

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 30th October, 2009

10.00 am

**Council Chamber, Sessions House, County Hall,
Maidstone**





AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 30th October, 2009, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone: **(01622) 694486**

Tea/Coffee will be available from 9:45 am

Membership

- Conservative (10): Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr K A Ferrin, MBE, Mr J A Kite, Mr R L H Long, TD, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A Willicombe
- Labour (1): Mrs E Green
- Liberal Democrat (1): Mr D S Daley
- District/Borough Representatives (4): Cllr Ms A Blackmore, Cllr M Lyons, Cllr Mrs J Perkins and Cllr Mrs M Peters

UNRESTRICTED ITEMS

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

Item	Timings
1. Substitutes	10.00 - 10.10
2. Declarations of Interests by Members in items on the Agenda for this meeting.	
3. Minutes (Pages 1 - 4)	10.15 - 10.25am
4. Primary Care Out of Hours Services (Pages 5 - 22)	10.10 - 11.10

Refreshment Break

5. The Future of PCT Provider Services (Pages 23 - 64)	11.25 - 12.10
6. Dover Healthcare	12.10 - 13.00

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| 7. | Department of Health Quality Accounts Consultation (Pages 65 - 72) | 13.00 -
13.10 |
| 8. | Draft Work Programme November 2009 to July 2010 (Pages 73 - 76) | 13.10 -
13.20 |
| 9. | Date of next programmed meeting – Friday 27 November 2009 at 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 and Local Leadership
(01622) 694002

22 October 2009

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, 2 October 2009.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr K A Ferrin, MBE, Mrs E Green, Mr R L H Long, TD, Mr C P Smith, Mrs J Whittle, Cllr Ms A Blackmore and Cllr M Lyons

ALSO PRESENT: Mr M Cayzer, Cllr J Cunningham, Mr R Kenworthy and Mr J Larcombe

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

10. Membership

(Item)

The Overview Scrutiny and Localism Manager informed the Committee that Mr R Tolputt had replaced Mr M C Dance on the Committee.

11. Minutes - 27 July 2009

(Item 3)

RESOLVED that the minutes of the meeting held on 27 July 2009 are correctly recorded and that they be signed by the Chairman subject to Minute 7 (4) reflecting that the question was asked by Miss Sergison not Mrs Sergison; and Minute 8 sub-paragraph (14) being amended to read

“The Chairman acknowledged due to other commitments Mrs Green had decided not to accept the invitation to be his Vice Chairman. Mrs Green indicated that she would like to be included in the agenda setting process for the Committee and it was confirmed by the Chairman that this would happen.”

12. South East Coast Ambulance Trust - Application for Foundation Trust Status

(Item 4)

(1) The Chairman welcomed to the Committee Mr Geraint Davies, Director of Business Development and Kelly Dower Technician (training to become a paramedic) of the South East Coast Ambulance Trust to the meeting to respond to the Committees questions on the Trusts proposed application for Foundation Trust status.

(2) The Committee had before them a briefing note prepared by the Committees Research Officer Tristan Godfrey which covered:-

- (a) What is a Foundation Trust?;
 - (b) The Governance Structure for a Foundation Trust including the role of a Foundation Trusts members, Board of Governors and Board of Directors ;
 - (c) Foundation Trust Board meetings;
 - (d) The authorisation process for Foundation trust status
 - (e) A list of those Foundation Trusts already licensed across the South East and those seeking to be licenced in 2009/10
 - (f) Background information to the South east Coast NHS Ambulance Trust application for Foundation Trust status; their consultation document "Your Service,Your Call";and
 - (g) The consultation document questions
- (3) The briefing note also had an appendix setting out the views of Medway Councils Health Overview and scrutiny Committee which had considered the Trusts application for Foundation Trust status on 20 August 2009.
- (4) Also contained within the papers for the Committees consideration was a presentation by Geraint Davies.
- (5) The Committee questioned Mr Davies about the development of the Ambulance Service, the modernisation programme and the benefits from the Trusts perspective of Foundation Trust status.
- (6) Overall, the Committee was pleased to hear about the different ways the Ambulance Trust is developing its service and the opportunities Foundation Trust status will provide the Trust.
- (7) The Committee asked searching questions about the proposed governance structure and expressed concern about a potential conflict of interest in having the same Chairman for the Board of Directors and Board of Governors.. The Committee noted that this is the way Foundation Trusts are obliged to arrange themselves.
- (8) The Committee asked to be kept informed of how Members of the Board of Governors are selected and appointed, and, in particular how the six local authorities will resolve the issue of choosing the one Governor allocated between them.
- (9) The Committee was very pleased to hear the pledge to hold all Board meetings in public, and believes that this, along with related practices such as publishing board papers, will aid transparency and accountability.
- (10) One member of the Committee felt unable to support the Trusts application for Foundation Trust status.
- (11) **RESOLVED:-** that the Committee supports the application of the South East Coast Ambulance Trust for Foundation trust status and delegate authority to the Overview, Scrutiny and Localism Manager in consultation with the Chairman, Vice Chairman and spokesmen of the Committee to agree the formal response of the Committee

13. Potential to Refocus and Restructure the Health Overview and Scrutiny Committee *(Item 5)*

(1) Further to Minute 8 (2009) the Overview Scrutiny and Localism Manager presented a further paper building on the comments of the Committee at its previous meeting to Refocus and Restructure the Committee

(2) Attached as Appendices to the report were:-

(a) A Paper on the potential to Refocus and Restructure the Overview and Scrutiny Function which had been the subject of a discussion at all the Policy Overview Committees, the Cabinet Scrutiny Committee, and, would be debated at the County Council meeting on 15 October 2009.

(b) The terms of reference for a Joint Kent and Medway NHS Overview and Scrutiny Committee; and

(c) The current protocols for the operation of Health Overview and Scrutiny across the administrative county of Kent.

(3) The Committee were invited to comment on a range of areas of potential development for the Committee:-

Local Involvement Network(LINk)

(4) The Committee noted that the Kent Local Involvement Network has distinct but complementary powers to the Health Overview and Scrutiny Committee. Steps which could be taken to develop partnership working included:-

(a) Two LINk representatives to become non-voting Members of the Committee in order to bring matters of concern to the attention of the Committee and provide updates of ongoing work;

(b) Protocols to be drawn up in consultation with the Adult Social Services Policy Overview Committee, Policy Overview Co Ordinating Committee and any other relevant Committees to agree how referrals from the Kent LINk will be managed; and

(c) LINk to assist in developing a pool of patient representatives who will be able to give a valuable perspective on specific issues.

(5) The Committee endorsed all these initiatives in developing the operation of the Committee for the future.

Borough and District Councils

(6) Proposals for development included more emphasis being placed on all the local authorities across Kent to share work programmes to enable co-ordinated working where appropriate and avoid duplication.

(7) The Overview, Scrutiny and Localism Manager informed the Committee that he was exploring with Scrutiny Officers from all the local authorities across Kent the opportunity to pool resources to deliver a shared work programme

(8) A second suggestion was to set aside two meetings of the Committee in each calendar year to consider issues raised by Borough and District colleagues. After debate this did not receive the support of the Committee

(9) Finally the Committee noted that whilst the protocols for the operation of Overview and Scrutiny of Health across the administrative county of Kent needed factually updating they were still appropriate and had not been used as they were intended - particularly the provisions for Joint Committees.

Medway Council

(10) The Committee noted that consideration was currently being given to the establishment of a Joint Committee with Medway Councils HOSC to examine proposals relating to mental health acute beds in Medway and Swale.

Rapporteurs

(11) The Committee noted that several members of the Committee had already expressed an interest in acting as a rapporteur or leading a small task and finish group eg maternity services in Maidstone and repatriation of a pain clinic to Maidstone Hospital

(12) The Committee then considered and commented on the topics which had already been identified for potential inclusion in the Committees draft work programme.

(13) **RESOLVED:** that

(a) the views of the Committee be incorporated into the report being prepared for the County Council meeting on 15 October 2009 on the Potential to Refocus and Restructure the Overview and Scrutiny Function;

(b) approval be given to revising the current set of protocols for the Health Overview and Scrutiny Committee, in conjunction with partners prior to them being agreed by the Committee and the County Council;and

(c) delegated authority be given to the Overview, Scrutiny and Localism Manager in consultation with the Chairman, Vice Chairman, committee spokesmen and partners such as the LINK and the NHS to agree the scheduling of the work programme

14. Date of next programmed meeting – Friday 30 October 2009

(Item 6)

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

To: Health Overview and Scrutiny Committee – 30 October 2009

Subject: Item 4. Briefing Note. Primary Care Out of Hours Services

Introduction

“Out of hours period’ means -

- (a) the period beginning at 6:30pm on any day from Monday to Thursday and ending at 8am on the following day,
- (b) the period between 6:30pm on Friday and 8am on the following Monday, and
- (c) Good Friday, Christmas Day and bank holidays;

‘out of hours services’ means services required to be provided in all of part of the out of hours period which would be essential services if provided by a provider of primary medical services in core hours.”¹

Out-of-hours care can include some or all of the following:

- GPs working in A&E departments, NHS walk-in centres or minor injury units (MIUs),
- teams of healthcare professionals working in places such as primary care centres, A&E, MIUs or NHS walk-in centres,
- healthcare professionals (other than doctors) giving home visits after a detailed clinical assessment, and
- ambulance services moving patients to places where they can be seen by a doctor or a nurse in order to reduce the need for home visits.²

Background

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

Prior to April 2004, GPs had a responsibility to provide urgent medical care during the out-of-hours period. In practice, many GPs delegated OOH provision to a third-party. A National Audit Office (NAO) report in 2006 states that at the beginning of 2004, “approximately 70 per cent of GPs had

¹ Department of Health, The Primary Medical Services (Out of Hours Services) Directions 2006, 22 December 2006, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_063687

² Taken from NHS Choices, <http://www.nhs.uk/conditions/Out-of-hours-services/Pages/Definition.aspx?url=Pages/what-is-it.aspx>

delegated the responsibility to a GP co-operative, and around 25 per cent to a commercial provider.”³

The introduction of a new General Medical Services (GMS) contract on 1 April 2004 allowed GPs to opt out of the responsibility for organising OOH care entirely. Where they did opt out, GPs gave up £6,000 per annum on average and the responsibility passed to their Primary Care Trust (PCT). The DoH “increased its out-of-hours development funding to around £3,500 per GP to help establish the new service, giving an average total of £9,500 for every GP opting out.”⁴ About 90% of GPs decided to opt out. The same NAO report adds, “at April 2005, the Department’s understanding, based on data gathered from Strategic Health Authorities, was that some 75 per cent of service provision was PCT-organised or contracted through co-operatives of various types, with the remaining 25 per cent provided by commercial providers, ambulance trusts and others, with NHS Direct supplying initial call handling and triage for many providers.”⁵

At the same time as the new GMS contract, in April 2004, NHS Direct was created in April 2004 out of 22 separate organisations. Originally established as a Special Health Authority, it became an NHS Trust in 2007. Along with the 24-hour helpline and website, NHS Direct also provides services to other NHS and healthcare organisations.⁶

From January 2005, OOH providers have had to comply with national quality requirements. The requirements are contained in Appendix 1.

Healthcare Commission Urgent and Emergency Care Review 2007/08

In September 2008, the Healthcare Commission (which has subsequently become part of the Care Quality Commission) produced the report *Not just a matter of time. A review of urgent and emergency care services in England*⁷.

This review looked at OOH GP services along with A+E services, emergency ambulance services and touched on urgent GP services as well. It carried out a detailed review of these services for 2007/08 and the report contains the following overview of OOH GP services across the whole of England:

- “During 2007/08, out-of-hours GP services received 8.6 million calls and completed 6.8 million medical assessments (there is no good national data on the long-term trend in the use of these services, but these levels are broadly similar to those in 2006/07).

³ National Audit Office, *The Provision of Out-of-Hours Care in England*, p.9, 5 May 2006, http://www.nao.org.uk/publications/0506/the_provision_of_out-of-hours.aspx#

⁴ Ibid, p.6.

⁵ Ibid, p.11.

⁶ Further information on NHS Direct can be found here: <http://www.nhsdirect.nhs.uk/article.aspx?name=AnnualReport2009>

⁷ Care Quality Commission, full report available at: http://www.cqc.org.uk/db/documents/Not_just_a_matter_of_time_-_A_review_of_urgent_and_emergency_care_services_in_England_200810155901.pdf

- They carried out 2.9 million assessments by telephone, 0.9 million assessments on home visits and 3 million assessments where the patient attended a primary care centre.
- Around 1.5% of the calls they deal with are classed as 'life-threatening' and 15% are classified as 'urgent'.
- The total cost of these services is around £400 million a year (or £8 per person).⁸

A detailed report was also produced on each PCT. Again the results only apply to the year 2007/08 and look at the wide range of 'urgent and emergency care' services.

Trusts were given an overall score comparing them to other Trusts. The scores were:

- Best performing.
- Better performing.
- Fair performing.
- Least well performing.

Trusts were also given a score from 1 and 5 against 36 indicators. A score of 3 meant the Trust met the national standard, or achieved average performance. Scores over 3 meant the Trust had exceeded the required standards or were above average. Scores below 3 meant it was performing below these levels. The indicators were grouped under three broad questions. They are set out in the table below.

Table showing scores for urgent and emergency care

PCT	Eastern and Coastal Kent ⁹	Medway ¹⁰	West Kent ¹¹
Overall	Better performing	Better performing	Better performing
Can people access services in a timely fashion, and in ways which meet their	2.79	3.08	3.07

⁸ Ibid, p.12.

⁹ Full breakdown of indicator scores and report available at:
http://2008ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?widCall1=customWidgets.content_view_1&cit_id=5QA&element=SR_UEC&subtype=technical

¹⁰ Full breakdown of indicator scores and report available at:
http://2008ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?faArea1=customWidgets.content_view_1&cit_id=5L3&element=SR_UEC&subtype=technical

¹¹ Full breakdown of indicator scores and report available at:
http://2008ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?widCall1=customWidgets.content_view_1&cit_id=5P9&element=SR_UEC&subtype=technical

needs?			
Are services working together to provide effective care?	3.15	3.08	2.62
How well are urgent and emergency care services managed?	3.56	3.33	3.89

Primary Care Foundation

In April 2009, a Department of Health backed study was produced by the research organisation Primary Care Foundation. According to a Health Service Journal article, this found, “GP out of hours services are costing more than three times more per patient in some parts of England than in others. The research organisation Primary Care Foundation has found out of hours provision costs less than £3.50 per head in the cheapest areas, and more than £12 in the most expensive. . . . Most variation is due to individual contractual arrangements set up by PCTs, the foundation said. This includes differences in types of service provided, such as requirements for more primary care centres to be open at particular times in some areas. There was also wide variation in cost per case, from £30 in some areas to £100 in others.”¹²

Care Quality Commission Review into Take Care Now

In June 2009, the Care Quality Commission (CQC) announced it would be carrying out a review of the provision and commissioning of out-of-hours GP services run by an organisation named Take Care Now. Specifically, the review was triggered by the death of a patient treated by a locum doctor from Germany working for Take Care Now through a locum agency.

