AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 7th September 2007 at 10.00 am
Darent Room, Sessions House
County Hall, Maidstone

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

Tea/Coffee will be available from 9:45 am

Membership (17)

Conservative (12): Lord Bruce-Lockhart (Chairman), Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr J A Davies, Mr D A Hirst, Mrs S V Hohler, Mr G A Horne MBE, Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed

Labour (4): Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and Mrs E D Rowbotham

Liberal Democrat (1): Mr D S Daley

UNRESTRICTED ITEMS

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

Item No		Timings
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes - 20 July 2007	10:00-10:15 am
4.	Potential to Restructure and Refocus the NHS Overview and Scrutiny Committee	10:15-11:00 am
5.	Tackling Obesity Select Committee - Monitoring report on how the recommendations of the Select Committee are being taken forward	11:00-11:30 am
	Break 11:30-11:45 am	
6.	Dartford & Gravesham NHS Trust's Application for Foundation Trust Status	11:45 am-1:00 pm
7.	Date of next programmed meeting – Friday 12 October 2007 commencing 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)

Stuart Ballard
Head of Democratic Services
(01622) 694002

30 August 2007

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

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held in the Council Chamber, Tonbridge and Malling Borough Council offices, Gibson Drive, Kings Hill, West Malling on Friday, 20 July 2007.

PRESENT: Mrs C Angell, Lord Bruce-Lockhart, Mr A R Chell, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Mr M J Fittock, Ms A Harrison, Mr G A Horne, Mr J F London (substitute for Mr B R Cope), Dr T R Robinson, Mrs P A V Stockell (substitute for Mrs S V Hohler), Mr R Tolputt, Mr R Truelove (substitute for Mrs E D Rowbotham), Mrs E M Tweed.

ALSO PRESENT: Mr P D Wickenden, Overview and Scrutiny Manager and Dr D Turner, Researcher to the NHS Overview and Scrutiny Committee

UNRESTRICTED ITEMS

40. Membership

The Overview and Scrutiny Manager reported that Lord Bruce-Lockhart and Dr T R Robinson had replaced the two Conservative Group vacancies on the Committee; and Mr B R Cope was substituting for Mr M J Angell and Mrs S V Hohler for Mrs B J Simpson.

41. Urgent Item

The Overview and Scrutiny Manager reported that Mr A R Chell had stepped down as Chairman of the NHS Overview and Scrutiny Committee. He sought and gained the Committee's approval to appoint a new Chairman, as this would enable the Committee to continue to expedite its business.

42. Election of Chairman

(1) Dr T R Robinson nominated Lord Bruce-Lockhart as Chairman of the Committee, with Mrs P A V Stockell seconding. There being no other nominations, Lord Bruce-Lockhart was duly elected Chairman without a vote.

(Lord Bruce-Lockhart presiding)

(2) Lord Bruce-Lockhart thanked the Committee for electing him as Chairman of the Committee and paid tribute to Alan Chell for all the hard work that he had undertaken during his chairmanship of the NHS Overview and Scrutiny Committee.

(3) In responding, Mr Chell informed the Committee that he had not stepped down as Chairman.

(4) Lord Bruce-Lockhart then set out his vision for the future operation of the Committee and the areas to which he saw the Committee paying particular attention.

43. Minutes

Matters Arising

(1) Mr Fittock said that he felt that it was important there was continuity in the membership of the Committee in order for it to maintain its credibility. This was acknowledged by Lord Bruce-Lockhart. He said that there should be no reason for substitutes except in case of illness.

Meeting with Maidstone & Tunbridge Wells NHS Trust Patient and Public Involvement Forum representatives

(2) Mr Fittock asked for feedback on an item of correspondence received from Maidstone & Tunbridge Wells NHS Trust Patient and Public Involvement Forum had been dealt with. Mr Chell said that he had held a very good meeting with representatives of the PPIF and explained in greater detail the role of the Committee and in particular the nature of Section 7 and Section 11 consultations.

Local Involvement Networks (LINks)

(3) Mr Fittock indicated that whilst he was aware that there was an update report later on in the agenda relating to Local Involvement Networks (LINks) he was keen to ensure that the PPIFs were kept informed of progress being made in the establishment of a LINk.

44. Mental Health Service Provision across Kent and Medway

(Peter Hasler, Director of Nursing and Human Resources, Kent and Medway NHS & Social Care Partnership Trust, Lauretta Kavanagh, Director of Commissioning – Adult Mental Health Services and Substance Misuse, and Marion Dinwoodie, Chief Executive, Medway PCT, Steve Phoenix, Chief Executive, Julia Ross, Director of Civic Engagement, Bob Deans, Director of Commissioning and Performance and Debbie Stock, Programme Manager for Mental Health, Dr James Thallon, Medical Director, West Kent PCT, were in attendance for this item)

(1) Mr Fittock declared that he had an interest in the Swanley Volunteer Centre and is a Trustee of the Invicta Advocacy Network (Dartford). Mr London declared he is a Member of Sevenoaks MIND.

(2) Further to Minute 37 of 2006, Mr Hasler gave a presentation (on behalf of Erville Millar, who was regrettably ill and unable to attend the meeting) on the first year's operation of the Kent and Medway NHS & Social Care Partnership Trust. A copy of the presentation is attached as Appendix 1 to these Minutes.

(3) Following the presentation Members of the Committee and others present raised a number of questions.

(4) Lord Bruce-Lockhart asked about the reasons for increasing demand for mental health services across different age groups. Mr Hasler responded that there was an ageing population in the UK and, as a result, there were more cases of dementia – but people with this condition could now be managed at home for longer than previously. As far as young people were concerned, the Trust was working closely

with schools in order to take a more preventative approach. Lord Bruce-Lockhart asked whether there were clear statistics on dementia, for instance from bodies such as the Alzheimer's Society. Mrs Dinwoodie, Chief Executive of Medway PCT, said that this was a question for commissioners as well as providers. Demand and the patient pathway needed to be in alignment; this would be achieved through Local Area Agreements and needs assessments.

(5) Mr Fittock asked about the audit of Kent Drugs and Alcohol Action Team (KDAAT) in 2006, in which the service had been assessed as 'fair', and whether measures were being taken to improve the service. Mr Hasler said that the audit of the service had pre-dated its transfer to the voluntary sector. The current providers, KCA and Turning Point, both had good histories and he was confident that there would be improvement in the service.

(6) In response to a question about early intervention for young people and the need for further work, Ms Kavanagh responded that the KDAAT was a multi-agency strategic partnership, chaired by the Managing Director of Communities at Kent County Council (Ms Amanda Honey). She said that she would provide a written answer to Mr Fittock. With regard to early intervention services for young people, national targets had been achieved. A new model of care had been implemented for 14–35-year-olds who were experiencing their first episode of psychosis.

(7) Mr Fittock asked about a recent report in *The Lancet*, according to which mental-health wards were at best untherapeutic and at worst unsafe. Mr Hasler responded that there were certainly some in-patient wards within the service where clients did not feel safe. He said that the Trust was moving towards single-sex wards, which would help address safety issues. He also explained that people on in-patient wards were now a much more ill group of people than in the past, as the policy was only to admit the most severely ill patients. He informed the Committee that national standards on improving in-patient services were being used. Asked about the timetable for single sex wards, he said the first women-only wards would be available later on this year. He said that most in-patient areas consisted of single rooms anyway, rather than bays (as in the acute hospital sector).

(8) In answer to a question about the Out of Hours service, Mr Hasler said that the Out of Hours Crisis Resolution Team was making a real difference. Ms Kavanagh explained that there was a need to look at other pathways into Out of Hours care (for all levels of patient need): Accident & Emergency departments; primary-care Out of Hours services (provided by GPs); and NHS Direct. Regarding Accident & Emergency departments, she said that there was a need to improve the competence of general hospital staff in dealing with patients who had mental health needs. Likewise, GP Out of Hours services needed further support so that they could improve their competence. NHS Direct was not commissioned locally, but the Trust did work with them. The Trust was also working with KCC to commission a local mental health telephone help line during weekday evenings, weekends and Bank Holidays. Mr Sinclair added that the County Council provided an Out of Hours adult social worker service, and attempts were being made to integrate this with other provision. Ms Kavanagh responded to a question from Mrs Angell about how patient pathways were being tracked for Out of Hours services. She explained that the services that were commissioned had contracts that included performance management measures. However, it became much more challenging where patients

presented to the NHS outside mental health pathways, for instance at Accident & Emergency departments.

(Mr Fittock presiding)

(9) Mrs Angell asked where Members could find statistical information regarding these areas. Ms Kavanagh said matters were complicated by the fact that different services had different commissioners. The Trust could certainly put in writing its commitment to joining up services for people presenting in mental health need.

(10) Ms Harrison asked about age-appropriate care and specialist services for under-16s; and about the new Mental Health Act, which had just received the Royal Assent. Mr Hasler said that there was a small unit at Maidstone that admitted under-16s. Some services were also provided by the private sector, including The Priory Ticehurst House in East Sussex. Only very occasionally was an under-16-year-old admitted to an adult ward – around three or four cases per year. Mr Tolputt spoke about the consultation which had taken place on mental health services in east Kent a couple of years ago and asked a question about who paid the Trust for treatment provided: was it the PCT where the patient lived? Mr Hasler said that there were 400 properties across the county providing mental health services. Many were very small, especially those relating to learning disabilities. Services had to be safe. Often small, isolated units were not as safe as they should be and did not have the "critical mass" of clients necessary to sustain them. This was a critical consideration in the Trust's estate strategy. He went on to explain to the Committee that beds for older people with mental health needs were best co-located at acute hospital sites. Other services would be provided in purpose-built facilities at St Martin's Hospital in Canterbury. Ms Kavanagh said the outline business case for the St Martin's site would be before the PCT and Trust Boards in September.

(11) Ms Kavanagh explained that it was the GP registration of the patient that dictated which PCT paid for treatment. This was in contrast to local authority services, where charging related to the service-user's usual address.

(12) Mr Daley noted that the Trust appeared to be financially sound, having actually made a profit. Regarding the Trust's plans for applying for Foundation Trust (FT) status, Mr Daley wondered whether FT status was appropriate in respect of mental health. Mr Hasler said that the Trust had not made a "profit"; it was in a surplus situation. Regarding FT status, he said the Trust saw many aspects of the FT "journey" as beneficial, especially the opportunity to engage the public more through the appointment of a Board of Governors. This was actually more in keeping with the philosophy in mental health than with that in the acute sector. Also, the fact that FTs had legally binding contracts meant that long-term planning was possible, instead of operating on a year-by-year basis. He acknowledged that FT status would mean there was no longer a line of accountability to the Strategic Health Authority. However, there would still be strong input from the NHS Overview and Scrutiny Committee. Mr Crowther indicated that he was pleased to hear that the NHS Overview and Scrutiny Committee would still have scrutiny powers, although he felt that the committee was already fairly toothless and might have fewer powers over a Foundation Trust. Mr Chell asked about the sum of £500,000 that had been taken from the Trust's budget in 2006–7. He also asked about the extent to which the Trust took responsibility for people living at home who had dementia problems. Mr Hasler responded that the £500,000 which had been lost to the Trust had been the subject

of arbitration with the Primary Care Trusts, but the Partnership Trust had lost the case. Dealing with patients with dementia in their own home was a complex issue as it meant the Partnership dealing with district nurses, voluntary organisations, the Primary Care Trust, etc. Ms Dinwoodie added that people were living longer and 30% of the adult population over 85 years of age would develop dementia. Many of the services for people with dementia were provided by Adult Social Services.

