barbara Beats (Assistant Medical Director – Older Adults), Justine Leonard (OPMHN and Specialist Service Line Director, KMP), Su Brown (Head of Operations, Communications and Engagement, NHS Kent and Medway) were in attendance for this item.

(1) The Chairman welcomed Health Service colleagues and invited them to introduce their preliminary paper on Older Persons Mental Health Services in East Kent.

(2) Ms White presented the paper which set out the outcomes of the formal consultation which would be presented to the NHS Kent and Medway Board in later in the month. Ms White confirmed that the Trust were part of a bid for national funding to make the implementation of improvements faster for those with dementia, this was an important work stream and there was partnership working with social care colleagues in relation to this important piece of work. The Trust was aware of the recommendations of the KCC Select Committee on Dementia.

(3) Ms Leonard confirmed that there were two options for the proposed provision at St Martins, these were either to build a new unit or to convert an existing facility but this would not be a ward in the older part of the hospital.

(4) Ms White explained that one of the pieces of work that was going on across the County was to ensure that support staff see the individual and not the dementia. There were dementia champions at each of the Acute Trusts. This was not part of the process being reported to the Committee today but was part of a wider agenda.

(5) In response to the reference to the patient safety aspect of the options, Dr White explained that option one would mean it was necessary to rota across three sites and it would be more likely that locum staff would need to be used. Whereas with option two, it would only be necessary to have a rota across two sites which would be easier to cover with Trust staff.

(6) In relation to a question on the increased prevalence of dementia within an aging population and the proposals ability to cope with this, Dr White stated that an increase in the number of people with dementia did not necessary mean that there was a need for an increased number of inpatient beds, what was needed was support in the community to enable better management of the condition and improved individual care in the persons own home. There should be more investment in crisis treatment and care in the community which would result in a reduced need for acute beds. There was a need to work closely with local authority colleagues to provide a joined up service and to be confident that the commissioning of beds met the needs now and in the immediate future. She emphasised that it was essential to build capacity in the community prior to the any planned reduction in acute beds. Ms White confirmed that there was a dedicated dementia crisis team.

(7) In relation to the demographic changes of an elderly population, Dr Betts stated that the proposal should provide sufficient flexibility to meet a wide range of needs alongside adequate community support and early discharge planning in to a supported home environment. Specifically, the importance of the proposals taking account of the older population who move into the Thanet coastal area was noted as one demographic factor.

(8) Regarding a question on mixed sex wards, Ms Leonard stated that the aim of the new provision was to provide single en-suite rooms with good access to a social space and a female only lounge. There will be mixed facilities which was normal in residential care facilities and they would do everything to cater for the individual and to protect privacy.

(9) Regarding respite provision, Ms White explained that this was an important element of their plan and was one of a number of things that they were working on with colleagues in social care on as part of their dementia plan.

(10) In response to a question on why there were no public consultation meetings held in Thanet Ms White explained that the three consultation meetings had been spread across the whole area based on advice from their communications and engagement team. In addition to these meetings there was also a lot of work carried out with groups that support older people with

Dementia and Mental Health needs across this area, such as Age UK and via the Dementia cafes.

(11) Ms White stated that the Trust was in discussion with Kent Community Health Trust regarding integrated teams and this was part of a whole system approach to the service.

(12) Responding to a specific question about what issues existed around recruiting clinical staff, Dr White stated that there had always been an issue with attracting doctors into the area of psychiatry, especially focusing on older people with dementia; it had a stigma and therefore healthcare professionals were less likely to select to work in this area. However, the Trust had been more successful than other areas in attracting staff and offered placements to doctors before they made their final choice of specialism so that they could do this based on a positive experience. She asked Members to do all that they could to reduce the stigma attached to Mental Illness.

(13) RESOLVED that the Committee support the Older People's Mental Health inpatient reconfiguration based on option 2.

8. Joint Health and Wellbeing Strategy
(Item 8)

Meradin Peachey (Director of Public Health, KCC) and Julie Van Ruyckevelt, (Interim Head of Citizen Engagement for Health, KCC) were in attendance for this item.

(1) The Chairman asked that, due to the lack of time to fully consider this item, Members email Ms Peachey with their comments on this first draft of the Joint Health and Wellbeing Strategy prior to consideration at the next meeting of the Committee.

(2) RESOLVED that consideration of the Joint Health and Wellbeing Strategy be deferred until the meeting of the Committee on 12 October 2012.

9. Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Relationship - Written Update
(Item 9)

(1) The Committee considered a letter on the integration between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust dated 22 August 2012 from the Trusts' Chief Executives.

(2) RESOLVED that the update be noted and the suggested new name "North Kent NHS Foundation Trust" be supported.

(Mr Adrian Crowther declared a personal interest in the Agenda as a Governor of Medway NHS Foundation Trust).

10. Date of next programmed meeting – Friday 12 October 2012 @ 10:00am
(Item 10)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 12 October 2012

Subject: Kent and Medway NHS and Social Care Partnership Trust: Foundation Trust Application

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1. Background

(a) Kent and Medway NHS and Social Care Partnership Trust have requested the opportunity to bring an update of the organisation's application for Foundation Trust status to the Committee.

(b) This issue was last considered by the Committee on 13 April 2012.

2. Recommendation

That the Committee consider and note the report.

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

To: Health Overview and Scrutiny Committee, 12 October 2012

Subject: NHS Foundation Trust Status and Monitor

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1. Foundation Trusts (FTs)

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

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

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

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

2. FTs are not statutorily required to break even, but must achieve the financial position set out in their financial plan. One main measure of an FT's financial performance is EBITDA (earnings before interest, tax, depreciation and amortisation).[2]

2. The Foundation Trust Pipeline

(a) There are currently 144 FTs across England. The NHS Operating Framework for 2012/13 provides the following summary of the FT Pipeline:

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

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

> *"Progress on the NHS Foundation Trust (FT) pipeline is not an end in itself but a critical means for creating clinically and financially sustainable organisations across the provider sector. NHS trusts are expected to achieve NHS FT status on their own, as part of an existing NHS FT or in another organisational form by April 2014, with a few concluding beyond this date by exceptional agreement. Plans for all NHS trusts have been agreed under Tripartite Formal Agreements (TFAs), which codify the locally owned issues, actions and processes and set out the journey each organisation must take going forward."*[3]

(b) Since October 2010, the Department of Health has been developing new processes to assist aspirant Trusts towards authorisation. The completions of a 'tripartite formal agreement' (TFA) for each Trust has been a core element of this with the TFA summarising the main challenges faced by each organisation along with the actions to be taken by the Trust, SHA and Department of Health.[4] Any issues were put into four categories:[5]

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

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

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

(d) The ***NHS Trust Development Authority (NTDA)*** was established as a Special Health Authority in June 2012 to be able to take on the responsibility for overseeing NHS Trusts (i.e. those which are not FTs) from April 2013 when SHAs will have been abolished.[6]

4. Monitor

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

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

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[3] Department of Health, *The Operating Framework for the NHS in England 2012/13*, 24 November 2011, p.29, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf

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

[5] All TFAs can be accessed here: http://healthandcare.dh.gov.uk/foundation-trusts-tripartite-formal-agreements/

[6] http://www.ntda.nhs.uk/about/

1. Assessing the readiness of Trusts to become FTs;
2. Ensuring FTs comply with their terms of authorisation and that they are well governed and financial robust; and
3. Supporting FT development.[7]

(c) When assessing an NHS Trust applying for Foundation Trust status, the focus is on three key questions:

1. Is the trust well governed with the leadership in place to drive future strategy and improve patient care?
2. Is the trust financially viable with a sound business plan?
3. Is the trust legally constituted, with a membership that is representative of its local community?[8]

(d) Once an FT has been authorised, Monitor looks to ensure it is compliant with its terms of authorisation which are a set of detailed requirements around how the FT must operate. Some of the areas covered in the terms of authorisation are:

- the general requirement to operate effectively, efficiently and economically;
- requirements to meet healthcare targets and national standards; and
- the requirement to cooperate with other NHS organisations. [9]

(e) Each FT is assigned an annual and quarterly risk rating which indicate the risk of failure to comply with the terms of authorisation. Two risk ratings are published:

1. governance (rated red, amber-red, amber-green or green); and
2. finance (rated 1-5, where 1 represents the highest risk and 5 the lowest).[10]

(f) Where an FT is at risk of breaching its terms of authorisation, Monitor can require an action plan from the organisation but has a range of formal intervention powers where improvement has not been demonstrated.

(g) FT development is supported through such programmes as service-line management which involves identifying specialist clinical areas and managing them as distinct operational units.[11]

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[7] http://www.monitor-nhsft.gov.uk/home/about-monitor/what-we-do
[8] http://www.monitor-nhsft.gov.uk/about-monitor/what-we-do-0#1
[9] http://www.monitor-nhsft.gov.uk/about-monitor/how-we-do-it/how-monitor-regulates-nhs-foundation-trusts
[10] Ibid.
[11] http://www.monitor-nhsft.gov.uk/SLM

(c) A number of changes to the role of Monitor are being introduced as a result of the health and Social Care Act 2012. It will become the sector regulator for health and carry out functions in the following areas:

1. Licensing providers of NHS care
2. Regulating prices;
3. Enabling integration;
4. Safeguarding choice and competition
5. Assessing NHS providers for FT status;
6. Supporting service continuity.[12]

(d) Monitor and the Department of Health jointly sponsor ***The Co-operation and Competition Panel*** (CCP). The CCP was formally established on 29 January 2009.[13] It provides advice on the application of the Department of Health's *Principles and Rules of Co-operation and Competition*.[14] Cases are undertaken by the CCP in the following four categories:

- Merger cases;
- Conduct cases;
- Procurement dispute appeals; and
- Advertising and misleading information dispute appeals.[15]

[12] Monitor, *Introduction to Monitor's future role*, 20 June 2012, http://www.monitor-nhsft.gov.uk/monitors-new-role/-introduction-monitors-new-role
[13] Co-operation and Competition Panel, *Guide to the Co-operation and Competition Panel*, http://www.ccpanel.org.uk/content/Guide-to-the-CCP.pdf
[14] Co-operation and Competition Panel, *Principles and Rules of Co-operation and Competition*, http://www.ccpanel.org.uk/content/Principles_and_Rules_REVISED5.pdf
[15] Co-operation and Competition Panel, *About the CCP*, http://www.ccpanel.org.uk/about-the-ccp/index.html

Kent and Medway NHS

NHS and Social Care Partnership Trust

Meeting	Kent County Council [KCC] Health and Overview Scrutiny Committee [HOSC]
Date	12 October 2012
Subject	Kent and Medway NHS and Social Care Partnership Trust [KMPT] Foundation Trust [FT] Application
Reporting Officer	Angela McNab, Chief Executive
Purpose	To seek HOSC views and support for KMPT plans

INTRODUCTION AND CONTEXT:

Kent and Medway NHS and Social Care Partnership Trust [KMPT] is one of the larger mental health Trusts in the country. It serves a population of 1.7 million and has a workforce of 3,400 (plus 272 seconded staff posts). It provides acute, community and specialist services including services to those with learning disabilities and those living with dementia.

It is government policy that all Trusts move towards becoming a Foundation Trust [FT]. KMPT previously went through an application but encountered some quality issues which it needed to address first. KMPT restarted its application in October 2011 and is making good progress through the new more rigorous process. In the last year the Trust has improved significantly in its performance and in its patient experience (moving from a Strategic Health Authority [SHA] rating of "underperforming" to "performance under review" with an overall Quality and Finance rating of performing in Quarter 4 2012/13). It has progressed through a number of standard external assessments of governance and quality and has received strong results showing measurable improved performance.

CURRENT POSITION:

Following the Readiness Review on 26 July 2012, the Trust has been invited to a Board to Board meeting with the SHA on 15 November 2012. It is expected following the Board to Board the Trust will be referred to the Department of Health [DoH].

The action plans from the three independent assessments: Quality Governance Framework [QGF], Board Governance Assurance Framework [BGAF] and Historic Due Diligence [HDD] have now been substantially completed. HDD2 has taken place and been reported on. Niche and Deloitte (external assessors) have undertaken their re-assessment of the QGF and BGAF; the outcome of the QGF re-assessment being a score

of 2 (the lower the score the better). The outcome of the BGAF re-assessment is expected shortly.

Membership is on track with the Trust currently having 10,674 members: 3,652 Staff and 7,022 Public. The Membership Strategy and Recruitment Plan have been updated and the Stakeholder Engagement Events continue to focus on staff engagement and hard to reach groups as identified by feedback from events so far and membership analysis.

The Integrated Business Plan [IBP] is close to competition.

ADVANTAGES OF BECOMING A FT:

FTs are membership based organisations, with Councils of Governors made up from stakeholder partnership governors and directly elected governors from the public and staff membership base. To become a FT, organisations must meet specific criteria in terms of quality, governance and financial viability. The legislative framework which establishes FTs allows organisations greater local flexibilities and financial freedoms than NHS Trusts.

KMPT believes that becoming a FT is the best way of achieving strategic goals. Specifically by becoming a membership organisation, local people and staff will have a direct say in actions and decisions.

In addition the standards set by Monitor mean KMPT will be demonstrating a high level of quality and performance which the population should expect and which the Trust wants to commit to deliver.

Finally there are opportunities for service development and expansion provided by becoming a FT which mean specialist services can be grown to the benefit of local people.

Benefits to patients, staff and the public are:

- ⇒ Assured levels of quality demonstrated by Monitor process and ongoing evaluation.
- ⇒ Membership providing local power and authority in decision making and future services.
- ⇒ Strong financial governance and assurance of long term sustainability.
- ⇒ A local focus.

RISKS ASSOCIATED WITH PURSUING FT STATUS:

The Trust believes that pursuing and attaining FT status is the appropriate means of securing long term stability and quality of services. It has therefore been maintaining a risk management system based on not achieving FT status. The key risk to achievement within the timeline is Board Member changes and the key risks to not being licensed are failure to maintain compliance with all required standards and financial risk ratings.

Some people have questioned whether pursuing FT status could be a costly process and potentially distract the Trust from its core purpose. However, the key elements necessary to become a FT are: good governance, focus on performance, and excellent quality

standards. Clearly these are identical to the core purpose of KMPT and the priorities local people and patients want to see. There is therefore no risk of 'distraction'.

In terms of cost, the Trust has largely used its internal capabilities to work on the application and has ensured resources have continued to be targeted at service delivery and improvements.

IMPACT ON DELIVERY, LOCATION AND QUALITY OF SERVICES OF ATTAINING FT STATUS:

The Trust's FT application is based on its *Clinical Strategy* (KMPT, 2012). Attaining FT status will accelerate the achievement of the Transformation Programme and the sustained improvements in service delivery.

There are no specific 'location' impacts associated with pursuing or attaining FT status and the Trust expects the impact on quality to be positive as the process requires this. The Trust will continue to test quality after FT is achieved.

OUTLINE OF ENGAGEMENT AND CONSULTATION PLANS:

KMPT agreed an engagement plan with the SHA in March 2012 and has completed the first phase. A summary of activities is below:

STAKEHOLDER	ENGAGEMENT CONTACTS
Public Events – Trust hosted	3
Public Events – attended by Trust	6
Service User / Carer Events	8
Staff Events and Meetings	21
Voluntary Sector / Commissioner Meetings	10
Member of Parliament [MP] Meetings	6
HOSC Presentations	2
Clinical Commissioning Groups [CCGs] / Commissioners	10
Letters to Stakeholders	181
E-mails to Members	>7,000

TIMELINE:

The Trust has been invited to a Board to Board meeting with the SHA on 15 November 2012, which, if successful, will result in the Trust's application being put forward to the Secretary of State [SoS] for approval. This is likely to take two months. The Trust will then enter the Monitor phase which will take three to four months. However the start date is at Monitor's discretion and the Trust is unable to influence this timing. It is hoped that FT status will be attained by the middle of 2013.

SUMMARY:

To summarise KMPT provides a wide range of mental health and specialist services to the population of Kent and Medway. The achievement of FT status for KMPT fully supports both Government policy and our local Clinical Strategy. KMPT believes that becoming a FT is the best way of achieving its strategic goals, through a membership organisation following a vigorous review of its governance, performance and quality standards.

RECOMMENDATION:

The HOSC is asked to consider and support KMPT's plans for achievement of FT status.

Kent and Medway NHS
NHS and Social Care Partnership Trust

Delivering Quality Through Partnership

Applying to be a Foundation Trust
KCC HOSC
12 October 2012

respect - open - accountable - working together - innovative - excellence

Kent and Medway NHS
NHS and Social Care Partnership Trust

Our Vision

"Deliver quality through partnership. Through a dynamic care system, with people receiving the right help, at the right time, in the right setting, with the right outcome."