Five Primary Care Trusts commissioned services from Take Care Now – NHS Suffolk, NHS Worcestershire, NHS Great Yarmouth and Waveney, and NHS South West Essex (in partnership with East of England Ambulance Service). The locum was also admitted onto the performers list of Cornwall and the Isles of Scilly PCT, in July 2007, but did not work for the PCT.

The full report is expected early in 2010. On 2 October 2009, the CQC released a progress statement on the Take Care Now enquiry¹³.

In its press release the CQC quoted Cynthia Bower, the CQC Chief Executive:

¹² Health Service Journal, *Study reveals three-fold cost variation in GP out of hours services*, 9 April 2009, <http://www.hsj.co.uk/news/primary-care/study-reveals-three-fold-cost-variation-in-gp-out-of-hours-services/5000264.article#>

¹³ Care Quality Commission, 2 October 2009, http://www.cqc.org.uk/db/documents/Interim_statement_on_TCN_FINAL.doc

“GP out-of-hours services provide vital care to people outside of normal surgery hours. As commissioners of these services, PCTs need to ensure people receive safe, quality care around the clock.

"Our visits to the five trusts that commission Take Care Now's services showed they are only scratching the surface in terms of how they are routinely monitoring the quality of out-of-hours services. If their monitoring is not robust enough, they may not be in a position to spot early indications of potential problems or poor care.

"Although we are still in the early stages of our enquiries, we believe this may point towards a national problem. We are therefore encouraging PCTs across the country to scrutinize in more detail the out-of-hours services they commission.

"PCTs need to dig deeper and keep a closer eye on important areas such as: efficiency and quality of call handling and triage; the number of unfilled shifts; the proportion of shifts covered by non-local doctors; the induction and training those doctors receive; and the quality of the decisions made by clinical staff. It's not just about monitoring numbers of people treated, or how much this costs. It's about examining the finer detail of the actual care patients receive, to ensure the service is safe and meeting people's needs.

"We have shared our findings with the Department of Health, which is today writing to all PCTs across the country asking them to make it a priority to review their monitoring arrangements for out-of-hours services."¹⁴

On the same day a letter was sent out to all primary care trusts from the Department. This letter contained the following:

“While the scope of CQC’s current enquiry is limited to a specific number of PCTs and a particular provider, the Department strongly supports these recommendations which are relevant to **all commissioners**. PCTs should have robust performance management arrangements in place to ensure their OOH service, like any other commissioned services, is delivering against contractual requirements, and world class commissioning will support PCTs to achieve this.”¹⁵

¹⁴ Care Quality Commission, 2 October 2009, http://www.cqc.org.uk/newsandevents/pressreleases.cfm?cit_id=35381&FAArea1=customWidgets.content_view_1&usecache=false

¹⁵ Department of Health, Dear colleague letter, 2 October 2009, http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_106349

Appendix - The National Quality Requirements¹⁶

1. Providers must report regularly to PCTs on their compliance with the Quality Requirements. (A provider is any organisation providing OOH services under GMS, PMS, APMS or PCTMS).

2. Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 a.m. the next working day. Where more than one organisation is involved in the provision of OOH services, there must be clearly agreed responsibilities in respect of the transmission of patient data.

3. Providers must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).

4. Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting PCT. The sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service. This audit must be led by a clinician with suitable experience in providing OOH care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service.

Providers must cooperate fully with PCTs in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one provider organisation.

5. Providers must regularly audit a random sample of patients' experiences of the service (for example 1% per quarter) and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting PCT. Providers must cooperate fully with PCTs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation.

6. Providers must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the contracting PCT. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

7. Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the

¹⁶ Department of Health, *National Quality Requirements in the Delivery of Out-of-Hours Services*, July 2006, pp.5-7, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_073808.pdf

third day of a Bank Holiday weekend. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.

8. Initial Telephone Call:

Engaged and abandoned calls:

- No more than 0.1% of calls engaged
- No more than 5% calls abandoned.

Time taken for the call to be answered by a person:

- All calls must be answered within 60 seconds of the end of the introductory message which should normally be no more than 30 seconds long.
- Where there is no introductory message, all calls must be answered within 30 seconds.

9. Telephone Clinical Assessment

Identification of immediate life threatening conditions

Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those calls must be passed to the ambulance service within 3 minutes.

Definitive Clinical Assessment

Providers that can demonstrate that they have a clinically safe and effective system for prioritising calls, must meet the following standards:

- Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person
- Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person

Providers that do not have such a system, must start definitive clinical assessment for all calls within 20 minutes of the call being answered by a person.

Outcome

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

10. Face to Face Clinical Assessment

Identification of immediate life threatening conditions

Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within 3 minutes.

Definitive Clinical Assessment

Providers that can demonstrate that they have a clinically safe and effective system for prioritising patients, must meet the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre

Providers that do not have such a system, must start definitive clinical assessment for all patients within 20 minutes of the patients arriving in the centre.

Outcome

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

11. Providers must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence

12. **Face-to-face consultations** (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

- Emergency: Within 1 hour.
- Urgent: Within 2 hours.
- Less urgent: Within 6 hours.

13. Patients unable to communicate effectively in English will be provided with an interpretation service within 15 minutes of initial contact. Providers must also make appropriate provision for patients with impaired hearing or impaired sight.

How are primary care out of hours services currently provided and what plans do the Trusts have to develop these services in the future?

OUT OF HOURS PROCUREMENT

1 INTRODUCTION

This paper provides the Health Overview and Scrutiny Committee of Kent County Council with an overview of the current Primary Care out-of-hours service across NHS Eastern and Coastal Kent. This is broken into two elements: an outline of the service that is currently provided together with current plans describing how these services will be developed in the future.

2 CURRENT SERVICE PROVISION

NHS Eastern and Coastal Kent serves a population of approximately 760,000 residents across the eastern half of Kent and includes the localities of Canterbury, Swale, Dover, Thanet, Dover, Ashford and Shepway. A Primary Care (GP) Out-of-Hours service is currently provided across all localities by a single provider, South East Health Ltd (SEHL). These services are provided between the hours of 18:00 – 08:00, Monday – Thursday, 18:00 Friday – 08:00 Monday and on Bank Holidays.

For those residents in the west of the Swale locality where it borders the Medway Unitary Authority who are registered with GPs in NHS Medway, this service is linked with the similar Meddoc Primary Care out of hours provision.

The scope of South East Health Ltd's service provision encompasses the following elements:

- i. **Telephone access to an out-of-hours GP service:** This is typically via the automatic forwarding to one of South East Health Ltd's call centres following a patient's initial call to their registered GP surgery, although there are instances where the patient is redirected to the out-of-hours provider via a recorded message.
- ii. **Telephone assessment:** Patient assessment, advice streaming and triaging is provided through South East Health Ltd's call-handling service, limiting the need for GP attendance unless clinically appropriate.
- iii. **Primary Care treatment:** Where the patient requires primary care intervention, such treatment is provided in a variety of settings. Patients may be directed to receive treatment in a Primary Care centre available in a range

of locations across localities. Alternatively, if a GP home visit is clinically appropriate, South East Health Ltd provide and transport on-call GPs to the patient to administer the appropriate care.

South East Health Ltd operates two call centres in east Kent from which all out-of-hours calls are handled; these are located in Ashford and Sarre (between Canterbury and Margate).

Where patients require primary care treatment but not necessarily a GP home visit, such treatment is provided in the following locations:

- Queen Elizabeth the Queen Mother Hospital, Margate
- Kent and Canterbury Hospital, Canterbury
- Queen Victoria Memorial Hospital, Herne Bay
- Victoria Hospital, Deal
- Buckland Hospital, Dover
- William Harvey Hospital, Ashford
- Sheppey Community Hospital, Minster
- Sittingbourne Memorial Hospital, Sittingbourne
- Royal Victoria Hospital, Folkestone

South East Health is performance managed on a monthly basis against thirteen National Quality Requirements (NQR) for out-of-hours primary care services.

The current contract with South East Health Ltd is valued at £7 million per annum and runs until 30th June 2010. Notice has been served on the current provider in line with the procurement of a new service which is described below.

3. PROCUREMENT OF NEW SERVICE

Re-tendering of the primary care out-of-hours service commenced in May 2009 with the objective of having a new contract awarded in January 2010 which can be mobilised from April 2010 (allowing suitable handover of contracts between providers) and in place from 1st July 2010.

The principle drivers behind the re-tendering are to stimulate improvements in patient experience, quality of service and value for money, whilst providing a seamless transition between service contracts

i) Governance

A Procurement Project Team has been established with representatives from across the PCT with expertise to inform the project. The team will meet on a regular basis throughout the procurement process. The team consists of representatives from Urgent Care Commissioning, Workforce, Information Management & Technology, Communications, Patient and Public Engagement, Human Resources, Legal, Market Management, Medicines Management, Finance, Infrastructure, and Contracting and Procurement.

A Clinical Project Team has been established with representation from each of the PCT localities and the Local Medical Committee. This team is contributing towards the development of the service specifications.

The out of hour's procurement project is being overseen by the PCTs Urgent Care Commissioning Steering Group.

ii) Service Specifications

Two sets of service specifications have been developed to represent the two aspects of the Service i.e. Lot 1 – Access and Assess and Lot 2 – Treat. Each of the two specifications has individual sets of Key Performance Indicators (KPIs) and a service credit regime for failure to perform against KPIs has been developed. This approach to KPIs will permit each aspect of the Service to be measured and managed independently.

The Clinical Project Team has provided extensive input to the specifications and have been invited to attend dialogue sessions with each of the Bidders. This is to ensure the service specifications have had the appropriate levels of clinical scrutiny and input from all localities.

The procurement project team have also reviewed and provided input to the service specifications which have been refined following dialogue meetings with each of the Bidders.

iii) Patient and Public Engagement

Patient representatives will be involved in the evaluation of bids by attending bidder's presentations. Patient representatives will also be invited to sit on the procurement project team.

A survey was carried out in June 2009 to understand public perception of the out of hours service. Over 300 responses were received and the results of the survey have been taken into account in the development of the service specifications. The survey has also been shared with Bidders.

iv) Procurement update

The procurement is on track to award contract(s) in January 2010 and for service implementation and mobilisation to commence thereafter and achieve full service commencement in July 2010. The long mobilisation period is necessary to address any TUPE issues which may arise. The Contract will be based on the standard Community Services Contract as mandated by the Department of Health.

Currently two Bidders are scheduled to submit outline solutions and complete the Financial Model Template on the 2 November 2009. These will be subject to evaluation and clarification with the Bidders prior to a request, following PCT Board approval, for submission of final tenders.

An evaluation team has been established with representatives from the Clinical Team, Urgent Care Commissioning, Workforce, Information Management & Technology, Communications, Patient and Public Engagement, Human Resources, Medicines Management, Finance, Infrastructure, and Contracting and Procurement. This team will be responsible for scoring final tenders and production of an evaluation

report for submission to the PCT Board with a recommendation as to the preferred Provider and Contract award.

Andrew Cole

Head of Commissioning – Urgent and Continuing Care

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Health Overview & Scrutiny Committee - 30 October 2009

How are primary care out of hours services currently provided and what plans does NHS West Kent have to develop these services in the future?

1. Current Service

- 1.1 The primary care out of hours service is delivered by two providers, the PCT Provider in the North of the PCT and South East Health (formerly On Call Care) in the South of the PCT. The two providers deliver different services to their localities as a result of historic legacy arrangements that persist despite the creation of NHS West Kent. The triage models used by each provider result in significant differences in patient outcomes, for example the percentage of calls ending with telephone advice ranges from 39% in the North to 51% in the South. Whilst it appears that the two services deliver effective out of hours provision there is limited connection between the providers and inadequate transparency of the value for money received.
- 1.2 Out of hours services are available to patients who need to see their GP urgently at night, on bank holidays or weekends. When patients ring their GP practice during these times they are usually re-directed automatically to the out of hours service. This service provides patients with telephone advice, the option to come to a base to see a GP or a home visit by a GP if this is thought necessary. Out of hours bases in West Kent are located in A&E at Maidstone Hospital and Darent Valley Hospital and within community hospitals and a health clinic.
- 1.3 Alongside the out of hours base in Maidstone Hospital, there is currently a pilot emergency primary care service in A&E. Here GPs work alongside A&E staff to manage patients attending with primary care conditions. The out of hours service and the pilot emergency primary care service are not currently fully integrated.

2. Case for Change

- 2.1 The National Audit Office review of out of hours care in 2006¹ compared the value for money delivered by providers and found that there was a difference of £3.20 per head per patient. A subsequent review by South East Audit concluded that the current situation of two providers does not deliver clear value for money nor demonstrate economies of scale.
- 2.2 The contract for South East Health expired in April 2007 and has been extended since that time. This is not an acceptable position for the PCT to hold and this cannot be resolved without undertaking a competitive tendering exercise.
- 2.3 The current out of hours services are not in line with the vision for World Class Commissioning which states that services should deliver better care for all by being evidence-based and of the best quality, and services should deliver better value for all through investment decisions that are made in an informed and considered way, ensuring that improvements are delivered within available resources.

¹ National Audit Office: The Provision of Out-of-Hours Care in England, 2006.

- 2.4 Audits in A&E departments have shown that between 20% and 60% of patients attending A&E could instead be treated within a primary care service. A similar audit in NHS West Kent found that 60% of people attending A&E were presenting with primary care conditions, such as sprains, and skin conditions. By attending A&E, many of these people are then drawn into the secondary care system. Studies have shown that A&E staff who treat patients with primary care needs refer patients more frequently than GPs for investigations such as blood tests and X-rays, and make more frequent referrals to specialist teams, all of which can lead to increased admissions and use of outpatient clinics². In addition, primary care professionals are best placed to ensure that patients with primary care needs receive continuity of care, are supported to improve self-care and are directed to appropriate community services.
- 2.5 The recently published Healthcare Commission review of urgent and emergency care services³ rated the performance of NHS West Kent as Better Performing. This assessment shows that the PCT has the highest rating for Management of all PCTs in the South East Coast Strategic Health Authority area, however it has the lowest rating for 'Integration and Effectiveness'.