(13) Ms Dinwoodie spoke to the committee about arrangements for commissioning mental health services. She said that it was exciting to have a joint NHS–local authority commissioning team. Only North and South Tyneside had a similar arrangement. She said that FT status for the Partnership Trust would mean that it had to have an integrated business plan, taking account of commissioners' needs.

(14) She said that Patient Choice and Payment by Results were coming to mental health and would give commissioners a much sharper edge, with the Trust being paid per patient rather than through block contracts.

(15) Mr Dean of the West Kent Primary Care Trust spoke about commissioning in his area. National initiatives indicated a shift towards a more preventive approach in mental health. A strategic review across the pathways of care was being carried out. He said there was a dearth of services at Levels 1 and 2 for Child and Adolescent Mental Health services. He added that some services, despite being known and loved by users, were not well used any more; they were costing money and needed to be reviewed. Rather than providing a sub-optimal mental health service which was spread thinly, there needed to be centres of excellence, providing a service that was therapeutic and safe.

(16) Mrs Joyce Epps of the East Kent Mental Health Carers Forum spoke about the Out of Hours service in east Kent, which had been dismantled with the advent of the Crisis Team. As a consequence, she said, since early 2004 there had been no access for those persons who had a lesser need. She added that 20% of people calling the help line needed intervention – the Crisis Team would not help people who could wait until morning. She said there was still the risk of violence and harm in such cases, but the Crisis Team would not intervene. Mrs Epps informed the Committee that the Department of Health had promised carers looking after persons with mental health needs that they would get the support that they required; however, this was not happening. She said it was not appropriate to keep on being put off and given assurances that the services would be there when they were not. There had been no attempt by commissioners to measure the scale of need. Health colleagues responded that they were very sorry that people felt fobbed off; they reassured Mrs Epps that lobbying was not a waste of time. It was pointed out that good planned care could minimise crises requiring Out of Hours intervention. Mrs Epps responded that the need for Out of Hours services could never be entirely eliminated. It was pointed out that there was also a social care dimension to Out of Hours care. Mrs Epps said it was important that there was seamless working between health and social care colleagues. Ms Kavanagh and Mr Leidecker undertook to take this forward having listened to the concerns of Mrs Epps.

(17) In answer to a number of questions from Mrs Witherden, Ms Moorland and Ms Hughes, health and social care colleagues indicated that service users, carers and the public would be fully involved in the Partnership Trust's application for FT status. Health and social care colleagues pointed out that £170,000 was spent annually on

service-user forums. Mr Leidecker said that the County Council had committed resources for two commissioners, David Woodward for East Kent and Paul Absolon for West Kent.

(18) A summit meeting was to take place that afternoon with service users which would seek to address the concerns being expressed before the Committee on service-user involvement. Currently a number of the service users felt excluded from the process.

(19) Service users had made it clear that they felt that they could do a lot more between meetings to assist. All these points would be picked up by the summit which was to take place. Mrs Tweed indicated that she was concerned to hear about the experiences of carers and users. She felt that unless these issues were addressed by the Trust and Adult Social Services then the carers and users had no alternative but to draw their experiences to the attention of this Committee.

(20) Asked about Heathside House at Coxheath, which provided in-patient mental health beds for older people, Mr Hasler answered that there was an oversupply of in-patient beds and that those currently at Heathside were no longer needed.

(21) Responding to a question about Kingswood Community Mental Health Centre in Maidstone, Mr Hasler said that there was no proposal at all to close this establishment. He said Kingswood was in an ideal location, although the building was not in a good condition. A very small element of the service there was being closed, namely the drop-in service. This was a historical throwback – nowadays such services were usually provided by the voluntary sector, with the NHS concentrating on providing therapeutic services. Alternative services were already being provided in the Maidstone area by voluntary-sector providers.

(22) RESOLVED that:-

a) health colleagues be thanked for the information they had provided; and

b) a further update on the progress made in the provision of mental health services provided by the Kent and Medway NHS & Social Care Partnership Trust be given to the meeting of the Committee in January 2008.

45. West Kent Community Hospitals Review

(Julia Ross, Director of Civic Engagement, Barrie Collins, Director of Nursing & Professional Development, Sharon Jones, Director of Community Services and Debbie Lyndon-Taylor, Assistant Director Adult Services, West Kent PCT were in attendance for this item)

(1) The following Members made declaration of interest:-

- Mr Fittock - Member of Benenden Hospital
- Mr Horne – Member of the League of Friends, Tonbridge Cottage Hospital
- Mr London – Member of the League of Friends, Sevenoaks Hospital

(2) A copy of the presentation given on the West Kent Community Hospitals Review is set out as Appendix 2 to these Minutes. The Committee was informed that the recommendations in the West Kent Primary Care Trust Board report for July 2007 had been approved. Mrs Ross spoke about the further work that needed to be done relating to the Minor Injuries Unit (MIU) at Edenbridge, the Tonbridge Cottage Hospital and the Livingstone Hospital in Dartford. Ms Harrison said she felt that, where beds were being done away with, it was important that the Primary Care Trust explain what they were replacing these beds with; communication with the public was key to service-change. This was acknowledged by Mrs Ross who very much hoped that local authorities would act as community leaders in concert with health colleagues.

(3) Health colleagues said they aimed to reduce the number of unnecessary journeys and provide more services in community hospitals, including bed-based "step up" and "step down" services, end-of-life care and neuro-rehabilitation. Mrs Ross informed the Committee that the Pembury Private Finance Initiative (PFI) hospital plans were predicated on the idea of a whole lot of services being provided in the community. Turning to specific local issues, Mr Horne said that the original review of community hospitals undertaken by the consultancy firm Tribal had not been favourably perceived in the community. The failure to come up with split tariff arrangements with local acute-service providers was detrimental to service-provision in the community hospitals. The need for 24-hour and seven-days-a-week care in some cases had not been properly acknowledged. Local GPs in the Tonbridge area had not been consulted, which ran counter to the idea of Practice-based Commissioning. Mrs Ross said in response that the plans for Tonbridge Cottage Hospital still had not been finalised, that consultation would take place and that Mr Horne would be fully involved in this process.

(4) Mrs Ross also confirmed that consultation would take place on the proposals for the Livingstone Hospital at Dartford when these had been finalised. With regard to the split tariff Mrs Ross said that this was still being discussed and that there were no outcomes to report yet. Ms Jones added that she had met with GPs on at least two occasions to discuss issues that had been raised in a letter to the Primary Care Trust. She argued that achieving an optimal length of stay in community hospitals would allow more people to be treated using fewer beds. She said that it would not be possible to keep surplus beds open in case they might be required. She acknowledged that there was always the need for some 24-hour seven-days-a-week care; and this would be provided in other parts of the system. She added that some care could take place at home, in a hospice or in a residential care home. She said that there would never be a situation where no beds at all would be required in community hospitals. Mrs Ross said that one option for the currently unused space at Tonbridge Cottage Hospital would be for some form of bed-based care. Mr Horne noted that Maidstone and Tunbridge Wells NHS Trust had been buying beds in the private nursing home sector, when there were perfectly good beds going unused at Tonbridge Cottage Hospital. He noted that the Hospice in the Weald was experiencing bed-blocking problems while beds remained closed at the Cottage Hospital and were under threat of being permanently closed. Dr Thallon said that the Primary Care Trust was desperate to get agreement on tariff splitting, as achieving this would be essential for the success of the new PFI hospital. The issue would have to be resolved, either locally or nationally. Mr Lake spoke as the local Member for Edenbridge and Sevenoaks. He said that the community he represented had no GP care at weekends and, as such, needed the MIU at the Edenbridge War Memorial

Hospital. He referred to a letter from Julian Webb, Emergency Care Consultant with Maidstone & Tunbridge Wells NHS Trust, about the quality of the service being provided at Edenbridge. Mr Lake said that the Edenbridge Hospital was being closed by the back door and local people did not understand what this was all about, they believed that it was effectively becoming a residential care home.

(5) Dr Andrew Russell, Chairman of the League of Friends of Edenbridge War Memorial Hospital, then addressed the Committee. He said that he was a retired GP. He did not share Mr Lake's perception that the hospital was becoming a rest home for the elderly. He said that it was a very vibrant hospital and he explained to the Committee the various consultant clinics that were available. What the League of Friends was petitioning against was the decision to change the name of the Minor Injuries Unit at Edenbridge before any consultation had taken place. He said that the Unit saw 4,000 patients per annum, with 28% of these receiving follow-up care. This was comparable to the services provided at Crowborough and Uckfield. Dr Russell said it was disingenuous of the Primary Care Trust to argue that the Edenbridge MIU was in reality just a "treatment clinic" because it was dealing with so many follow-up cases. There was only one nurse at Edenbridge Hospital who was kept very busy, often working beyond the hours for which she was paid. He said that changing the name now, in advance of the formal consultation on the future of the MIU, undermined the service. Dr Thallon made it clear to the Committee that he did not agree with the contents of Julian Webb's letter. Turning to the Livingstone Hospital, Mrs Angell said that the service provided by the Hospital was an exemplar of good practice. If the service was to be relocated to another site in Dartford she very much hoped that it would continue to be provided by the Primary Care Trust.

(6) Mrs Hall of the Tonbridge Cottage Hospital League of Friends expressed concern about Maidstone and Tunbridge Wells NHS Trust buying services from residential care homes in the independent sector, rather than using Tonbridge Cottage Hospital. Unlike care homes, the hospital provided rehabilitation and had a resident doctor. In some cases elderly patients from Tonbridge who had never left the town before were being sent to Rochester when they could be cared for in their local cottage hospital.

(7) She said that it was important that the closed beds at Tonbridge Cottage Hospital were reopened immediately. Finally, in response to a question as to whether or not there was provision for a community hospital in the Maidstone area, to provide "step up" and "step down" care, Dr Thallon answered that there were no such plans.

(8) RESOLVED that the report be noted.

46. Chronic Pain Services

(Dr Joan Hester, Consultant in Pain Management at King's College Hospital NHS Trust and President of the British Pain Society, was in attendance for this item)

(1) A copy of Dr Hester's presentation is attached as Appendix 3 to these Minutes. Members expressed concern that colleagues from the Primary Care Trusts and acute Trusts were not present for this item and asked that the Committee's disappointment be communicated to them.

(2) The Committee discussed and questioned with Dr Hester a range of issues around the complex matter of dealing with pain management at various levels. Dr Hester acknowledged that the Committee was in advance of its counterparts elsewhere in addressing the issue and inviting her to speak on it.