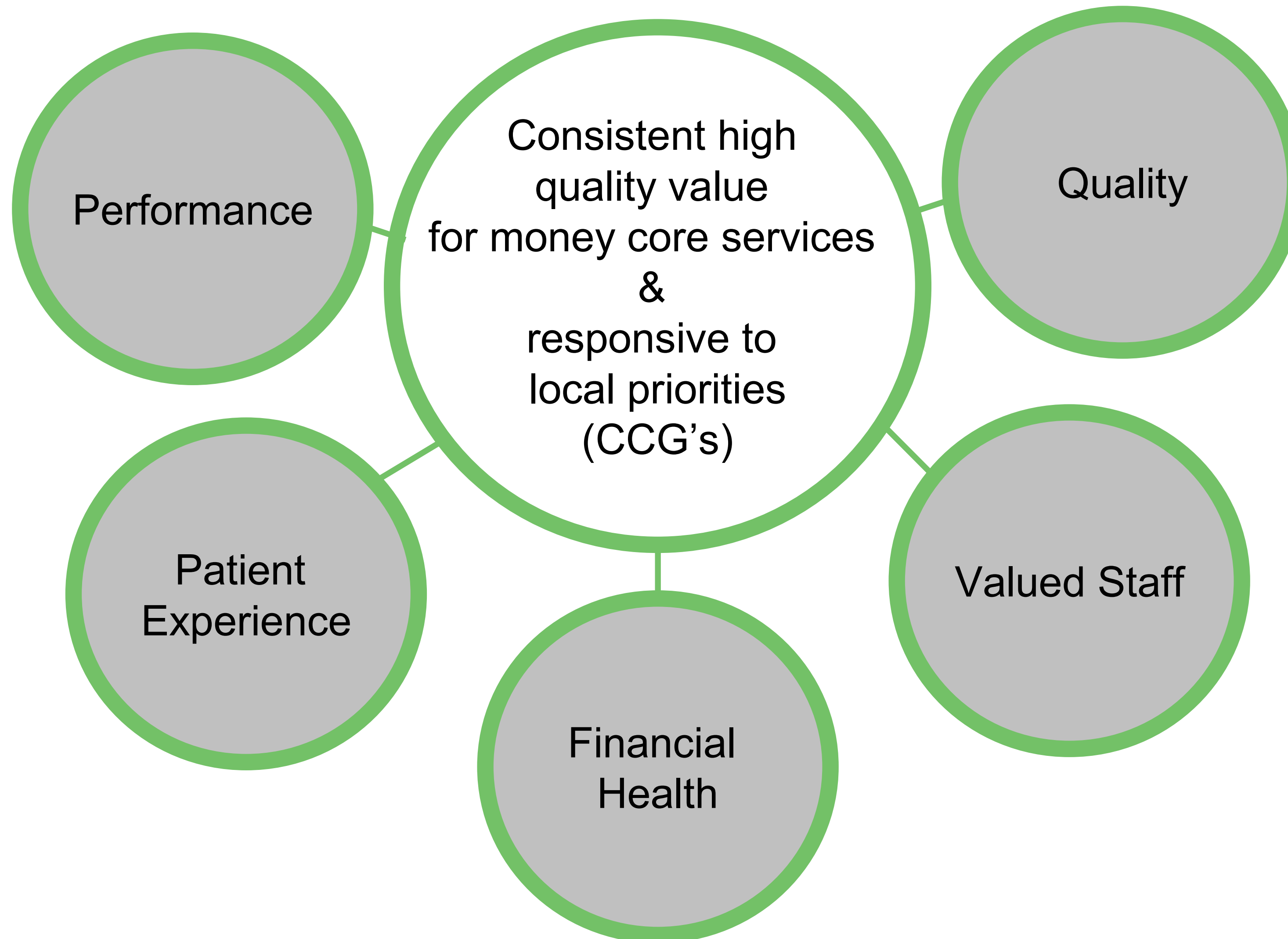
The impact and benefits of FT

- Symbol of quality and high standards
- Strong membership organisation directly influencing actions
- Stronger financial management, but more freedoms and flexibility
- Freedoms allow innovation and growth
- Membership enabling more direct feedback/input for service users and carers – focus on experience and quality

Reasons for becoming FT

- We want for people of Kent
  - Quality badge
  - Financial strength
  - Local focus and influence
  - Membership
- No FT?
  - Risk of no “Kent” focus

Priorities, Impact and Risks



Kent and Medway NHS
NHS and Social Care Partnership Trust

Engagement Activity

- Broad support for application from all
- High levels of support for membership and Council of Governors
- Staff keen to understand the opportunities for them in an FT

50 events and meetings attended

11,300 people signed up as members

Support from 7 CCGs in Kent and the current PCT Cluster

eagerness to start to appoint / elect 40 shadow Governors

Kent and Medway NHS
NHS and Social Care Partnership Trust

FT Milestones

2011

- Oct – Enter SHA process
- Nov – Chairman appointed
- Dec – Key Strategies and IBP and LTFM submission

2012

- Feb – Key document 2nd submission
- March – Final Board positions confirmed
- April – Key documents 3rd submission
- Autumn – Final submission
- Autumn – Formal B2B
- Winter – SoS submission

2013

- Monitor Assessment Complete
- Licensed as an FT

Excellent care, personal to you

Kent and Medway NHS
NHS and Social Care Partnership Trust

Conclusion

- Becoming FT will benefit Kent public
- Quality, location and delivery of service will be “enabled”
- “Membership” principle supports local voice and influence
- Risks are no different to any organisational risks
- Local engagement is positive and supportive

By: Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform

Meradin Peachey, Director of Public Health

To: Kent Health Overview and Scrutiny Committee

Subject: Developing Kent Joint Health and Wellbeing Strategy – The process for engaging Public and Stakeholders

Classification: Unrestricted

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1 Introduction

1.1 This paper outlines the process for developing and undertaking patient and stakeholder engagement in developing Kent's Joint Health and Wellbeing Strategy.

2 Developing the Draft Joint Health and Wellbeing Strategy

2.1 The Health and Social Care Act 2012 introduced duties and powers for Health and Wellbeing Boards in relation to the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategies (JHWS). Upper Tier Local Authorities and Clinical Commissioning Groups have an equal and joint duty to prepare JSNAs and JHWS through the Health and Wellbeing Board. JSNAs are local assessments of current and future health and social care needs. The current JSNA for Kent can be found at http://www.kmpho.nhs.uk/jsna/. The JHWS is the strategy for meeting the needs identified in the JSNA.

2.2 Initial development of Kent's JHWS (the current Draft version is at Appendix A) took into account the key themes from the JSNA, a range of national and local related information (see Appendix B) as well as discussions at Kent Health and Wellbeing Board meetings and other forums where strategic discussions, particularly on health services, are being held - for example the NHS Chairs and Chief Executive forum.

2.3 The current Draft Joint Health and Wellbeing Strategy focuses on five overarching outcomes identified as the most important for the population of Kent:

- Every child has the best start in life

- People are taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental ill health are supported to live well
- People with dementia are assessed and treated earlier.

2.4 These outcomes are supported by a number of key principles including:

- Engaging with the community via Healthwatch and other engagement mechanisms
- Halting the widening of health inequality gaps both within and between communities and improving healthy life expectancy.
- Focus on prevention and the individual taking more responsibility for own health and care.
- Providing good quality joined up support and care to people with long term conditions and dementia, preventing unnecessary hospital admissions. By care we mean both health and social care.
- Reducing premature deaths by the key killers including: Cancers and respiratory diseases
- Integrating commissioning of health and social care services as well as integrating how those services are provided.
- Ensure cost effectiveness and efficiency are not achieved at the cost of quality.

An Equalities Impact Assessment has also been produced to accompany the draft strategy.

3 Engaging patients and stakeholders in developing the JHWS

3.1 There is a statutory duty to involve certain groups and organisations in the development of a JSNA and the resultant JHWS[1]. These include people who live or work in the area, local Healthwatch and if applicable district councils. There should also be wider engagement, for instance with other agencies, the voluntary sector and health and social care providers. This involvement should be continuous, from early development onwards.

3.2 The following engagement timeline was agreed by the Kent Health and Wellbeing Board on the 18th July:

- 18th July – discussion and agreement by the Kent SHWB on the stated outcomes and overall steer of the draft strategy.
- End July to end August – engagement with key stakeholders (CCGs, KCC, district councils) to build on the draft strategy
- 19th September – Feedback from this first stage of engagement to Kent Shadow Health and Wellbeing Board (SHWB).
- September to November – wider public engagement on the revised draft strategy

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[1] DH January 2012 Draft guidance on Joint Strategic Needs Assessments and joint health and wellbeing strategies

- Mid November – sign off by the SHWB of the final version of the Strategy.
- End 2012 – Publication of the JHWS.

(Key milestones diagram is at Appendix C)

3.3 Engagement with key stakeholders started mid-August and responses to a survey designed for this have been asked for by 12th September, so that these can be fed into the next iteration of the draft JHWS (Survey and cover letter are at Appendix D and E).

3.4 The wider public engagement on the draft strategy will tie into parallel work taking place in the CCGs on the development of the 2013 – 2014 Annual Operating Plans.

3.5. A range of engagement methods will be used in phase 2 – the wider engagement stage - that are deemed 'fit for purpose'. These will include:

- Draft JHWS and questionnaire published both in paper form and online on KCC, PCT and LINk websites
- Paper documents placed in public places, such as libraries, leisure facilities, town halls
- Attendance at existing forums with particular interest/focus groups on one or more of the four outcomes
- Discussions with GP Patient Participation Groups, LINk/Local Healthwatch and other service user/participation groups, ensuring inclusion of diverse groups.

4. Conclusion

4.1. Information from the wider engagement phase will be used to inform and develop the final version of the JHWS. This will be published at the end of 2012 and will demonstrate how public and stakeholder engagement has influenced its final development.

Recommendation

The Health Overview and Scrutiny Committee is asked to note the approach being taken. We are also seeking the views of the HOSC as part of the engagement process.

Appendices:
Appendix A – Draft Health and Wellbeing Strategy
Appendix B – Supporting Information
Appendix C - Key milestones diagram
Appendix D – Copy of Survey
Appendix E – Covering email to partners from Roger Gough

Contact details Julie Van Ruyckevelt, Interim Head of Citizen Engagement for Health, KCC 07799472930

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Kent Health and Wellbeing Board

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Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

DRAFT Engagement Document

If you have any queries or require this strategy in another format, please contact…..name.surname@kent.gov.uk

Foreword

This consultation document is part of the development process for the first Joint Health and Wellbeing Strategy for Kent. This strategy aims to address the health and wellbeing needs of the people of Kent at every stage of their lives. In general, the health of Kent's residents is better than elsewhere in the country; however there are significant differences in people's health across Kent, and there are actions that we can take to continue the improvements of people's health and wellbeing in Kent. The priorities, approaches and outcomes outlined in this document were taken from the needs identified in the Joint Strategic Needs Assessment. Taken together, the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy aim to improve the health and wellbeing of the people of Kent, they are not an end in themselves but a continuous process of strategic assessment and planning.

This document is seeking your views on whether we are focussing on the right key health social care and wellbeing issues for Kent and that we are taking the right approach to tackling those issues. This document builds on many years of joint working between local government and health, which have delivered improvements in services leading to improvements in people's health.

This document has been produced by the Kent Health and Wellbeing Board. This is a new partnership between local government and health. Members include GPs, County Council and District Council Councillors; LINks (patient and public representation) and senior officers for Families and Social Care and Public Health. The partnership was established as a result of the Health and Social Care Act 2012, and gives the opportunity to look at the health and care system as a whole; to identify what we should be addressing to improve people's health and ensuring that this is undertaken collectively through GP and local government commissioning plans and integrated working. Our aim is to improve the quality of life, health and wellbeing, including mental well being, for the residents of Kent. This strategy is the starting point for this approach.

Signed by Roger Gough
Chair of the Kent Health and Wellbeing Board.

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Summary

This is the first Joint Health and Wellbeing Strategy for Kent. Good health and wellbeing is fundamental to living a full and productive life. Overall Kent has a good standard of health and wellbeing, but this hides some significant areas of poorer health and differences in life expectancy (15 years between the healthiest and least healthy wards in Kent).
This overarching strategy aims to identify the health and social care outcomes that we want to achieve for the people of Kent. This document will set out the challenges we face, what we are going to do to address them and what we hope to see as a result.

However, we need first to ensure that we are focussing on the right things for the people of Kent. Please take some time to respond to this consultation document by completing the questionnaire which can be accessed via the following weblink........

Our Vision:

Our vision in Kent is to deliver better quality care, improve health outcomes, improve the public's experience of health and social care services and ensure that the individual is at the heart of everything we do.

The Health of the People of Kent

This document is based on data and evidence in the Kent Joint Strategic Needs Assessment, the Kent Health Profile 2012, the Kent Health Inequalities Plan and guidance from the Department of Health. These documents can be found at:

Joint Strategic Needs Assessment http://www.kmpho.nhs.uk/jsna/
Kent Health Profile 2012 http://www.healthprofiles.info
Kent Health Inequalities Plan http://www.kmpho.nhs.uk/health-inequalities/?assetdet1118452=228636

The Joint Strategic Needs Assessment identified the following key priorities that need to be addressed:

- Improving the health of children in their early years
- Improving lifestyle choices particularly of young people
- Preventing ill health and preventing existing health conditions from getting worse.
- Shifting of care closer to home and out of the hospital (including dementia and end of life care) and improving the quality of care.
- Tackling Health Inequalities

This Strategy will outline how we will address these issues; Clinical Commissioning Groups, Kent County Council and other partners will then produce more detailed plans on how the issues will be addressed locally to where you live. Please see Appendix A for more information.

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The Challenges that we face in Kent:

Demographic Pressures

Kent ranks 102 out of 152 county and unitary authorities in the English Indices of Deprivation 2010 (ID2010). This places Kent within England's least deprived third of authorities (a rank of one indicates the most deprived area). However, there are areas within Kent that fall within the 20% most deprived in England.

Kent has the largest population of all of the English counties, with just over 1.46 million people. The health of the people of Kent is mixed. Life expectancy is higher than the England average for both men and women, with men living for 79.1 years and women living for 82.7 years. However, life expectancy is significantly lower in deprived areas, with a man in a deprived area living on average 8.2 years less, giving him a life expectancy of 70.9 years and a woman living on average 4.5 years less, with a life expectancy of 78.2 years.

Just over half of the total population of Kent is female (51.1%) and 48.9% are male. People living in urban areas make up 71% of Kent's population; the remaining 29% of the population live in rural areas. Over the past 10 years Kent's population has grown faster than the national average, growing by 7.8% between 2000 and 2010, above the average both for the South East (6.7%) and for England (6.1%). Kent's population is forecast to increase by a further 10.9% between 2010 and 2026.

Overall the age profile of Kent residents is similar to that of England. However, Kent does have a greater proportion of young people aged 5-19 years and of people aged 45+ years than the England average. Just under a fifth of Kent's population is of retirement age (65+). Kent has an aging population. Forecasts show that the number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026, yet the population aged under 65 is only forecast to increase by 3.8%. 70% of Kent residents describe themselves as being in good health and 16.5% of Kent's population live with a limiting long term illness. Kent's ageing population will place significant pressures on health and social care services.

Where Kent is performing below the national average for health:

Kent's performance on smoking in pregnancy, breast feeding initiation, healthy eating among adults and obesity in adults is worse than the national average. Continued poor performance in these areas will have a significant impact on the health of the population over the coming years with smoking and poor diet being a contributory factor in cancer and heart disease and obesity contributing to the increase in type 2 diabetes.

To improve people's long term health we have to improve healthy lifestyles; encourage healthy eating in adults, address the challenges of an ageing population; give every child the best start in life and enhancing the quality of life for people with long term conditions, mental health and dementia. We will need a real focus on differences in outcomes both within and between communities. In addition to this, we will need to look at how we improve people's knowledge of both the symptoms of various diseases such as cancer, and what they can do prevent them e.g. encouraging physical activity.

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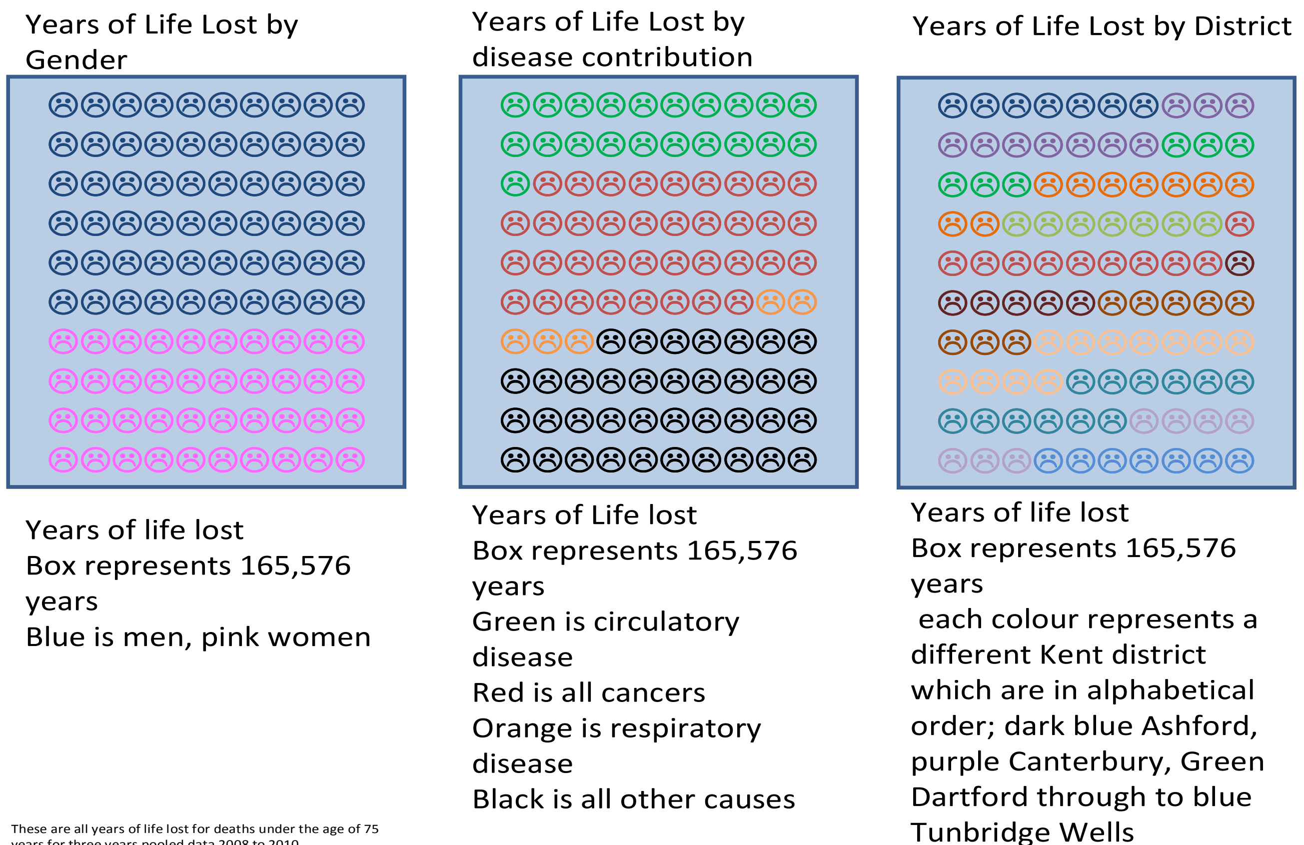
We will also need to address the wider determinants of ill health e.g. lifestyle, access to services, employment status and housing conditions. If these are tackled successfully they will have a significant long term impact on people's health.

Years of life lost by people dying early.

A simple way to identify the impact of poor health and lifestyle choices on life expectancy is by looking at how many years of life are lost by people dying prematurely. In Kent, the number of years of life lost by people dying of preventable causes before the age of 75 is **165,576**. The key diseases that have led to the years of life lost are circulatory disease, cancer and respiratory disease; all of which can be reduced by taking a more proactive approach to health and care. The graphic below depicts the breakdown of years of life lost by men and women; the types of disease contributing to this and the years of life lost by district.



Many factors affect our health and wellbeing; our environment, living and working conditions, genetic factors, economic circumstances, how we interact with our local community and choices we make about our own lifestyles.

We know these are difficult economic times for everybody. Public sector organisations are facing tough decisions, about how to deliver the best, most efficient services within

reduced budgets. This is made more challenging by an increase in demand on services such as social care and rising expectations of residents for higher quality services.

This strategy takes into account the health and wellbeing challenges facing Kent and the difficult financial situation for public services. It is important we look across organisations in Kent and consider how we may change the way we work together so that we can improve the health and wellbeing of every person in Kent. The Health and Wellbeing Board will champion and work hard on behalf of the residents of Kent to ensure we make these improvements.