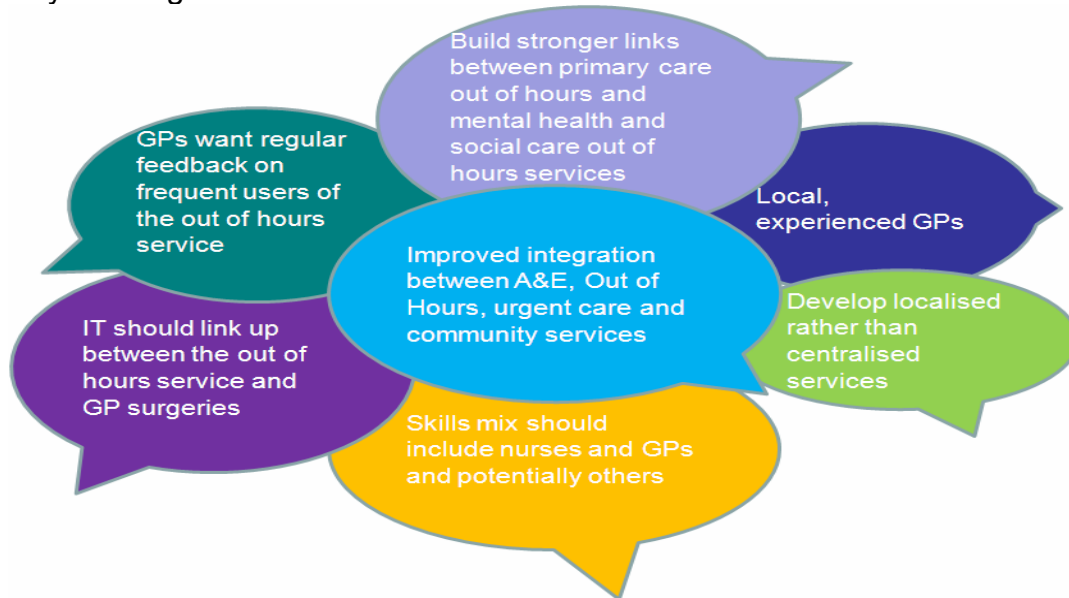
3. Service Model development

- 3.1 A strategic commissioning review was undertaken from June 2008 to February 2009 and included
- A review of urgent care policy drivers
 - Stakeholder engagement - patients, public, clinicians, and other professionals including social care and children's services
 - Health needs assessment
 - Review of the primary care out of hours services and the emergency (GP) primary care service pilot in Maidstone Hospital
 - Market assessment
 - Options appraisal
 - Development of a commissioning plan and business case
- 3.2 Wide stakeholder engagement was undertaken including a professional survey distributed to 328 GPs and 90 other professionals and a public survey distributed to 450 of NHS West Kent's Health Network as well as directly to Black Minority Ethnic groups in West Kent. Two further surveys were carried out at Maidstone Emergency Care Centre. In total 1,212 responses were received. The key messages from the consultations are

² Dolan, B & Holt, L (Eds). Accident & Emergency: Theory into Practice, 2000. (Crouch, R. Primary Care: the A&E Dimension, Chapter 32).

³ Healthcare Commission: Not Just a Matter of Time - A review of urgent and emergency care services in England, September 2008.

Key messages from clinicians and staff:



Key messages from patients and the public:



3.3 Using the feedback from stakeholders and the public as well as analysis of the current services and market place, three potential models were recommended to the PCT Board. These were;

Model 1: Primary Care Out of Hours Service

Model 2: Integrated Primary Care Out of Hours and Emergency Primary Care Service in A&E

Model 3: Integrated Primary Care Out of Hours, Emergency Primary Care and Community Care Services

3.4 All stakeholders agreed that commissioning a single GP out of hours service for NHS West Kent would not deliver the level of service as the current provision. The GP out of hours services across the PCT have been enhanced since being established to incorporate elements of urgent primary care, in the form of a GP Emergency Primary care front end pilot at Maidstone Hospital and a nurse led urgent care centre (UCC) at Darent Valley Hospital. Whilst there was enthusiasm to develop a fully integrated out of hours, urgent care and community care service this was considered too complex to be attempted in a single stage. The preferred proposal to the PCT Board was therefore that the PCT commissions an integrated primary care OOH and emergency primary care service in the A&E Departments at Maidstone Hospital, Darent Valley Hospital and the new Pembury Hospital when it is completed.

3.5 The PCT project team developed an outcomes-based service specification and a set of key performance indicators (KPIs) in conjunction with stakeholders and developed a business case, which received PCT Board approval in June 2009. PCT commissioners, A&E clinicians and A&E management in the acute trusts have since agreed the specification for the emergency primary care service in A&E as well as governance arrangements, and final discussions are now taking place between the PCT and acute trust management concerning new contract terms.

3.6 In August, following approval of the business case for the integrated primary care OOH and emergency primary care service in the A&E departments, NHS West Kent initiated a procurement process to commission a single provider across West Kent. The new service will start in April 2010.

4. Benefits

4.1 The procurement of an integrated primary care out of hours service and emergency primary care service in A&E is expected to deliver:

- Improved integration between out of hours and emergency primary care and with in-hours GPs, community health, social care, voluntary sector and independent sector services
- Improved support for people with long-term conditions and palliative care needs
- Successful and consistent outcomes for patients with similar needs
- Improved patient experience
- An integrated service to shift care closer to home

- A reduction in health inequalities in line with PCT public health plans e.g. by referring patients to smoking cessation and weight management support
- Informed choice (through education) and appropriate use of services
- Improvements in older people's health and well-being by preventing avoidable hospital admissions and improving continuity of care, self-care and directing older people to appropriate community services
- A reduction in A&E attendances and inappropriate non-elective admissions
- A reduction in avoidable 0-1 day admissions
- Support to A&E to deliver the 4-hour A&E target
- Improved real time information sharing with primary and community care
- Improved monitoring information to commissioners relating to patient activity, quality of care and patient behaviours and experience.

4.2 The current Emergency Primary Care Service in Maidstone ECC has demonstrated that GPs admit fewer patients than A&E staff for the top 10 conditions seen by GPs during the first year of the pilot. The service has also led to attendance savings. By commissioning an integrated OOH and primary care service in the A&Es it is anticipated that through economies of scale and a more integrated approach to service provision that the overall cost of the service should be reduced.

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

To: Health Overview and Scrutiny Committee – 30 October 2009

Subject: Item 5. Briefing Note. The Future of PCT Provider Services

Background

On 30 June 2008, the final report of Lord Darzi's NHS Next Stage Review, *High Quality Care for All*¹ was published. Soon after, on 3 July 2009, the companion report, *NHS Next Stage Review: Our Vision for Primary and Community Care* was published. This latter document set out the broad direction for the future development of PCT provider services (PCTPS):

“We will support the NHS in making local decisions on the governance and organisational models that best underpin the development of flexible, responsive community services. Some PCTs have done this by developing arms length provider organisations that remain accountable to their Board. In other areas, the NHS is exploring other organisational options such as community foundation trusts, care trusts, social enterprises or integration with acute trusts or NHS Foundation Trusts. We will support local decision-making by drawing together and publishing advice on this range of organisational options and their implications for issues such as governance, patient choice, competition and employment, so that staff and PCTs can work together to identify the arrangements that best empower staff to improve patient care.”²

This policy was developed further through the *Operating Framework 2009/10*³ and the publication on 13 January 2009 of the policy document, *Transforming Community Services: Enabling new patterns of provision*.⁴ A range of supporting material for the Transforming Community Services (TCS) policy has also been published.⁵

¹ Department of Health, 30 June 2008, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_085828.pdf

² Department of Health, 3 July 2008, p.44, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_085947.pdf

³ Department of Health, 8 December 2008, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091445

⁴ Department of Health, 13 January 2009, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197

⁵ Department of Health, see the menu on the left-hand side for further documentation, <http://www.dh.gov.uk/en/Healthcare/Primarycare/TCS/index.htm>

Timetable

The Department of Health Document, *Transforming Community Services: Enabling new patterns of provision*, set down a timetable for TCS:

- By April 2009, there should be an internal separation between the commissioning and provider functions of a PCT and a contractual relationship should exist between them.
- By October 2009, PCT commissioners, working closely with practice-based commissioners, have to develop a detailed plan for TCS, for agreement with the Strategic health Authority (SHA)⁶.

However, on 30 July 2009, the NHS Chief Executive, David Nicholson wrote to all SHAs and PCTs explaining that instead of the October 2009 deadline there will be a “more flexible approach to the timetable for developing future organisational options for providing community services. . . . SHAs will determine the timetable for the development and assurance of the proposals for the future organisational form(s) of their PCT provider services.”⁷

Options for future organisational form

There has been no prescribed organisational form or type of model for TCS. A range of possible options was presented in the document *Transforming Community Services: Enabling new patterns of provision*. The following series of tables contains the name and description of the options set out in the document⁸:

NHS Organisations	
Direct Provision	<p>1. Provision of services remains with the PCT but with separate governance arrangements so that the provider service is treated like any other provider.</p> <p>2. An alternate approach would be for the PCT to agree with another PCT either to manage or to deliver their directly provided services: under a delegation arrangement the relevant functions are delegated to the other PCT.</p> <p>A PCT can also commission services from another PCT; this could involve existing staff transferring to the provider PCT.</p>
Community Foundation Trust	<p>A Public Benefit Corporation consisting of members who may be in constituencies of the public, patients and staff. There is a Board or Council of Governors and a Board of Directors.</p>

⁶ Department of Health, 13 January 2009, p.7, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197

⁷ Department of Health, Dear Colleague Letter 30 July 2009, *Transforming community services*, http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_103459

⁸ Department of Health, 13 January 2009, pp.43-54, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197

Social Enterprises*	
Social enterprises are businesses that trade primarily for social purposes, with profits reinvested into services it provides or into the wider community. There are several legal organisational forms, including, amongst others, a Community Interest Company, a Company Limited by Guarantee, and an Industrial and Provident Society.	
Company Limited by Guarantee	Usually non-profit distributing, often combined with charitable status. Members play a role similar to that of shareholders. Profits are retained within the company to be applied in accord with its purpose.
Industrial and Provident Community Benefit Society (BenCom)	BenComs are incorporated industrial and provident societies (IPS) that conduct business for the benefit of their community. Profits are not distributed amongst members, or external shareholders, but returned to the community.
Industrial and Provident Societies (Bona Fide Co-operative)	In a bona fide co-operative, eligibility for membership will be based on a common economic relationship with the society - employees in a worker co-operative, tenants in a housing co-operative, etc. The eligibility criteria will feature within the registered rules.
Community Interest Company (CIC)	Designed for the pursuit of community benefits, CICs can be either limited by guarantee or limited by shares and are additionally required to satisfy a 'community interest test'.
Charitable Incorporated Organisation (CIO)	This form becomes available by regulation in 2009. It is a separate legal entity with a constitution consisting of members who may have no liability or liability limited to a maximum amount.

Commercial Enterprises
 Although these forms may be contracted with by PCTs to provide community services, they are not available for PCT provider organisations to establish directly.

Contractual, partnership and joint working arrangements	
In addition to direct contracts with PCTs by independent organisations to provide community services, there are also some possible arrangements between the same or different types of organisation, and do not, therefore, constitute organisations in themselves. Below are some models of how services might be arranged.	
Vertical Integration	These can be arrangements between NHS organisations and other bodies, whether other NHS organisations (eg NHS trusts, NHS Foundation Trusts), or local authorities or third sector organisations, typically, carrying out different stages of a patient or user pathway. These can be carried out through a contractual Joint Venture, a Community Interest Company, partnerships, or a Section 75 Agreement. There is no

	prescribed form for vertical integration. Proposals for vertical integration must be compliant with the requirements of the <i>Principles and Rules for Cooperation and Competition</i> .
Horizontal Integration between PCT providers and/or LAs.	PCTs enter joint arrangements or services are transferred to (“hosted by”) another PCT. PCTs and LAs enter section 75 partnership arrangements whereby the LA performs the PCT’s community health services function. Typically such arrangements are developed between providers delivering the same part of a patient pathway or service. Proposals for horizontal integration must be compliant with the requirements of the <i>Principles and Rules for Cooperation and Competition</i> .
Partnership arrangements under s.75 of the NHS Act 2006	Under these arrangements a local authority provides the relevant former PCT community health services.
Services provided on behalf of a PCT by a third party.	Options for these include joint or delegation arrangements with another PCT (see ‘horizontal integration’ above). For external bodies other than another PCT, the PCT cannot delegate functions to such a body.
Integrated Care Pilot (ICP)	An entity that takes overall responsibility for ensuring coordinated care for a defined and registered (GP) population wherever that care is to be provided i.e., across part or the whole patient pathway, irrespective of sector. These are being piloted following the NSR (Next Stage Review).
Primary Care Contracts	May still be used for the purposes they were originally intended.
NHS Contracted Arrangement	An existing hospital Foundation Trust managing some community services (Downwards). Primary and community care organisations managing some acute services from community base (Upwards).

* Social enterprises – PCT staff are entitled to declare an interest in establishing a social enterprise, which might apply to a part or the whole of the current provider organisation. Any request should “have been considered and approved or rejected within 6 months of the request being made.”⁹ Further information about this policy was set out in *Social Enterprise - Making a Difference: a guide to the Right to Request*.¹⁰

Where a PCT decides to continue direct provision of community services, it should review its service periodically.¹¹

⁹ Ibid, p.26.

¹⁰ Department of Health, 20 November 2008, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090460

¹¹ Department of Health, 13 January 2009, p.13, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197

Annual Health Check 2008/09

On 15 October, the results of the Annual Health Check for 2008/09 were published. For the first time a separate score was given to PCTs for compliance with the core standards as commissioners and providers.

For providing services, they were given one of four scores:

Fully Met Almost Met Partly Met Not Met

Table 1: Annual Health Check 2008/09 scores for providing services

PCT	Score
NHS Eastern and Coastal Kent ¹²	Almost Met
NHS Medway ¹³	Almost Met
NHS West Kent ¹⁴	Fully Met

For reference, in the Annual Health Check, PCTs were given one of the following four overall scores for “quality of commissioning services” and “quality of financial management.” These scores were one of:

Excellent Good Fair Weak

Table 2 - Annual Health Check 2008/09 scores for quality of commissioning services and financial management.

PCT	Quality of Commissioning	Quality of financial management
NHS Eastern and Coastal Kent	Fair	Good
NHS Medway	Fair	Good
NHS West Kent	Fair	Fair

¹² Annual Health Check results for NHS Eastern and Coastal Kent available from the Care Quality Commission at:
http://2009ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?widCall1=customWidgets.content_view_1&cit_id=5QA&element=P_QUAL

¹³ Annual Health Check results for NHS Medway available from the Care Quality Commission at:
http://2009ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?FaArea1=customWidgets.content_view_1&cit_id=5L3&element=P_QUAL

¹⁴ Annual Health Check results for NHS West Kent available from the Care Quality Commission at:
http://2009ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?widCall1=customWidgets.content_view_1&cit_id=5P9&element=P_QUAL

Select Glossary

Commissioning The full set of activities that local authorities and Primary Care Trusts (PCTs) undertake to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively.

Provider A generic term for an organisation that delivers a healthcare or care service.

Primary Care Trusts (PCTs) Freestanding statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions.

Service level agreement (SLA) This is a formal written agreement made between a provider and the commissioner of a service. It specifies in detail how and what services will be provided, including the quality standards that the service should maintain.

Strategic Health Authority (SHA) The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans and for ensuring that Primary Care Trusts (PCTs) are performing well. They are the link between the Department of Health and the NHS.¹⁵

¹⁵ All of these definitions taken from: Department of Health, 13 July 2006, *Health reform in England - update and commissioning framework: annex - the commissioning framework*, pp.73-77, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_4137230.pdf

Extract from NHS Eastern and Coastal Board Papers, 23 September 2009

Date of meeting:	23 September 2009
Report Number:	B102/09
Agenda item:	9
Subject:	Delivering the Transforming Community Services Programme
Reporting officer:	Amanda Harrison, Director of Assurance and Strategic Development

Summary

The Department of Health (DH) programme Transforming Community Services was established following the publication of the *DH Operating Plan 2009/10* and the *NHS Next Stage Review, High Quality Care for All*. The PCT Board established the Shaping Community Services (SCS) Programme Board to corporately oversee the implementation of the Transforming Community Services work locally.