(3) Members were unanimous that this was a very important issue and one that they should seek to continue to address with colleagues in the Primary Care Trusts and acute Trusts. Health colleagues did not appear to have a strategy or a uniform approach to this important issue, which affected much of the population at some time during their lives.

(4) RESOLVED that Dr Hester be thanked for a very informative presentation.

47. LINks update

(1) The Overview and Scrutiny Manager updated the Committee on the development of LINks. The Local Government and Public Involvement in Health Bill, which set out the proposals for the development of a LINk, was expected to receive the Royal Assent in the autumn.

(2) The proposal was that the Commission for Patient and Public Involvement in Health, and the Patient and Public Involvement Fora would be abolished on 31 March 2008 and LINks would be operational from 1 April 2008.

(3) The Committee was reminded that it was often overlooked in the discussion on LINks that they would also be encompassing social care, as well as health services.

(4) The Committee noted the issues that were emerging from those authorities that had been identified as “early adopter” sites.

(5) Local Authorities across the country continued to struggle with the concept of LINks in the absence of any guidance. However, the Department of Health was clear that this presented an opportunity for local authorities to do what was right for them within the LINk framework.

(6) A number of documents that had been delayed several times already were expected to be published shortly. These included:-

a) a model contract for procuring the host organisation to establish the LINk;
b) what a model LINk might look like; and
c) an interim report on the outcomes of the “early adopter” sites.

(7) The Overview and Scrutiny Manager acknowledged that Patient and Public involvement Fora representatives were becoming disheartened by the lack of progress. However, existing Patent and Public Involvement Fora representatives had so much knowledge and experience that they would represent a key component of the LINk. He affirmed his offer to speak with Patient and Public involvement Fora, or their Locality Groups, to reassure them of their continuing contribution as the new structure emerged.

(8) The Committee noted that a steering group led by the Cabinet member with responsibility for Public Health (Mr G Gibbens), supported by a representative of the

Chief Executive's Directorate, was to be established to take the development of the Kent LINk forward. The NHS Overview and Scrutiny Committee would have representation on this steering group.

(9) RESOLVED that the report be noted.

Kent and Medway NHS
NHS and Social Care Partnership Trust

The Partnership Trust One Year On

20 April 2007

Erville Millar
Chief Executive

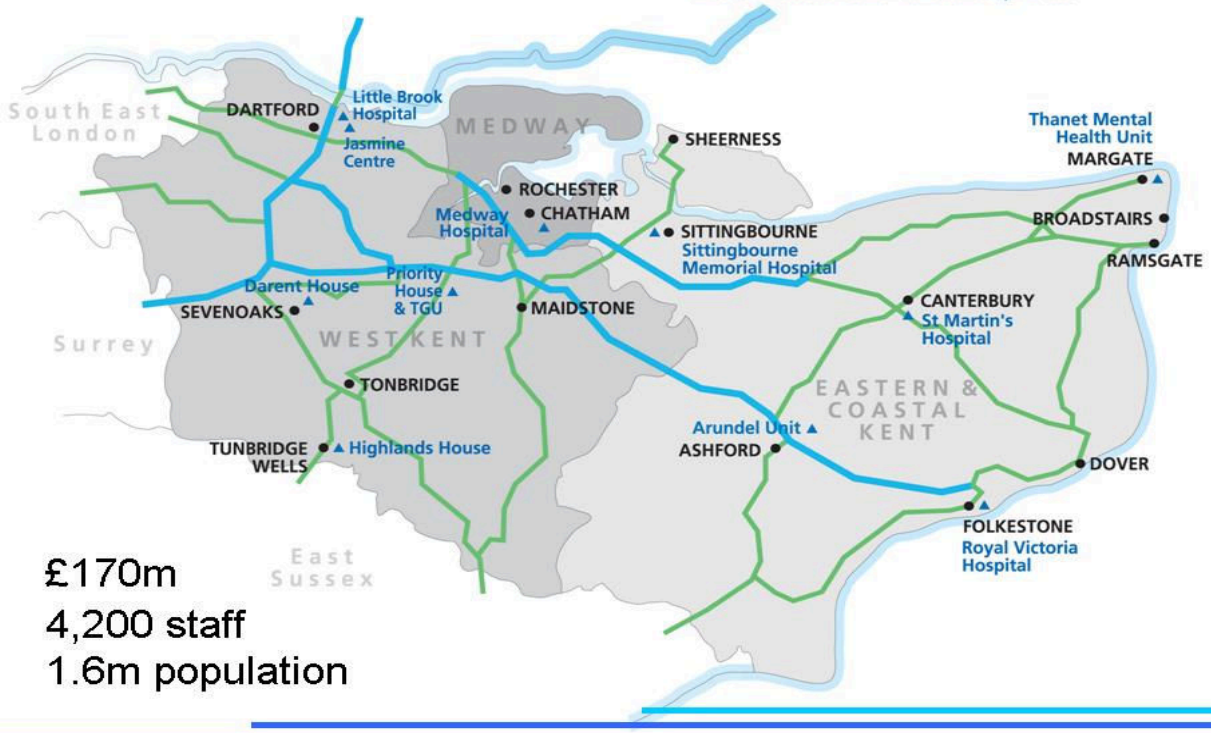
Kent and Medway NHS
NHS and Social Care Partnership Trust

About the Trust

- The Trust was established on 1 April 2006
- The Trust was formed from West Kent NHS and Social Care Trust and East Kent NHS and Social Care Partnership Trust
- The establishment of this new Trust on 1 April 2006 focused on the organisational and senior management arrangements, with current service improvements and planned development projects continuing

About the Trust

Kent and Medway NHS
NHS and Social Care Partnership Trust



- £170m
- 4,200 staff
- 1.6m population

Kent and Medway NHS
NHS and Social Care Partnership Trust

Services

- Mental health services for adults
- Older persons mental health services
- Child and adolescent mental health services
- Substance misuse services
- Services for people with learning disability
- Some specialist services for both local populations and extended areas

Kent and Medway NHS
NHS and Social Care Partnership Trust

Our Vision and Statement of Mission

"We will work in partnership to provide responsive and dependable mental health and substance misuse services to the communities we serve in Kent & Medway. We aim to provide hope, **recovery**, **well-being** and social inclusion, individual **choice** and independence through high quality care and environments; Services that are **safe**, sustainable and stigma-free and a culture of development and continuous improvement, taking account of ethnicity, culture and gender. In this mission we shall endeavour to keep the child, younger person or adult, with their family – at the centre of everything we do"

Kent and Medway NHS
NHS and Social Care Partnership Trust

Key Strategic Objectives

- Commissioning
- Financial Management
- Service Provision
- National Care Records Service
- Strategy Development
- Foundation Status

Kent and Medway NHS
NHS and Social Care Partnership Trust

Strategy Development

- Service User Involvement
- Carer Involvement
- Staff Involvement
- Community Involvement
- Service Strategy
- Estates Strategy

Kent and Medway NHS
NHS and Social Care Partnership Trust

Foundation Trust [FT] Status

- The Trust is aiming to achieve Foundation Trust status by 2008
- Foundation Trust status will mean the Trust is locally accountable with legally binding contracts and local people will have more say

Kent and Medway NHS
NHS and Social Care Partnership Trust

A successful NHS FT has to …

- Meet and exceed national standards
- Have a continually growing membership base to which the NHS FT is responsive
- Be financially stable
- Be locally innovative in how you use your freedoms
- Meet your statutory duty of being run effectively, efficiently and economically

Kent and Medway NHS
NHS and Social Care Partnership Trust

What are the benefits?

- Accountability to local people through membership and Board of Governors
- Builds upon relationships with stakeholders
- Greater protection for investment in mental health
- Legally binding and clear contracts
- Complete consistency of systems across Trust
- Freedom to enter into joint ventures
- Freedom to retain financial surpluses and freedom to borrow from commercial sources
- Opportunity to think more holistically and enter into partnerships to provide more employment and housing opportunities to service users

Kent and Medway NHS
NHS and Social Care Partnership Trust

Next FT Steps

- Finish SHA Diagnostic – a range of financial based tests
- Ensure plans in place for future development and governance
- Decide if we are ready to make an application to gain FT status
- Recruit members

Kent and Medway NHS
NHS and Social Care Partnership Trust

Financial Performance 06/07

Target	Actual	Target Achieved
Break Even	£123,0000 surplus	Yes
Remain within External Financing Limit	£50,000 under shoot	Yes
Remain within Capital Resource Limit	£484,000 under spend	Yes
Achieve a 3.5% Capital Cost Absorption Duty *(with a margin of +/- 0.5% flexibility)*	4.3% achieved	No *

Kent and Medway NHS
NHS and Social Care Partnership Trust

Financial Outlook 07/08

- Contracts
- Targets
- Progress to date
- Key challenges

Kent and Medway NHS
NHS and Social Care Partnership Trust

In Summary

- It has been a busy and challenging 1st year
- We have made progress, but there is much to do
- The journey to FT status will help our cause
- Continuous involvement and dialogue with service users and carers is critical

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West Kent PCT
Community Hospitals Review

Sharon Jones
Director of Community Services

West Kent NHS
Primary Care Trust

Principles

- Quality of care
- Safety & governance
- Efficiency
- Quality of environment
- Equity
- National and local policy
- Affordability and sustainability

West Kent NHS
Primary Care Trust

Process

- Stakeholder events
- Commissioners and what they wish to purchase
- Benchmarking
- Capacity planning & modelling
- Best practice review
- Estates advice

West Kent NHS
Primary Care Trust

Findings

- Unnecessary variations in average length of stay
  - Potential to improve to 18 days
- Rehabilitative focus
- Inconsistent admission and referral criteria, operational policies and service standards
- No service level agreements in the south
- Day centres not consistently optimised for health gain

West Kent NHS
Primary Care Trust

Outcomes of the Review

Potential future for all in line with White Paper

Will be providing high quality clinical care and expanding this in **ALL** sites

But to be sustainable we need to:

- Modernise service models, appropriate to individual need across all sites
- Be more effective and efficient
- Develop and provide services in a different manner

West Kent NHS
Primary Care Trust

Recommendations

- Re-open closed beds in Hawkhurst & Edenbridge over next 3-6 months
- Re-open closed beds in Sevenoaks in a phased approach to allow for refurbishment
- Pursue opportunity for renal dialysis unit in Tonbridge
- Submit a capital bid to the Department of Health

West Kent NHS
Primary Care Trust

Edenbridge MIU

- Rename as a treatment clinic with immediate effect
- Consult on the future of the treatment clinic (formerly the MIU)
- Provide a redressing clinic for 1 to 2 days a week for existing patients
- Redirect new redressing patients to other services

West Kent NHS
Primary Care Trust

Livingstone Hospital

- A successful nationally recognised model of care, *but …* the building no longer meets modern standards
- Cost benefit analysis of possible refurbishment, reprovision or rebuilding to be undertaken
- Working assumption that reprovision is most likely to be the most cost-effective option
- Retain a dedicated 'Livingstone Unit' run and managed by PCT staff on another site

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West Kent NHS
Primary Care Trust