We also believe it is important that local communities have a greater role in shaping and influencing services and improving health and well being in communities. This will be supported by the role of democratically elected members and our local HealthWatch representatives (patient representation is an integral part of the Health and Wellbeing Board). Not only do we think this will help us tailor services to meet the needs of local people we also understand the value of community in improving the health and well being of residents.

What difference will this strategy make?

Partnership working on health and wellbeing issues is not new in Kent. We have a long history of doing so; the recent establishment of the Kent Health and Wellbeing Board will enable even closer working.

This Joint Health and Wellbeing Strategy is a new opportunity for the Health and Wellbeing Board members to explore together the local issues that we have not managed to tackle on our own. It sets out collectively what the greatest issues are for the local community, based on evidence in our Joint Strategic Needs Assessment, how we will work together to deliver the agreed priorities and what outcomes we intend to be achieved.

The Health and Wellbeing Strategy will inform commissioning decisions made by local partners especially GP Commissioning Groups (CCGs) so that they focus on the needs of patients, service users and communities, tackle factors that impact on health and wellbeing across service boundaries and influence local services beyond health and care to make a real impact on the wider determinants of health (e.g. employment, housing and environment).

Guidance for the Joint Strategic Needs Assessment and Health and Wellbeing Strategy is very clear in that we should prioritise what needs most attention so we do not try and take on everything at once. By focusing on key issues we can make the biggest differences. This strategy sets out what we propose to focus on, how we purpose to deliver improvements to health and wellbeing in Kent and what outcomes we want to achieve. It has not been developed in isolation, reflecting the evidence base of our Joint Strategic Needs Assessments and other key partner documents and data sources. This is also a high level strategy; our partners have detailed plans on how they plan to deliver improved services in Kent including improving people’s health and wellbeing. This strategy will not repeat those documents; it will instead focus on issues we need to tackle together.

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We will focus on an "outcomes based approach", in other words, what will be the tangible difference if we deliver everything we plan to deliver.

We will:

- Help ensure services are tailored to local needs and utilise local assets within communities
- Encourage people to make better lifestyle choices and support them to consider their own future health needs
- Use our influence to ensure key organisations work more efficiently and differently together so that we can improve the health and wellbeing of residents within available resources. This will include the development of integrated services so that patients receive joined up holistic health and social care.
- Ensure that the patient is at the centre of everything that we do.

We intend to test out the priorities and outcomes outlined in this document to ensure we have chosen correctly. Please follow the link to the website, where you can feedback your comments. Insert new weblink here for public feedback

What are we aiming to do?

To promote healthier lives for everyone in Kent our **Priorities** are to:

- Tackle the key health issues where Kent is not performing as well as the England average. For example tackling the levels of adult obesity.
- Tackle Health Inequalities across and within Kent. For example delivering the Kent Health Inequalities Action Plan (previously agreed by Kent County Council)
- Tackle the gaps in provision and quality of care and support that the people of Kent receive. For example ensuring improved rates of diagnosis for mental health problems and get people into the right services when they need them.
- Transform services to improve health and care outcomes, patient experience and value for money and quality.

With limited resources we need to focus on the key health issues that have been identified through the Joint Strategic Needs Assessment, this includes moving our focus from treatment to prevention; by adopting healthier lifestyles our health will improve reducing the risk of getting ill.

We also need to focus on doing the right things well, in other words, commissioning the right services that improve health as well as delivering value for money. The priorities outlined above will be delivered through three key **Approaches**:

- Integrated Commissioning, leading to
- Integrated Provision (delivering seamless services to the public), which will be
- Person Centred, we will get better at treating the whole person and not just the condition.

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Patients and the public should experience seamless services; and a way in which this can be achieved is through integrating the way we commission services and how those services are provided. By health and local government commissioning services together, we will ensure that patients get the right services at the right time and in the right place. We know that patients can spend longer in hospital because they cannot go home as a result of their home not having the right adaptations. If we commission services together, we can work towards this sort of thing no longer happening.

We also want to see a move from treating the condition to treating the patient. Quite often patients will experience more that one health problem, these needed to be treated together, rather than separate treatment and appointments for each health problem; saving both patient time and improving clinical outcomes.

From these **Priorities** and **Approaches** come 5 key **Outcomes** against which we will measure our success in improving the health of the people of Kent. These key outcomes are:

1. Every Child has the best start in life
2. People are taking greater responsibility for their health and wellbeing
3. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
4. People with mental ill health are supported to live well.
5. People with dementia are assessed and treated earlier.

We will achieve our outcomes by:

- Engaging with the community via HealthWatch and other engagement mechanisms
- Halting the widening of health inequality gaps both within and between communities and improving healthy life expectancy.
- Focus on prevention and the individual taking more responsibility for own health and care.
- Providing good quality joined up support and care to people with long term conditions and dementia, preventing unnecessary hospital admissions. By care we mean both health and social care.
- Reducing premature deaths by the key killers including: Cancers and respiratory diseases
- Integrating commissioning of health and social care services as well as integrating how those services are provided.
- Ensure cost effectiveness and efficiency are not achieved at the cost of quality.

There is already a lot of good work going on across Kent in these areas and this strategy is not intending to duplicate the work already taking place but we do want to ensure we are aware of these areas and make sure we are performing well.

All of this activity will deliver the priorities and targets identified in the National Outcome Frameworks for Public Health, National Health Service and Social Care (Children's Services

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is due). This is important as these Outcome frameworks set the national and local priorities for service delivery and outcomes. By identifying what is important for Kent, the Joint Health and Wellbeing Strategy is also the Health and Care Outcomes Framework for Kent.

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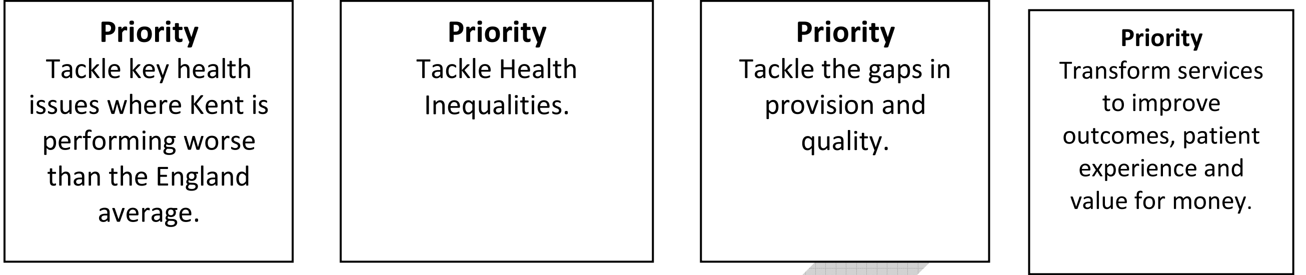
Joint Health and Wellbeing Strategy



Priority
Tackle key health issues where Kent is performing worse than the England average.

Priority
Tackle Health Inequalities.

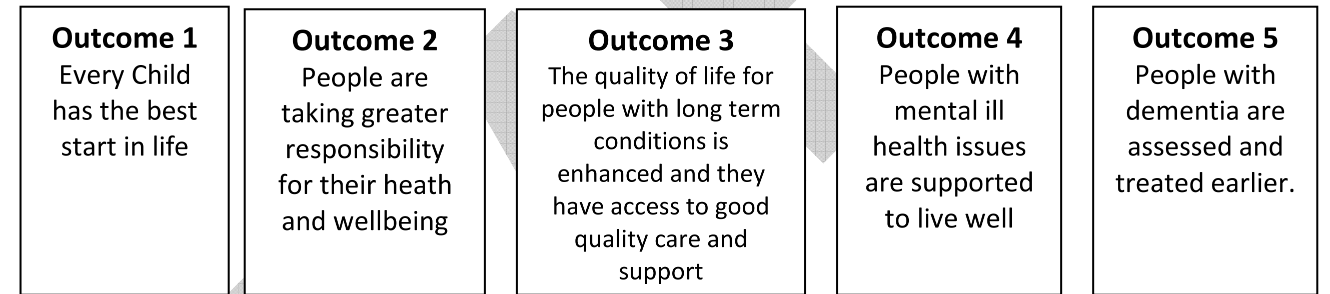
Priority
Tackle the gaps in provision and quality.

Priority
Transform services to improve outcomes, patient experience and value for money.

Approach: Integrated Commissioning

Approach: Integrated Provision

Approach: Person Centred



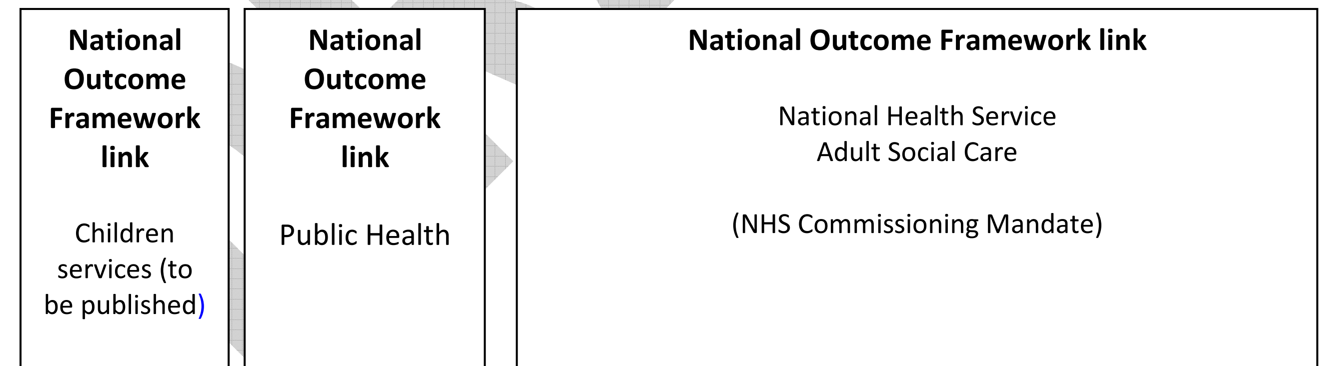
Outcome 1
Every Child has the best start in life

Outcome 2
People are taking greater responsibility for their heath and wellbeing

Outcome 3
The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

Outcome 4
People with mental ill health issues are supported to live well

Outcome 5
People with dementia are assessed and treated earlier.



National Outcome Framework link

Children services (to be published)

National Outcome Framework link

Public Health

National Outcome Framework link

National Health Service
Adult Social Care

(NHS Commissioning Mandate)

Proposed Kent Health and Care Outcomes

We believe that the Kent Health and Wellbeing Board should focus on the key health and care outcomes over the next 3 years:

- Every child has the best start in life
- People are taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
- People with mental ill health issues are supported to live well
- People with dementia are assessed and treated earlier.

The following pages outline why we want to focus on these areas and what we plan to do to tackle them. We welcome your views on these outcomes (please see online survey).

Outcome 1: Every child has the best start in life

We know that improving health and wellbeing in early life contributes considerably to better outcomes in later life and helps reduce inequalities.

If we do this in Kent the following will happen: Over the next 3 years we would hope to see an increase in breast feeding take up. We would also like to see targeted support on healthy eating in families leading to an increase in healthy weight levels. There will also be an increase in MMR take up, particularly in east Kent. Kent will see an additional 450 Health Visitors by 2015 who will support families with young children.

We will focus on:

1. Increasing breast-feeding initiation rates and prevalence at 6-8 weeks in all parts of Kent
2. Improving MMR uptake and improve access to the vaccination particularly for the most vulnerable groups
3. Promoting healthy weight for children particularly those in deprived areas
4. Ensuring women have access to good information and health and wellbeing in pregnancy and book their maternity care early
5. Roll out the increase in Health Visitors and ensure they are engaged with GPs and Children's Centres.
6. Better use of Community Assets such as children centres to deliver integrated health and social care to high risk vulnerable families
7. Rolling out Total Child Pilot to schools to help schools identify health and wellbeing problems for pupils
8. Working with families to promote healthy eating and increased physical activity
9. Reduce the numbers of pregnant women who smoke through their pregnancies
10. Delivering the intensive family worker intervention programme and Family advice workers in each District.
11. Improving child and adolescent mental health services (CAMHS).
12. Implement the Adolescent support workers programme, to deliver brief interventions as part of a wider team supporting young people and their families.

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13. Ensure there is adequate health provision in Special Needs schools and for children with Special Needs in mainstream schools.
14. Safeguarding target?
15. Reduce risk taking behaviour in children and adolescents e.g. smoking, sexual health, teenage conception, drugs and alcohol.

Outcome 2: People are taking greater responsibility for their health and wellbeing

We all make decisions which affect our health and wellbeing. We want to ensure we have provided the right environment in Kent for people to make better choices.
We have already got some good examples of where we are working with communities to promote healthy living, diet and exercise such as the Change 4 Life. Kent is performing below average on obese adults and healthy eating and we are average on physically active adults. We will work towards ensuring that patients and the public are better informed about symptoms of major diseases such as cancer.

If we do this in Kent the following will happen: A continued increase in people accessing treatment for drug and alcohol problems; fewer alcohol related admissions to hospital; an increase in people quitting smoking and staying smoke free; more people supported to manage their own conditions.

We will focus on:

1. Working with young people, in school settings, particularly those who are vulnerable to tackle substance misuse and underage drinking and other risk taking behaviour
2. Reducing the levels of inequalities for Life Expectancy
3. Reduce homelessness and its negative impact for those living in temporary accommodation
4. Reducing rates of deaths attributable to smoking in all persons targeting those who are vulnerable or most at risk
5. Ensuring there is provision for people with a learning disability living within residential accommodation to engage in physical activity and have a healthy diet
6. Ensure rehabilitation pathways and screening services are in place and systematically applied so all people eligible are offered service.
7. Ensure people are aware of symptoms, particularly cancer and encouraged to access services early.
8. Developing health checks appropriate for local populations
9. Improve the proportion of our adult population that enjoy a healthy weight, a healthy diet and are physically active.
10. Ensuring primary preventative strategies are systematically in place locally to address the lifestyle contributory causes of the big killers, e.g. smoking, obesity alcohol and illegal drugs consumption

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11. Ensure secondary prevention interventions are systematically in place locally and delivered at scale in order to have an impact on life expectancy.eg cardiac rehabilitation
12. Ensure the critical care pathways are in place across the Kent population to manage acute events according to nationally advised guidance (e.g. NICE) e.g. heart attacks and strokes.
13. Ensure that all providers maximise the opportunities to improve people's health e.g. implement the NHS Every Contact Counts initiative.

Outcome 3: The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

We know that our population is ageing and is living longer; we need to focus on not just adding years to life, but life to years. Currently, as we age, we start to experience a number of long term conditions (high blood pressure, COPD, heart problems) and these have a limiting affect on the quality of life and have an impact on resources. We want people with long term conditions to experience well co-ordinated services which prevent them from being admitted to hospital unnecessarily or experiencing a crisis.

If we do this in Kent the following will happen: More patients and their carers will be supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improve access to patient information; reduce number of times patients have to repeat information to professionals (Tell us Once); see a 15% reduction in A&E admissions; a 20% reduction in emergency admissions and a 14% reduction in elective admissions. More importantly this will lead to a 45% reduction in the rates of people dying earlier than expected.

We will focus on:

1. Ensuring risk profiling is carried out consistently across the population of Kent using the same tool and done at scale, using both GP and social care data, which will help to prevent unplanned hospital admissions
2. Ensuring we have multi-professional teams working together not in silos so that people who need support from a variety of organisations do not face duplication of assessment and numerous referrals around the system
3. Ensuring people can be supported to live as independently as possible at home
4. Enabling General Practitioners to act as navigators, rather than gatekeepers, retaining responsibility for patient care and experiences throughout the patient journey
5. Enabling Clinical records to be shared across the multi-professional team, by assessing patient record schemes e.g. Patient Knows Best.
6. Reduce the numbers of hip fractures for people aged 65 and over, where Kent is currently performing significantly worse than the England average.
7. Integration of services so that the patient does not see a gap between health and social care.

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8. Palliative and end of life care
9. Ensuring a range of self management approaches are in place including:
   - patient and carer education programmes
   - medicines management advice and support
   - the provision of telecare and telehealth,
   - psychological interventions (e.g. health trainers)
   - pain management
   - patient access to own records
   - systematic training for health providers in consultation skills that help engage patients

Outcome 4: People with mental ill health issues are supported to 'live well'

We have been working hard to ensure we deliver the Kent wide integrated strategy (Live it Well) for mental health and wellbeing of people in Kent. We have been putting into place the action plan to deliver high quality services for people with mental ill health issues. We know this can only be achieved by organisations working together across Kent, particularly in primary and secondary care. In addition we will work with partners to continue to improve mental health service provision and implement "No health without mental health"

If we do this in Kent the following will happen: Early recognition of mental ill health will be increased, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support and early intervention services will see an increase in people reporting an improvement in their own mental ill health and wellbeing. The stigma of mental ill health will be reduced.

We will focus on:

1. Improving rates of recognition and diagnosis in Kent and get people into the right services when they need them.
2. Promoting independence and ensuring the right care and support is available to prevent crisis
3. Awareness raising and access to good quality information
4. Ensure more people with mental ill health are recovering
5. Ensure more people with mental ill health have good physical health
6. Ensure more people with mental ill health have a positive experience of care and support
7. Ensure more people with mental ill health are supported in employment and/or education
8. Work with the voluntary sector, other provider, carers and families to reduce the social isolation of people with mental health issues
9. Ensure we have robust audit processes around mental health e.g. suicide prevention.

Outcome 5: People with dementia are assessed and treated earlier.

There are currently 9200 people living with dementia in Kent, and this figure is set to more than double over the next 30 years. Dementia is a progressive disease (which means it will

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only get worse) placing a significant strain on services, families and carers (who are often elderly and frail themselves). We have been working hard to ensure we deliver the National Dementia Strategy in Kent. Following Kent County Council's Dementia Select Committee we have been putting into place the action plan to deliver high quality services for people with dementia. We know this can only be achieved by organisations working together across Kent. In addition we will work with partners to continue to improve mental health service provision.

If we do this in Kent the following will happen: Early diagnosis of Dementia will become the norm, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support including housing, supported housing options and dementia friendly communities will lead to patients being able to stay within their own communities for longer. GPs and other health and care staff will be able to have the appropriate conversations with patients and their families about end of life care.

We will focus on:

1. Deliver the Integrated Dementia Plan
2. Developing an integrated model of care
3. Improving rates of early diagnosis in Kent and get people into the right services when they need them.
4. Early intervention to reduce care home placements and hospital admission
5. Improve accommodation and hospital care
6. Work with the voluntary sector, other provider, carers and families to reduce the social isolation of people with dementia.
7. Awareness raising and access to good quality information
8. Work with partners to develop dementia friendly facilities and communities in Kent.

What happens next?