This paper details the work undertaken and sets out some recommendations on the future of Eastern and Coastal Kent Community Services (ECK-CS). Much of this paper is focused on the work undertaken to transform services in order to improve quality, productivity and ensure ECK-CS is business ready, in its own right. The assessment of organisational options has also been part of the Transforming Community Services Programme since it was launched nationally. The NHS Chief Executive has recently written to all PCTs informing them that do not now have to make a definitive decision about organisation form in October 2009, which was the original national milestone. However due to the significant work undertaken locally this paper begins our assessment of organisational models.

This paper recommends that Direct Provision remains the model of delivery for ECK-CS in the short to medium term, but acknowledges that the PCT corporately needs to support the autonomy and ambition of ECK-CS and allow the PCT as a commissioner to concentrate on its World Class Commissioning responsibilities. To do this it is recommended that the PCT will continue to strengthen its internal governance to further separate ECK-CS under the umbrella of the PCT, ensuring that becoming a stand alone provider, external to the PCT, is a viable long term option.

It also recommends that although there remain uncertainties around the Community Foundation Trust and Integrated Care Pilot models the PCT and ECK-CS should work with the SHA and DH to support the development of these models as their transition and implementation paths become clearer.

Board Action

The PCT Board are asked to:

- Agree and ratify the recommendations set out in Section 10.0
- Endorse the Next Steps set out in Section 11.0
- Ratify the ECK-CS Board Terms of Reference in Appendix 1.

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This report contributes to the following PCT strategic objectives
This report contributes to the PCT Strategic Objective focused on ensuring effective governance of the PCT Provider.

This report gives assurance against a risk identified in the Assurance Framework	
Assurance Number: 8.1	Brief Description: A lack of clarity on the future of Community Services and governance arrangements are not clear, leading to uncertainty

Equality Impact Assessment	
Has the paper undergone the screening process for Equality Impact Assessment?	
If yes, what further action needs to be taken?	If no, explain why The Community Services Commissioning Strategy and the ECK-CS Business Plan will need detailed Equality Impact Assessments.

Background Information		
This report has been considered by the following committees:		
Shaping Community Services Programme Board	On: 27 th Aug 09	Comment: Received comments which have been included in the final report.
ECK-CS Management Board	On: 1 st Sept 09	Comment: Received comments which have been included in the final report.
Legal Services	On: N/A	Comment:

Report History	
First reported to the Board on:	February 2007
Update Reports made on:	March 2008
	March 2009

For further information or for any enquiries relating to this report please contact:	
Phil Edbrooke	01233 667706

Delivering the Transforming Community Services Programme in NHS Eastern and Coastal Kent

Recommendations on the future of the PCT Provider

September 2009. Version 0.7.

Executive Summary

The Department of Health (DH) programme Transforming Community Services was established following the publication of the *DH Operating Plan 2009/10* and the *NHS Next Stage Review, High Quality Care for All*. The PCT Board established the Shaping Community Services (SCS) Programme Board to corporately oversee the implementation of the Transforming Community Services work locally.

This paper details the work undertaken and sets out some recommendations on the future of Eastern and Coastal Kent Community Services (ECK-CS). Much of this paper is focused on the work undertaken to transform services in order to improve quality, productivity and ensure ECK-CS is business ready, in its own right.

The production of the Community Services Commissioning Strategy and the ECK-CS Five Year Integrated Business Plan are integral milestones in this Programme. These documents set out the vision and principles for the development of community services over the next five years including a strong commitment to equality and the embracing of diversity as an employer, and within our commissioning and provision. Primarily these principles will ensure community health provision is available to all, regardless of age, sex, disability, gender, race, ethnic origin, religion, belief or sexual orientation.

The assessment of organisational options has also been part of the Transforming Community Services Programme since it was launched nationally. However the NHS Chief Executive wrote to all Strategic Health Authority (SHA) and Primary Care Trust Chief Executives on the 30th July 2009 to focus Primary Care Trusts (PCTs) on delivering “responsive, personalised, productive services of a consistent high quality, embedded within a coherent approach to Quality Innovation Productivity and Prevention,” rather than on organisational structures. He also stated that PCTs do not now have to make a definitive decision about organisation form in October 2009.

However, before this letter at the end of July, a significant amount of work had been undertaken regarding organisational models, especially ensuring engagement with staff, so it is appropriate to begin our assessment of these models within this paper. However our thinking around organisational models will continue to develop as the Commissioning Strategy and Business Plan are implemented.

This paper recommends that Direct Provision remains the model of delivery for ECK-CS in the short to medium term, but acknowledges that the PCT corporately needs to support the autonomy and ambition of ECK-CS and allow the PCT as a commissioner to concentrate on its World Class Commissioning responsibilities. To do this it is recommended that the PCT will continue to strengthen its internal governance to further separate ECK-CS under the umbrella of the PCT, ensuring that becoming a stand alone provider, external to the PCT, is a viable long term option.

It also recommends that although there remain uncertainties around the Community Foundation Trust and Integrated Care Pilot models the PCT and ECK-CS should work with the SHA and DH to support the development of these models as their transition and implementation paths become clearer.

The PCT Board are also asked to ratify the ECK-CS Terms of Reference in Appendix 1.

1.0 Introduction

- 1.1 The PCT Provider, NHS Eastern and Coastal Kent Community Services, (ECK-CS) has been evolving since the PCT was established in 2006. In February 2007 the PCT Board agreed to set up a programme to develop the capability and service models within the PCT Provider. In March 2008 the PCT Board agreed revised internal governance and management arrangements to enable the PCT Provider to become an arms length provider and in April 2009 ECK-CS was assessed as Business Ready to operate as an Autonomous Provider Organisation.
- 1.2 This paper details the work that has been undertaken as part of the local implementation of the national Transforming Community Services Programme and sets out some recommendations on the future of ECK-CS.

2.0 Context

- 2.1 The DH programme Transforming Community Services was established following the publication of the *DH Operating Plan 2009/10*, the *NHS Next Stage Review, High Quality Care for All*, and the partner publication, *Our Vision for primary and community care*, which made a public commitment to creating modern, responsive community services of a consistently high standard. It reaffirmed the central importance of services in the community in delivering the national vision of integrated, personalised care outside of hospital and made quality the organising principle of the NHS. Quality improvement is a key deliverable of both the national and local community services programmes.
- 2.2 The DH Transforming Community Services Programme includes work streams focused on clinical transformation (including the strengthening of clinical skills and leadership and the development of pathway based transformational guides) and business transformation (including the implementation of a national standard contract and the World Class Commissioning of Community Services).
- 2.3 The *DH Operating Plan 2009/10* made it clear that “PCTs should ensure that their operational provider services are fit for purpose and able to perform effectively alongside all other providers” and that “by April 2009, provider services should be in a contractual relationship with their PCT, providing sufficient separation from Commissioning roles to avoid potential conflicts of interest”.
- 2.4 In January 2009 the DH published *Enabling New Patterns of Provision (ENPoP)* which set out a framework and timetable for PCTs and SHAs to use to guide local delivery and decision making. It is focused on ensuring an effective internal separation of PCTs and guides PCTs in how to make decisions about future organisational form setting a deadline for agreeing future organisational models of October 2009. It also sets out requirements to strengthening the commissioning of community services.
- 2.5 Since the publication of *ENPoP* the NHS Chief Executive has written to all SHA and PCT Chief Executives on the 30th July 2009 to reiterate that the Transforming Community Services Programme should be focused on delivering “responsive, personalised, productive services of a consistent high quality, embedded within a coherent approach to Quality Innovation Productivity and Prevention”. He states this is the “over-riding priority for community services” and not organisational structure. He also states PCTs do not now have to make a decision

about organisation form in October 2009 but that each SHA will set out a locally derived process that meets two key criteria:

- Readiness and capability to transform services, set within a robust approach to delivering Quality Innovation Productivity and Prevention.
- The strength of local leadership.

2.6 To this end we have focused much of this paper on the work undertaken to transform services from a commissioning and providing perspective but recognise that a significant amount of work had been undertaken regarding organisational models, especially ensuring engagement with staff, so it is appropriate to begin our assessment of organisational form in Section 8.0.

3.0 Scope

3.1 The PCT Board established the Shaping Community Services (SCS) Programme Board to corporately oversee the implementation of the Transforming Community Services work locally. It is chaired by the PCT Chief Executive and has executive and non-executive membership from the PCT Board and the Community Services Management Board.

3.2 The core objectives of the SCS Programme Board are:

1. The PCT, as a commissioner, will ensure it has the capacity and capability to commission services in the community that effectively drive down health inequalities, deliver the best clinical outcomes and ultimately meet the health needs of our local communities.
2. The PCT, as a commissioner, will define service requirements and improvements that build on the strong community services that already exist locally.
3. The PCT, as a commissioner, will commission services that improve access, increase the scope of services provided in the community, ensure consistent quality, increase the personalisation of care and offer choice to people, where and when this is most appropriate.
4. The PCT, as a provider of care, will assess the viability of its services, better understand its business plan for the next five years, and put plans in place to develop a high quality workforce that has the right skills and competencies to deliver the services in the community to empower them to improve patient care and focus on quality.
5. The PCT, as a provider of care, will ensure their services are sustainable, efficient and offer value for money and begin measuring and benchmarking their performance against national and international best practice.
6. The PCT, as a corporate body, will make an informed decision on the future organisational model(s) for the services it currently provides through NHS Eastern and Coastal Kent Community Services.

3.3 Achievement of these objectives will ensure that the PCT is able to effectively determine its commissioning intentions for services in the community and commission those services and ECK-CS effectively, whilst ensuring that ECK-CS is able to operate an effective provider in its own right. It will also allow the PCT corporately to make a decision about the future

organisational model and assess whether ECK-CS meet the two criteria outlined by the NHS Chief Executive in his July letter.

- 3.4 Although the Programme Board is focused on the six objectives stated above the Programme can be defined into six wider areas with Engagement encapsulated within all areas. This is shown in Figure 1 below:



Figure 1: Key Parts of the Shaping Community Services Programme

- **Business Readiness and Governance**

- 3.5 Prior to April 2009 much work was undertaken to enable ECK-CS to meet the requirements of the *DH Operating Plan 2009/10*. This focused on ensuring strong governance and financial arrangements in place so that ECK-CS could operate autonomously from the PCT on an equal footing with other providers. A formal Management Board of ECK-CS was established as a committee of the PCT Board and the governance and management arrangements strengthened to operate effectively. On the 24th April 2009 the South East Coast SHA determined that “as a result of this assessment I am happy to confirm that ECKCS is substantially business ready in line with the Operating Framework requirements”.
- 3.6 A new Lay Chair has been appointed from the 1st August 2009 and three additional Lay Members have been in place from 1st September 2009. Alongside this a Managing Director role is now in place which together with the Associate Directors, Lay Members and two PCT Non-Executive Directors will form a constituted Community Services Board as a PCT Board Committee from 1st October 2009.
- 3.7 The chart overleaf shows the reporting relationships between the PCT Board and its Committees, and the ECK-CS Board

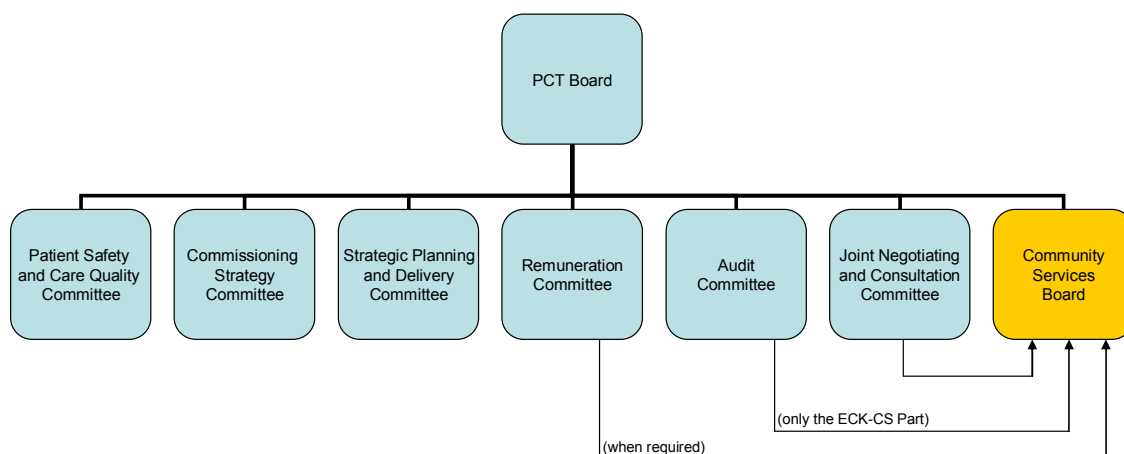


Figure 2: PCT Committee Structure

Further work will continue to ensure that these governance arrangements evolve and develop as the arrangements for a future organisational model mature.

3.8 • **Contracting and Commissioning**

The *DH Enabling New Patterns of Provision* guidance makes it clear that the transformation of community services can only happen if services are commissioned effectively in line with World Class Commissioning principles and that consistent contracts are applied to services in the community. From the 1st April 2009 the PCT contracted with ECK-CS through the national contract which provides consistent terms and conditions to all community providers across the country. Also Lead Commissioners have been developing a Community Services Commissioning Strategy which sets out the commissioning intentions up to 2013 and for the first time starts to describe the landscape of community provision within the Eastern and Coastal Kent area. This is described in more detail later in the paper.

3.9 • **Quality, Performance and Productivity**

Quality has been at the heart of ECK-CS' development from its establishment and it has a strong quality and safety governance structure, mechanisms and culture through the organisation. It has now registered in its own right with the Care Quality Commission and is performance managed by the PCT and assessed by regulators like any other provider. The PCT is currently part of a national pilot to test the DH Quality Framework for community services which include testing quality indicators which will be in place nationally from April 2010.

3.10 ECK-CS has initiated a large scale productivity programme called 'Brainwave vs Tidalwave' which drives aims to drive productivity through local innovation and quality improvement projects. This is an exciting development which aims to ensure ECK-CS prepares effectively for the downturn in NHS finances through a focus on quality and innovation.

3.11 • **Clinical Visions, Models and Skills**

ECK-CS has undertaken work in this area as an enabler to the Five Year Integrated Business Plan. The work is based on the conviction that the only way to build a strong

3.12 provider organisation is to have strong products and services that meet patients' and commissioners' needs. Clinical leadership, workforce planning, skills development and designing the right delivery models are imperative to success. Much effort has been put into really engaging staff and clinical leaders within ECK-CS, at a strategic and operational level in influencing the organisation of services to deliver effective clinical outcomes and offer the best patient experience. This is described in more depth later in the paper.