Tonbridge

- Original proposal for a renal dialysis unit fell through
- Now working up alternative options with GPs and local stakeholders
- Options paper to go to September Board
- Public consultation later in the year

West Kent NHS
Primary Care Trust

Other recommendations

- Modernise day centres to get maximum health gain
- Assess value for money of hotel services
  - 3 providers
  - Appears to be significant variance in costs
- Review model of medical cover across the hospitals
  - Work with GPs and practice based commissioners

West Kent NHS
Primary Care Trust

Capital Bid

- £6m bid supported by the SHA
- Sevenoaks
  - Outpatients
  - Ward areas
  - Rehabilitation facilities
  - MIU
- Edenbridge
  - X-ray
  - PACS
  - Equipment & Room
- Tonbridge
  - To be agreed
- Need to use funding to ensure estate is as flexible as possible – future proofing

West Kent NHS
Primary Care Trust

Summary

- Overall very good news – hospitals that were at threat of closure now have a secure future
- The PCT is committed to investing in all the hospitals to develop and expand services
- Community Hospitals will deliver a consistently high quality of care to best practice standards

West Kent NHS
Primary Care Trust

"Community hospitals can act as a hub for local health and social care services providing a centre of excellence in integrated care"

A Recipe for Care – not a single ingredient

Department of Health, 2006

West Kent NHS
Primary Care Trust

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Chronic Pain Services

Dr Joan Hester
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Strengths

- Chronic pain services do improve outcomes and reduce use of healthcare resources
- Multidisciplinary team
  - Doctor, specialist nurse, physio, psychologist, occupational therapist, admin staff
- Out-patient based with small proportion requiring day-case procedures/more complex interventions
- Holistic approach; suitable for shift to primary care if delivered in the right way, with specialist pain service available for more complex cases

Weaknesses

- Unlimited supply of referrals; 21% prevalence of chronic pain in the population
- No quick fixes
- Requires training and expertise
- Difficult
- Many patients with chronic pain have complex biopsychosocial problems

Opportunities

- Can really improve quality of life
- Can reduce referrals to orthopaedics, rheumatology, neurosciences
- Training opportunities for healthcare professionals
- Can lead the field in chronic illness management
- Self help/self management programmes

Threats

- "Cinderella" service
- Perceived as being low turnover and unimportant
- Lack of understanding
- Can be done very badly if personnel not properly trained
- Poor management
- "Burn out" of staff/overwhelmed by numbers of referrals

Best practice 2007:primary care

- Trained GPswiSI; established competencies
- Consultant input into the service (weekly presence)
- Careful assessment which includes psychosocial
- Training programme
- Trained specialist nurses and physios, psychologist
- Patient support groups
- Can offer a wide range of therapies
  - TENS, acupuncture, drugs, simple injections, exercise programmes, relaxation, pain management programmes, education classes

When to refer to specialist pain service

- Clear guidelines for GPs and specialist nurses in primary care
- Complex cases with multiple problems
- Neuropathic pain not easily treated
- Acute sciatic or nerve root pain
- Psychological morbidity
- Second opinion
- Problem drug use (opioids)
- Specialist investigation required (MRI)

When to refer to regional pain service

- Complex Neuropathic Pain
- Central Pain (e.g. after stroke, spinal cord injury)
- Severe cancer pain
- Complex co-morbidities
- Pain Management Programmes
- Spinal drug therapies
- Neurosurgical procedures/blocks

18 week Commissioning Pathway for Chronic Pain: DH

- In early stage of development
- Lists assessment, diagnostic possibilities, and treatments that can be expected in primary care, specialist pain services and supra specialist (regional) pain services

Chronic Pain Policy Coalition

- www. paincoalition.org.uk
- **PAIN [the 5th vital sign]** is designed to raise **awareness** and encourage **early assessment** of pain in order to help improve the **prevention**, **management** and **treatment** of chronic pain in the UK.

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By: Paul Wickenden, Overview and Scrutiny Manager

To: NHS and Health Overview and Scrutiny Committee – 7 September 2007

Subject: **Potential to Restructure and Refocus the NHS Overview & Scrutiny Committee**

Introduction

1. Members of the Committee will recall discussing on several occasions the ways in which the enormous workload for the Committee might be discharged without being unduly burdensome and resource intensive on either the County Council or the Health Service and other colleagues who are required to attend meetings of the Overview and Scrutiny Committee.

NHS Overview and Scrutiny Committee

2. (1) The County Council's NHS Overview and Scrutiny Committee was established in November 2001, some 13 months in advance of the enactment of legislation providing the powers to do so (the Health and Social Care Act 2001) on 1 January 2003.

(2) Members of the Committee are reminded that this Act amended Section 21 of the Local Government Act 2000 and made it mandatory for local authorities with social services responsibilities to ensure that their Overview and Scrutiny Committee or Committees had the power to scrutinise the planning, provision and operation of health services.

(3) Committee Members are reminded that its terms of reference are as follows:-

> "To review and scrutinise matters relating to the National Health Service in Kent and to exercise the powers to be conferred on Council under the Health and Social Care Act 2001".

Membership of the Committee

3. (1) In addition to the elected County Members who serve on the Committee, provision was made for four representatives of the 12 Borough and District Councils (representing what were the four existing health economies in Kent under the former Primary Care Trust structure), as well as the Community Health Councils (subsequently replaced by the Patient and Public Involvement Fora) to serve on the Committee.

(2) Members will be aware that the Patient and Public Involvement Fora are to be abolished on 31 March 2008 and will be replaced by a "Local Involvement Network" (LINk), which will have a larger and looser membership. The Committee is reminded that a "LINk" is not just about Patient and Public Involvement in Health but also Social Care.

Joint Committee Arrangements with Medway Council

4. Members will be aware that both this Council and Medway Council have embedded within their Constitutions a framework/protocol for convening a Joint Committee at short notice when there are issues of a strategic geographical-Kent nature which warrant such consideration (see Appendix 1).

Framework for the Operation of Health Overview and Scrutiny across Kent

5. Prior to the Committee's establishment in 2001, a framework in which the Committee would operate, together with protocols for the operation of the Committee, were agreed by the Kent Association of Local Authorities (see Appendix 2). These protocols are embedded in each of the Local Authorities' Constitutions across the County. These protocols need reviewing in conjunction with Health, Borough/District, and Patient and Public Involvement Fora colleagues.

Opportunities for Review and Change

6. (1) It has been evident for some time that the NHS Overview and Scrutiny Committee is in need of a review and that there is potential for restructuring and refocusing.

(2) Drivers for change include:-

(a) the establishment of two Primary Care Trusts across the administrative County of Kent, focused on commissioning;

(b) the joint appointment of a Director of Public Health, which presents an opportunity for the Overview and Scrutiny Committee to proactively assist in pulling together aspects of this important agenda and making positive contributions to the reduction of health inequalities;

(c) the willingness of a number of Borough and District Councils to embrace Health Overview and Scrutiny (e.g. Maidstone, Canterbury and Shepway) and the consequent potential to formally delegate to them some of the statutory powers of the NHS Overview and Scrutiny Committee;

(d) the Local Government and Public Involvement in Health Bill, which includes:-

(i) a proposal to abolish the Patient and Public Involvement Fora at the end of March 2008, replacing them with Local Involvement Networks (LINks) on 1 April 2008;

(ii) a proposed duty to co-operate with scrutiny which impacts on Adult Social Services and Children's Services; and

(e) the localism agenda and the potential opportunity to streamline a number of democratic processes in which Health issues may have a role.

Overview and Scrutiny of Health

7. (1) The Overview and Scrutiny of Health continues to play an important part in the Government's commitment to place the patient and the public at the centre of Health Services. It is a fundamental way by which democratically elected community leaders may voice the views of their constituents and require local NHS bodies to listen and to respond. Through Overview and Scrutiny of the Health Service, Local Authorities can assist in the reduction of health inequalities and promote and support health improvement.

(2) If Scrutiny is to have an effective and positive impact, those involved need to focus on giving careful and early consideration to the objectives and context for scrutiny.

(3) Members of Scrutiny Committees need to take a constructive but challenging approach to the role, bringing together evidence and people's experience to identify priority issues, make clear recommendations and drive forward improvement. To achieve this, it is important that Members of the Committee (including possible substitutes) gain an understanding of the NHS and the provision of Health Services. Consistency of membership is key to the success of the Committee and substitute members should only be necessary on very rare occasions. This is an area which Members may feel requires review in developing an ongoing training programme.

(4) The Health showcase on 24 July 2007 represented a contribution to this training need. However, the Committee might wish to consider whether it feels it should be mandatory for Members of the Committee to have training before serving on the Committee. This would be similar to the training delivered to Members before they serve on the Planning Applications Committee.

Relationship with the Executive/Council

8. (1) Overview and Scrutiny is not the only, or even the main, form of engagement between Local Authorities and Local NHS bodies. Increasingly, Health and Local Government provide and commission Health and Social Care Services in partnership. They also work together in Local Strategic Partnerships, on the development and the implementation of joint objectives, and on the countywide Local Area Agreement.

(2) It is, therefore, important that the Chairman of the Committee and the Executive Member leading on Health and Health Partnerships have regular contacts to discuss a broad range of issues.

(3) Inevitably Health Overview and Scrutiny Committees looking at Health issues will be holding to account for their actions and decisions their own Local Authorities' Executives, and the wider public sector, as well as NHS bodies.

(4) The Scrutiny function must operate independently of the Executive. However, it is advisable that Health Overview and Scrutiny Committees consider the Council's wider aims and activities in relation to health.

Work Programme, "Ways of Working", and Meeting Dates

9. (1) The Committee has discussed on a number of occasions the fundamental need to develop an agreed forward work programme.

(2) The Committee may also wish to consider whether the protocols for the Overview and Scrutiny of the NHS need any amendment over and above updating them and correcting factual inaccuracies.

(3) The Chairman of the Committee has met with colleagues both on the Committee and within the two Primary Care Trusts to discuss the "Way of Working" of the Committee, and to consider ideas for a draft work programme. These discussions were highly constructive, and amongst the suggestions made were the following:-

(a) There was a unanimous view in support of having nine meetings a year, from 10:00 am – 1:00 pm. Members are reminded that meeting dates for the Committee for the remainder of the year are:

12 October;
9 November; and
14 December.

For 2008 the dates proposed are:

11 January;
8 February;
28 March;
9 May;
13 June;
18 July;
5 September;
17 October; and
28 November.

(b) The Chairman suggested that it might be useful for the Committee to adopt a style of working more akin to that of Parliamentary Select Committee, instead of focussing on presentations and information sharing. To achieve this, health colleagues and other stakeholders would be invited well in advance to submit written information and evidence about the issues selected for each individual meeting. Early discussions with Health colleagues on this style of working have been positive.

(c) With regard to a draft work programme, there was unanimity that this work programme should start from the perspective of Kent patients and residents. Areas to be looked at would include:-

(i) *Value for Money / Funding / Efficiency / Productivity / Performance and Management / Staff Issues*

PCT colleagues have indicated that these issues might best be looked at in terms of finance and planning at the November and

February meetings of the Committee. However, finance is an ongoing issue which may warrant the Committee's continuing attention.