This consultation document sets out the key priorities and outcomes that the Kent Health and Wellbeing Board proposes to focus on over the next 3 years. We are asking your views on whether we have identified the right outcomes and if we are taking the right approach to tackle them.

We want to hear your views on our proposals. You can have your say by completing the online survey on insert web address.....the closing date for the consultation is.......

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Kent Joint Health and Wellbeing Strategy - Supporting Information

1. National Context

'The ambition is for health and wellbeing boards to go further than analysis of common problems and to develop deep and productive partnerships that develop solutions to those commissioning challenges, rather than just commenting on what those problems and challenges are. Building on enhanced JSNAs, the Bill places an additional duty on the local authority and CCGs to develop a joint health and wellbeing strategy for meeting the needs identified in the relevant local JSNA are to be met. This could potentially consider how commissioning of services related to wider health determinants such as housing, education or lifestyle behaviours can be more closely integrated with commissioning of health and social care services. Once again, this function is to be undertaken through the health and wellbeing board. In line with other local authority committees, the health and wellbeing board is able to request information for the purposes of enabling or assisting its performance of functions from the local authority and certain members and persons who are represented on the health and wellbeing board. In preparing JSNAs and joint health and wellbeing strategies, local authorities and CCGs must have regard to any guidance issued by the Secretary of State and to the Secretary of State's mandate to the NHS Commissioning Board. The NHS Commissioning Board must appoint a representative to participate in preparation of JSNAs and joint health and wellbeing strategies. The joint health and wellbeing strategy may consider services beyond health and social care – how the commissioning of health and social care services, and wider health-related services, could be more closely integrated – enabling the board to look more broadly at factors affecting the health and wellbeing of their populations. Both JSNAs and joint health and wellbeing strategies must be published.'

A key element of the health reforms is the move towards commissioning for **outcomes**; rather than the current situation which is commissioning to achieve targets, that often relate to process, not outcomes.

The national ambition is to deliver outcomes that are amongst the best in the world, supported by three outcomes frameworks:

- The NHS Outcomes Framework,
- The Public Health Outcomes Framework and
- The Adult Social Care Outcomes framework

The three outcomes frameworks will drive future commissioning and thus are critical to the context of our health and Wellbeing strategy for Kent.

NHS Outcomes Framework

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on:

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
Domain 4	Ensuring that people have a positive experience of care; and
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Overall the NHS Outcomes aspiration is to:

- Reduce years of life lost from conditions amenable to health care intervention and improve under 75yrs of age life expectancy.
- Improve health related quality of life for people with long term conditions.
- Improve experience of people of the care they receive.
- Reduce emergency admissions (for acute conditions that should not usually require hospital admission) and readmissions within 30 days of discharge
- Reduce the number of patient safety incidents including those that result from sever harm or death.

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Public Health Outcomes Framework

In January 2012 the Department of Health published ‘Improving Outcomes and Supporting Transparency. Part 1 A public health outcomes framework for England, 2012 to 2016’. The framework is geared to refocus around achieving positive health outcomes for the population and reducing health inequalities.

The framework is focused on two high-level outcomes which are:

1. **increased healthy life expectancy**
2. **reduced differences in life expectancy and healthy life expectancy within and between communities**

It is acknowledged that improvements in these outcomes make take years – sometimes even decades- to see marked change. Thus a set of supporting public health indicators have been developed to show how well we are doing year on year. These are as follows:

Domain 1	improving the wider determinants of

	health
Domain 2	health improvement
Domain 3	health protection
Domain 4	healthcare public health and preventing premature mortality.

Social Care Outcomes Framework (ASCOF)

The ASCOF is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care. They are not a performance measurement tool but have been devised nationally to guide local commissioning and provision of service.. The framework will allow benchmarking and comparison with other areas which is critical to local accountability of councils and reporting to their citizens on a consistent basis

Again, the ASCOF is structured into four domains as follows:

Domain 1	Enhancing quality of life for people with care and support needs
Domain 2	Delaying and reducing the need for care and support
Domain 3	Ensuring that people have a positive experience of care and support
Domain 4	Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm

Delivery of these outcomes will require collective effort over all parts of the Kent system and Kent population and provides the opportunity for systematic coherence in order to protect and improve the health of the people of Kent.

2. Local Context

Bold Steps for Kent

Bold Steps for Kent sets out how Kent County Council needs to change the way it works to reflect the changing shape of public services, as the Government has set out plans to

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fundamentally reform how key public services, such as education and health, will be provided in the future, underpinned by the clear message that residents should have more influence on how services are provided locally.

There are three clear aims that run throughout Bold Steps for Kent:

- To help the Kent economy grow - We must support and facilitate the new growth in the Kent economy by delivering the priorities in our regeneration framework Unlocking Kent's Potential, by delivering new housing and new infrastructure and by working with key business sectors.
- To put the citizen in control – power and influence must be in the hands of local people so they are able to take responsibility for their own community and service needs.
- To tackle disadvantage – We will make Kent a county of opportunity where aspiration rather than dependency is supported, particularly for those who are disadvantaged or who struggle to help themselves and their family.

More specifically the County set out the following in relation to Health:

Bold Steps for Health

The health reforms proposed by the Government will give greater power to GPs to choose the best services for their patients, with local government having strategic responsibility to ensure the County's health needs are met. We must use this opportunity to improve the quality of the health service in Kent.

- We will help ensure that GP commissioning plans meet the health needs of all residents and communities in Kent. Working at County and District level we want Locality Boards to play a key role in this commissioning process, better connecting KCC and wider public services with health provision at the local level.
- We will work with GP consortia to encourage new healthcare providers to enter the market for health services in Kent. This will drive up standards, provide competition, increase choice and drive greater value for money for GPs and patients.
- We will work to join up and integrate health and social care service provision to reduce costs and demand that could be avoided - for example, by joining up our assessment processes.
- We will focus on a preventative approach to public health, supporting people to make better lifestyle choices and consider their own future health needs – so expensive health services aren't required as frequently as now.

3 Summary

The context within which this Health and Wellbeing Strategy is produced reflects not only the national changes happening in a reorganising NHS and Local Authority environment,

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but also in a context of national and local aspiration to improve health outcomes, reduce health inequalities and integrate care in order to improve the health of the population of Kent.

Summary and priorities from the Joint Strategic Needs Assessment

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What are the big issues in Kent and how can we get the biggest health gains for Kent?

National policy emphasises a life course approach towards improving health inequalities and health and wellbeing, where a combination of health, social and economic factors affect people's health outcomes at different periods in their lives. In Kent, a number of priorities have been suggested orientated around five main areas:

1. Early Years

Improving the continuation (and recording) of breastfeeding rates beyond six weeks.

There is no doubt over the benefits of breastfeeding towards health and wellbeing of children. However breastfeeding is not being sustained into the early months of infancy for a large number of children. The rates of breastfeeding in Kent drop from around 70% at birth to 25% at six months of age.

Health and social care organisations need to fully implement key recommendations from the Healthy Child and Baby Friendly Initiative Programmes, in order to improve the uptake and continuation of breastfeeding.

Improving MMR uptake as well as general routine immunisation rates and reduce variation in general practice coverage to ensure herd immunity and prevent future epidemics.

The current MMR vaccination rates by Year 5 are 84% and 87% in east and west Kent respectively, well below the 95% coverage required for herd immunity (the level at which risk of spread of infection is reduced)

This will be achieved through closer working between the immunisation and vaccination coordination service and GP practices, utilizing a targeted approach to those practices and vulnerable population groups where uptake is lowest. Social marketing campaigns and improved monitoring systems.

Using Children Centres more effectively to deliver integrated services to vulnerable high risk families

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This includes services such as health visitors delivering messages around health promotion and behaviour change such as reduction of second hand smoke, alcohol and substance abuse, domestic violence and improving healthy weight and emotional wellbeing.

2. Young People and Lifestyle choices

The numbers of young people drinking responsibly has increased in Kent as it has nationally, and fewer children drink. However the small number of young people who do drink at increasing risk or higher risk levels and those who regularly binge drink are likely to be drinking more hazardously. 11% of 11- 16s in the Kent Children's *Smoking Drinking and Drugs* survey (2008) indicated that they did drink alcohol most days or once or twice a week. They are also likely to be from a more vulnerable group of young people. In the same way, although most children will not misuse drugs, and most of those young people who do experiment will not continue to do so, these more vulnerable young people are more likely to continue in dangerous drug use. This small group of young people in Kent are likely to have multiple risk factors such as parental substance misuse, family breakdown, domestic violence, poverty, truancy or school exclusion. They show significant levels of poor physical and mental health as well as poor sexual health and substance misuse issues. They are often disengaged from school as a result of behavioural issues, and are more likely to be 'Looked after Children' or known to the Youth Offending Service. The more vulnerable the young person is, i.e. the more risk factors they have: the more likely it is that the child will misuse drugs, alcohol and tobacco.

Young people benefit from life skills approaches to early intervention. They need to be engaged in learning and in school: and positively engaged in activity to build resilience over time through developing friendships, life skills and positive social peer networks. Positive relationships with adults in specialist services who understand the needs of young people and adolescent behaviours like substance misuse and risking sexual health are also needed. Currently, there are specialist services commissioned to tackle young people's substance misuse needs, and this includes understanding the dangers and consequences of a range of risk-taking behaviours. The DUST screening tool is promoted to identify those who need help, and further work is being developed in 2012 to support those families and young people in greatest need in Kent and help them to tackle their problems.

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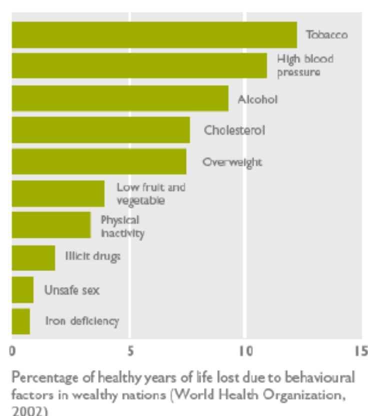
3. Prevention

Percentage of health years of life lost due to behavioural factors in wealthy nations.



Percentage of healthy years of life lost due to behavioural factors in wealthy nations (World Health Organization, 2002)

Percentage of health years of life lost due to behavioural factors in wealthy nations.
Cabinet Office (2010) Applying behavioural insight to health

Significant variation in the prevalence of unhealthy lifestyles exists across the 12 districts, often linked with deprivation.
80% heart disease, stroke and type 2 diabetes, and 40% cancer could be avoided if common lifestyle risk factors were eliminated. Smoking, high blood pressure and alcohol contribute to the largest proportion of healthy years life lost [Figure 3]. Therefore, people, who are at future risk, need to be identified early enough and their lifestyle and behaviour should be modified accordingly through self management, supported by social marketing campaigns such as Change 4 Life and integrated frontline services such as Stop Smoking, IBA (Alcohol), and Healthy Weight. Therefore, the rollout of the national Health Checks programme across Kent needs to be accelerated across the county and a specific focus on keys areas such as Thanet and Swale.

Change4Life three year social marketing strategy
In just three years, Change4Life has become one of the most instantly recognisable brands in health improvement, enjoying high levels of trust and involvement, not only from the public, but from healthcare professionals, staff in schools and early years' settings, local authorities, community leaders, charities and businesses.
The first year of Change4Life in 2009 was successful, awareness of the brand built rapidly and attitudes towards it were (and remain) very positive.
Over 400,000 families joined Change4Life in its first year and over 1 million mothers claimed to have made changes to their children's behaviours as a direct result of Change4Life Tesco club card research analysing the purchases of 10,000 Change4Life families has shown early signs of positive behaviour change in food

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purchasing patterns and that the campaign is resonating with and attracting the intended target audience (DH 2010)

Locally NHS West Kent developed – the **Change 4 Life (C4L) – Healthy Passport Club,** a locally designed social marketing campaign to promote the Department of Health 'Change4life' programme since April 2011. The aim of the club is to promote the national C4L messages of healthy living, diet and exercise. The campaign has set out to build a supportive environment, provide tools for people to set goals, record achievements and provide motivational support in a fun way. To date more than 14,000 people from all walks of life have joined the club, a significant proportion encouraged by GPs. All the activities undertaken by those involved are recorded as steps around the world; currently this stands at 10,562,491 steps or 5,300 miles. As this campaign has been so successful in west Kent it has been agreed that it should be rolled out across Kent.

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4. The Shift to Out of Hospital Care

The population of Kent in the older age group (65+ and 85+) is predicted to increase significantly over the next 5 to 10 years. This is a demographic bubble leading to disproportionate numbers of older folk in our population. It is just emerging now and expected to persist for the next 25 years or so. This bubble along with the changing nature of longevity and health deterioration, has led us to consider major changes to the way the health and social care system work.

The system we operate comprises myriad silos of care, with inherently high levels of referral out of one and back to another. There is limited coordination and integration between them. The environment is such that, these transfers from one isolated part of the system to another, almost occur by default for reasons of infrastructure and culture. For example after hours care providers do not usually have access to information from the patient record, other providers who may need to make decisions in isolation e.g. community matrons, may be similarly disconnected from the central primary care information store. As a result, emergency admissions in the elderly for falls and dementia have increased by more than 50% and 85% respectively over the last 5 years.

Risk stratification of the Kent population is urgently required to pro-actively identify complex elderly patients in need of a multi disciplinary integrated approach (across primary care, community, and acute care and social services) towards crisis response and support, and exacerbation management ultimately resulting in hospital admission avoidance.

Risk stratification – key points

Predictive risk models are used for predicting events such as unplanned hospital admissions, which are undesirable, costly and potentially preventable.

Such models have been shown to be superior to other 'case finding' approaches, including threshold models and clinical opinion. Although the Department of Health has previously funded two predictive models for the NHS in England, the current policy is to promote an open market in terms of suppliers of risk tools.

Commissioners should consider a range of factors when choosing whether to 'make or buy' a predictive model, including the outcome to be predicted, the accuracy of the predictions made, the cost of the model and its software, and the availability of the data on which the model is run.

Predictive models should be seen as one component of a wider strategy for managing patients with chronic illness.

In NHS Blackpool, risk profiling was used to target resources more effectively to reduce unplanned care activity, using the combined predictive model. Approximate annual spend is around £26 million per year and makes up 65% of occupied bed days. The model used primary care and hospital data, (inpatient, outpatient and A&E data). The initial results showed that out of the 150,000 population in Blackpool approximately 765 patients were identified as very high risk generating more than 2,639 unplanned admissions in the previous year and the admissions avoided (323) if the necessary clinical intervention was delivered, generating £586,000 in gross savings. Apart from the benefits of identifying very high risk patients the tool enables access to real-time clinical patient data and prioritisation of community matron workload. *Nuffiield Trust (2011)*

5. Information sharing

The successful delivery and evaluation of programmes will depend on developing more robust arrangements for sharing information between health and social care organisations. For example use of an identifier such as NHS number will help to understand how patients access services across the continuum of care.

Care for older people in Torbay

Care for older people in Torbay is delivered through integrated teams of health and social care staff, first established on a pilot basis in 2004 and since extended throughout the area. Each team serves a locality of between 25,000 and 40,000 people and is aligned with the general practices in the locality. Budgets are pooled and used flexibly by teams who are able to arrange and fund services to meet the specific needs of older people. A major priority has been to increase spending on intermediate care services that enable older people to be supported at home and help avoid inappropriate hospital admissions. The work of integrated teams has been taken forward through the work of the Torbay Care Trust, created in 2005. Results include a reduction in the daily average number of occupied beds from 750 in 1998/9 to 502 in 2009/10, emergency bed day use in the population aged 65 and over that is the lowest in the region, and negligible delayed transfers of care. Since 2007/8, Torbay Care Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes, with a corresponding increase in home care services targeted at prevention and low-level support.

Chronic care management in Wales

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In Wales, three Chronic Care Management Demonstrators in Carmarthenshire, Cardiff and Gwynedd Local Health Boards pioneered strategies to co-ordinate care for people with multiple chronic illness. By employing a 'shared care' model of working between primary, secondary and social care – and investing in multidisciplinary teams – the three demonstrators report a reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent respectively between 2007 and 2009. This represented an overall cost reduction of £2,224,201.
Nuffield Trust (2012).

In summary the Kent JSNA in totality has pointed to a large number of priorities.

Specifically it highlights the following as priorities for Kent:

- Early Years
    - Improving breast feeding rates
    - Improving coverage of immunisations
    - Improving the use of children and families centres
- Young people and lifestyle choices
- Prevention
    - Reduction in risk from life style behaviours
    - Roll out of Health Checks
- Shifting care to outside hospitals
    - Risk profiling
    - Provision of integrated care teams
    - Move to self management
- Information sharing between organisations

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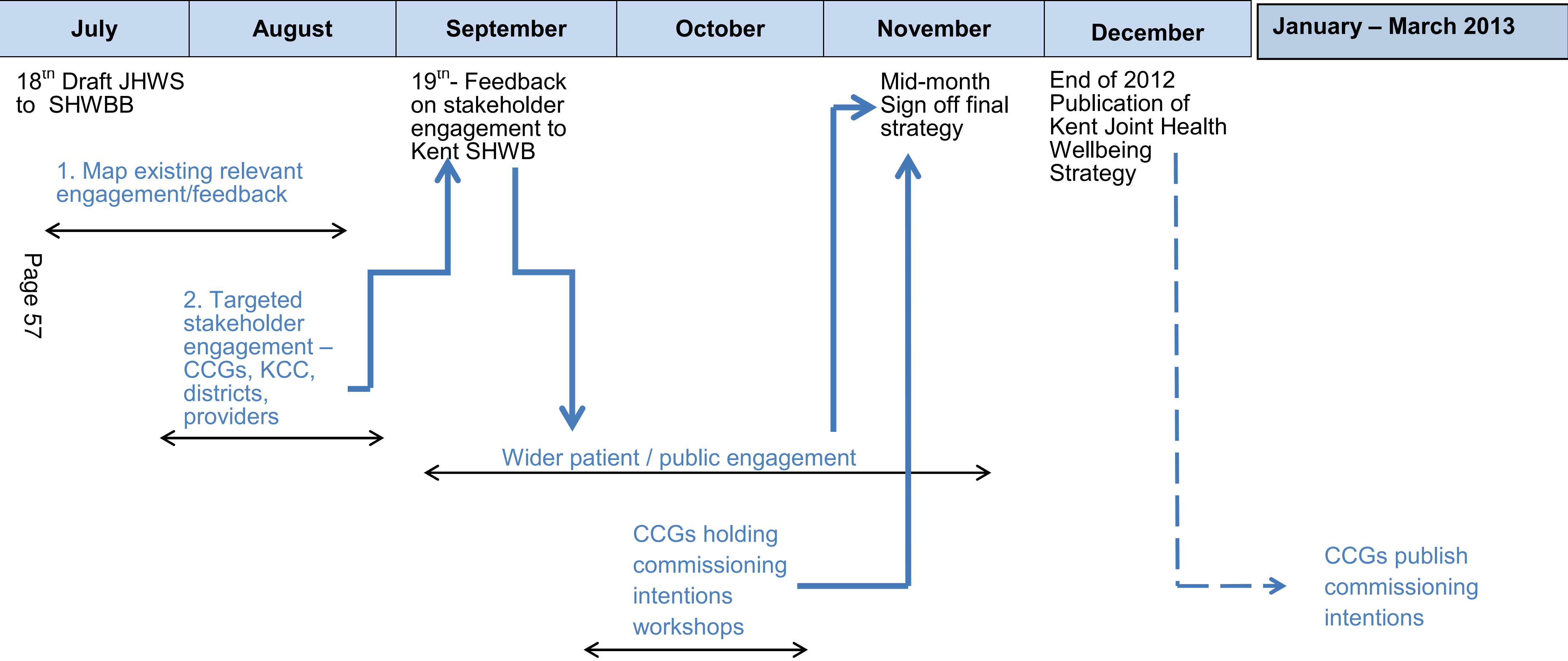
Appendix C

Kent Joint Health and Wellbeing Strategy

Key Milestones



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Appendix D

Draft Joint Health and Wellbeing Strategy

Survey Questions

1. Our Vision

Our vision in Kent is to deliver better quality care, improve health outcomes, improve the public's experience of health and social care services and ensure that the individual is at the heart of everything we do.