- **Five Year Business Planning and Infrastructure**

3.13 ECK-CS has used the outputs from the Clinical Visions, Models and Skills area to develop a clinically driven Five Year Integrated Business Plan that sets ambitious visions and underpins those visions with effective clinical models, proper workforce planning, the right infrastructure development and robust financial planning. Due to the change in financial climate ECK-CS will need to make clear within the plan its revenue assumptions, and where possible, gain acceptance to these by their commissioners. It will also test those plans through sensitivity and scenario planning, to ensure ECK-CS can be a sustainable and viable commercial organisation in the long term.

3.14 The PCT has invested significantly in ensuring both the commissioning and providing parts of the organisation have the right infrastructure to succeed. The DH guidance, *Enabling New Patterns of Provision* sets out arrangements with which PCTs must protect assets and the interests of taxpayers, and ensure the provision of safe, fit for purpose buildings. It states that estate "should not normally transfer to providers". To this effect it has been agreed that the clinical delivery property that the PCT owns or leases will be retained by the PCT as Commissioners and in October the management of this property will move from ECK-CS back to the PCT within the Assurance and Strategic Development Directorate.

3.15 This change will ensure that commissioners can ensure best value and really utilise estate in the best interests of patients and in alignment with the PCTs commissioning intentions. This establishes a landlord/tenant relationship between the PCT and ECK-CS and applies to those buildings currently owned and leased by the PCT for the provision of clinical services. This relationship will be established with all providers of services from PCT buildings through Memoranda of Occupation linked to service contracts. In line with national guidance the PCT as owner of the estate is developing a Commissioners Investment and Asset Management Strategy. This is a new approach to developing an Estates Strategy and promotes an alignment between PCTs commissioning strategies and its plan for the future of its estate. This will be published in April 2010.

3.16 With regards to the IT infrastructure ECK-CS will retain ownership of desktop assets and has a dedicated support contract in place with the Kent and Medway HIS. The PCT will retain ownership of networks and control access onto the NHS networks, ensuring both information governance and technological standards are maintained. This will be developed further during 2009 and 2010.

- **Information and Pricing**

3.17 It has been widely recognised that access to good information about clinical delivery in community services is poor and that block contracts with community providers do not help providers themselves or commissioners understand what is being delivered or how each provider is performing. The DH published *Currency and Pricing Options for*

Community Services in January 2009 which sets out how PCTs need to move the contracting of community provision, over the coming years, from block contracts to cost and volume contracts and ultimately to a payment by results type framework.

3.18 The failure of the Local Service Provider contract for the Southern Cluster as part of the National Programme for IT has led to significant delays in the deployment of a community information system. Currently the three community providers in Kent are pursuing a joint procuring of such a system whilst the DH and Connecting for Health explore the possibility of procurement under an ASCC contract. The aim is to have procured and implemented a community information system through the route that offers the best solution, in 2010. This will revolutionise the quality and availability of data both for clinicians to use during their care but also for providers and commissioners to use to performance manage their services.

3.19 In tandem with this the Community Contracting department within the PCT are leading some initial pilots of cost and volume contract and payment mechanisms, in shadow form, for some community services, starting with those that currently have access to an adequate information system. Over the next two years this will ensure the PCT can move ECK-CS from block contracts to a more sophisticated activity and payment model.

3.20 In preparation for these developments significant work is being undertaken to understand the makeup of ECK-CS income especially in understanding the total cost for each service including overheads and indirect costs. Strong financial footings are essential and this continues to be a priority during the rest of 2009/10.

- **Engagement**

In undertaking the work described, specific and appropriate engagement has been undertaken.

3.21 Within ECK-CS this has included engagement with staff around the service visions and development of the five year Business Plan. 26 staff engagement sessions were held between February and August 2009 with 940 staff attending.

3.22 Each session was tailored to reflect the Shaping Community Services journey and included opportunities to update staff on the progress to date, gaining input into the ECK-CS purpose, values and service visions and gathering suggestions for how to further develop services over the next five years. There was also opportunity for staff to understand each of the organisational options and ask questions and provide comment on each of their preferred options.

3.24 Engagement with Staffside has also been positive with the Chair of the Staffside a member of the Shaping Community Services Programme Board and Community Services Management Board. They have been actively involved in these work streams and the JNCC have received updates on the Programme at each of its meetings.

3.25 Another area of engagement within ECK-CS has been raising awareness of the national Right to Request mechanisms. The 'right to request' is a commitment set out within the *NHS Next Stage Review*. It entitles primary and community care staff to put a business case to the PCT Board to set up independent social enterprises and to have their case considered. If approved, the PCT will support the development of the social enterprise and award it a contract to provide services, still free at the point of

delivery. To date no services or staff have initiated their 'right to request'.

3.26 Within the PCT as a commissioner, the development of the Community Services Commissioning Strategy has involved engagement with all parts of the commissioning organisation. Specifically Practice Based Commissioning, Social Care and Primary Care have been engaged and communicated with and the Patient and Public Engagement Team have set up events with Kent LINK for local people to influence the strategy.

Commissioning Community Services

The Shaping Community Services Programme has three commissioning-led objectives.

4.0

In order to achieve these objectives a Community Services Commissioning Strategy has been developed. It is part of a suite of strategies that underpin the PCTs Strategic Commissioning Plan (SCP) for 2008-2013. These include strategies for elective care, urgent care, maternity services, long term conditions and end of life. The Community Services Commissioning Strategy will sit alongside these as a vehicle for the delivery of the SCP.

4.1

4.2

4.3

The Community Services Commissioning Strategy is not purely a strategy for services provided by ECK-CS but encapsulates all the current and future services it is intended should be provided outside of major (acute) hospital settings and is supported by a strong commitment to ensuring access to all, regardless of age, sex, disability, gender, race, ethnic origin, religion, belief or sexual orientation.

4.4

In delivering the Community Services Commissioning Strategy, the Commissioning Strategy Committee agreed the direction of travel, expectations and timetable for delivery of the Strategy in July 2009. Since then there has been consultation with Practice Based Commissioners and stakeholders and wider consultation events with the public and patients, which has been supported by the Kent LINK. The final Strategy will be submitted to the Commissioning Strategy Committee in October for ratification. However, the strategy has been sufficiently developed to allow its draft outputs to inform this paper.

4.5

The current community provider landscape includes ECK-CS, other PCT's Provider arms, EKHUFT, KMPT, Kent County Council, General Practices and private and voluntary sector providers. There are Integrated Care Pilots being developed and Section 75 agreements between health and social care. The Primary and Community Nursing Strategy integrates community nursing directly with primary care. The Community Services Commissioning Strategy will bring together the commissioning of all the elements of community care into one integrated approach and will enable the development of quality provision through a plural market of providers.

4.6

Both the Strategy and the ECK-CS Business Plan have been written against five agreed Department of Health priority areas for community care. These have been developed for both adults' and children's services:

- Long Term Conditions and Rehabilitation
- End of Life
- Acute Services Closer to Home
- Promoting Health and Wellbeing
- Mental Health

4.7 In developing the Strategy commissioners have defined some strategic commissioning principles for community services. They have also specifically identified the key commissioning principles, outcomes, requirements and the potential impact on the service provider market for each service area.

Strategic Commissioning Principles

5.0 Within the Strategy there are six key principles that will drive the commissioning of community services. These are:

- 5.1
- Deliver more services in local community settings, ensuring they promote personalisation and independence and are responsive to patients
 - Use analysis of local health and social care needs to inform commissioning that will address and reduce inequalities
 - Improve the integration and communication across community care and all other health and social care providers
 - Increase patients' and health practitioners' knowledge of services available in the community to enable them to make informed choices and referrals
 - Increase the focus on education and prevention through health and well-being services.
 - Ensure that clinically-led quality, safety, efficiency and value for money are at the heart of all community services through a focus on the delivery of measurable outcomes

5.2 These Strategic Principles and the underlying detail for each DH priority area will enable the delivery of all the commissioning objectives of the Transforming Community Services Programme, specifically the objective which requires the PCT to define service requirements and improvements that build on the strong community services that already exist locally.

Community Services Five Year Integrated Business Plan

6.0 The Shaping Community Services Programme has two objectives specific to ECK-CS. In order to achieve these objectives ECK-CS conducted five key pieces of work.

6.1 Firstly it assessed the viability of its services by conducting an analysis of its portfolio. This allowed ECK-CS to understand the makeup of its services, the way in which they interact and identify any services it feels could be at risk from its own business perspective or from an assessment against commissioning intentions. It has also allowed it to build an internal Operating Model.

6.2 Secondly it has used the intelligence gathered from the first exercise to create 5 year visions for each service linked to the DH service areas described previously. This has enabled the organisation to set some ambitious targets, drive its business development capability and empower strong clinical leadership at all levels.

6.3 Thirdly it has put quality improvement at the heart of its operations and made productivity and innovation a key part of its development for the long term. It is also bolstering its performance management mechanisms and embedded a high performance culture at both strategic and

6.4 operational levels, in line with its contracted and corporate responsibilities.

6.5 Fourthly it will publish, to the first formally constituted Community Services Board in October, its Five Year Integrated Business Plan produced from the clinically led developments described above. It will aim to show ECK-CS as a sustainable, commercially viable organisation that offers quality and value to the patient and the commissioner.

The key overriding principles for ECK-CS can be summarised as:

- 6.6 • Further integration of our services to deliver continuous quality improvement, a strong and embedded commitment to ensuring equality, and embracing diversity, and a better and more consistent patient experience.
- Focus on what we do best, become more productive and expand existing services where appropriate.
- Develop and win new services (focusing on reducing acute demand and developing services that would have traditionally been provided in acute settings).
- Expanding our service delivery to other areas by responding to the commissioning intentions of commissioners other than NHS Eastern and Coastal Kent.

6.7 Finally ECK-CS will align its infrastructure, support and corporate services with the clinical visions and ambitions so that the clinical services in their current and future state are appropriately supported by proper workforce, financial, infrastructure and corporate planning.

6.8 In meeting the second provider-led Shaping Community Services Objective it continues to be an ambition for ECK-CS and the other PCT Providers it works closely with to be able to benchmark their performance against each other. It will use the introduction of the national quality indicators as the first stage in this development.

Alignment between Commissioning and Provision in Community Services

7.0 Alignment of this kind is not a one off event but part of a continuous cycle of development for both the commissioner and providers. It is important to ensure, at this critical stage, that there is an alignment in intentions but it is equally important to understand the mechanisms that are in place to refresh priorities and developments over time, as both the Commissioning Strategy and ECK-CS Business Plan are live documents.

7.2 In aligning the current intentions of both the Commissioning Strategy and the ECK-CS Business Plan both representatives from ECK-CS and Lead Commissioners met during the summer to bring together their draft plans. A key area where this was particularly successful was Long Term Conditions and Rehabilitation. The PCTs commissioning principles for Long Term Conditions and Rehabilitation focus on strong integration across multi-disciplinary teams, greater independence and well being for both carers and patients with a greater focus on self care and moving rehabilitation services closer to home.

7.3 ECK-CS has set ambitions that will improve patient care in this area and supports these commissioning principles. An example of this include ECK-CS' aim to create a Long Term Conditions Integrated Health and Social Care Team that works in partnership with social care and is integrated with primary care. The service model will bring together nursing, therapy and medical practitioners who will focus on patients with long term conditions. They will ensure seamless care between professions and organisations whilst supporting patient

independence and reducing hospital admissions.

7.4 Another example of alignment is Health and Well-Being. The PCTs commissioning principles in this area focus on personalising services to the needs and choice of the individual. There is a focus on sexual health, for which ECK-CS intends to be a market leader, smoking and healthy weight.

7.5 In order to support these intentions ECK-CS aims to extend its general practice provision in this area including vascular services and lifestyle clinics with a focus on 'at risk' men. Extending provision in dental health will also support PCT ambitions both at a general and specialist dental level. ECK-CS also has an aim to work with sports and fitness groups targeting prevention of musculoskeletal injuries and at the other end of the spectrum aims to extend its provision in Weight Management and Obesity services for adults and children. The development of a Sexual Assault Referral Centre as a joint venture with Kent Police is a specific ambition as well as more targeted work with the Lesbian, Gay, Transsexual and Bi-Sexual Community.

7.6 Whilst there is alignment between the commissioning intentions of NHS Eastern and Coastal Kent and the ECK-CS Business Plan it must be made clear that the PCT commissioning principles include a desire for increased plurality of provision for example in the area of Long Term Conditions and the intention to review the specification and provider landscape for a number of service areas such as Adult Speech and Language Therapy and Physiotherapy. Where there are currently known implications for ECK-CS these areas have been subject to more robust sensitivity analysis in the ECK-CS Business Plan.

7.7 This picture will not be uncommon across the provider landscape. There will be services in all parts of the health system that are subject to commissioning led review or market testing. It requires providers to develop strong sensitivity analysis and scenario planning to understand the implications of loss and gain in revenue to its overall business model. As the commissioning cycle is implemented for each service area changes to the provider landscape will manifest themselves in a variety of way. These include:

- Services being market tested and procured by commissioning
- Natural modernisation and service improvement by either the commissioner or provider
- Pathway based commissioning that adjusts the way services are organised,
- Providers moving away from an area of provision outside of their mandatory services
- The 'Right to Request' mechanism.

ECK-CS recognises this within their Business Plan and gives confidence that their overall business model can flex to natural service movement.

7.8 Ensuring ongoing alignment will require continued focus and there are now mechanisms in place to support this. Through operational performance meetings which cover all service areas, ECKCS and its commissioners are able to evolve and develop services to meet changing needs, including discussing service innovation and developments at a strategic level. In addition ECKCS will participate in groups led by commissioners that bring together providers from across a pathway to integrate processes and ensure seamless provision. This will ensure an ongoing alignment between the developing Business Plan of ECKCS and the strategic commissioning plans of commissioners.

7.9 There is also public health and patient experience intelligence gathered by the PCT which is available to ECK-CS and other providers to support their ambitions and enhance the delivery of PCT commissioning intentions. Market Analysis completed by the PCT will also inform

7.10 procurement plans in the future. These mechanisms provide confidence that alignment will continue as the Commissioning Strategy and ECK-CS Business Plan are implemented.

Organisational Options

8.0 One of the core principles of the Shaping Community Services Programme is to drive service transformation, patient experience improvement and not specifically focus on Organisational Models. Over the last year many options have been tested in various forms by PCTs across the country. As described earlier, PCTs are no longer required to make an organisational decision in October 2009 but a significant amount of work had been undertaken in the PCT before this requirement was put in place. Therefore it is appropriate to show the work that has been undertaken and begin our assessment of these models below.

8.1

The DH *Enabling New Patterns of Provision* sets out nine organisational options:

- 8.2
- Direct Provision
 - Community Foundation Trust
 - Social Enterprise
 - Vertical Integration
 - Horizontal Integration with Local Authority
 - Partnership Arrangements
 - Integrated Care Pilots
 - Primary Care Contracts
 - NHS Contracted Arrangement / Services provided on behalf of a PCT by a third party

8.3 There is no nationally prescribed model and all options have advantages and disadvantages. It is not a requirement that the whole provider arm follows the same organisational model. Most of the models above can be applicable to the whole organisation, to individual services, or even groups of services that have proven synergies for patient care delivery; however no model is mutually exclusive from another.