(ii) *Access – Balancing Proximity of Health Service/need for Specialist Services/Economies of Scale/Travel and Transport Links*

The Committee needs to be aware that included in the existing Topic Review work programme for all the Overview Committees is a Select Committee to undertake a focussed piece of work on Access to Health Services. This has been endorsed by the Policy Overview Co-ordinating Committee, but the Project Plan for this piece of work has not yet been prepared. It is currently planned to start the work of the Select Committee in the Autumn of 2007. However, this will not be taken forward until the Committee's views are known on how it wishes to respond to the incremental service changes which are anticipated as part of the review of Health Services across Kent and Medway known as Fit for the Future.

(iii) *Care – Patients' view of care and patent experience, patient satisfaction, time allocated and availability of services, quality of information, waiting times, infection rates and control*

Members are reminded that one way in which the Committee may involve itself and influence some of these issues is to make a commentary on how each Health organisation across the County is meeting the Health Care Commission Core Standards. The most appropriate meeting to do this would be at the March meeting of the Committee. However, arguably this could be an ongoing process; the Committee's commentary for the Healthcare Commission needs to be evidenced-based, and the gathering of evidence should be a continual year-round process.

(iv) *Choice – Availability for Kent Residents of the most advanced treatments and health technology, and the most effective drugs*

(v) *Public Health Improvement – Role and Responsibilities of NHS, Public Sector Partners, Private and Voluntary Sector, Kent Residents, Assessing Progress and Performance*

(4) Many other issues will need to be looked at by the Committee. Some will fall under Public Health, such as obesity, drug abuse, etc; some, such as chronic pain and out-of-hours services will come under "Access" or "Care"; issues such as "effective Commissioning" will fall under "Value for Money". The Committee will need to decide its priority issues for inclusion in the next 12 months' programme

Developing the Work Programme

10. (1) The NHS Overview and Scrutiny Committee protocols are quite explicit about the way the work programme should be developed, and Members' views are sought on whether this needs to be renegotiated.

(2) One of the challenges for the Committee has always been the sheer volume of activity and how, on the one hand, it needs to be responsive to service changes while, on the other hand, being proactive and finding creative solutions to issues through open and transparent public engagement. The power to scrutinise needs to be applied both robustly and responsibly to focus on its prime aim of improving the health of our residents and addressing health inequalities. Members' views are sought on how the Committee can be focussed strategically and yet respond responsibly to all the other local issues; and whether this is appropriate as was originally intended through a Joint Committee and Select Committee style of operation at a Borough and District level, as set out in the protocols attached to this report.

(3) Representation of Borough and District colleagues on the NHS Overview and Scrutiny Committee was based on these representatives being appointed by a number of Borough and District Councils to represent the four distinct Health Economies across the County. Likewise Patient and Public Involvement Fora were invited to appoint two representatives to the Committee. Both Borough and District Councils, and Patient and Public Involvement Fora representatives have served on the Committee on a non-voting basis.

(4) It is evident from the Health Overview and Scrutiny Committees established across the country that the way in which Committees are structured is different in each Authority. Some have appointed a representative from every Borough and District Council within the area, some allow voting rights for these representatives and others none. Some local authorities (where there are a large number of Borough and District Councils) have invited half of the Local Authorities to serve on the Committee for one year with voting rights, and then the other half the second year on a rotational basis. Other Committees invite individuals and organisations to be co-opted on to the Committee, depending on the issue to be considered. Some Health Overview and Scrutiny Committees have combined their role with that of Social Care overview and scrutiny. This is an issue that the Committee may wish to consider, bearing in mind the proposed establishment of the Local Involvement Networks (LINks), which are not solely about health, but also relate to Social Care. The relationship of the Committee to the LINk needs very careful consideration.

(5) Bearing in mind the discussions which have taken place to refocus the Committee so that it is much more patient and public focussed, the LINk input into developing the Committee's work programme will be crucial.

Health and Well-Being Partnership

11. (1) Key to the development of the work programme for the Health Overview and Scrutiny Committee is the duty on Primary Care Trusts and Local Authorities to develop Joint Strategic Needs Assessment and for the Local Authority to produce a Local Area Agreement.

(2) There is a move away from national targets to health and well-being targets set at the local level. These priorities will be derived from joint needs assessments and captured in the Local Area Agreements. This Committee will need to decide how it wishes to discharge its role in scrutinising the Local Strategic Partnerships.

Conclusions

12. The opportunities to restructure and reform the Committee have never been greater. This report sets out the issues and areas for a wide ranging debate on how this can be taken forward.

Recommendations

13. Members are asked to consider the suggestions in paragraph 9 above for changing the "Way of Working", Meeting Dates; and the Draft Work Programme.

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Appendix 1

Kent and Medway NHS Joint Overview and Scrutiny Committee

Terms of Reference

1. To receive evidence in relation to consultations initiated by local NHS bodies regarding proposals for substantial development or variation of the health service which effect both Medway and a substantial part of Kent.

2. To make comments on behalf of the relevant overview and scrutiny committees of Medway Council and Kent County Council on any such proposals to the NHS body undertaking the consultation.

3. To undertake other scrutiny reviews of health services if requested to do so by the relevant overview and scrutiny committees of both Medway Council and Kent County Council.

4. To report on such other scrutiny reviews to the relevant overview and scrutiny committees of Medway Council and Kent County Council.

Rules

1. These rules apply to the joint committee and any sub-committee established by it.

2. The committee will appoint a chairman at its first meeting in each municipal year, and that chairman will normally be drawn in rotation from Kent County Council members and Medway Council members. Where a review is unfinished at the end of a Municipal Year, members may agree that the previous year's chairman (if still a member of the committee) may continue to preside over consideration of matters relating to that review.

3. If the joint committee cannot agree a single response to an NHS consultation then a minority response which is supported by the largest minority, but at least three members, may be prepared and submitted for consideration by the NHS body with the majority response. The names of those who dissent may, at a member's request, be recorded on the main response.

4. The response of the joint committee to a consultation will normally be submitted to the chair and spokespersons of the relevant overview and scrutiny committees of Kent County Council and Medway Council prior to its submission to the NHS body and at least ten working days before the closing date of the consultation.

5. Following receipt of the joint committee response by the chair and spokespersons of the relevant overview and scrutiny committees, either of those committees (or an appropriately empowered sub-committee thereof) may meet and resolve to inform their proper officer of views or comments they wish to have incorporated in the joint committee's response. If such a request is received by a proper officer before the closing date of the consultation, those

views or comments will be appended to the joint committee's response and that appendix will form part of the joint committee's response.

6. These rules will take precedence over the rules in the constituent authorities constitutions, which will otherwise apply to the joint committee. Where the rules of the constituent authorities' constitutions are in conflict the chairman's ruling will determine which applies.

Annex B:
Protocol for National Health Service Overview and Scrutiny

5B.1 These protocols are agreed within a context that assumes organisationally:

- the bringing into force of the Health and Social Care Act 2001
- the continued development of partnership working, especially between Social Services and NHS bodies
- the continued existence at District/Borough level of local overview and scrutiny committees concerned with NHS matters
- the continued existence of representative organisations operating at sub-county level
- a partnership approach working with not against NHS bodies in the county

5B.2 The protocols are based on the principles that:

- Overview and Scrutiny should focus on supporting the improvement of health services to Kent residents.
- Overview and Scrutiny should minimise the additional administrative burdens on local authorities or NHS bodies.
- Overview and Scrutiny agendas need to be developed jointly by the local authorities and the NHS bodies.
- Overview and Scrutiny needs to operate at different levels within Kent.

STRUCTURES

5B.3 Overview and Scrutiny structures will comprise:

District Council Overview and Scrutiny Committees

To look at local service issues:

- Local co-ordination (or joint committees) to ensure cross-district issues dealt with jointly
- Local KCC Members and CHC representatives to have rights of participation
- Focused on PCTs

KCC Health Service Scrutiny Committee

To look at broad and wide area issues, including from the viewpoint of the County Council's Social Service responsibilities:

- An emphasis on working through themed (topic) reviews conducted by Select Committees (smaller ad hoc groups) including District and Patient members
- DC and CHC representatives to have rights of participation
- Service reconfigurations to be looked at through Select Committees (ad hoc time limited sub-committees including DC and CHC participation) reporting to the KCC Health Service Scrutiny Committee to consider reference to the national Reconfiguration Panel (when the legislation is brought into force)

- Focused on Health Authorities

Medway Overview and Scrutiny Committee

To combine both levels of operation within the Medway area but linked into the co-ordinated system.

CO-ORDINATION

5B.4 Overview and Scrutiny activity at local and Kent level needs free exchange of information and protocols for co-ordination of work and resolution of conflicts. To facilitate this there will be:

- a regular meeting of Committee Chairmen and NHS representatives to agree a programme of work across the county and Medway
- a similar officer forum to support and advise the Chairmen on the work programme and co-ordinate requests for NHS officers to provide papers, information or attend committee meetings

5B.5 The KCC Committee membership allows for DC and CHC membership:

- a permanent representation of three District/Borough Members nominated by KALA and two CHC representatives nominated by the CHCs on a non-voting basis
- a right for the Chairmen of each District/Borough Overview and Scrutiny Committee (or another relevant Member) and each CHC to attend and speak at the KCC Committee (or send a representative) on a matter particularly affecting that area
- appointment of members of relevant District Overview and Scrutiny Committees and CHCs to individual topic reviews (agreed through the Chairmen's meeting)

5B.6 District Committees will allow local KCC Members and CHC representatives to attend and speak at the Committee.

5B.7 KCC and DC members on CHCs will be briefed by and feed back to their appointing Councils.

REVIEW PLANNING

5B.8 Overview and Scrutiny will take the form of a programme of reviews. Each review should be preceded by a Review Plan discussed within the officer forum and agreed with the relevant NHS bodies. Any disagreement should be considered by the relevant Overview and Scrutiny Committee after the NHS representative has attended the Committee to express the NHS view and answer member questions.