Do you agree with our overall vision? (Please tick one)

☐ Yes
☐ Partly
☐ No
☐ Don't know

What was the reason for your answer?

What else would you like to see added?

2. Health and Wellbeing Strategy Priorities

The following 4 priorities have been identified for Kent; please state how much you agree with the priorities (please tick)

	Priority	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
1	Tackle key health issues where Kent is performing worse than the England average.					
2	Tackle health inequalities					

3	Tackle the gaps in provision and quality.					
4	Transform services to improve outcomes, patient experience and value for money.					

3. Health and Wellbeing Strategy Outcomes

To promote healthier lives for everyone in Kent we have focused on 5 key outcomes. These are:

1. Every Child has the best start in life
2. People are taking greater responsibility for their health and wellbeing
3. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
4. People with mental ill health
5. People with dementia are supported to live well.

How much do you agree with each of the 5 outcomes (please tick one in each row)

	Outcome	**Strongly agree**	**Agree**	**Neither agree or disagree**	**Disagree**	**Strongly disagree**
1	Every Child has the best start in life					
2	People are taking greater responsibility for their health and wellbeing					
3	The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.					
4	People with mental ill health issues are supported to live well					
5	People with dementia are assessed and treated earlier.					

How would you rank the 5 in order of priority? (1 being top priority)

	Outcome	**Priority**
1	Every Child has the best start in life	
2	People are taking greater responsibility for their health and wellbeing	
3	The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.	
4	People with mental ill health issues are supported to live well	
5	People with dementia are assessed and treated earlier.	

Please give your reasons below:

Are there any key outcomes you think we've missed? If so, please describe below:

4. Any other comments

Having read the draft Health and Wellbeing Strategy are there any other suggestions or comments you would like to make?

What could your organisation do to help deliver the Health and Wellbeing Strategy?

Did you find the supporting information useful?

☐ Yes
☐ No

Do you have any comments about the supporting information?

5. About you.

1. Are you completing this questionnaire as an individual or on behalf of a group?

☐ Individual ☐Group

2. Which of the following best describes your role:

☐ Member of the public
☐ County Councillor
☐ District Councillor
☐ County Council Officer
☐ District Council Officer
☐ NHS: Commissioner
☐ NHS: GP
☐ NHS: Clinician
☐ NHS: Provider
☐ Other Public Sector Organisation
☐ Business Organisation
☐ Voluntary, Community or Faith Sector
☐ Service Provider
☐ LINk member
☐ Other Please State:

Which Organisation do you represent? *(optional)*

Appendix E

Sent on behalf of Roger Gough, Chair of Kent Shadow Health and Wellbeing Board

Dear Colleague

Draft Kent Joint Health and Wellbeing Strategy

As you are aware, the development of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy (JHWS) are two of the main duties of the Kent Health and Wellbeing Board, as both of these documents will form the basis of commissioning plans in both health and social care.

At the last meeting of the Kent Health and Wellbeing Board, we looked at and discussed an early version of the Kent JHWS. We agreed at that meeting that we would circulate an updated version (reflecting the comments made during the discussions) to the Health and Wellbeing Board and its wider membership, for further comment. I am pleased to share with you for consultation the draft Joint Health and Wellbeing Strategy for Kent. This consultation document sets out the key priorities and outcomes that the Kent Health and Wellbeing Board propose to focus on over the next 3 years. We are now seeking your views on whether we are focussing on the right issues for Kent and if we are taking the right approach to tackle them. Also included is some supporting information and a copy of the survey that we would like you to complete online at, through the following link:
http://www.kent.gov.uk/health_and_wellbeing/joint_health_and_wellbeing_str.aspx

We are consulting on this document with key partners in health, local government and beyond in late August/early September. We will be taking those views into account and feeding back to the Kent Health and Wellbeing Board at its September meeting, before undertaking wider consultation during the autumn of 2012 and the final version of the Strategy will be published in December 2012. The wider consultation on the JHWS will take place alongside the development of the CCG Commissioning plans for 2013/14.

This will not be your only opportunity to comment on the development of the JHWS; you will be able to further comment during the wider engagement phase in the autumn. We will also engage directly with various partners such as clinicians to ensure that we fully capture their views.

We want to hear your views on our proposals and you can have your say by completing the online survey. I would be grateful if you could send in your comments by the consultation deadline of the 12th September 2012.

I shall look forward to receiving your comments.

Roger Gough
Chair of Kent Shadow Health and Wellbeing Board

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Item 7: East Kent Hospitals NHS University Foundation Trust Clinical Strategy Review.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 12 October 2012

Subject: East Kent Hospitals NHS University Foundation Trust Clinical Strategy Review.

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1. Background

(a) Representatives of East Kent Hospitals NHS University Foundation Trust attended the meeting of 3 February 2012 to present and discuss the initial work being undertaken in the development of its clinical strategy. An extract from the Minutes of this meeting is attached for information.

(b) The Committee requested the opportunity to receive an update in due course.

2. Recommendation

That the Committee consider and note the report.

Extract from the Minutes of the Health Overview and Scrutiny Committee meeting, 3 February 2012[1]

Liz Shutler (Director of Strategic Development and Capital Planning, East Kent Hospitals NHS University Foundation Trust), Noel Wilson (Divisional Medical Director for Surgical Services, East Kent Hospitals NHS University Foundation Trust), Robert Rose (Divisional Director for Urgent Care and Long Term Conditions, East Kent Hospitals NHS University Foundation Trust), Carmen Dawe (Assistant Director of Marketing and Fundraising, East Kent Hospitals NHS University Foundation Trust), and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(1) The Chairman introduced the item and explained that the Chief Executive of East Kent Hospitals NHS University Foundation Trust had requested the opportunity for the Trust to bring the work being done on developing a clinical strategy to the Committee. The subject had also generated some media interest in the East of the County and so the Chairman hoped there would be clarification around it as a result of the day's meeting.

(2) Trust representatives outlined the main features and drivers of the review. It had begun in October 2010 to look at various clinical issues and those raised by the need to continue to provide core services as well as enable healthcare closer to home. No decisions around service configuration had been made but the Committee would be continually involved in the Trust's developing strategy.

(3) The whole development of the strategy needed to be seen in the context of a shift of emphasis nationally from the work which had been done to improve planned care, such as the 18-week pathway, and towards improving emergency care. Emergency care was a high risk area, and one of the drivers for change was the Royal College of Surgeons report, *Standards for Emergency Care.* Members had a summary of this document in their Agenda pack and several Members highlighted the finding in the report that 80% of surgical mortality arises from unplanned/emergency surgical intervention and it was clarified that this referred to 80% of deaths which occurred as a result of surgery. The emergency surgery mortality rate for the Trust was below the national average, but this was not seen as a reason for complacency.

(4) The same principles around clinical care applied in East Kent as they did elsewhere, such as in West Kent, and would continue to do so and there were areas where work was being done with West Kent, such as vascular surgery.

[1] Complete set of Minutes for 3 February 2012 available at:: https://democracy.kent.gov.uk/documents/g3977/Printed%20minutes%2003rd-Feb-2012%2010.00%20Health%20Overview%20and%20Scrutiny%20Committee.pdf?T=1

(5) Consultants were rightly involved in planned care, but emergency care could be improved by involving them more at the 'front door' of hospitals to establish a quality care plan for emergency patients with a one stop assessment. Consultant acute physicians had already been brought into front door services and EKHUFT achieved 97% against the 4-hour A&E target in January, which is a very challenging month.

(6) Consultants needed to be supported by appropriately skilled teams and so achieving this raised workforce issues. There was a need to maintain locally accessible services, but there was also a requirement for specialisation of services in some areas. This had happened with cardiac care being centralised at the William Harvey Hospital in Ashford. There had also been centralisation of vascular surgery. Breast surgery was an area of increasing specialisation and there was also the requirement to develop a Level 2 Trauma Unit at William Harvey. In addition, some specialist centres were not in Kent at all. Trust representatives explained that the 'hub and spoke' model was applicable in many areas.

(7) In relation to transfers to the Trauma Unit, the Trust representatives explained that this would only be necessary in a minority of cases, and in many instances, the necessary skills were present at the Queen Elizabeth the Queen Mother Hospital (QEQM) in Margate meaning treatment would continue to be provided locally in Thanet.

(8) The specific issue of travel times was raised by Members with the response given was that travel times were based on clinical evidence, which supported the idea of taking patients further to access specialist services. More broadly, Trust representatives explained that they were concerned about transportation issues where the transport network was geared more towards going into London than travelling across East Kent. A transport group was being established and this would work with the emerging Clinical Commissioning Groups and the Ambulance Trust to look at such issues as travelling between sites.

(9) There was a potential knock on effect to elective surgery and Trust representatives explained that a clear separation between emergency and elective teams was being made. Currently a 24 hour emergency theatre (known as a CEPOD theatre, referring to *The Confidential Enquiry for Peri-operative Deaths*) was kept specifically for emergency surgery and one discussion was around whether to invest in a second. The development of trauma rotas was geared to an aspiration towards having dedicated teams. This was a whole workforce issue and the review needed to look at the currently available workforce as well as what sorts of skills would be required in the future. Consultants were costly, but there were ways of working smarter.

(10) This was demonstrated by the Trust in response to specific concerns raised by Members about the future of services at the QEQM. Dealing with heart attacks and strokes, for example, was seen as a core service

to deliver locally in Thanet. Bringing consultants to the front door of the hospital meant that many patients would be able to be dealt with as ambulatory cases, rather than having to be admitted as inpatients. Where there may need to be some specialisation is in using such medical advances as treatments to directly dissolve clots in the brain. Similarly with gastroenterology, there had been no discussions about moving services from QEQM as this is a core medical component of the services provided by the hospital, and in terms of surgery, it would only involve the very specialist kinds of care.

(11) Further examples of services being developed at the QEQM were provided. More investment was being made in CT scanners. The Trust was looking to introduce a pathway model of care, already introduced in Peterborough, for fractures of the neck of the femur which would see patients under the care of medical consultants, and benefitting from surgery available at QEQM.

(12) As with travel times, Trust representatives provided information on the evidence base. There were a wide range of different measures and more were being developed specifically around the patient experience. This was collected and published. The example of vascular care was given, where there were national peer reviews and data available down to the level of individual surgeons. This connected with a point raised by a Member about the tension between a focus on process and a focus on care, to which NHS representatives felt that as the processes did impact on the patient outcomes, the two things went together.

(13) The Trust felt this could further be seen in the priority it gave to dealing with healthcare associated infection. East Kent Hospitals had very low MRSA and C. diff. rates but were not complacent and the separation of elective and emergency care was a core element in keeping rates low. The achievements the Trust has made in reducing length of stay also made an important contribution.

(14) As with the previous item, the Chairman looked to the Committee to make a specific resolution on this issue rather than simply noting the report and asked Mrs Green to suggest one which would be appropriate.

(15) AGREED that the Committee notes the high level of concern of residents in East Kent to any proposed changes and that the HOSC will continue to monitor the situation very closely and scrutinise any further developments as and when they emerge to ensure we look after the best interests of Kent residents.

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

To: Health Overview and Scrutiny Committee, 12 October 2012

Subject: Drivers for Change: a) Emergency Surgery Standards, b) Trauma Networks, and c) European Working Time Directive

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Introduction

(a) In the report submitted to the Health Overview and Scrutiny Committee by East Kent Hospitals University NHS Foundation Trust for the 3 February 2012 meeting, a number of 'key drivers of change' behind their clinical strategy review were outlined.[1] This background paper provides additional information on several of these. It is for use with both Items 7 and 8 of this Agenda.

(b) At the previous meeting of the Committee on 7 September 2012, the issue of the impact of the European Working Time Directive (EWTD) was raised and discussed and the hope expressed that this be an issue which could be returned to. Additional information on the EWTD is included for Member's background information.

Part A – Emergency Surgery Standards

1. Introduction.

(a) In February 2011, the Royal College of Surgeons of England produced the document *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*.[2] This had the aim of providing information and standards on emergency surgical service provision for both adult and paediatric patients.

(b) The following provides a summary of the report.

2. What is emergency surgery?

(a) The report explains that an emergency surgical service is not one that simply operates out of hours. Instead, six elements are outlined:

1. Undertaking emergency operations at any time, day or night.

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[1] East Kent Hospitals University NHS Foundation Trust, *Clinical Strategy Review,* Health Overview and Scrutiny Committee 3 February 2012, https://democracy.kent.gov.uk/documents/s29810/Clinical%20Strategy%20Briefing%20from%20East%20Kent%20Hospitals%20NHS%20University%20Foundation%20Trust.pdf

[2] The Royal College of Surgeons of England, *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*, February 2011, http://www.rcseng.ac.uk/publications/docs/emergency-surgery-standards-for-unscheduled-care

2. The provision of ongoing clinical care to post-operative patients and other inpatients being managed non-operatively, including emergency patients and elective patients who develop complications.

3. Undertaking further operations for patients who have recently undergone surgery (i.e. either planned procedures or unplanned 'returns to theatre').

4. The provision of assessment and advice for patients referred from other areas of the hospital (including the emergency department) and from general practitioners. For regional services this may include supporting other hospitals in the network.

5. Early, effective and continuous acute pain management.

6. Communication with patients and family members/others providing support.[3]

(b) For most surgical specialties, providing emergency surgical care works out to around 40-50% of the workload. This varies according to the speciality; for example, in neurosurgery over half the admissions are non-elective and account for 70-80% of the workload.

3. The case for change and common issues:

(a) A number of reasons for changing the way emergency surgical care is delivered are given:

- "Patients requiring emergency surgery are among the sickest treated in the NHS.
- Outcome measurement in emergency surgery is currently poor and needs to be developed further.
- Current data show significant cause for concern – morbidity and mortality rates for England and Wales compare unfavourably with international results.
- It is estimated that around 80% of surgical mortality arises from unplanned/emergency surgical intervention.[4]
- The NHS has to reduce its costs significantly over the coming years – savings can only be delivered sustainably through the provision of high quality and efficient services. The higher complication rate and poorly defined care pathways in emergency surgery (when

[3] Ibid., p.7.
[4] Meaning 80% of those deaths which result from surgery.

compared to elective surgery) offer much greater scope for improvement in care and associated cost savings.

- The reduction in working hours for doctors and the focus on elective surgical care has changed the level of experience and expertise of trainees when dealing with acutely ill surgical patients.

- Patients expect consultants to be involved in their care throughout the patient pathway.

- Evidence from a survey of general surgeons indicated that only 55% felt that they were able to care well for their emergency patients.

- At least 40% of consultant general surgeons report poor access to theatre for emergency cases." [5]

(b) A number of common issues to be addressed are outlined in the report[6]:

- Priority and timeliness of surgery.

- Understanding quality and outcome issues.

- Teamworking.

- Organisation of staff.

- Organisation of facilities.

- Clinical interdependencies.

- Communication with patients and family members/others providing support.

4. Models of care.

(a) Within the clinical interdependencies which exist, a number of models of care are outlined in the report:[7]

- Consultant-based care.

- Separating elective and emergency care.

- Surgical assessment units.

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[5] Ibid., p.13.
[6] Ibid,. pp.8-12.
[7] Ibid., pp.13-16.

- Clinical networks.
- Extending the working day.
- Outcomes and quality indicators.

(b) The report is not prescriptive as to which model of care should be adopted, and the bulk of the report consists of describing the standards underpinning unscheduled surgical care applying to both paediatric and adult patients.

Part B – Trauma Networks

1. Background

(a) Selected key facts about major trauma:[8]

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

2. Regional Trauma Networks

(a) Over the years, there has been a growing body of evidence concerning the need to improve trauma services. In 2007, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) produced a report entitled *Trauma: Who Cares?* This found "Almost 60% of the patients in this study received a standard of care that was less than good practice. Deficiencies in both organisational and clinical aspects of care occurred frequently."[9]

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

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

(b) The need for regional trauma networks formed part of the 2008 NHS Next Stage Review.[10] On 1 April 2009, Professor Keith Willett was appointed as the first National Clinical Director for Trauma Care.[11]

(c) A National Audit Office (NAO) report, *Major trauma care in England* (published 5 February 2010), found there was:

- "unacceptable variation in major trauma care in England depending upon where and when people are treated…. Care for patients who have suffered major trauma, for example following a road accident or a fall, has not significantly improved in the last 20 years despite numerous reports identifying poor practice, and services are not being delivered efficiently or effectively."[12]

(d) The NAO report was warmly welcomed by the Royal College of Surgeons of England which supported its recommendation to introduce regional trauma centres. The Royal College's report *Regional Trauma Systems. Interim Guidance for Commissioners*, published in December 2009, identified the following priorities in trauma care:

- "identifying major trauma patients at the scene of the incident who are at risk of death or disability;
- immediate interventions to allow safe transport;
- rapid dispatch to major trauma centres for surgical management and critical care;
- coordinated specialist reconstruction; and
- targeted rehabilitation and repatriation."[13]

(e) A series of commitments around developing regional trauma networks was made by the Department of Health at a hearing of the House of Commons Public Accounts Committee on 22 March 2010.[14] This was consolidated in *The NHS Operating Framework for 2011/12*:

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

[11] Department of Health, *National Clinical Director for Trauma Care*, http://www.dh.gov.uk/health/about-us/people/ncd/ncdtc

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

[13] The Intercollegiate Group on Trauma Standards, *Regional Trauma Systems. Interim Guidance for Commissioners*, December 2009, p.10, http://www.rcseng.ac.uk/news/docs/Regional_trauma_systems.pdf

[14] Summarised in: Department of Health, *Establishment of Regional Networks of Trauma Care*, 16 September 2010, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/di

- "All regions should be moving trauma service provision into regional trauma network configurations in 2010/11. Tariff changes will be introduced from April 2011 that are designed to recompense for the complexity of multiple-injury patients. Designated Major Trauma Centres should be planning the continuous provision of consultant led trauma teams, immediate CT scan options, and access to interventional radiology services for haemorrhage."[15]

(e) *The NHS Operating Framework* for the current year, 2012/13, set out that the scope of the Payment by Result (PbR) tariff would be extended to:

- "introduce a 'quality increment' which may apply to patients being treated at regional major trauma centres, designed to reward high-quality care and facilitate the move to trauma care being delivered in designated centres."[16]

(f) A network of 22 new major trauma centres was announced by the Department of Health on 2 April 2012:

- "Working alongside local hospital trauma units, 22 Major Trauma Centres will operate 24 hours a day, seven days a week and be staffed by consultant-led specialist teams with access to the best state of the art diagnostic and treatment facilities.