8.4 Work has been undertaken within ECK-CS to determine where synergies exist across services provided by ECK-CS and how these synergies can be further developed for greater patient benefit. This has significantly influenced the overall operating model for ECK-CS, as part of the development of the Business Plan, and supports the synergies between both adult and children's services.

- **Assessment of Models**

It is appropriate to look at how the nine organisational models listed above could be applied to ECK-CS.

8.5 Two of the models above (Partnership Arrangements and Primary Care Contracts) exist currently within Eastern and Coastal Kent and will continue to form part of the rich picture of contractual models used across the health economy. However they do not provide a solution to the overall organisational model for ECK-CS as the examples below show they are best applied to specific services and pathways in a way that delivers the right benefits to patients.

8.6

- **Partnership Arrangements**

Partnerships are a key part of the purpose and vision of both the PCT and ECK-CS. It features heavily in the SCP and the values of ECK-CS and will remain a key priority

- 8.7 across the health system in Eastern and Coastal Kent.
- 8.8 There are many partnerships in operation; both formal and informal and support patients across organisational boundaries and enable seamless care provision, especially across different sectors. There are Section 75 arrangements in place with both Adult and Children's Social Services including the Learning Disabilities Community Teams which enable integrated care provision and multi-disciplinary working.
- 8.9 The Community and Primary Nursing Commissioning Strategy has partnerships at its core and integrates community nursing into primary care, supporting general practice in the management of patients with long term conditions, palliative care and wound care, for example.
- 8.10 Both the PCT and ECK-CS have explicit reference to partnerships in their strategies and regardless of the overall organisational model recommendation a strong component to the future of community services will be partnership arrangements.
- **Primary Care Contracts**
- 8.11 Although Primary Care Contracts are not the principle contracting route for community services, they are used to contract with primary care providers across the health economy. ECK-CS have seven PMS contracts for the general practices they manage. These contracts are being reviewed currently as part of a PCT Board decision in January 2009 to move the contracting to S-PMS contracts. ECK-CS as part of its clinical visions work has given notice to the PCT for one of its practices which the PCT contracting team is processing.
- 8.12 Whilst Primary Care Contracts will continue to be used to contract primary care services across the health economy, they are not an appropriate form of contract for community services as a whole. A national community contract is already in place and will be utilised regardless of organisational form.
- 8.13 The model described as 'NHS Contracted Arrangement / Services provided on behalf of a PCT by a third party' offers a wider solution than the previous two models and is described below.
- **NHS Contracted Arrangement / Services provided on behalf of a PCT by a third party**
- 8.14 It is possible to contract between NHS organisations for the delivery of services on behalf of each other. Local examples of this include the delivery of EKHUFT and Medway Outpatient Services within Community Hospitals, administered and managed by ECK-CS through inter-provider contractual arrangements. Also Adult Speech and Language Services and Dietetics and Nutrition Services are provided to the patients of EKHUFT under contract to ECK-CS. These are sub-contractual relationships between providers.
- 8.15 These mechanisms offer providers and commissioners flexibility to contract appropriately. They will continue to be used to increase capacity and capability in particular services.
- 8.16 With regard to more detailed contractual arrangements, Regulation 10 of the NHS (Functions of Strategic Health Authorities and Primary Care Trusts) and Administration Arrangements Regulations 2003 (SI 2003/2375) enables a PCT to: (a) delegate provider functions to a committee or employees of the Trust; and (b) enter arrangements under

which the provider functions are delegated to another PCT or a joint committee. Also Section 21(2) of the NHS Act 2006 enables a PCT to provide community services for another PCT under a commissioning arrangement.

8.17 These regulations therefore allow for the PCT to enter into a contract with another PCT or NHS organisation to provide the services that are currently provided directly. There are test cases within the South East Coast SHA and across the country. However they do not offer a long term solution and can be subject to detailed competition/collaboration processes. Due to the size of ECK-CS as the fifth largest provider in England it will not offer value to the PCT or patients to move the responsibility (but not the overall accountability) further away from the PCT Board.

8.18 It should be recognised that the PCT Board will still remain accountable for the services but the management of those services will be delegated to a third party outside of the PCT's direct control. There have been no specific requests or enthusiasm for an outward transfer of ECK-CS, however the PCT must be ready to respond to requests for an inward transfer of another PCT Provider. In preparation for this a risk based partnership framework is being developed corporately for the PCT and will be published in the Autumn.

8.19 Due to reasons described above these three models should not be subject to more detailed assessment as an overall organisational model for ECK-CS. This does not exclude them from future assessment for individual services as the Commissioning Strategy and ECK-CS Business Plan are implemented but are not appropriate at this time.

The remaining six models can be applied as an overall organisational model and are relevant for a more in depth analysis.

8.20 **Assessment of Models against Criteria**

9.0 The Shaping Community Services Programme Board agreed a process with which it would assess relevant organisational options. Once the alignment between the Commissioning Strategy and the ECK-CS Business Plan had been reviewed the PCT must take a corporate view of appropriate future organisational model(s).

9.1 It was agreed that the following ten criteria will guide the assessment of the corporate risk and benefit of each remaining model:

- 9.2
1. Effect on quality of service delivery
 2. Effect on staff
 3. Effect on risk and reputation of the organisation
 4. Effect on Service Continuity
 5. Financial implications of transition and sustainability
 6. Ability to allow synergies between services
 7. Ability to be flexible in a changing NHS market
 8. Sustainability and resilience in the long term
 9. Viability in the current economic climate
 10. Ability to promote patient choice

9.3 The following matrix describes the remaining six organisational models, progress made nationally against this model and the main corporate risks and benefits for the PCT, for each model, guided by the ten corporate criteria.

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Direct Provision	<p>Although not seen as the long term solution the DH is keen for PCTs to focus on service transformation rather than organisational form in the medium term.</p> <p>National guidance on governance arrangements for PCT Providers gives opportunities to progress internal separation further to operate as two separate organisations within one umbrella organisation.</p>	<ul style="list-style-type: none"> - Conflicts of Interest's may still exist and these need to be managed appropriately. - Could be seen internally and externally as not being ambitious enough in delivering transformation. - ECK-CS have a desire to be a standalone provider in the long term. - Potential loss of momentum on the journey to separation and progress onwards could get diluted. - The ECK-CS Business Plan is ambitious and requires ECK-CS Board to have the ability to make strategic long term decisions that may be different to that of the PCT. - Commissioning decisions that impact ECK-CS may be delayed or stopped if there is a corporate impact on the PCT. - Potential not to be sustainable and resilient in the long term so the potential for organisational change continues. - A service level agreement imposed by PCT as commissioner would have no legal enforceability (PCT cannot contract with itself) 	<ul style="list-style-type: none"> - The PCT can focus on service transformation and quality improvement rather than organisational change. - Staff can continue to deliver services without disruption, other than that generated by service developments. - The PCT does not have to finance large scale organisational change which supports the current economic climate. - Synergies within services and across services can be developed further as part of the implementation of the Commissioning Strategy and Business Plan. - Allows flexibility in the future as services are reviewed and commissioned. Allows services to determine their own path and the organisation can flex accordingly. - The Commissioning Strategy and Business Plan will have an opportunity be mid-way through implementation before organisational change. Also patient choice can be developed.

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Community Foundation Trust (CFT)	<p>Six Provider Arm Pilots have been established for over 1½ years and developing under guidance from the DH. KMPG have reviewed the capabilities of the pilots in Spring 2009 and highlight that there are still some challenges to be overcome with regard to capability, policy decisions and process agreement with Monitor. Two pilots are developing faster than the others and they are moving forward. First likely date of authorisation is Spring 2011.</p> <p>The DH asked for declarations of interest in April from PCTs that would be interested in pursuing a CFT path. Those declarations had to be assured by the SHAs. Around 30 declarations were made including that of this PCT.</p> <p>As this is a viable model for the provision of the existing complex organisation providing multiple services rather than only for individual services the PCT has put a declaration of interest to form a CFT into the SHA which has sent to the DH for processing.</p>	<ul style="list-style-type: none"> - Uncertainties as to the viability and application path for community providers to become CFTs. - Asset light model needs further investigation nationally and with Monitor. - Would mean three large FTs within ECK area and could restrict patient choice. - Monitor processes and regulation is complex and restricts some freedoms. - Long transition and authorisation period with significant focus and time commitment required by ECK-CS Executive and Non-Executive Team. - Potential to focus more on finance than quality (although this is being addressed) - Cost of transition could be substantial. 	<ul style="list-style-type: none"> - Staff engagement shows enthusiasm and a willingness to proceed to FT - Strong governance focus within FT authorisation provides assurance to the PCT - Strong local ownership and public engagement model that supports community ethos. - Provides a separate legal form away from the PCT, allows absolute autonomy for ECK-CS. - Would feel relatively seamless transition for staff as development is over a long period and service structures continue. - Synergies within ECK-CS can continue and prosper. - Allows ECK-CS to compete on an equal footing with other local and national FTs.

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Social Enterprise (SE)	<p>Significant enthusiasm and energy at DH level for Social Enterprise formation. Seen as a springboard to innovation, clinical leadership and entrepreneurship which gives freedoms to NHS staff they don't have within the traditional NHS Structure, through the Right to Request process.</p> <p>Investment available nationally to support development of business cases and transition. Test cases have focused on small community focused models with no complete PCT Providers having made the transition, although some PCT providers are developing significant business cases to float off complete providers into this model.</p> <p>Few 'right to request's' have been made as there is still apprehension over the NHS pension within a SE model.</p>	<ul style="list-style-type: none"> - Not a model that would support the straight transfer of ECK-CS in its current form. - Staff largely not enthusiastic about the model, although there are some small clinical services that may develop this further in the long term. - NHS Pensions guaranteed on transfer to the social enterprise but there are circumstances once in the enterprise that this is not the case. - All major staff-side organisations are advising staff against this model. - Largely untested model in the NHS. No large scale test cases to assess. - Economical climate could hinder long term viability. - Social Enterprise may not want to carry on with services that PCT would consider to be mandatory. - Could be public objection to the movement of services outside of the traditional NHS family. 	<ul style="list-style-type: none"> - Separate legal entity away from PCT. - Supports innovation and clinical leadership. - Supports patient choice and plurality of provision. - Synergies in services can be maximised and supports strong integrated working. - Regulated by the Financial Services Authority and Care Quality Commission which offers assurance to the PCT.

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Vertical Integration	<p>This form of integration focused on movement into secondary or primary care organisations.</p> <p>There are test cases in England that show PCTs moving their provider into hospital acute trusts, mental health trusts and into primary care.</p> <p>Most movement into hospital and mental health trusts are for fixed periods of time while services can be market tested, and are seen as holding positions, unless the said provider wins the business through procurement.</p> <p>Varying degrees of enthusiasm for the model given the national policy to move care out of acute into the community.</p> <p>Movement into primary care provision is more in line with national direction and integration with primary care is seen as more positive. (see Integrated Care Pilots)</p>	<ul style="list-style-type: none"> - PCT may find it less easy to implement its plans to manage acute demand and develop care pathways which have no acute service elements when the provider provides both community and acute care - Potential for very large monopoly foundation trust provider – does not support patient choice. - Most acute providers do not have the experience of providing wide ranging community services. - There is a risk of asset/resource stripping to meet other key needs of the acute business. - Economies of scale lost and business continuity compromised when individual practices employ services. 	<ul style="list-style-type: none"> - Whole care pathway solution - Potential financial incentives towards system efficiencies - Support integration between services - Terms and Conditions of staff remain the same (unless employed in primary care) - Supports economic climate

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Horizontal Integration with Local Authority	<p>Where Local Authority boundaries match PCT boundaries there are national examples of where the PCT Provider and Social Services have formed integrated organisations, either through transfer of NHS staff into the Local Authority or through Section 75 agreements.</p> <p>Operationally there are significant barriers both from a cultural and technological perspective but the most successful integrations do show patient benefit.</p> <p>Joint posts at senior levels have also been appointed to, but mainly from a commissioning perspective.</p> <p>Section 75 agreements are used regularly for service specific partnerships.</p> <p>Care Trusts are not seen as an option for community services.</p>	<ul style="list-style-type: none"> - Constitutionally complex in practice - Employment terms and conditions will vary between staff groups - Governance arrangements may be complex on a large scale - Different financial regimes and positions may hinder progress. - Accountabilities can be difficult to define. - Payment and charging issues may cause tensions in service delivery and design. - Cultures and working practices may be different. - May not be clinically driven and clinical leadership may suffer. - Frictions from two-system approach. - Kent Adult Social Services have just completed a large scale restructure bringing together commission and provision functions. - Enthusiasm for whole-scale integration is low but high for service level operational integration. 	<ul style="list-style-type: none"> - Established and flexible model suitable for a large number of different applications/situations - Integration across organisational boundaries can preserve existing staff benefits, although secondment models can be complex and open to challenge. - Support integration agenda - Gives a locally shared vision of care out of hospital - Strengthens the use of pooled budgets, co-location and strategic planning.

Model	Progress Nationally	Main Corporate Risks	Main Corporate Benefits
Integrated Care Pilots	<p>This programme is designed to explore different ways in which health and social care could be provided. The aim is to look beyond traditional boundaries (e.g. between primary and secondary care) to explore new, integrated models.</p> <p>16 Integrated Care Pilots (ICP) were announced by the Department of Health.</p> <p>Two bids from the Eastern and Coastal Kent area were not accepted. PCT is supporting a local programme to develop these and further pilots.</p> <p>There is much enthusiasm for this model both nationally and locally.</p> <p>ECK-CS are partners in both local pilots.</p>	<ul style="list-style-type: none"> - The model is in its infant stages and needs time to develop to fully understand benefits over and above current service provision models. - 3 year pilots mean that whole-scale move to this model will take time. - Economies of scale lost and business continuity compromised when individual practices employ services. - Contractual arrangements could be complex for the PCT. - Potential friction between whether these pilots become structural organisations or functional networks managed by a shared board. 	<ul style="list-style-type: none"> - Patient focused and clinically led - Local models being development with ECK-CS involvement - As a functional rather than structural solution may be more readily realised. - Improved partnerships in care provision across health and social care sectors. - Better use of scarce resources and more effective and economic delivery systems - Method of Improving relationships, governance, risk management and innovation in specific delivery systems

9.4 Taking into consideration the risks and benefits for each model, and the current progress nationally this matrix suggests that Direct Provision continues to have the best balance between risk and benefits. The other models should remain under consideration and be progressed if appropriate once the national and local picture becomes clearer.

9.5 Other than direct provision, establishing a Community Foundation Trust is currently the most viable option for the wholesale transfer of the existing service model whereas all other options would be better applied to individual or small scale services.