5B.9 The Review Plan should:

- set the terms of reference for the review including the general nature of the expected outcome
- set an approximate timetable of meetings and a reporting date
- state the officers supporting the review within the local authority, the NHS and the CHCs and estimate the time commitment required of them

- state the main witnesses and information sources expected to be involved

REVIEW ADMINISTRATION

5B.10 The arrangements for meetings of Overview and Scrutiny Committees shall ensure that:

- Dates for witnesses to attend Committee meetings are agreed with witnesses as far in advance as possible
- NHS Chief Executives and other local authorities' Chief Executives arrange for appropriate officers chosen by them to attend to give evidence on the identified topics (subject to any provision to be made in statutory regulations)
- Advance notice is given of the areas to be covered in questioning
- Information is wherever possible distributed to the Committee in writing before the witness attends

MEETING PROTOCOLS

5B.11 All Overview and Scrutiny Committees should incorporate in their Procedure Rules or otherwise ensure that:

- Committee Members should endeavour not to request detailed information from officers of the NHS or another local authority at meetings of the Committee, unless they have given prior notice through the Clerk. If, in the course of question and answer at a meeting of Committee, it becomes apparent that further information would be useful, the officer being questioned may be required to submit it in writing to members of the Committee through the Clerk
- In the course of questioning at meetings, officers of the NHS or another local authority may decline to give information or respond to questions on the ground that it is more appropriate that the question be directed to a more senior officer or Member
- Officers of the NHS or another local authority may decline to answer questions in an open session of the Committee on the grounds that the answer might disclose information which would be exempt or confidential as defined in the Access to Information Act 1985. In that event, the Committee may resolve the exclude the media and public in order that the question may be answered in private session
- Committees may not criticise or adversely comment on any individual officer of another local authority or of an NHS body by name

REPORTING

5B.12 All local authorities should ensure that:

- A record is made of the main statements of witnesses appearing before the Committee and agreed with those witnesses prior to publication or use by the Committee (Committee meetings may be electronically recorded)
- Drafts of Committee reports and recommendations should be made available for comment by the relevant NHS body (or local authority) whose operations might be commented on and any adverse comments or concerns reported to the Committee before the final report is published

- The Chief Executive of any NHS body and/or the Chief Officer of any other local authority involved with the review is given advance notice of the date of publication of the report and consulted on the text of any accompanying press release
- Reports should include an agreed timetable for any NHS body and/or other local authority involved to publish a response to the report's recommendations once confirmed by the appropriate Overview and Scrutiny Committee

SERVICE RECONFIGURATIONS

5B.13 NHS bodies remain responsible for public and other consultation on service reconfiguration proposals.

5B.14 The intention to carry out a consultation will be discussed in the officer forum.

5B.15 The KCC Health Service Scrutiny Committee will consult District/Borough Councils and CHCs for the areas affected by each proposal on whether to:

- consider the matter at a full meeting of the Committee
- set up a KCC Select Committee to consider the proposal
- request a District/Borough Overview and Scrutiny Committee to consider the proposal

5B.16 If a Select Committee is established or a District/Borough Overview and Scrutiny Committee requested to carry out a review:

- paragraphs 8-12 above shall apply to its work programme and proceedings
- the Review Plan shall as far as possible be integrated with the NHS body's consultation programme
- consideration shall be given to:

  - including one or more members of District/Borough Councils on the Select Committee or KCC members on the District/Borough Overview and Scrutiny Committee
  - including CHC members on the Committee
  - other arrangements for ensuring all local authorities and CHCs may express their views and seek information on the proposal

- the review report shall be submitted to the KCC Health Services Scrutiny Committee who will consider the recommendations together with any response by the NHS body and decide whether to refer the proposal to the Reconfiguration Panel.

By: Graham Gibbens – Cabinet Member for Public Health

To: NHS Overview and Scrutiny Committee – 7 September 2007

Subject: Tackling Obesity – NHS OSC Select Committee Report

Summary: Progress has been made on the recommendations of the select committee report.

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1 Introduction

1.1 Tackling Obesity is the report of the Select Committee of the KCC NHS Overview and Scrutiny Committee published in December 2006. It contains 13 detailed recommendations for action. This report brings the Overview and Scrutiny Committee up to date with progress made so far on each of the recommendations.

2 Report

2.1 The Select Committee report gives a clear picture of the issue of obesity in Kent and the recommendations provide a comprehensive framework for tackling the issue. The action plan attached to this report gives details of what has so far been done to implement them.

2.2 In addition to the actions listed two other potentially important contributions to the implementation of the recommendations should be noted:

- £900,000 has been secured from the Big Lottery Fund to finance a wide range of programmes and projects designed to improve levels of physical activity, nutrition and mental wellbeing across the County. This was the result of successful partnership working between the Primary Care Trusts, KCC Directorates and the Kent Department of Public Health to compile and submit a robust and credible bid.
- For the first time in three years the full allocation of Choosing Health money to the Kent PCTs (c.£4m) has been designated for use on public health interventions.

2.3 The Action Plan attached to this report details the main activity currently being undertaken to support recommendations in Tackling Obesity. A Kent-wide obesity strategy is currently being drafted and should be issued for comment very shortly.

3 Conclusion

3.1 Members of NHS Overview and Scrutiny Committee are asked to note the progress made on the recommendations of the select committee report.

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Mark Lemon
Policy Manager
Ext: 4853

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Select Committee – Tackling Obesity

Recommendation	Current & Planned Action	Timescale	Lead Body
Recommendation 1 All future developments in Kent should be required by planning authorities to make provision for healthy lifestyles – including adequate footpaths and cycle paths, and sports and leisure facilities.	▪ Discussions opened with Leigh Herington re planning action required and use of Health Impact Assessments in planning process ▪ KSDU is negotiating with District Councils to enable cheaper/subsidised access to sports and leisure centres. ▪ Policy will be part of the Obesity Strategy that will be drafted by end September for adoption by all LA's ▪ Making walking more accessible for people with disabilities is a priority for the KCC Public Rights of Way team.	Ongoing Ongoing Ongoing – October Ongoing	Planning Authorities
Recommendation 2 Food manufacturers should adopt a standard system of food labelling, to enable consumers to make better-informed choices.	▪ Local discussion with providers to be initiated.		Food manufacturers
Recommendation 3 All local councils should include in local guides reference to the availability of facilities for breastfeeding.	▪ Improving rates of breast feeding is a national public health priority and is part of the public health strategy and the Kent Agreement. ▪ Corporate policy on breast feeding will be considered by the Public Health Board ▪ East Kent has already put significant investment into increasing rates of breast feeding and it will be developed as part of the Kent-wide obesity strategy	Ongoing 3-6 months Ongoing	District Councils Sure Start schemes Children's Centres

Recommendation 4 KCC CFE Directorate should continue to promote the Healthy Schools programme and the Extended Schools concept – including Breakfast Clubs and use by the wider community of school sports facilities.	▪ 300 schools in Kent now have Healthy Schools status and this target is on track to be met. ▪ Discussion with District Councils about how best to link the Building Schools for the Future programme to the best community use of schools and other facilities is under way including CFE and Communities directorates from KCC	Ongoing Ongoing	CFE Directorate
Recommendation 5 All local authorities in Kent should: Support initiatives that encourage young people (including girls) to participate in sport Consider appointing Sports and Health Managers, to promote active lives for the community. Do as much as possible to capitalise on the public interest generated by the 2012 London Olympics in order to promote wider participation in sport.	▪ Kent School Games will take place in Autumn 2007 to May 2008 with more than 600 schools involved in 14 different sports ▪ Kent has been acknowledged by the LGA as being in the vanguard of preparing for and using the 2012 Olympics to promote activity ▪ 75% of 5 and 6 year olds are currently taking part in 2 hours of exercise per week in school ▪ £900,000 has been secured from the Big Lottery Fund to promote exercise and better diets across Kent which will fund a wide range of projects ▪ Go Cycle Kent has built upon the Tour de France and the Olympics to promote cycling as a family activity ▪ Sport Specific Development Officers have been employed including for swimming and archery ▪ 18 Associate Officers have been appointed to develop sports for people with disabilities ▪ District Councils are now part of the County Sports Partnership (run by KSDU)	Now to May 2008 Ongoing Ongoing Now to 2010 Ongoing Ongoing	All Kent authorities
Recommendation 6 KCC Sports Development Unit and KPHD, and the Kent Physical Activity	▪ The activities related to Recommendation 5 are being carried out in partnership between these units and the collaboration will continue to be	Ongoing	KCC SDU KDPH KPAA

Alliance must work more closely together to promote physical activity.	developed		
Recommendation 7 All PCTs should encourage GPs to prescribe exercise to patients where appropriate. This prescribing should include referral to sports and leisure centres with staff trained to provide specialist services tailored to individuals' clinical needs.	▪ No action specific required but the issue is part of negotiations and discussions in a number of arenas.	Ongoing	PCTs
Recommendation 8 In order for LSPs to play their part in addressing obesity, and other public-health issues, the government must ensure they are properly funded and resourced for this purpose. LSPs also need more direction and more structures of accountability.	▪ No specific actions required but tackling obesity is a major priority of the public health strategy for Kent and LSPs will need to play an active part in delivering the necessary interventions. Closer working between the KDPH and the LSP representatives from KCC is being developed.	LSP Workshop October 2007	Dept for Communities and Local Government
Recommendation 9 The production by KCCs PHD of a detailed obesity strategy for the whole of Kent, in collaboration with partners and stakeholders, must take place as soon as possible following the reorganisation of the NHS in Kent and Medway.	▪ The first draft of this strategy will be issued very shortly.	September 2007	KDPH
Recommendation 10 KCC should seek to set an example of good practice in encouraging and	▪ Work is continuing with the KCC Staff Care Manager to develop this and a number of initiatives are being undertaken including	Ongoing	KCC

facilitating healthy lifestyles among its workforce. The innovative work of the E&R Directorate in this regard should be copied by all KCC Directorates. A business case setting out the benefits for employers of this approach should be developed by KCC and shared with other employers in Kent.	fit4health.		
Recommendation 11 All sports and leisure centres should seek to remove perceived barriers to using their service (relating to age, gender, ethnicity, disability, etc) so that they can serve all groups in the community.	▪ A workshop involving the District Councils and other leisure providers to highlight and share best practice on this issue is planned by the KDPH	October 2007	Sports and leisure centres
Recommendation 12 The money allocated to PCTs to fulfil the Choosing Health objectives should be ring-fenced by the DH. KCCs NHS O&SC should receive a breakdown of how this money has been spent each year by PCTs in Kent.	▪ No further action required but it should be noted that following representations from the KDPH and KCC the full Choosing Health allocation ahs been committed to public health interventions by both Kent PCTs for the first time. Lobbying of DH may be needed if situation changes. ▪ A breakdown of the spending of Choosing Health money has been presented to KCC cabinet.		DH NHS O&SC PCTs
Recommendation 13 KCC's NHS O&SC should initiate a research programme, in partnership	▪ Discussions with Canterbury Christ Church University have resulted in a proposal for a study of short-term interventions being	Ongoing	KCC NHS O&SC

with Canterbury Christ Church University's Dept. of Sport Science, Tourism and Leisure, to evaluate the effectiveness of brief interventions in primary care in tackling obesity. This should include evaluation of giving patients pedometers, referral to leisure centres and referral to Health Walks.	accepted.		

CFE	Children Families and Education (KCC Directorate)
DH	Department of Health
KCC	Kent County Council
KDPH	Kent Department of Public Health
KSDU	Kent Sports Development Unit
LGA	Local Government Association
LSP	Local Strategic Partnership
NHS O&SC	NHS Overview and Scrutiny Committee

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NHS Overview and Scrutiny Briefing Note

Foundation Trust status

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30 August 2007

What is Foundation Trust status?
The Department of Health (DoH) states that "The introduction of NHS Foundation Trusts represents a profound change in the history of the NHS and the way in which hospital services are managed and provided".