- "Previously, patients who suffered major trauma were simply taken to the nearest hospital, regardless of whether it had the skills, facilities or equipment to deal with such serious injuries. This often meant patients could end up being transferred, causing delays in people receiving the right treatment.

- "The new network means ambulances will take seriously injured patients directly to a specialist centre where they will be assessed immediately and treated by a full specialist trauma team. Patients who have suffered a severe injury often need complex reconstructive surgery and care from many professionals, and so the trauma team includes orthopaedics, neurosurgeons,

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gitalasset/dh_119423.pdf. Uncorrected transcript of Public Accounts Committee hearing, 22 March 2010 available at: http://www.publications.parliament.uk/pa/cm200910/cmselect/cmpubacc/uc502-i/uc50202.htm

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

[16] Department of Health, *NHS Operating Framework 2012/13*, 24 November 2011, p.38, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf

radiologists, physiotherapists, occupational therapists and speech therapists."[17]

(g) A map showing the location of the 22 centres is at Appendix 1.[18]

3. Key Definitions

(a) The NHS Clinical Advisory Groups Report, *Regional Networks for Major Trauma*, contains a number of key definitions. These are found in Appendix 2.[19]

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

Table: Injury severity score group and mortality[20]

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

Part C - European Working Time Directive and Medical Training

1. Introduction[21]

(a) The European Working Time Directive (EWTD) became law for most British workers on 1 October 1998, with an extension of up to 12 years to prepare to introduce it for doctors in training. The hours junior doctors were allowed to work were limited to 58 hours per week since August 2004, 56 since August 2007 and 48 hours since August 2009. Some rotas were allowed time-limited derogation to operate at 52 hours per week. Money was allocated to Primary Care Trusts to support implementation.

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[17] Department of Health, *New major trauma centres to save up to 600 lives every year*, 2 April 2012, http://mediacentre.dh.gov.uk/2012/04/02/new-major-trauma-centres-to-save-up-to-600-lives-every-year/

[18] Sourced from: NHS Choices, *Major Trauma Centres,* April 2012, http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Documents/2012/map-of-major-trauma-centres-2012.pdf

[19] Sourced from: NHS Clinical Advisory Groups Report, *Regional Networks for Major Trauma*, September 2010, pp.5-6, http://www.excellence.eastmidlands.nhs.uk/welcome/improving-care/emergency-urgent-care/major-trauma/nhs-clinical-advisory-group/

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

[21] Introduction sourced from: Medical Education England*, Time for Training. A Review of the impact of the European Working Time Directive on the Quality of Training*, May 2010, pp.64-69, http://www.mee.nhs.uk/pdf/JCEWTD_Final%20report.pdf.

(b) The definition of working time includes job-related training, working lunches, paid and some unpaid overtime, time spent on-call in the workplace. As a result of a European Court of Justice ruling (in the SiMAP case), on-call time when a doctor is obliged to be resident in a hospital counts as working time even when time is spent asleep.

(c) The EWTD also includes a range of rest and break entitlements such as 11 hours continuous rest in every 24-hour period. The Jaeger case ruling by the European Court of Justice means that compensatory rest for missed rest must be taken immediately the shift ends and not aggregated to be taken later.

(d) Individual doctors can opt-out of the EWTD, but cannot be made to do so and may opt back in. Rotas cannot be planned on the basis of doctors opting out but must be planned as if the EWTD applied.

(e) In addition doctors in training have been covered by the New Deal (the employment contract) since 1991. Working hours must comply with the EWTD and New Deal. All trainees have been limited to 56 hours per week since August 2003; various restrictions apply depending on the rota pattern worked. Trusts are required to monitor the working arrangements of their doctors in training; this ensures they are placed in the correct pay band.

2. Impact of the EWTD – Temple Report.[22]

(a) Following the full implementation of the EWTD in 2009, the Secretary of State for Health asked Medical Education England to commission an independent review of its impact on the training of dentists, doctors, healthcare scientists and pharmacists. Professor Sir John Temple was appointed as the Independent Chair.

(b) Key findings:

- Headline:
  High quality training can be delivered in 48 hours.
  This is precluded when trainees have a major role in out of hours service, are poorly supervised and access to learning is limited.

- Specific findings

  - Gaps in rotas result in lost training opportunities

  - The impact of EWTD is greatest in specialties with high emergency and/or out of hours workloads

  - Traditional models of training and service delivery waste learning opportunities in reduced hours

[22] Full report: Ibid.

- Consultant ways of working often support traditional training models
- EWTD can be a catalyst to reconfigure or redesign service and training

(c) Recommendations:

- Implement a consultant delivered Service
- Service delivery must explicitly support training
- Make every moment count
- Recognise, develop and reward trainers
- Training excellence requires regular planning and monitoring

3. Recent Developments

(a) The House of Commons Health Committee considered junior doctors' training in its 2012 report, *Education, training and workforce planning*, and produced the following recommendation:

- "While we recognise that introduction of the European Working Time Directive has had a significant impact on working and training practices, we do not feel any rose tinted nostalgia for a system which used to rely on over-tired and under-trained junior doctors. We have received a broad basis of evidence which shows how it is possible to reconcile reasonable hours for junior doctors with high quality training and, most importantly, high standards of care for patients."[23]

(b) The Government response to the Health Select Committee report stated that the *Better Training Better Care* programme had been developed to enable the delivery of the key recommendations of the Temple report along with the findings of Professor John Collins' report

[23] House of Commons Health Select Committee, *education, training and workforce planning*, 15 May 2012, p.22, http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/6/6i.pdf

Foundations for Excellence.[24] This project currently has 16 pilot sites, including East Kent Hospitals University NHS Foundation Trust.[25]

[24] Department of Health, *Government Response to the House of Commons Health Select Committee First Report of Session 2012-13: Education, Training and Workforce Planning*, p.9, https://www.wp.dh.gov.uk/publications/files/2012/09/CM8435-Government-response-to-HSC-inquiry-on-ETWP.pdf; Medical Education England, *Foundation for Excellence An Evaluation of the Foundation Programme*, October 2010, http://www.mee.nhs.uk/pdf/401339_MEE_FoundationExcellence_acc_FINAL.pdf

[25] Health Education England, *BTBC Pilot Sites,* http://www.hee.nhs.uk/work-programmes/btbc/btbc-pilot-sites/

Major Trauma Centres

April 2012

Adult and Children's Major Trauma Centres

1. Addenbrooke's Hospital Cambridge
2. Frenchay Hospital Bristol
3. James Cook University Hospital Middlesborough
4. John Radcliffe Hospital Oxford
5. King's College Hospital London
6. Leeds General Infirmary
7. Queen's Medical Centre Nottingham
8. Royal London Hospital
9. Royal Victoria Infirmary Newcastle
10. St Mary's Hospital London
11. St George's Hospital London
12. Southampton General Hospital

Adult Major Trauma Centres

13. Derriford Hospital Plymouth
14. Hull Royal Infirmary
15. Northern General Hospital Sheffield
16. Queen Elizabeth Hospital Birmingham
17. Royal Preston Hospital
18. Royal Sussex County Hospital Brighton
19. University Hospital Coventry
20. University Hospital of North Staffordshire Stoke on Trent

Children's MTCs

21. Alder Hey Children's Hospital Liverpool
22. Birmingham Children's Hospital
23. Royal Manchester Children's Hospital
24. Sheffield Children's Hospital

Collaborative

25. Manchester Collaborative MTC
    a) Salford Royal NHS Trust
    b) Manchester Royal Infirmary
    c) University Hospital South Manchester
26. Liverpool Collaborative MTC
    a) Aintree University Hospital
    b) Walton Centre
    c) Royal Liverpool University Hospital

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1 Case for change

This section lays out the CAGs case for change. It defines the components of a regionalised approach to trauma care, examines the overall need for reform in the NHS context and then examines the rationale for change at each stage of the trauma care pathway.

1.1 Definitions

In this document the definitions used are as follows.

Clinical Advisory Groups (CAGs) – Five clinical advisory groups were established in order to produce this advice, each covering a separate aspect of the care pathway as follows:

- Pre-hospital and inter-hospital transfers
- Acute Care and Surgery
- Ongoing Care & Reconstruction
- Rehabilitation
- Network Organisation (incl. governance)

Major Trauma – NHS Choice defines 'Major Trauma' as multiple, serious injuries that could result in disability or death. These might include serious head injuries, severe gunshot wounds or road traffic accidents. Major Trauma is defined in the scientific literature using the Injury Severity Score (ISS), which assigns a value to injuries in different parts of the body and totals them to give a figure representing the severity of injury. An ISS greater than 15 is defined as Major Trauma. This would include serious injuries such as bleeding in the brain or a fracture of the pelvis and cases of multiple injuries; however, this definition does not include all those who should benefit from the regionalisation of trauma care.

This document refers to severely-injured patients, meaning those who have suffered potentially life-threatening or life-changing physical injuries, i.e. all those who could benefit from regional networks. Psychosocial consequences of such injuries are common but patients suffering such symptoms in isolation without injury as a result of a "traumatic experience" are not covered.

Inclusive Trauma System – An Inclusive Trauma System (ITS) describes a model in which commissioners; providers, public health representatives and other stakeholders of trauma care in a geographical region collaborate to plan, provide and manage the treatment of people injured as a result of Major Trauma.

The ITS is responsible for all aspects of trauma care, from the point of injury to rehabilitation, as well as for injury prevention. Each ITS comprises of one or more 'Trauma Networks' (see definition below). The ITS also features:

- a population-based approach to the assessment of need and the provision of treatment.
- a role for every hospital and provider of care.
- provision for the speedy transfer of patients between facilities, particularly where the severely injured have been under triaged away from the Trauma Centre.
- a quality assurance structure that penetrates across the region and to each stage of care, which underpins providers' clinical governance processes, identifies inadequate performance in order to support its correction and ultimately can apply sanctions where this does not occur. It also informs commissioners about the quality of care being delivered.

The Royal College of Surgeons advises that the ITS should have in place a plan which sets out the

detail of the 'Trauma Care Pathway' (TCP) for the region.

Trauma Care Pathway – This is the process through which care is provided for patients who have suffered Major Trauma; specifically, it describes the 'the location and capability of each trust/hospital within the ITS and outlines ambulance bypass protocols and thresholds for transferring patients to more specialist units'.

Trauma Network – A Trauma Network (TN) is the name given to the collaboration between the providers commissioned to deliver trauma care services in a geographical area. At its heart is the 'Major Trauma Centre'. A TN should include *all* providers of trauma care, particularly: pre-hospital services, other hospitals receiving acute trauma admissions (Trauma Units), and rehabilitation services. The TN has appropriate links to the social care and the voluntary/community sector. While individual units retain responsibility for their clinical governance, members of the Network collaborate in a Quality Improvement programme.

Major Trauma Centre – A Major Trauma Centre (MTC) is a multi-specialty hospital, on a single site, optimised for the provision of trauma care. It is the focus of the Trauma Network and manages all types of injuries, providing consultant-level care.

- It is optimised for the definitive care of injured patients. In particular it has an active, effective trauma Quality Improvement programme. It also provides a managed transition to rehabilitation and the community.
- It takes responsibility for the care of all patients with Major Trauma in the area covered by the Network. It also supports the Quality Improvement programmes of other hospitals in its Network.
- It provides all the major specialist services relevant to the care of major trauma, i.e. general, emergency medicine, vascular, orthopaedic, plastic, spinal, maxillofacial, cardiothoracic and neurological surgery and interventional radiology, along with appropriate supporting services, such as critical care.

The Royal College of Surgeons cite research advising that such centres should admit a minimum of 250 critically injured patients per year

Trauma Unit – A Trauma Unit (TU) is a hospital in a Trauma Network that provides care for most injured patients and:

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

Local Emergency Hospital (not designated as TU) – The Local Emergency Hospital (LEH) is a hospital in a Trauma Network that does not routinely receive acute trauma patients (excepting minor injuries that may be seen in an MIU). It has processes in place to ensure that should this occur patients are appropriately transferred to an MTC or TU. It may have a role in the rehabilitation of trauma patients and the care of those with minor injuries.

East Kent Hospitals University NHS
NHS Foundation Trust

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

CLINICAL STRATEGY: UPDATE

1. Introduction

1.1 East Kent Hospitals University NHS Foundation Trust (EKHUFT) has earned its enviable record for safety and performance by its continued search for improvement and better results for patients. As we strive to achieve the best for people in East Kent and whilst we recognise that our staff work extremely hard to deliver a safe and high quality service, we know that we can do better.

1.2 Although we achieve good outcomes for patients, we need to continue to improve. We recognise that improved treatments require improved facilities and we need to ensure that we make the best use of the resources that we have. The Trust like every NHS Trust in the country is expected to plan services to make them sustainable, drive efficiency and deliver high quality care.

1.3 As part of this improvement process the Trust has been working on developing a clear strategy for its clinical services, since the end of 2010.

1.4 The process began with discussions with our clinicians and other stakeholders, to draw on their knowledge and experience of advancements in treatments, technologies and standards and that has shaped the current thinking around the Trust's Clinical Strategy.

1.5 At this stage we have not taken any decisions or ruled anything in or out and we are seeking to establish the viability of the suggestions that have come forward from our clinicians.

1.6 That being said, we cannot promise that everything will stay the same for ever. Advances in technology and science will lead to change over a period of time.

2. Purpose of paper

2.1. The purpose of this paper is to provide the members of the Health Overview and Scrutiny Committee with an update from the latest thinking relating to the Trust's Clinical Strategy that have resulted from our discussions as we continue to engage with staff and other stakeholders across the health economy.

2.2. It also summarises the activities that have taken place to date as part of the initial communication and engagement phase which was launched at the end of October 2011 and highlights how we plan to engage further with staff and other external stakeholders so that we can further test the validity of the ideas so far.

3. The key policy and service drivers behind the work

3.1 The key policy and service drivers that have led the Trust to undertaking a Clinical Strategy review are the following:

a. Recent publications from both the Association of Surgeons for Great Britain and Ireland (ASGBI) *“Emergency General Surgery: The Future”* and the guidelines from the Royal College of Surgeons (RCS) on *“Standards for Emergency Surgical Care”* outline that outcomes for patients requiring out of hours surgery i.e. at night and at weekends, are relatively poor, as opposed to those treated during “normal” working hours on weekdays.

4. Aim of the review and key principles

4.1 As work has progressed on the Clinical Strategy Review, key themes have emerged around quality of care, patient safety, financial pressures, trends in care provided by primary care (GP surgeries), community services and location of services.

4.2 As part of this review all the services provided by the hospital were examined and taking account of the emerging themes, the Trust agreed some principles. Relating to our vision for services in East Kent these were:

a. The highest priority for the Trust is “emergency care”. This means that patients, who are cared for and/or treated in our hospitals as an emergency, receive high quality, safe care every day of the week, around the clock.

b. The Trust also provides a wide range of other clinical services across its five hospitals and it was also agreed that there needed to be a clear strategy for “planned care” and specialist services. The Trust wants to ensure that if a patient needs a referral to hospital for care or treatments, for example (for an operation or for investigations) they would be happy to “choose” one of our hospitals to treat and look after them.

c. The geography of East Kent and the current pattern of service provision also dictate the need to develop improved community services, in line with national best clinical practice. The Trust also wants to increase the types of care and treatments that it can provide for patients as either daycase procedures or in short stay facilities as opposed to inpatient care.

4.3 In agreeing these principles it was recognised that services need to be clinically safe, affordable and provide equity of access for patients and their families. So our current focus is on areas that we know we need to change and improve:

a. Planned Care
b. Outpatient Care
c. Emergency Care (across all specialties)
d. Trauma Care

5. Details of current service provision and performance in the areas being explored

5.1 The following section outlines the current service provision and performance in the areas being looked at. As part of this work the Trust has agreed the following. The Trust will continue to:

a. provide emergency medical services from all three of its acute sites; WHH at Ashford, KCH at Canterbury and the QEQMH at Margate. This will require on site general surgical support;
b. provide acute inpatient care of the elderly services from the WHH, KCH and the QEQMH;
c. provide inpatient acute services for gynaecology and paediatrics from the WHH and the QEQMH;
d. provide acute inpatient fractured hip (neck of femur) and non complex trauma services from the WHH and the QEQMH; and
e. take into account the recommendations from the Royal Colleges, particularly the Royal College of Surgeons.

5.2 So taking note of these agreements the “Case for Change” for specific clinical areas is as follows:

Short Stay Care – Reasons for change

5.3. We recognise that patients spend considerable time within hospital and waiting for care. This time could be better spent if care were provided in other ways; day care; ambulatory care and short stay admissions.

So what might it look like?

5.4. In line with best practice nationally we need to treat 70% of all unexpected admissions as “short stay” or be discharged within one day. This type of care could utilise both hospital and community facilities. To help us achieve this we are exploring new and innovative ways to use technology to deliver medical services and we are looking at different ways of treating over forty clinical pathways.

Outpatients - Why do we need to make changes?

5.5. The Trust recognises that its outpatient department (clinics) are the front window of its clinical services and first impressions which form part of the patients experience are made around choice, quality, patient safety, privacy and dignity. We acknowledge that a number of our outpatient facilities need modernising so that they provide a welcome environment for our patients and relatives and importantly, support the proposed new models of care.

5.6. Currently we provide outpatient services from 22 sites across East Kent. We have acknowledged that the ways in which the clinics are currently organised are not providing the best service to our patients.

5.7. Although there is a large number of geographical areas where we run clinics we know that we still have a fair number of patients travelling more than 20 minutes drive time for their hospital clinic appointment and patients are often required to visit multiple sites for their assessment and treatment and “***we think our patients deserve better”.*** We also know that only a few specialities are offered from some of those sites.