10.0 Recommendations

- 10.1 This paper set out to describe the local implementation of the national Transforming Community Services Programme. It has focused on service transformation and quality improvement but also assessed the corporate suitability to the organisational models that the *DH Enabling New Patterns of Provision* describes.
- 10.2 In conclusion the following recommendations are made to the PCT Board for ratification:
- The PCT Board are asked to endorse the significant work that has been undertaken in delivering the Transforming Community Services Programme to-date, within the PCT and ECK-CS.
 - Endorse the local approach to Transforming Community Services that focuses on making quality improvement and service transformation the organising principle for change rather than organisational form.
- 10.3 On the basis of the organisational model assessment and our focus on quality improvement and service transformation, a further seven recommendations are made:
1. Direct Provision will remain the model of delivery for ECK-CS in the short to medium term to allow time to transform local services and improve quality through the implementation of the Community Services Commissioning Strategy and the ECK-CS Business Plan.
 2. To support the autonomy and ambition of ECK-CS and allow the PCT to concentrate on its World Class Commissioning responsibilities the PCT will strengthen its internal governance to further separate ECK-CS under the umbrella of the PCT, with the intention it will be a standalone provider, external to the PCT, in the long term. It must also show during its journey to absolute separation that it can demonstrate best value, productivity and efficiency, alongside any other provider.
 3. Although there remain uncertainties around the Community Foundation Trust and Integrated Care Pilot models the PCT should support the development of these models as their transition and implementation paths become clearer. In the meantime ECK-CS should use the tools supplied by Monitor to develop its capability and capacity to operate as a commercially viable NHS business.
 4. To begin implementation of the Community Services Commissioning Strategy and ECK-CS Business Plan, once ratified, and recognise that this may mean discrete services that currently sit within the Direct Provision model are identified for more detailed commissioning or provider-led reviews. A programme of reviews will be shared between the PCT and ECK-CS and recommendations following any reviews will be subject to normal PCT Board agreed processes.
 5. The PCT should allow innovation and clinical entrepreneurship to prosper as ECK-CS continues to evolve, as well as continue to allow staff and individual services the opportunity to develop business cases that support the right to request principles to become a Social Enterprise or other organisational form.
 6. To undertake the SHA assessment, once determined, to assess PCT compliance against the two key tests outlined by the NHS Chief Executive in July 2009.

7. To stand-down the Shaping Community Services Programme Board in December 2009 following its work to further strengthen the current governance arrangements. It will then meet again in March 2010 for a one off meeting to review commissioning and provider progress and review any national developments. It will then report its review and any further organisational option recommendations to the PCT Board in May 2010.
- 10.4 The PCT Board are asked to ratify the following (See Appendix 1):
- Terms of Reference for the ECK-CS Board so that it has agreed Terms of Reference in place in time for the first public ECK-CS Board Meeting on the 2nd November 2009.

11.0 Next Steps

The PCT Board are asked to endorse the next steps:

- Ratification of the full Community Services Commissioning Strategy in October 2009 by the Commissioning Strategy Committee.
- Ratification of the ECK-CS Integrated Business Plan by the Community Services Board on the 2nd November 2009.
- Develop a risk based partnership framework that sets out the governance arrangements and approval routes for ECK-CS to enter into high level partnerships.
- Inform the SHA in their role of assurance, of our recommendations in line with national timescales and work with them and the DH on developing the Community Foundation Trust model and processes.
- Review the relevant governance documents to ensure governance arrangements are further strengthened and ECK-CS has an appropriate decision making abilities, autonomy and licence to act for all its functions and clinical and non-clinical services.
- Publish a PCT Estates Strategy in April 2010.
- The PCT as Commissioner and ECK-CS to agree the principles for any service reviews and identify any service areas that are likely to be reviewed over the coming year.
- Review of any further developments around the organisational model options to inform a further report to the PCT Board in May 2010.

NHS EASTERN AND COASTAL KENT COMMUNITY SERVICES BOARD

TERMS OF REFERENCE (Version 7)

1.0 PURPOSE

The NHS Eastern and Coastal Kent Community Services (ECK-CS) Board is a formal Committee of the Board of NHS Eastern and Coastal Kent Primary Care Trust (“the PCT Board”), and reports directly to it.

It has overall strategic and operational responsibility for the PCT Provider as an Autonomous Provider Organisation (APO).

ECK-CS will establish a robust governance framework to ensure that ECK-CS is run within the appropriate standards of probity, transparency and integrity.

2.0 DUTIES

The ECK-CS Board (“the Board”) duties are to:

- (1) Set the NHS Eastern and Coastal Kent Community Services Five Year Integrated Business Plan and Vision. It will ensure that the Strategic Objectives are met through integrated systems, processes and internal controls of business management and governance within ECK-CS.
- (2) Set Strategy and Policy for ECK-CS and ensure all services provided meet commissioning intentions, are performing well, are productive against commissioner and service user requirements, are of a high quality, safe, and are developed in line with the ECK-CS Strategic Objectives.
- (3) Ensure effective management systems within ECK-CS that safeguard public funds and implement the requirements of integrated governance.
- (4) Achieve value for money from the resources available to ECK-CS, using to best effect the funds available for providing healthcare.
- (5) Ensure that ECK-CS meets its statutory duties relating to equality and diversity, specifically as an employer and in the delivery of its services.
- (6) Approve and monitor the risk management programme for ECK-CS and ensure effective governance systems are in place, monitored through the ECK-CS Assurance Framework and ECK-CS Risk Register.
- (7) Make decisions based on recommendations from the Clinical Quality and Safety Committee, the Performance Management Committee, the Incident Management and

Learning Committee, the Infection Control and Cleanliness Committee, the Audit Committee, Remuneration and HR Committee, Joint Negotiating and Consultative Committee, and their own sub-groups.

- (8) Be responsible for the achievement of all relevant national requirements including NICE, National Service Frameworks (NSF), National Targets and the Care Quality Commission registration requirements, within ECK-CS.
- (9) Oversee the development of clinical and support services within ECK-CS.
- (10) Ensure the business of the ECK-CS Board is conducted in accordance with these Terms of Reference, the Scheme of Delegation, Standing Orders, Standing Financial Instructions and the statutory and legal obligations of ECK-CS.

2.1 In addition to the duties described above the ECK-CS Board has the following roles and responsibilities:

Equality and Diversity

Further to duty 5 above, the ECK-CS Board will:

- ensure that it does not approve or recommend strategies, policies, plans or initiatives without assessing their impact on the equality and diversity policies of ECK-CS
- ensure that its services are available to all who require them (as per referral/acceptance criteria), regardless of age, sex, disability, gender, race, ethnic origin, religion, belief or sexual orientation.

Health and Safety

The ECK-CS Board will:

- provide leadership to health and safety across the organisation and receive assurance from the Health and Safety Group via the Clinical Quality and Safety Committee
- take action to ensure that it and its reporting committees meet their statutory duties in relation to health and safety
- ensure that it does not approve or recommend strategies, policies, plans or initiatives without understanding their impact on the health and safety policies of ECK-CS.

Business Continuity and Emergency Planning

The ECK-CS Board will:

- ensure that ECK-CS can meet its statutory responsibilities under the Civil Contingencies Act 2004
- ensure that it can operate as required in the event of the emergency and/or when business continuity plans are activated.

Information Governance

The ECK-CS Board will:

- take action to ensure it and its reporting committees act in line with the statutory obligations of the organisation in relation to information governance. Specifically:
 - the publication scheme in line with Freedom of Information requirements
 - data security requirements.

3.0 MEMBERSHIP

The membership and composition of the ECK-CS Board shall be:

- (1) An Independent Lay Chairman appointed by the Appointments Commission for a specified time and who is designated as a Non Officer Member;
- (2) Three other Independent Lay Members appointed by the Appointments Commission for a specified time and who are designated as Non Officer Members;
- (3) Two Non-Executive Directors appointed to the ECK-CS Board by the PCT Chairman for a specified time and who are designated as Non Officer Members.
- (4) Six voting employees of ECK-CS (the "Officer Members") consisting of:
 - Managing Director
 - Associate Director of Finance
 - Deputy Managing Director
 - Associate Director of Nursing
 - Associate Medical Director
 - Associate Director of Quality and Performance
- (5) Non Voting Members:
 - Associate Director of AHP & Specialist Clinical Services
 - Associate Director of Business Development
 - Assistant Director of HR and Organisational Development
 - Chair of the Joint Negotiating and Consultative Committee
 - Any Other Associate / Assistant Directors as co-opted
- (6) The Chief Executive and the Director of Human Resources and Organisational Development of the PCT may also attend meetings if they so wish.
- (7) The ECK-CS Board may co-opt non-voting stakeholder members, such as the Local Authority and patient and public representatives. .

4.0 CHAIR

The Lay Chair ("the Chairman") will be appointed independently of the PCT by the Appointments Commission and will be given responsibility for the chairmanship of ECK-CS

At any meeting of the ECK-CS Board the Chairman shall preside.

The Chairman and members of the ECK-CS Board may appoint one of their number, who is not an Officer Member, to be Vice-Chairman, for such period, not exceeding the remainder of his/her term as a member of ECK-CS.

If the Chairman is absent from a meeting or absent temporarily on the grounds of a declared conflict of interest, the Vice-Chairman shall preside. In the event of the absence of both the Chairman and the Vice-Chairman, those present shall select one non-officer member to act as Chair for the duration of the meeting.

The decision of the Chairman of the meeting on questions of order, relevancy and regularity and interpretation of the Terms of Reference, Standing Financial Instructions and Scheme of Delegation at the meeting, shall be final.

5.0 SECRETARY

The Associate Director of Quality and Performance or their nominee shall act as Secretary to the Committee.

6.0 QUORUM

No business shall be transacted at a meeting unless at least one-third of the membership including the Chairman (including at least one member who is an Officer Member and one member who is a Non Officer Member) is present.

Those in attendance for an Officer Member but without formal acting up status approved by the Board may not count towards the quorum.

If the Chairman or member has been disqualified from participating in the discussion on any Matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

7.0 FREQUENCY

Ordinary meetings of the ECK-CS Board shall be held bi-monthly in public at such times and places as the ECK-CS Board may determine.

8.0 NOTICE OF MEETINGS

The Chairman of ECK-CS may call a meeting of the ECK-CS Board at any time.

One-third or more members of the ECK-CS Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

In advance of any meeting held in public, the ECK-CS Board will ensure that a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at ECK-CS Headquarters at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a))

9.0 CONDUCT OF MEETINGS

The ECK-CS Board shall be conducted in accordance with the provisions of the current PCT Board approved Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

9.1 Admission of public and the press

The public and representatives of the press may attend all meetings of the ECK-CS Board, but shall be required to withdraw upon the ECK-CS Board passing the following motion:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

Guidance should be sought from the PCT's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

General disturbances

The Chairman or the person presiding over the meeting held in public, shall ensure that ECK-CS business can be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The Chairman can require the public to withdraw from the ECK-CS Board meeting if continued interruption and disruption is causing unacceptable disturbance.

Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the ECK-CS Board following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the ECK-CS Board.

Members and Officer Members or any employee of ECK-CS in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of ECK-CS, without the express permission of ECK-CS.

Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Terms of Reference shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of ECK-CS or Committee thereof. Such permission shall be granted only upon resolution of ECK-CS.

Observers at ECK-CS Board meetings

ECK-CS will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the ECK-CS Board meetings and may change, alter or vary these terms and conditions as it deems fit.

9.2 Voting

Every question put to a vote at a meeting shall be determined by a majority of the votes of members present. In the case of an equal vote, the person presiding (i.e.: the Chairman of the meeting) shall have a second, and casting vote.

At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

If at least one-third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

If a member so requests, their vote shall be recorded by name.

In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to formally fill a voting member vacancy shall be entitled to exercise the voting rights of the Officer Member.

A manager attending the ECK-CS Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member.

An Officer's status when attending a meeting shall be recorded in the minutes.

9.3 Declaration of Interests

ECK-CS Board members are required to declare interests which are relevant and material to their membership of the ECK-CS Board. All existing ECK-CS Board members should declare such interests. Any ECK-CS Board members appointed subsequently should do so on appointment.

Interests which should be regarded as "relevant and material" can be found in the current PCT Board approved Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions in place from time to time.

Any Member of the ECK-CS Board who comes to know that ECK-CS has entered into or proposes to enter into a contract in which he or any person connected with him has any pecuniary interest, direct or indirect, the ECK-CS Board member shall declare his/her interest by giving notice in writing of such fact to the ECK-CS Board Chairman as soon as practicable.

At the time ECK-CS Board members' interests are declared, they should be recorded in the ECK-CS Board minutes.

Any changes in interests should be declared at the next ECK-CS Board meeting following the change occurring and recorded in the minutes of that meeting.

During the course of an ECK-CS Board meeting, if a conflict of interest is established, the ECK-CS member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

The Managing Director will ensure that a Register of Interests is established to record formally any declarations of interests of ECK-CS Board members.

These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Register will be available to the public and the Managing Director will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

10.0 AGENDA AND SUPPORTING PAPERS

In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

No business shall be transacted at the meeting other than that specified on the agenda.

A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman and Associate Director of Quality and Performance at least 15 clear working days before the meeting. Requests made less than 15 working days before a meeting may be included on the agenda at the discretion of the Chairman.

The Agenda will be sent to members six working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear working days before the meeting, save in emergency. The ECK-CS Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

11.0 MINUTES OF MEETINGS

The names of the Chairman and Members present at the meeting shall be recorded in the minutes. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

Minutes shall be circulated in accordance with members' wishes and be made available to the public as required by Code of Practice on Openness in the NHS.

12.0 REPORTING

The ECK-CS Board will report to the PCT Board on matters that the PCT Board retains corporate responsibility for, which includes strategic financial management, workforce information, health and safety reporting and the reporting of any decisions, risks or events which may impact on the ability of the PCT to perform its functions or adversely affect the reputation of the PCT which includes any major decisions on the future organisational structure(s) of ECK-CS or its constituent services.

The confirmed minutes and a report from the Managing Director will be presented to the PCT Board at each of its meetings.

13.0 APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

The ECK-CS Board may appoint committees of ECK-CS.

ECK-CS shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

14.0 REVIEW

These Terms of Reference will be reviewed at least annually or sooner if there is significant change.

If for any reason these Terms of Reference are not complied with, full details of the non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of

the ECK-CS Board and PCT Board for action or ratification. All members of the ECK-CS Board and staff have a duty to disclose any non-compliance with these Terms of Reference to the Chairman as soon as possible.

Any variation of these Terms of Reference is subject to PCT Board approval.

Health Overview & Scrutiny Committee – 30 October 2009

A progress report on the separation of Commissioner and Provider Functions

1 Introduction

- 1.1 The NHS Next Stage Review¹ made a public commitment to creating modern, responsive and consistently high quality community services. This commitment is at the heart of guidance² issued in January this year to primary care trusts requiring the separation of provider and commissioner functions.
- 1.2 In accordance with this guidance NHS West Kent Primary Care Trust (the PCT) has separated out its commissioner and provider services, forming an autonomous provider organisation known as West Kent Community Health (WKCH), from 1 October 2009.

2 Governance framework

- 2.1 During this transitional phase, accountability over the community services provided by WKCH remains with the PCT Board and with the PCT Chief Executive as Accountable Officer.
- 2.2 A governance framework which ensures there is clarity over this accountability and delegated authority has been agreed and introduced. This establishes WKCH Management Board as a formal sub-committee of the PCT Board and the necessary adjustments made to the PCT's Standing Orders.
- 2.3 Memoranda of Understanding cover the accountabilities between the PCT and its provider organisation and between the PCT Chief Executive and the WKCH Managing Director.
- 2.4 For the period during which WKCH remains accountable to the PCT there is a corporate services service level agreement in place which describes the mutual support between commissioner and community services provider to maximise the existing back-office resource and ensure continuity of corporate service provision.
- 2.5 One of the PCT Non Executive Directors has been appointed as Chairman of the WKCH Management Board. Independent appointments are being made to bring balance to the WKCH Management Board. These independent members have all been identified through the Non Executive Director interview process of the national Appointments Commission.