Foundation Trusts (FTs) were established under the Health and Social Care (Community Health and Standards) Act 2003 as "independent public benefit corporations". These are a new type of organisation, existing within the public sector to provide public services on a non-profit basis – but with unprecedented commercial and managerial freedoms. The government states that the model for these corporations is the "mutualism" and "social ownership" of co-operatives, "social enterprises" and the voluntary sector.

FTs are part of the NHS, and their "principal purpose" is to provide NHS treatment free at the point of use; but they are able to act in ways that are not open to the rest of the NHS. FTs are free to:

- borrow from the private sector;
- retain any financial surpluses that they generate;
- retain all moneys from the sale of NHS land and other assets;
- exercise a greater degree of flexibility than other Trusts in setting pay and benefits for staff;
- provide paid-for healthcare services, in order to generate additional income;
- form joint ventures with the private sector.

FTs are also free from the control of the Secretary of State for Health, and are not subject to performance-management by their local Strategic Health Authority.

Each FT is run by a Board of Directors, which works with an elected Council of Governors, representing "key stakeholders". Some Governors are elected by Trust "Members", who are drawn from among local residents, patients and staff (residents and patients must opt in; staff membership can be on an opt-in or opt-out basis, depending on the constitution of the FT concerned). There must be a "staff constituency" and a "public constituency" for elections; there may also be a "patients' constituency". Other Governors are appointed to represent local partner organisations (Primary Care Trusts, local authorities and others). Governors play an advisory, guardianship and strategic role; they are not involved in the day-to-day running of the FT and so do not deal with matters such as budget-setting and performance-management.

Governors directly appoint the non-executive directors of FTs, including the Chair, but cannot mandate or recall them. The DoH states that "The executive directors are appointed by a committee consisting of the Chair, the other non-executive directors

and the chief executive". The Chief Executive is appointed by the non-executive directors, subject to approval by the Governors.

A regulatory body, the Office of the Independent Regulator (known as "Monitor"), which has the status of an independent corporate body, grants authorisation for Trusts to become FTs and ensures that they comply with their terms of authorisation.

Access to FT status is based on the principle of "earned autonomy" – only Trusts that perform well (as evaluated by the Healthcare Commission) are permitted to apply for FT status. Trusts must show a financial surplus before they are permitted to become FTs.

The government is committed to seeing all hospital Trusts in a position to apply for Foundation status by 2008, a target that all Strategic Health Authorities must seek to fulfil. There appears to be an intention for all NHS Trusts to become FTs eventually (along with the service-delivery arms of PCTs – which are to become "Community Foundation Trusts").

As NHS Bodies, FTs remain subject to local authority NHS Overview and Scrutiny Committees – but matters relating to FTs cannot be referred by OSCs to the Secretary of State; instead, the power of referral is to "Monitor".

It has been suggested that Trusts that fail to become FTs, especially those that are small and financially weak, could be subject to predatory takeover bids by FTs. This has already happened in one case: Good Hope Hospital NHS Trust in Birmingham was recently taken over by Heart of England NHS Foundation Trust. Opinions differ as to whether this will turn out to be an important precedent or just an isolated case.

What are the arguments in favour of Foundation Trust status?
FTs are a major plank of the government's NHS reforms and have proved to be politically controversial (the passage through Parliament of the Bill that established them saw a substantial backbench revolt on the government side in the Commons).

The main arguments in favour of FT status are as follows:

- FTs are a key expression of the government's commitment to the decentralisation of public services and the creation of a patient-led NHS. FTs are intended to allow the devolution of decision-making to local level, making Trusts more responsive and accountable to their patients and communities.
- By becoming more autonomous, flexible and locally accountable, FTs are better able to tackle health inequalities.
- FTs are able to offer additional financial incentives to staff, so as to address the problem of recruitment and retention in areas that have a high cost of living or are unattractive to work in.
- FTs have greater financial freedom than other Trusts, which incentivises innovation and entrepreneurialism, leading to the improvement of services.
- FTs support the Patient Choice agenda by increasing the plurality and diversity of providers within the NHS.

FTs are subject to a set of legal safeguards, designed to ensure that they do not damage the cohesion and continuity of the NHS:

- local ownership and control, through “Members” and Councils of Governors, representing patients, staff and other stakeholders in the community;
- legal incorporation as non-profit “independent public benefit corporations”, with “Members” (rather than shareholders who draw dividends) and provision of free NHS care as FTs’ “principal purpose”;
- a “lock” on NHS assets (designated “protected property” may not be sold to generate a surplus), preventing any “asset-stripping”;
- controls on borrowing by FTs from private sources;
- a “cap” on income from private patients, ensuring that FTs cannot fundamentally shift the balance of their activities away from their “principal purpose” of providing NHS care;
- a ban on charging NHS patients for care (in accordance with primary NHS legislation);
- protection of staff under nationally negotiated agreements on terms and conditions of employment;
- regulation by “Monitor”, which ensures that FTs abide by the terms of their authorisation;
- continued applicability of national NHS standards, performance ratings and systems of inspection (enforced by the Healthcare Commission and other regulatory bodies).

What are the arguments against Foundation Trust status?
FT status is opposed by a number of stakeholders (including several major trade unions within the NHS) on the basis that:

- The existence of FTs will lead to the creation of a two-tier NHS, widening health inequalities and geographical disparities in healthcare. FTs are able to poach staff from other Trusts (by “topping up” national terms and conditions of employment) and have access to sources of funding not open to other Trusts (private-sector borrowing, sale of assets, commercial income-generation). The resulting “uneven playing field” is even more damaging in the context of Payment by Results.
- FTs are not genuinely accountable to their local communities. Governors have only limited powers. Not all Governors are elected and those that are elected, are elected by “Members”, who are a small group of self-selecting individuals and are not accountable to the wider community. Only a small minority of “Members” may actually be involved in elections (in some cases, e.g. University College London Hospitals NHS Foundation Trust, Governors have been elected with votes in single figures).
- FTs are primarily “market actors”, pursuing surpluses within an emerging NHS “market”, rather than ensuring provision of the services that their local population needs. FTs can choose, on the basis of commercial considerations, which services they will provide – this runs counter to the core NHS principle of needs-based planning of services.
- FTs do have scope to shift the balance of their activities towards providing paid-for private healthcare. The “cap” on income from providing private healthcare: allows for private work to grow in line with overall growth in income; does not cover all commercial income; and does not cover income generated in joint ventures with commercial partners or through subsidiaries and spin-off companies (it has recently been reported that many FTs are now going down these routes in order to circumvent the cap on private income). Moorfields Eye

Hospital NHS Foundation Trust is controversially using its ability to borrow more freely in order to set up a clinic in Dubai, in the United Arab Emirates, providing paid-for services under, as the Chief Executive has put it, "the widely recognised Moorfields brand name". Meanwhile, the Foundation Trust Network, which represents FTs, is lobbying for the abolition of the private-income cap.

- The "lock" on NHS assets is not absolute. If a service is contracted to an outside provider, the NHS estate thereby freed up can be "unlocked" and disposed of, with the proceeds staying entirely within the FT.
- FTs have a commercial incentive to charge patients for an enhanced NHS service. The possibility of such charging within the NHS is shown by the "Jentle Midwifery" premium NHS service (offering continuity of care from a designated midwife), now being provided for a £4,000 fee by Queen Charlotte's and Chelsea Hospital (which is actually not a FT hospital). There is also an incentive to charge privately for procedures that can be re-classified as "cosmetic" and thereby removed from the scope of NHS provision. This is illustrated by the case of the Foundation Skin Clinic, set up by the Harrogate and District NHS Foundation Trust, which charges for services previously available as free NHS care. FTs further have an incentive to maximise revenue from charging NHS patients for facilities such as parking and telephone services.
- "Monitor" is essentially a market regulator, concerned primarily about FTs' financial viability, rather than their provision of services. It is not bound to ensure the continuation of a comprehensive, free and universal NHS.
- Handing more power to certain privileged acute Trusts, through FT status, cuts across the empowerment of the Primary Care sector, which the government has said is a key strategic aim for the NHS.

Becoming a Foundation Trust
Preliminary Stage: A Trust wishing to apply for FT status must first prepare:

- a service development strategy (showing it is financially viable in the long term);
- a draft constitution (detailing governance arrangements, including the recruitment of "Members" and Governors);
- a long-term vision (including a Human Resources strategy).

This will involve consultation with staff and the public. The Trust must then apply to the Secretary of State for permission to proceed with its FT status application. Success at this stage is no guarantee of success at the next stage.

Preparatory Stage: Once the Secretary of State has approved the application for FT status, the Trust must draw up a detailed business plan and compile further information for submission to "Monitor".

If "Monitor" grants authorisation (effectively a licence to operate as a FT), the Trust enacts its constitution in "shadow" form before finally "going live" as a FT. Annual reports must be submitted to "Monitor", and the Trust must continue to show compliance with the terms of its authorisation.

Possible themes for questions on Dartford and Gravesham NHS Trust's FT status application

- In 2006, Dartford and Gravesham NHS Trust's service development strategy indicated that it envisaged, as a FT, playing a competitive commercial role,

seeking to draw in patients from South London, South Essex and elsewhere in the South East through "marketing services to a wider population" under Patient Choice. This raises the question of whether this strategy could work to the detriment of less commercially advantageous services for local people – and to what extent FT Members and Governors would be able to influence the direction of FT policy in this regard.

- Similar issues potentially arise regarding the possibility of the Trust, as a FT, disposing of assets and seeking income from providing paid-for healthcare in response to commercial imperatives, and whether Members and Governors could influence decisions on such matters.
- The service development strategy referred to the shift towards Primary Care envisaged by the government in the White Paper *Our Health, Our Care, Our Say*. However, the strategy did not spell out how FT status would allow the Trust to work with this agenda, and this might be queried.
- As regards how FT Members would be informed and involved, the Trust's 2006 consultation document said only that the Trust would develop a strategy for this. Further detail could be sought on what this "membership communication strategy" will entail and how successful it is likely to be.
- The Trust's FT status application stalled in 2006 as a result of the Trust's financial problems. It would be appropriate to ask whether the Trust's finances are now sufficiently sound, on a long-term basis, to allow it to progress to FT status – especially given the continued high cost of the PFI contract for Darent Valley Hospital (which consumes around 20% of the Trust's annual turnover).
- The continuing NHS "Fit for the Future" programme in Kent and Medway, and the "A Picture of Health" project in London, will potentially have significant impacts on Dartford and Gravesham NHS Trust. Questions might be asked regarding how FT status will affect the way that the Trust deals with those impacts.

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Dartford and Gravesham NHS
NHS Trust

Foundation Trust Application

Briefing Paper

Kent County Council NHS Overview and Scrutiny Committee

7 September 2007

1. Background

Between Dec 2005 and May 2006 the Trust prepared an application for Foundation Trust status, having been invited, as a high performing Trust, to apply by the Department of Health. In June 2006 the Trust Board agreed to defer the application. This was done in order to allow the necessary actions to be taken to return the Trust to financial balance.