So what might it look like?

5.8. We want to provide a wider range of services across six sites and ensure that over 90% of patients can access outpatient services within a 20 minute drive time. We also want to improve diagnostic and treatment facilities that will allow for a “one stop clinic” approach and maximise the use of clinics by providing early evening clinics as well as possible clinics on a Saturday morning which will better meet the needs of our population. To support this work we plan to rebuild the facilities at Dover to provide up-to-date, modern facilities.

5.9. We plan to, over the next few years, improve our other four outpatient facilities. We are already improving our appointment systems. We want to try the new technology available that will allow us to communicate with GPs and patients directly preventing, where appropriate, an appointment for a hospital visit. We want to discuss this more widely with the public to make sure that we get this right and we will, of course, have to discuss this with staff groups who will potentially be asked to work differently. Finally we will have to link this with other planned changes to ensure that there is the best use of professional staff time.

5.10. One outstanding area is the location of the site for the North Kent Coast. Work continues to assess the opportunities for this location.

5.11. The Trust is also looking at opportunities to expand other forms of care, such as radiotherapy and is discussing whether we could extend this in East Kent to the QEQMH site. In addition, our focus is to extend where possible, specialist emergency outpatient services such as ophthalmology to new sites, again such as QEQMH.

Emergency Paediatrics – What do we want to improve?

5.12. We want to prevent children having to wait unnecessarily in an Emergency Department (ED). If they do arrive in an ED, we want to make sure that they are seen in a child-friendly environment with an assessment by child trained nurses and doctors. We need children to be seen rapidly as their conditions can change quickly and we need fast, expert decisions, especially at peak times of the day.

What might it look like?

5.13. By introducing a “GP hotline to a paediatric consultant” we will ensure access to direct clinical settings. We want to introduce this as soon as we can. We also want Paediatric doctors (consultants and middle grades) and nurses to be allocated to the ED, during peak activity hours and alongside this we want to create a dedicated Children’s Emergency area as part of the ED.

Emergency Gynaecology - What do we currently provide?

5.14. Currently many women regularly attend the ED and then are referred to the Gynaecological team to be seen in the early pregnancy service the next day. There are three early pregnancy clinics on three sites, WHH, QEQMH and KCH. If women attend the ED, they may have to wait a long time because the doctors are responsible for providing cover to the Maternity for (labour ward) and Gynaecological services.

So how might it look like in the future?

5.15. The aim is for women to avoid the ED altogether, except for out-of-hours and if clinically unstable. By providing a combined early pregnancy / emergency gynaecology service during core activity hours at the WHH and the QEQMH seven days a week and by maintaining the early pregnancy service at KCH, we believe that women will have direct access to the care they need. We also have plans to extend the current emergency gynaecology service at the QEQMH and launch the same service at the WHH.

Emergency Medicine - What happens now?

5.16. We all recognise that patients need to see expert doctors and nurses as soon as possible. At the Trust many patients can be referred direct to the Clinical Decisions Unit (CDU) which is managed by the Acute Physicians who are the specialist doctors who are able to effectively manage many patients in emergency medicine.

5.17. Within our Emergency Department we have difficulties recruiting consultants and middle grade doctors and the Emergency Care Intensive Support Team (ECIST) has stated that we need to provide a consultant led service, providing strong leadership for 16 hours each day at both the WHH and the QEQMH sites.

What might it look like in the future?

5.18. Our plan is to develop a model so that we have a consultant led service 7 days a week between 8 am and midnight.

5.19. Additional consultants would need to be recruited to the Trust and rotated between the WHH and the QEQMH.

5.20. Nurse consultants will provide additional support to the clinical teams and further enhancements to the current service would be met by the further extension of the GP service (Integrated Urgent Care Centre) and the maintenance of the Emergency Care Centre Model with Acute Physicians.

5.21. The suggested improvements for Emergency Medicine are supported by the Royal College of Emergency Medicine and it is believed that it will address the recruitment issues.

Surgery – Reasons why we need to change

5.22. The increase in sub-specialisation means we can no longer rely on some surgeons to provide general surgical emergency services. For example, vascular surgeons no longer form part of the general surgical rota and a question has arisen as to how appropriate it is for breast surgeons to continue to work on the general surgical emergency service.

5.23. We also believe that junior doctors should not be unsupervised when making major decisions in emergency pathways. With small teams of general surgeons at two sites, a consultant is not always available in an emergency and this may cause delays for some patients.

5.24. General Surgery emergency services are currently delivered from two acute sites (WHH and the QEQMH).

How might it look in the future?

5.25. Emergency care is the Trust's highest priority and we need to ensure consultants deliver medium and high-risk surgery appropriately and with the best possible outcome. This means having dedicated general surgery teams without conflicting duties.

5.26. The options that have come forward to date that deliver these aspirations are modelled on a ***"Hub and Spoke"*** principle.

5.27. In this instance:

a. ***"HUB***" *is a Centre for medium and high risk colorectal and general surgical cases. This means that one team of general surgeons would be available every day and night with consultant led decision making and involvement in all complex cases; .*

b. ***"SPOKE"*** *would mean that Consultants are on site Monday to Friday during normal working hours. Weekends and out-of-hours general surgical advice would be provided by the resident middle grade doctors.*

The suggested location options are shown in table one and are as follows:

Table One

Option 1	*Hub WHH – 1 spoke at QEQM; assumes KCH remains largely unchanged.*
Option 2	*Hub at KCH – 2 spokes; WHH and QEQM*
Option 3	*Hub QEQM & WHH (continue as now but increase workforce to meet improved professional standards and service improvements).*

6. Trauma Services

6.1. Evidence shows that survival rates and recovery for patients suffering major trauma are improved if patients receive immediate treatment and transport to a specialist centre.

6.2. The Kent and Medway Critical Care Trauma Network has indicated that they would wish to develop three trauma units in Kent - at Pembury, Medway and WHH, Ashford. EKHUFT has responded by making it clear that it is not in the best interests of the whole community to redesign part of the emergency services in isolation and is not therefore intending to make any decision regarding trauma until it concludes its overarching Clinical Strategy.

6.3. We need to consider the provision of major trauma in our clinical strategy and it will need to be provided from a site with a trauma team.

7. Stakeholder Engagement Events and Key Findings from Events that have taken place to date

7.1 On the 27 October 2011 EKHUFT launched the initial engagement and communication process for the Trusts Clinical Strategy Review, highlighting the emerging themes and key drivers for change.

7.2 At the launch a series of presentations to the hospital staff across the main hospitals sites was undertaken. This was followed by an afternoon session with the Clinical Commissioning Groups (CCGs) and GPs in East Kent.

7.3 Since January 2012 the Trust has undertaken a series of engagement presentations to help ensure wider engagement amongst key stakeholders. These included:

a. CCG Board meetings and CCG consortia meetings;
b. The East Kent Commissioning Federation – Whole System Delivery Group;
c. HOSC;
d. Local Borough Councils (Thanet and Ashford);
e. Council of Governors;
f. Hospital League of Friends (QEQMH);
g. MPs;
h. Staff Committee and presentations at the Trust’s Chief Executive Forum; and at the
i. Patient Group at QEQMH (Urgent Care and Long Term Conditions Division)

7.4 Following the CCG / GP Stakeholder Engagement Event which was held on 25 July 2012, which was attended by GP leaders from Ashford, C4G (Canterbury), Thanet and Swale CCGs, it was clear that they were vital to the process. Both parties agreed and said they were committed to work in partnership to jointly agree any short and long term strategies for a sustainable future.

7.5 There were three key actions that were jointly agreed by all participants:

a. A commitment to establish a Group to reflect on the longer-term needs and to examine and build up what this might look like for the health economy for the sustainable future.

b. A commitment to establish a small group to reflect on the current meeting structures to ensure that they are ***"fit for purpose***" for the long-term. From these groups it is paramount that the objectives and outputs are consistent and also take account of the vision and any future strategies for the long term. Confirmation has now been given that the current meeting structure is "fit for purpose".

c. To meet with the East Kent Commissioning Federation (and Swale CCG) and the local National Commissioning Board (NCB) to identify a new radical approach to engagement, so that a wide array of key stakeholders across Kent are engaged in the process.

8. Plans for further strategy development and engagement

8.1 As an iterative part of the engagement process the Trust is now developing the second phase of its engagement process and will meet again with staff and other key stakeholders to share the latest thinking. It is planned that phase two of the engagement process will continue to take place over the next few months.

8.2 The next steps are to:

a. test our plans with the long term commissioning plans; and to

b. take independent advice from the Royal College of Surgeons on the surgical options and appropriate clinical adjacencies (a visit from the RCS is due in late November).

9. Timeline of the Process

9.1 Timelines will need to be agreed with the CCGs. It is anticipated that in the event of public consultation this can only take place in 2013 after the Trust and the East Kent CCGs have had the opportunity to engage with stakeholders across the health and social care economy.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 12 October 2012

Subject: Trauma Services in Kent and Medway

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1. Background

(a) The Health Overview and Scrutiny Committee has considered the topic of Trauma Services in Kent and Medway on a number of occasions over recent years. This occurred most recently on 9 September 2011.

(b) Additional background information on trauma networks can be found in the background briefing to the preceding item.

2. Recommendation

That the Committee consider and note the report.

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NHS
Kent and Medway

Kent and Medway Trauma Project Update

1. Summary

- Setting up a major trauma system in Kent and Medway is a National directive.
- The Kent and Medway Major Trauma Network has joined with the South East London Major Trauma Network to form a new Network, SELKaM.
- Trauma units in Kent and Medway will be aligned to Kings College Hospital as their Major Trauma Centre.
- The Medway Maritime Hospital and the Tunbridge Wells Hospital had trauma unit designation visits in September and the recommendation from the panel was that they are designated as trauma units.
- Work is continuing with East Kent Hospitals University Foundation Trust to raise standards of care for major trauma patients in east Kent via the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital. They remain committed to providing a trauma unit/s.
- Work is underway with partners to agree the optimum model of major trauma care for all residents in Kent and Medway so that a recommendation can be taken to Kent and Medway Clinical Commissioning Groups for their decision.

2. Background

Major trauma may typically occur because of a road accident, a violent incident, or a serious fall. Although the number of major trauma patients is relatively small, less that 0.2% of hospital emergency work, their injuries are often complex and serious putting them at risk of death or disability. For example, somebody who has been in a road accident might have both chest and head injuries. In order to improve chances of survival it is imperative that care is based on the individual needs of this patient group, rather than geographical boundaries or the location of individual acute institutions.

Nationally the NHS has recognised the importance of making improvements to the pathway for major trauma patients. In the future patients will be treated more quickly and receive a higher standard of care in a dedicated 24-hour specialist major trauma centre or a local trauma unit based on their individual needs. Less serious traumas will continue to be dealt with at an emergency department local to the patient.

The need to improve care for major trauma patients was highlighted in a National Audit Office report (2010). It stated that there were unacceptable variations in care for this most severely injured group of patients and made recommendations to improve standards. A nationwide programme to form regional trauma networks was set up by the Department of Health following a recommendation from Lord Darzi that Major Trauma Centres would save lives.

Kent and Medway major trauma leads have been working with partners on three main areas:

- A merger of the South East London Major Trauma Network and the Kent and Medway Major Trauma Network in order to form a new Network, the South East London Kent and Medway Major Trauma Network (SELKaM). This is now established.

- The development of a robust Kent and Medway major trauma system, which is equitable for all residents, improves patient outcomes and saves lives.

- Improving the rehabilitation pathway for major trauma patients so that they receive the best on-going care, have improved outcomes and can receive care as close to home as possible.

3. Current progress in developing major trauma services in Kent and Medway

Within the SELKaM Trauma Network trauma units for Kent and Medway will be based at the Medway Maritime Hospital and the Tunbridge Wells NHS Trust, Tunbridge Wells Hospital. In addition the Network are working with East Kent Hospitals NHS Foundation Trust to ensure a trauma unit is in place in East Kent.

Trauma unit pre designation visits took place in March to establish whether they fully met the trauma unit criterion. The designation panel concluded that all sites had made substantial progress towards becoming trauma units. However they suggested they needed to work closely with the emerging SELKaM Trauma Network and partners, including South East Coast Ambulance Service (SECAmb) and Helicopter Emergency Medical Service (HEMS), to show they could fully meet the criteria at a second designation visit.

Discussions are on-going with East Kent University Foundation Trust (EKHUFT) regarding the development of a trauma unit in east Kent. EKHUFT has advised it wishes any final decision on which site/s should be trauma unit/s to be taken after its Clinical Strategy Review but it remains fully committed to the continuous improvement in major trauma care at both the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital.

Second designation visits took place at the Medway Maritime Hospital and the Tunbridge Wells Hospital in September. The visiting panels were impressed with the progress both hospitals had made particularly with regards to TARN (Trauma Audit and Research) data collection and analysis, education and training, governance, and pathways. Their recommendation is therefore that both hospitals should be designated as trauma units.

SELKaM and NHS Kent and Medway are now working with partners to devise a robust model for trauma care in Kent and Medway with the overarching driver being improving care and outcomes for major trauma patients in all areas of Kent and Medway. This model, once fully developed, will be taken to the Clinical Commissioning Groups and the SELKaM Major Trauma Board along with the panel recommendations from the trauma designation visits.

4. How trauma services in Kent and Medway connect with those of London and the South East Coast area

A merger of the South East London Trauma Network and the Kent and Medway Trauma Network has taken place in order to form a new Network, the South East London Kent and Medway Major Trauma Network (SELKaM). This took effect from the 1st April 2012 and the inaugural meeting was held on 13th June 2012. The emerging SELKaM Major Trauma Network is supporting the development of the trauma system for Kent and Medway patients and ensuring on-going improvements to standards of care for patients across South East London and Kent and Medway. Sub groups are in place or in the process of being set up in order to concentrate on specific areas, for example TARN data, imaging, nursing, and rehabilitation, so that the same standards of care and pathways are in place right across the system.

The majority of Kent and Medway patients who require specialist Major Trauma Centre care will go to Kings College Hospital either directly or through secondary transfer after stabilisation at a trauma unit. However some patients from the borders of west Kent may be taken to the Royal Sussex County Hospital Major Trauma Centre.

Work has started on improving the rehabilitation pathway for major trauma patients so that they receive the best on-going care and can return to their local area at the earliest opportunity. The first SELKaM Major Trauma Rehabilitation Board meeting took place on 27 September 2012 and the initial focus is on understanding what services are available to patient across South East London and Kent and Medway including the gaps and issues. The overall aim is to improve the rehabilitation care patients receive, improve patient outcomes and provide on-going care as close to home as possible.

5. Challenges to developing the Trauma Network

The key challenge for the Kent and Medway aspect of the SELKaM Major Trauma Network is that the small number of major trauma patients in Kent and Medway does not support a model where all acute hospitals are designated as trauma units. The small numbers 2-3 patients at week maximum would be too low to maintain specialist skills. NHS Kent and Medway, the SELKaM Major Trauma Network, acute providers and partner organisations are therefore working in partnership to ensure:

- Major trauma patients receive the best possible care to improve their chances of survival and best outcomes.
- Care is supplied as close to home as is practical and reasonable, taking into account individual patient needs and the standards required of specialist Major Trauma Centres and trauma units.

6. Impact of the Trauma Network on the wider health economy

The location of sites for trauma units was based on the overall needs of the Kent and Medway population, geography, the need to ensure specialist staff are available to support the trauma units 24/7 and ambulance travel times. Representatives from each of the Kent and Medway acute trusts were party to this decision.

It was not expected that the establishment of the trauma units would impact on the remaining acute hospitals as the staffing requirements for a trauma unit are similar to those for a robust emergency department. In addition major trauma patients account for only approximately 0.2% of hospital emergency work so very few patients will be directed away from their nearest emergency department and to a trauma unit or Major Trauma Centre. All non-major traumas will continue to go to emergency departments as at present, for instance patients with fractured neck of femur.

Discussions are on-going with East Kent Hospitals University Foundation Trust (EKUFT) regarding the development of trauma unit/s in East Kent. They have advised this needs to be addressed as part of their review of clinical strategy which is looking specifically at the provision of urgent care services. They remain committed to the SELKaM Major Trauma Network and to the process of continual improvements in trauma services at both the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital.

7. Timeline of the process

The designation visits to the Medway Maritime Hospital and the Tunbridge Wells hospital took place in September 2012 and the panel has recommended that they are put forward as designated TUs. This recommendation and an update on East Kent University Foundation

Trust's progress will be taken to the NHS Kent and Medway Cluster Commissioning Committee on 10 October 2012 for discussion. They will also be asked to agree the decision making process for the proposed model for the Kent and Medway element of the SELKaM Major Trauma system.

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SECAmb submission to Kent Health Over view and Scrutiny committee

12th October 2012

Background

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provides the emergency response to major trauma across the whole South East Coast (SEC) area, which covers all of Sussex, most of Kent and most of Surrey. As well as an emergency response provided by land ambulance, which includes Critical Care Paramedics who have further training and skills in the care of the seriously injured, SECAmb works with the Kent Surrey and Sussex Air Ambulance Trust (KSSAAT) enabling us to provide enhanced medical teams to the scene of the most serious cases, and for them to be evacuated by air to appropriate hospitals in a timely fashion.

With effect from April 2012, trauma care within the UK was re-organised into regional networks, comprised of a (usually central) Major Trauma Centre (MTC), supported by a number of Trauma Units (TU). The remaining hospitals in an area which are neither MTCs nor TUs are termed Local Emergency Hospitals(LEH). The area covered by SECAmb includes parts of three such networks.

SW London and Surrey network covers the county of Surrey

Sussex Network covers the whole of Sussex including Brighton and Hove

SW London and Surrey network and Sussex Network have both been live since April 2012.

The MTCs are St. Georges Hospital, Tooting and The Royal Sussex County Hospital, Brighton respectively.

It is planned that Kent and Medway will adopt the same network approach to trauma, joining the existing SE London network focused on Kings, from November 2012. This network will be known as the South East London, Kent and Medway Trauma Network (SELKAM)

Arrangements for Trauma in Kent and Medway

The principle of the trauma network is that patients with major trauma are moved directly where possible to the MTC, this is associated with the best outcomes for patients. Where this is not possible within the nationally agreed time frame of 45 mins, then such patients should be taken to the Trauma Unit hospital for a brief assessment and any immediately needed emergency stabilisation, prior to a rapid second journey to definitive care in the MTC.

To be recognised as a Trauma Unit a hospital is assessed against specific criteria, compliance with which means that they have the necessary skills and equipment to rapidly diagnose and manage patients to the point of stabilization for transfer to the MTC.

The MTC for Kent and Medway has been agreed as being Kings College Hospital, Denmark Hill which is already functioning as an MTC.