¹ Our vision for primary and community care – Department of Health – July 2008

² Transforming Community Services - Enabling New Patterns of Provision – Department of Health - January 2009

2.6 Following an initial assessment in April 2009, the business readiness of WKCH has been re-assessed by the PCT's internal auditors. This will be the subject of consideration by NHS South East Coast Strategic Health Authority towards the end of October.

3 Strategy for community services

3.1 In parallel with establishing the necessary governance arrangements the PCT, with its provider organisation, is determining its strategy for community services for the future based on the needs of its patients and local communities, within the context of the whole health economy.

3.2 The guiding principles in the transformation of community services are that:-

- the interests of patients and carers must be paramount:
- organisations must enable the provision of safe, effective, personalised care
- there is a clear commissioning strategy which has improving quality and reducing inequalities at its core
- proposals must deliver value for tax-payers' money
- decisions about service provision are led and made locally, with robust consultation
- there is a recognition that different solutions may suit different services, even within the same locality
- there should be early and continued staff involvement prior to any decisions
- high quality HR management is followed throughout the transformation
- assurance, approval and authorisation processes are clear, robust and transparent
- proposals must enable integrated care with Local Authority services, World Class Commissioning and patient choice
- the Department of Health's *Principles and Rules for Cooperation and Competition* are complied with
- options are equality impact assessed, and there is adequate provision of safeguards for service continuity, assets and staff pensions

3.3 For West Kent, this forms part of refreshing the PCT's overarching Strategic Commissioning Plan which has involved members of the Local Authority, the Health Network and a wide range of other stakeholders.

3.4 The PCT's strategic vision encompasses six key delivery areas:-

- Health and wellbeing
- Children, young people and their families
- Long term conditions
- Rehabilitation services
- Acute care closer to home
- End of life care

- 3.5 The draft strategy incorporates priority action plans for each area to meet the core objectives of:
- 3.3.1 Substantially reducing health inequalities for our local population
 - 3.3.2 Significantly improving life expectancy across West Kent
 - 3.3.3 Delivering the best possible health outcomes and value
 - 3.3.4 Commissioning integrated services designed around patient need
 - 3.3.5 Optimising the quality of life for those with ill health and long term conditions
 - 3.3.6 Providing leadership to the health community and ensuring that the patient voice and experience shape our services

The vision and draft strategy will be presented to the PCT Board in November following which further consultation with stakeholders will be undertaken.

- 3.6 The preferred future form of WKCH will be identified as a result of this detailed work.
- 3.8 Currently, there are a number of options for future form available to community services provider organisations, including the following:
- NHS organisations
 - Foundation NHS Trusts
 - Social enterprises
 - Commercial enterprises
 - Contractual, partnership and joint working arrangements for example through contracts with Integrated Care Pilots and/or Primary care providers

4 Next steps and timescale

- 4.1 It is early days in the consideration of future form for community services. The following table shows the possible timescale for ultimate separation:

Milestone	Target date	By whom
Governance framework assessment	21 October 2009	NHS South East Coast Strategic Health Authority
WKCH Business readiness assessment	21 October 2009	NHS South East Coast Strategic Health Authority
Vision for community services	26 November 2009	NHS West Kent PCT
Consultation	December 2009 – February 2010	NHS West Kent PCT
Identification of preferred future form of WKCH	April 2010*	NHS West Kent PCT
Development of WKCH towards independence as a separate legal entity	April 2010 onwards	WKCH with NHS West Kent PCT support
Full separation	2012*	

*Indicative

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager
To: Health Overview and Scrutiny Committee – 30 October 2009
Subject: Briefing Note. *The Framework for Quality Accounts. A Consultation on the Proposals*. Department of Health, 17 September 2009.

Recommendation

The Committee is asked to:-

- (a) decide whether or not to respond to this Department of Health consultation; and
- (b) should it be decided to respond to the consultation whether the response should be prepared by the full committee or be delegated to the Overview, Scrutiny and Localism Manager in consultation with the Chairman, Vice-Chairman and spokesmen.

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

To: Health Overview and Scrutiny Committee – 30 October 2009

Subject: Item 6. Briefing Note. *The Framework for Quality Accounts. A Consultation on the Proposals.* Department of Health, 17 September 2009.

Key Points

- In 2010, NHS Trusts, Foundation Trusts and their private/voluntary equivalents will be required to provide a Quality Account.
- From 2011, Quality Accounts will be introduced for the primary and community care sectors.
- The Department of Health is currently inviting responses to a consultation document about the proposed framework for Quality Accounts.
- One of the consultation questions asks whether overview and scrutiny committees should be given the opportunity to comment on a provider's Quality Account and have this included within it.

Background

The final report of the NHS Next Stage Review, *High Quality Care for All*, outlined the intended purpose of Quality Accounts:

“For the first time we will systematically measure and publish information about the quality of care from the frontline up. Measures will include patients' own views on the success of their treatment and the quality of their experiences. There will also be measures of safety and clinical outcomes. All registered healthcare providers working for, or on behalf of, the NHS will be required by law to publish 'Quality Accounts' just as they publish financial accounts.”¹

Quality Accounts are being introduced as part of the Health Bill currently going through Parliament.

What is a Quality Account?

In broad terms, “Each Quality Account should address the quality of the services offered by the organisation as a whole and should be presented as a

¹ Department of Health, *High Quality care for All – Next Stage Review Final Report*, 30 June 2008, p.11, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_085828.pdf

short, readable document that is accessible to all members of the local community.”²

Quality Accounts were produced by all Foundation Trusts in England and NHS providers in the East of England in the summer of 2009 to trial the format³. Next year, NHS Trusts, Foundation Trusts and their private/voluntary equivalents will be required to provide a Quality Account. There is an exemption for small providers (defined as fewer than 100 NHS patients each year or an NHS contract of less than £100,000 per year). The current consultation document sets out the framework only for those organisations which will be required to publish a Quality Account next year, although the principles will be carried forwards to future years.

As for the contents of a Quality Account, the intention is that some content will be set nationally, but a large amount should be decided locally and reflect local targets.

The consultation document, the nationally mandated comment is likely to include the following 6 statements:

1. statement from the board – an overall statement of accountability from the board;
2. priorities for improvement – confirmation that the organisation has identified key improvement priorities and the monitoring and reporting arrangements to track progress;
3. review of quality performance – confirmation that the organisation has set three indicators for each of the domains of quality; has reviewed the range of its services with a view to developing a quality improvement plan; and has demonstrated that it monitors quality by participating in clinical audits;
4. research and innovation – confirmation that the organisation participates in clinical research and uses the Commissioning for Quality and Innovation (CQUIN) payment framework;
5. what others say about the provider – a statement on the organisation’s CQC registration (e.g. whether conditional) and of any concerns arising from periodic and/or special reviews; and a statement from Local Involvement Networks (LINKs) and primary care trusts (PCTs);
6. data quality – a simple data quality score.⁴

² Department of Health, *The Framework for Quality Accounts, A consultation on the proposals*, p.5,

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_105315.pdf

³ The Department of Health website provides the Quality Account for The Queen Elizabeth Hospital in King’s Lynn as an example. This is available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_105714.pdf

⁴ Department of Health, *The Framework for Quality Accounts, A consultation on the proposals*, p.7,

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_105315.pdf

Quality Accounts and Overview and Scrutiny Committees

It is in relation to the second part of number 5 above that views are requested on the possible contribution of Overview and Scrutiny Committees to Quality Accounts. This section is quoted in full:

“ii. Statement from Local Involvement Networks and primary care trusts

2.42 Providers will be encouraged to include in their Quality Accounts a response from their LINKs and their lead (the co-ordinating commissioner) PCT(s) on their view of their Quality Account (a description of the PCT’s additional role in assurance is at paragraph 2.61).

2.43 Department of Health guidance will advise that providers should consider sharing the proposed content of their Quality Account at an early stage with commissioners, their own staff and patient groups such as LINKs. This is to ensure that the proposed content is a fair representation of the quality of the health services provided and that it highlights areas that are of particular interest to the local community.

2.44 We propose that the regulations would require providers to send copies of their Quality Account to their relevant LINKs and to their lead PCT prior to publication for comment, and require the provider to include those comments in the published Quality Account.

Q11: Do you agree that Local Involvement networks and primary care trusts should be given the opportunity to comment on a provider’s Quality Account and that providers should include this response in their account? Should this include local authority overview and scrutiny committees?

Q12: How much time should Local Involvement networks and primary care trusts be given to provide a response on a provider’s Quality Account?”⁵

A full list of consultation questions can be found at the end.

Further information

The consultation is running from 17 September until 10 December 2009.

The consultation document and related material can be found at: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_105304

Consultation questions

1. Do you agree that the inclusion of a mandatory statement from the board is the best way to demonstrate board accountability for the Quality Account?

⁵ Ibid., p.27.

2. Some providers may not have a formal board structure. We would welcome views on how the provisions of the regulations should apply to such bodies.
3. Do you agree that at least three priorities for improvement, agreed by the board, and the rationale for their selection should be included in Quality Accounts? Do you think that providers should report on previously set improvement targets using indicators of quality and including historical data where available?
4. Do you agree that at least three indicators covering each of the domains of quality should be included in Quality Accounts?
5. Do you think that the inclusion of the statement from the board to state that it has reviewed the available data on the quality of care in its services provides an assurance of the quality of services provided?
6. Do you think boards should include an explanation of how the review of services was conducted, and how patients and the public were involved?
7. For the statements on participation in clinical audits, please provide your view on their suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation and provide any other comments on the proposed statement.
8. For the statement on participation in clinical research, please provide your view on its suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation.
9. For the statement on the use of the Commissioning for Quality and Innovation (CQUIN) payment framework, please provide your view on its suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation and provide any other comments on the proposed statement.
10. For the statements from the Care Quality Commission (CQC), please provide your view on their suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statements are well defined or open to interpretation and provide any other comments on the proposed statement.
11. Do you agree that Local Involvement networks and primary care trusts should be given the opportunity to comment on a provider's Quality Account and that providers should include this response in their account? Should this include local authority overview and scrutiny committees?
12. How much time should Local Involvement networks and primary care trusts be given to provide a response on a provider's Quality Account?
13. For the statements on data quality, please provide your view on their suitability for inclusion as nationally mandated content in Quality Accounts. In addition, please identify whether the description of the statement is well defined or open to interpretation and provide any other comments on the proposed statement.

14. Do you agree that our proposals for the nationally mandated content of Quality Accounts meet the objectives set out in the proposal?
15. Are there any other areas that should be included in the nationally required section of Quality Accounts?
16. Do you agree with the proposed publication methods?
17. Do you have any other comments on the proposals?
18. Some providers may be individuals, partnerships or bodies that are not incorporated. We would welcome views on how the proposals would operate for such bodies.
19. Do you agree that small providers should be exempt from producing Quality Accounts? If so, are the proposed criteria the right ones?
20. What are your views on the proposed process for delivering Quality Accounts in the primary and community care setting?
21. Our testing showed that a typical cost for a provider to produce a Quality report was around £14,000–£22,000. Do you think that this is a realistic estimate?

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager
To: Health Overview and Scrutiny Committee – Friday 30 October 2009
Subject: Draft Work Programme for November 2009 to July 2010.

Introduction

1. (1) The Committee will recall that, at its meeting on 2 October, it had before it a paper on the Potential to Refocus and Restructure the Health Overview and Scrutiny Committee. This report highlighted for the Committees discussion the specific issues, challenges and opportunities for the Committee as part of the overall review of the Potential to Refocus and Restructure the County Councils Overview and Scrutiny Function which was before the County Council for debate on 15 October 2009.

(2) One of the outcomes of the Committees discussion on 2 October was to identify a list of Topics for inclusion in a draft Work programme for the Committees consideration today.

Draft Work Programme

2. (1) The outcome of this request is a Draft Work Programme for the period November 2009 to July 2010, which is attached as an Appendix to this report. The views of the Committee on additional organisations/stakeholders/persons it would like to invite to give written evidence or to be interviewed by the Committee would be welcome.

(2) The draft Work Programme is only indicative of the issues/items already known to the Committee. It does not take into account any unplanned items, such as referrals from the Local Involvement Network (LINK), other authorities or Councillor Call for Actions.

Task and Finish Groups (Select Committees)

(3) The Committee will recall that at its last meeting when considering the topic of Dementia for inclusion in the draft work programme I notified the Committee this Topic had been proposed as a potential Topic review for a select Committee.

(4) The Policy Overview Co Ordinating Committee met on 16 October and would like this Committee to conduct a Select Committee review based on the proposal form setting out the areas for inclusion in the review agreed by the Policy Overview Co Ordinating Committee commencing in the summer 2010.

Rapporteurs

(5) The Committee will also recall that a number of its Members have offered to act as rapporteurs. I am pleased to report that the County Council in agreeing the report on the way forward for the Overview and Scrutiny Function has agreed that the Scrutiny Board in conjunction with the Cabinet will provide some criteria and guidance for the operation of a "rapporteur scheme"

Recommendations

3. The Committee is asked to agree the draft Work Programme for November 2009 to July 2010.

Draft Forward Work Programme for the Health Overview and Scrutiny Committee, 2009-10

Meeting date	Topic(s)	Witness(es)
27 November 2009	Maidstone and Tunbridge Wells NHS Trust Service Redesign Update	<ul style="list-style-type: none"> • NHS West Kent • Maidstone and Tunbridge Wells NHS Trust • LINKs
	Access to Healthcare (Transport) Update	<ul style="list-style-type: none"> • Martyn Ayre (written evidence only)
8 January 2009	Dentistry	<ul style="list-style-type: none"> • NHS Eastern and Coastal Kent • NHS West Kent • LINKs • Dental representative.
5 February 2010	Emergency Care Pathways (cardiac, stroke, trauma)	<ul style="list-style-type: none"> • TBC
26 March 2010	Use of Community Hospitals	<ul style="list-style-type: none"> • NHS Eastern and Coastal Kent • NHS West • LINK
7 May 2010	Reporting back to the Committee of any rapporteurs/select committee reports.	<ul style="list-style-type: none"> • TBC
	Update of PCTs' Strategic Commissioning Plans/Operational Plans	<ul style="list-style-type: none"> • NHS Eastern and Coastal Kent • NHS West Kent
11 June 2010	Reporting back to the Committee of any rapporteurs/select committee reports.	<ul style="list-style-type: none"> • TBC
	Update on the Future of PCT Provider Services	<ul style="list-style-type: none"> • NHS Eastern and Coastal Kent • NHS West Kent • LINKs
23 July 2010	Accessing Mental Health Services	<ul style="list-style-type: none"> • NHS Medway • Kent and Medway NHS and Social Care Partnership Trust

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