These plans were delivered and the Trust ended 2006/07 with a small surplus. The S.E. Coast Strategic Health Authority proposed the Trust for FT status again and it was accepted onto the 'Wave 7' list of applicants.

2. How are Foundation Trusts different to other NHS Trusts

NHS foundation trusts are part of the NHS and subject to NHS standards, performance ratings and systems of inspection. However they differ in the following respects.

- They are independent legal entities - Public benefit corporations.
- They have unique governance arrangements and are accountable to local people, who can become members and governors. Each NHS foundation trust has a duty to consult and involve a Council of Governors (comprising patients, staff, members of the public and partner organisations) in the strategic planning of the organisation.
- They are set free from central government control and are no longer performance managed by health authorities.
- They have new financial freedoms and can raise capital from both the public and private sectors within borrowing limits determined by projected cash flows and therefore based on affordability. They can retain financial surpluses to invest in the delivery of new NHS services.
- They are overseen by Monitor (the Foundation Trust regulator).

3. Rationale for Foundation Trust – What are the advantages to Dartford & Gravesham NHS Trust, its patients, staff and the public

There are a number of reasons why the Trust believes FT status will bring benefits to the organisation, its patients, staff and the public.

- Foundation Trust status is a 'badge of honour'. The Trust believes that as a recognised high performing organisation, we will be better able to deliver high quality services to patients and to continuously improve our care, than if the Trust did not achieve this status.

- As a self-governing organisation, it would be free to determine its future, acting flexibly and quickly to meet local needs and priorities. The freedoms granted from central government control mean that it can focus more time and resource on health outcomes and, with the PCT, its contribution to reducing inequalities.

- It can retain financial surpluses to invest at Darent Valley Hospital in improving patient care. This new ability to reinvest surpluses or to borrow money means that new developments, agreed with governors and members to meet specific local needs, can be implemented quickly.

- It would strengthen efforts to involve patients & the public in shaping services, engaging in a way it could not achieve before. The Board of Governors is responsible for representing the interests of the local community in the management and stewardship of the NHS Foundation Trust, and for sharing information about key decisions with other NHS Foundation Trust members.

- The Trust would be much more accountable to governors and members and therefore the local population, and can take decisions autonomously in the best interests of the Trust and local people, rather than through SHA or Secretary or State direction as before.

- It would build on the way in which it uses the skills and experiences of its staff to deliver modern & effective care & treatment and to explore innovative approaches to a range of workforce issues e.g. creating new types of jobs, new ways of working and more flexible shift patterns to meet local needs.

- It could better thrive in the 21st century NHS across Kent and SE London, developing as the community grows along the Kent Thameside.

4. Consultation & Membership

4.1 Consultation

A copy of the 2006 Consultation Response is attached to this paper. A number of postscripts update certain aspects. Having undertaken this process last year the Trust does not need to formally re-consult in full. However it does need to demonstrate effectively that key partners and stakeholders are engaged in, and supportive of, the move to FT status.

From July-Oct 07 the Trust will engage with a wide range of partner organisations and the general public in re-communicating the key aims and objectives of the application and seeking continued support for it.

The response last year showed broad support for all the relevant aspects of the application. The table below is an extract from the response.

Membership	Broadly supportive
Board of Governors	Broadly supportive (further explanation of the role)
Board of Directors	Broadly supportive
Elections	Broadly supportive
Constituencies	Broadly supportive
Boundaries	Broadly supportive
Constitution	Broadly supportive
Age limits	Little comment
Youth Representation	Little comment
Staff representation	No one preferred option.
Vision	Broadly supportive

During the pre-consultation and consultation process the Trust engaged with patients and carers, staff, members of the public, MPs, Councillors, Overview and Scrutiny, GPs, minority ethnic groups, faith groups, disability groups, neighbouring NHS organisations, schools, colleges and universities.

4.2 Membership

A comprehensive Membership Strategy was developed in 2006. The Trust is now aiming to sign up c1000 members from the public and partner organisations. This is an increase on those that it targeted in 2005/06. It wants membership to be meaningful, with members choosing from a range of levels of involvement, from recipients of information about the Trust to active involvement in the Trust's activities. The intention is to develop a public membership that is fully representative of the local community, reflecting the local socio-economic, ethnic and cultural diversity of people that are served by the Trust.

It plans to change its staff membership from an 'opt in' to an 'opt out' scheme and will ensure that all members are involved effectively in the governance arrangements for the Trust. The Board of Directors and Council of Governors, once constituted, will agree a set of objectives and actions to maintain effective membership activities. Broadly these will be.

- Building and developing the membership base
- Communicating with members to assist them in contributing effectively
- Reinforcing the Trust's position as a trusted and accessible participant in the life of the community
- Working with other membership organisations
- Evaluating success – has the membership strategy become the property of the membership? Is the strategy still meaningful for the evolving membership?

- Planning future recruitment

5. Developments since the 2006 application

One of the main concerns raised in the previous consultation was financial stability. This was accepted by the Trust and was the reason for deferral. The Trust has now delivered financial balance (and a small surplus), has robust strategies in place to maintain this, and is therefore in a much stronger position to apply.

The other main changes relate to the service developments the Trust was proposing to undertake as part of its overall strategy. In the main these have been delivered, either fully or in part. They were.

- Cancer services repatriation – The Trust now provides breast, lung, lower GI and haematological oncology.

- Heart Centre development – This opened in January 07 and means local people can have interventional cardiology locally, in purpose built, high quality facilities, rather than travel to London.

- Growth in maternity services and a midwife led unit opening – The Trust delivered its 3000th baby for 2006/07 at the end of March. The midwife led unit opened in May and provides high quality service for low risk deliveries, adjacent to the maternity unit

For this application the key service developments the Trust will focus on are linked to its 2006/07 three strategic objectives.

- Darent Valley will be the “First Choice” for patients in West Kent and South East London

- Dartford and Gravesham will become a NHS Foundation Trust

- Darent Valley will deliver the 18 week Referral to Treatment target.

Within these high level objectives are a number of key supporting developments that will take place over the next few years. They include.

- Developing the Heart Centre further to increase its capacity and expertise in treating patients locally

- Planning for the Kent Thameside expansion and, with partners, ensuring the health needs of this population are met.

- Working with West Kent PCT and other organisations in delivering the objectives of the ‘Fit for the Future’ programme for specialist services.

- Working with the SE London ‘A Picture of Health’ project to plan for more patients to come to Darent Valley Hospital from the Bexley and Sidcup areas.

6. Timetable

- July –Sept 07 –Complete application
- End October –Application to Secretary of State
- End December –Approval by Secretary of State
- Jan –March 08 –Monitor assessment phase
- April 08 –Authorisation as FT by Monitor*

* There is currently a backlog of Trusts to be assessed by Monitor and therefore this deadline may change.

7. Future relationship with the Overview and Scrutiny Committee.

The Trust has always valued its relationship with the Overview and Scrutiny committee, and regards it as an important marker of accountability to local people. This can only strengthen as the Trust becomes more responsive to local views through its members and governors, however the Trust would still expect to be called to account for its actions by the OSC. Regarding any statutory duties relating to NHS relationships with Overview and Scrutiny committees, we will need to watch carefully if there are future amendments to Section 11 of the Health Act, (for example in relation to the demise of Patients Forums and establishment of Links).

8. Recommendation

NHS Overview and Scrutiny Members are asked to re-assert their support for the Foundation Trust application and to consider a process for nominating a KCC representative to the Council of Governors.

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Responses to Dartford and Gravesham NHS Trust application for Foundation Trust status

Respondent	Response
Sutton-at-Hone and Hawley Parish Council – 21 August 2007	"This Parish Council supports any moves to improve the service to and treatment for our residents. We would be interested in contributing to your membership strategy both by nominating a Parish Councillor and encouraging representatives from our local residents should you welcome that input."
Mr John Beadle (member of the Working with Darent Valley Hospital Patient and Public Involvement Forum) – 19 August 2007	"I am concerned about the question of Accountability for Services which are provided at Darent Valley Hospital by neighbouring Trusts. My specific concern relates to Audiology. A 'Service' is provided at Darent Valley by Medway Maritime Trust, but for a catchment area the size of DVH (250,000 growing to 310,000), this is currently one of the worst in the UK. This is NOT due to lack of effort by the Staff but quite the reverse. The Staff are dedicated to attempting to provide a Service, often working additional hours, but are handicapped by totally inadequate facilities provided by DVH Trust. The 'Best Practice Standards for Adult Audiology' published in July 2002 clearly define the facilities required, but those at DVH fail on several counts, and cannot house the number of Audiology Staff required for the catchment area of the Hospital. These deficiencies have been identified by the PPI Forum for the past three years, and although minor changes were made a year ago, the situation remains unsatisfactory. The Audiology 'Service' provided at Darent Valley Hospital clearly fails the high aims set in this Briefing Paper, and this situation needs to be urgently addressed."
Mrs Audrey Gee (member of the Working with Darent Valley Hospital Patient and Public Involvement Forum) – 18 August 2007	"At the moment I am visiting my husband , daily, in DVH as he has had a major stroke. I am observing first hand how the ward is run and how the patients are cared for. I have great concerns, not for the quality of the staff but the LACK of them. They are trying to look after very helpless patients with far too few nursing staff . Visitors have to daily check on their patients needs and see they are comfortable, not slipping out of bed, that they are having oxygen masks on, food and water drips working, and are getting some treatments. This is not because the staff do not care but because in cutting back staff they can barely cope with basic needs. Will Foundation Status improve this situation, or is it just another layer of administrators, absorbing the limited funds?

Respondent	Response
	Will the funds that could be retained for patient care really go to increasing the grass level staffing? The care for the patient is the biggest problem at the moment, but this is what is needed. No more administrators please in fact a reduction in the top layer would be sensible. Will you really be able to keep to an 18 week service? Will that include Audiology? The hospital is too small , always has been and is unlikely to cope with the 'Gateway surge'. Are there any realistic plans to raise money to extend the hospital? If the Foundation Trust is not positive about these concerns, they should not proceed."
West Kent Patient and Public Involvement Forum – 24 August 2007	"*First Comment* I have scanned through the report and it all seems very sensible as far as it goes, but all I have to say at the moment is that there must be some potential disadvantages to the Trust's proposed course of action, however I have seen none mentioned in the report. In a properly balanced report both sides of an argument should be set out and the rationale for favouring a particular outcome demonstrated. In my opinion the objectivity of this report is, therefore, suspect. I would have appreciated more time to consider this matter, and obtain further information about the issues. As usual, the Forum members are expected to give their considered responses to a consultation process within a totally unrealistic timescale. *Second Comment* As we have not been informed whether there is any opposition to this application, and if so, on what basis, it is impossible to give an informed opinion based solely on the Trust's own briefing paper. *Third Comment* Having experienced an attempt to give hospitals Foundation Trust status in the early 1990s, I ask if the new Foundation Trust initiative will allow the Trusts to set their own rates of pay. If rates of pay are set at a higher level than the NHS, prime nursing staff will be attracted to work for Foundation Trust Hospitals to the detriment of local NHS hospitals. It is hoped there will be parity in rates of pay with the NHS."