Three hospitals are potential TUs, these are:

- Medway Maritime (MMH)
- Pembury Hospital (PH)
- The William Harvey Hospital (WHH)

The specific geography of Kent and Medway and the location of Kings means that the MTC is more than 45 minutes away for most of Kent, with only the area around Darenth Valley Hospital being within 45 mins of Kings, as seen in fig.1.

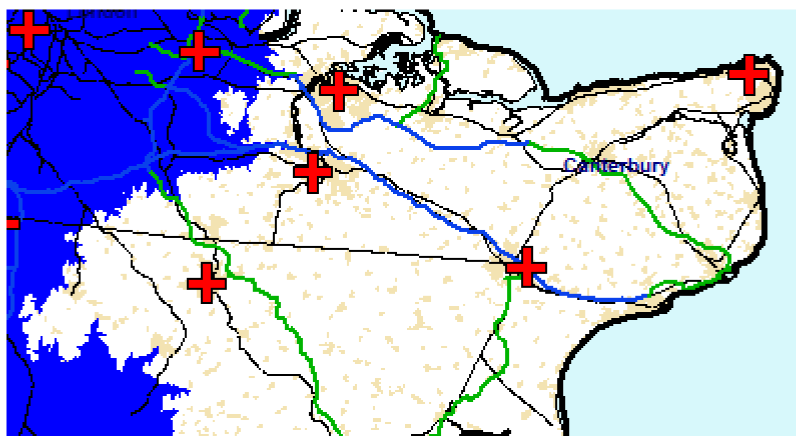

Fig 1. 45 mins from MTCs for Kent. Blue area is within 45 mins of an MTC, red crosses are existing hospitals.

1) Progress: Accreditation visits by the trauma network to the three potential TU hospitals are in progress, with Medway and Pembury having received accreditation visits. We understand that a visit to William Harvey Ashford to provide further guidance in their preparations for TU status is planned.

   SECAmb has already implemented trauma networks twice, with SW London and Surrey and Sussex. An agreed triage tool to aid triage of patients and recognise those with serious injuries requiring care in an MTC is established in these areas, and the crew learning package has been refined as lessons have been learnt from both these roll-outs. We are confident that our crews will be able to undertake the necessary learning and use the tool with

confidence very quickly to support go-live of the trauma network. They will also be supported by having a dedicated clinician with critical care experience based in the control centre. Crews are expected to discuss care with this clinician, in particular to agree which is the most appropriate hospital, for a range of scenarios. This has been in place 24/7since September.

We also have a dedicated auditor who reviews all major trauma calls in the Sussex area, the most recent go-live area, and will take on this roll for Kent and Medway in the first months after go-live, to ensure crews are appropriately supported in decision-making.

2) Connections with other trauma networks: London Trauma services are divided into quadrants, with 4 MTCs, one in each sector. The London Trauma network was the first in the country to go live, in April 2011. Kings and St. Georges hospitals serve the area of London south of the Thames. London Ambulance service take patients to both of these MTCs. They use the same triage tool as is proposed in Kent and Medway, so the care of patients near northern boundaries will not be affected by which ambulance service treats them. In the southern area, SECAmb crews are already fully operational with the network.

   Medical teams for KSSAAT treat patients on scene and then may accompany the patient in onward transport, either by air or road. Under normal circumstances the air ambulance is used to allow the more rapid transfer direct to the MTC within the 45 mins time frame. When this does not occur, as may happen in the event of fog, care is delivered by the doctor under SECAmb auspices in the ambulance pending transfer either to a nearby TU or to an MTC.

3) Challenges: It is understood by SECAmb that the biggest risk to the planned go-live date of 12th November is the potential for delay to the accreditation of WHH as a TU. This would leave parts of the eastern Kent area not within 45 minutes of a hospital of TU standard, as well as already being considerably further from an MTC than 45 mins. For implementation of the trauma network, it is essential that Ashford does meet the standards of a TU, permitting rapid life-saving care to be delivered to patients who are not well enough to travel further to the MTC or another TU.

   It is also important that SECAmb crews have clear pathways to follow. This is one of the most significant changes to ambulance care pathways since the introduction of primary coronary angioplasty at Ashford. SECAmb therefore believes it would not be safe to go-live in part of the area, as crews could be uncertain whether or not they should go to a TU or the local hospital, and patient care could be compromised by going to the wrong destination. We feel

we could however, safely implement a “by-pass to Kings” for areas within 45 minutes without problem, and this could allow a “shadow go-live”, of by-pass in the West of Kent, without any other change in patient flows for the initial pre-hospital phase. For TUs that were approved secondary transfers could be speedily undertaken, and ongoing work with the aspirant TU(s) to reach the accreditation standard continue.

The KSSAAT hopes in the future to be able to provide some night flights, which will increase the ability to rapidly treat and evacuate patients in more distant parts of Kent, however, this will not be immediately available, and adverse weather conditions will continue to prevent air ambulance access to all patients.

4) Impact evaluation on broader health care in Kent: The SE London and Kent network team will provide an update on this.

5) The projected timeline is currently for go-live in November 2012, this will be contingent on adequate TU provision.

Jane Pateman
Medical Director, SECAmb.
3rd October 2012.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 12 October 2012

Subject: The Tunbridge Wells Hospital: One Year On

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1. Background

The Committee has requested the opportunity to receive an update on the progress of the new Tunbridge Wells Hospital.

2. Recommendation

That the Committee consider and note the report.

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

To: Health Overview and Scrutiny Committee, 12 October 2012

Subject: Private Finance Initiative and the NHS

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1. Overview

(a) The Private Finance Initiative (PFI) formally dates from the 1992 Autumn Statement of the then Chancellor of the Exchequer, Norman Lamont. The stated aim was to increase the involvement of the private sector in the provision of public services.[1]

(2) The National Audit Office has summarised PFI deals as follows:

- "Under a typical PFI deal, the public sector enters into a long-term contractual arrangement with private sector companies, which undertake to design, build, operate (and often maintain) an asset."[2]

(c) As of 31 March 2012, there were 717 projects with a total capital cost of £54.7 billion. The Department of Health had the second highest number of projects, 116, totalling £11.6 billion. The Department for Education had more projects, but the Department of Health had the highest total capital costs.[3]

(d) The use of PFIs has been much debated over the years. The House of Lords Select Committee on Economic Affairs has summarised the two broad conflicting views as follows (taking PFIs as a form of Private Finance Project (PFP)):

- "Their supporters say that private capital at risk has brought much-needed rigour and efficiency to building and maintenance of public infrastructure and delivered more than would have been possible without them.
- "Their opponents condemn PFPs as expensive and inflexible, a drain on non-PFP public service budgets and a way for Governments to evade public spending rules and fudge national

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[1] House of Commons Library Research Paper, *The Private Finance Initiative (PFI)*, 21 October 2003, http://www.parliament.uk/documents/commons/lib/research/rp2003/rp03-079.pdf
[2] National Audit Office, *Lessons from PFI and other projects*, 28 April 2011, p.12 Full Report, http://www.nao.org.uk/publications/1012/lessons_from_pfi.aspx
[3] HM Treasury, *UK Private Finance Initiative Projects: Summary data as at March 2012*, http://www.hm-treasury.gov.uk/d/summary_document_pfi_data_march_2012.pdf

accounts by excluding PFP liabilities. They also deny that real risk transfer takes place."[4]

(e) HM Treasury published a consultation document on reforming the PFI in December 2011.[5] Earlier that year, in February, the Treasury announced a pilot project to seek savings at the PFI project at Queen's Hospital in Romford. This was followed in July 2011 with a Treasury plan to deliver £1.5 billion savings from 495 PFI projects in England.[6]

2. The NHS and PFI

(a) In a June 2010 report, *The performance and management of hospital PFI contracts*, the NAO provided the following summary:

- "Private Finance Initiative (PFI) hospital contracts are awarded and managed by local Trusts. The contracts use private funding to build and maintain hospital buildings. The contractor often provides support services, typically including cleaning, catering and portering, often referred to as hotel services.

- "The Department of Health (the Department) is responsible for approving new contracts with a capital value of over £35 million or those that are high risk. The Department also supports Trusts in negotiating and managing the contracts. The Department currently supports 76 such operational PFI contracts in England, costing £890 million a year.

- "The Department's accountability for the contracts depends on the type of Trust managing the contract:

    a) … Foundations provide NHS services but are independent of the Department. The Department cannot require Foundations to provide information or direct Foundations to take specific action. Each Foundation chief executive is directly accountable to Parliament as an Accounting Officer.

    b) NHS Trusts… have not yet achieved Foundation status and remain directly accountable to the Department. The Department aims that all NHS Trusts obtain Foundation status by the end of 2013-14."[7]

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[4] House of Lords Select Committee on Economic Affairs, *Private Finance Projects and off-balance sheet debt*, 17 March 2010, p.5, http://www.publications.parliament.uk/pa/ld200910/ldselect/ldeconaf/63/63i.pdf

[5] HM Treasury, *Reform of the Private Finance Initiative*, December 2011, http://www.hm-treasury.gov.uk/d/condoc_pfi_call_for_evidence.pdf

[6] House of Commons Library Research Paper, *Recent PFI developments*, 21 December 2011, http://www.parliament.uk/briefing-papers/SN06007

[7] National Audit Office, *The performance and management of hospital PFI contracts*, 17 June 2010, p.4 Full Report, http://www.nao.org.uk/publications/1011/pfi_hospital_contracts.aspx

(b) This report contained the following conclusion on value for money:

- "This report looks at the value for money achieved by hospital PFI contracts once they are operational. We found that most PFI hospital contracts are well managed. And the low level of deductions and high levels of satisfaction indicate they are currently achieving the value for money expected at the point the contracts were signed. However, as the cost and performance of hotel services are similar to those in non-PFI hospitals there is no evidence that including these services in a PFI contract is better or worse value for money than managing them separately."[8]

3. Financial Support for NHS Trusts[9]

(a) On 3 February 2012, the Department of Health announced that 7 Trusts may receive additional funding support from the DH. The Trusts are:

1. Barking, Havering and Redbridge NHS Trust;
2. Dartford and Gravesham NHS Trust;
3. Maidstone and Tunbridge Wells NHS Trust;
4. North Cumbria NHS Trust;
5. Peterborough and Stamford Hospitals NHS Foundation Trust;
6. South London Healthcare NHS Trust; and
7. St Helens and Knowsley NHS Trust.

(b) These Trusts had demonstrated they face "serious structural financial issues" and have historic PFI arrangements. Subject to 4 tests, these Trusts will be able to access financial support up to £1.5 billion over 25 years. A local plan to achieve long term, financial balance must also be in place.

(c) The 4 tests are:

1. The problems they face should be exceptional and beyond those faced by other organisations;

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[8] Ibid., p.8.
[9] This section sourced from: Department of Health, *NHS trusts to receive funding support*, 3 February 2012, http://mediacentre.dh.gov.uk/2012/02/03/nhs-trusts-to-receive-funding-support/

2. They must be able to show that the problems they face are historic and that they have a clear plan to manage their resources in the future;

3. They must show that they are delivering high levels of annual productivity savings;

4. They must deliver clinically viable, high quality services, including delivering low waiting times and other performance measures.

Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust

Tunbridge Wells Hospital - One Year On

Background report for Kent County Council Health Overview and Scrutiny Committee, 12th October 2012

1. Trust Profile

1.1 Maidstone and Tunbridge Wells NHS Trust (MTW) is a large acute hospitals trust providing a full range of high quality general hospital services to a population of 500,000 people living in the south of West Kent and parts of East Sussex.

1.2 Many of the people served by MTW live in the Maidstone, Tonbridge and Tunbridge Wells areas and are treated at Maidstone Hospital or the new all single room Tunbridge Wells Hospital. In addition, the Trust provides specialist cancer services, through its cancer centre at Maidstone and cancer unit at Kent & Canterbury Hospital, for the whole of Kent, Hastings and Rother, a population of some 1.8 million people.

1.3 The Trust provides services predominantly from its two main sites. Increasingly services are provided beyond these hospitals in a variety of additional care settings as the Trust provides more integrated `end-to-end' healthcare in cottage hospitals and town centre locations.

1.4 The Trust is also at the forefront of developments in minimally invasive laparoscopic surgery in the NHS and continues to increase the range of other highly specialised services available locally to patients, with centres of expertise in trauma (emergency surgery and orthopaedics), maternity, paediatrics (children's inpatient care), planned orthopaedic surgery, planned complex surgery and cellular pathology. The Trust is also at the forefront of diagnostic care and imaging with the latest MRI scanners.

2. Our patients

2.1 Each year the Trust's two main hospitals collectively see in the region of:

- 140,000 A&E attendances
- 50,000 emergency inpatients (patients who spend a night or longer in hospital)

- 9,400 planned inpatients
- 25,000 planned day cases (patients who go home the same day as their pre-arranged treatment)
- 11,000 regular admissions (patients who frequently come into hospital e.g. chemotherapy patients)
- 400,000 outpatient attendances
- Over 5,000 births

2.2 While MTW treats patients registered at over 400 different GP practices each year, around 90% of these patients are registered at one of just 60 practices.

2.3 The populations served by the Trust have a projected growth in the region of 8% between 2011 and 2020. It is expected the same areas will also see an increase in the over 65s, with almost 20% of the population of West Kent aged over 65 by 2017 and 30% by 2020.

2.4 Currently, 33% of patients in the over 65 age group have long term health conditions. 15% of the Trust's population live with one or more of four long term conditions:

- COPD (chronic obstructive pulmonary disease)
- Chronic Heart Disease
- Diabetes
- Stroke

3. Trust Clinical Strategy

3.1 In 2011 the Trust successfully implemented a major clinical strategy to improve patient care and ensure core services could be provided and sustained to ensure the best possible patient outcomes. Central to this was the concept of ensuring clinical `critical mass' for services.

3.2 The changes provided more consultant-led care, improved the safety of out of hours service provision and improved patient outcomes.

3.3 The key development within this strategy was the new Tunbridge Wells Hospital which enabled the Trust to reduce its main acute sites from three to two. This enabled the Trust to provide modern healthcare within a brand new state of the art 513-bedded hospital with single en-suite rooms and bespoke treatment areas. This provides unparalleled standards of privacy and dignity, and replaced old Nightingale-style wards at Kent & Sussex Hospital which had the largest number of mixed sex breaches in the country.

3.4 The Trust reconfigured a number of its frontline clinical services as part of the strategy, creating a Trauma Centre (for emergency surgery) at Tunbridge Wells Hospital and an Elective (planned) Surgery Centre at Maidstone. This

was achieved by reconfiguring Trauma and Orthopaedic services, and elective and emergency surgery.

3.5 Women and children's services were also reconfigured to provide inpatient paediatric care and obstetric services at Tunbridge Wells Hospital and a short stay paediatric unit and midwifery-led birth centre at Maidstone. Day care surgery and outpatient services continue on both sites, keeping the majority of care local. This completed the first phase of the Trust's clinical strategy.

3.6 The reconfigurations were strongly resisted publicly in the Maidstone area and referred to the Independent Reconfiguration Panel. Both elements were ultimately approved and have led to planned improvements in patient care including:

I. The Trust having fully staffed paediatric teams with children being seen and treated by experienced senior doctors more of the time

II. Enhanced onsite obstetric presence, with consultant obstetricians on the labour ward for longer each day, improving the availability of specialist care for women

III. Women have more birth options following the opening of the new Maidstone (midwifery-led) Birth Centre.

IV. Patients are being operated on in an emergency sooner by senior highly skilled and experienced surgeons

V. Fewer cancelled operations on the day of surgery

VI. Increasing surgical sub-specialisation with surgeons able to specialise in specific areas of care, improving patient outcomes

VII. Major improvement in the patient environment in Tunbridge Wells with unparalleled patient privacy and dignity

VIII. Near total compliance with single sex accommodation standards across the Trust

IX. Continuing very low levels of avoidable hospital-acquired infections such as Clostridium difficile and MRSA

3.7 The opening of the (Tunbridge Wells) hospital created some challenges for the Trust as it sought to embed new ways of working. This was evident in A&E where changes were required to working practices. These changes were made to the benefit of patients.

3.8 The Trust is working closely with local healthcare commissioners and the Department of Health to ensure the cost of the patient improvements which have come about as a result of the development of the new Tunbridge Wells Hospital continue to be financially sustainable.

3.9 While the Trust does not intend to undertake further major changes at this time, developments in modern medicine and healthcare technology will mean that the way in which some patients have traditionally been seen and treated will change in the future. Additionally, the NHS and its partners are seeking to reduce emergency admissions, managing more patients as day cases (ambulatory care) and in community settings.

4. Integrated care pathways

4.1 The Trust's Clinical Strategy included the provision of new community-based services, with patients benefiting from the Trust's acute specialist skills and expertise closer to home.

4.2 New off-site services now being provided by the Trust include diabetes services (Abbey Court) in Tunbridge Wells and inpatient stroke rehabilitation (12 bed unit) at Tonbridge Cottage Hospital. The Trust also has specialist nurses caring for patients in the community.

4.3 The Trust is continuing to look at partnership opportunities to deliver more effective integrated care pathways for patients that include primary, community, secondary, and tertiary services.

4.4 The Trust is working closely with commissioners to manage the ongoing shift from unplanned to planned care and from acute to non-acute settings in a way that supports improved care for patients and the shared objectives of the local health economy.

5. Patient Survey Results

5.1 The Trust ended 2011-12 with high levels of positive patient experience, in spite of a year of massive change, as indicated through its daily patient satisfaction surveys and audits.

5.2 The Trust now surveys an average of over 450 patients a month (one in every 10 inpatients) to gauge levels of satisfaction in four key areas

- Patient Information and Treatment
- Staff Behaviour
- Ward Environment
- Satisfaction with Overall Care

5.3 Patient overall satisfaction has been consistently high following the opening of the new hospital, addition of the new Stroke Rehabilitation Unit at Tonbridge Cottage Hospital and changes to services offered at Maidstone.

6. Future Vision

6.1 The Trust’s new centres of expertise, together with other established services such as the Kent Oncology Centre, emergency services (A&E departments), ambulatory care and medical admissions at both hospitals, form the platform for a new phase in its clinical strategy.

6.2 The Trust will continue to develop its main centres of expertise, while acknowledging and responding to the changing balance point between acute hospital and community services.

6.3 The Trust is now focusing on the development of other acute services, and the patient environment and patient experience as a whole, at Maidstone Hospital. The Trust plans to invest heavily in both services and facilities at the hospital over the next six years. This will ensure the hospital remains fit to provide acute hospital care, is able to provide more care locally (repatriation of services from London) for its patients, and is positively positioned to meet the forthcoming opportunities in ambulatory and community care.

6.4 The Trust is also planning to achieve Foundation Trust Status by 1st April 2014. In preparation for this, the Trust will start to build its membership scheme from November 2012.

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