AGENDA

NHS OVERVIEW AND SCRUTINY COMMITTEE

Friday, 20th July, 2007, at 10.00 am
Tonbridge & Malling Borough Council Offices, Gibson Building, Gibson Drive, Kings Hill, West Malling ME19 4LZ

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

Tea/Coffee will be available 15 minutes before the start of the meeting in the meeting room

Membership (15)

Conservative (10):	Lord Bruce-Lockhart, Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mrs S V Hohler, Mr G A Horne, MBE, Dr T R Robinson, Mr R Tolputt, Mrs E M Tweed.
Labour (4):	Mrs C Angell, Mr M J Fittock, Ms A Harrison, 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)

Substitutes

Minutes - 8 June 2007

Declarations of Interest

Mental Health Service Provision across Kent and Medway — 10:10-11:00 am

Erville Millar, Chief Executive, 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, West Kent PCT will be in attendance for this item.

Break 11:00-11:15 am

Mental Health Service Provision across Kent and Medway (cont'd) — 11:15 am-12:10 pm

Lunch 12:10-1:00 pm

West Kent Community Hospitals Review — 1:00-2:00 pm

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 will be in attendance for this item.

Chronic Pain services

Dr Joan Hester, Consultant in Pain Management at King's College Hospital NHS Trust and President of the British Pain Society, and Mr Matthew Kershaw, Chief Operating Officer, East Kent Hospitals NHS Trust, Julia Ross, Director of Civic Engagement, West Kent PCT and representatives from Dartford & Gravesham NHS Trust and Maidstone & Tunbridge Wells NHS Trust will be in attendance for this item. 2:00-3:00 pm

LINks update 3:00-3:15 pm

Date of next programmed meeting - **Friday 7 September 2007**
Commencing at 10:00 am in the Council Chamber, Sessions House, County Hall, Maidstone.

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

12 July 2007

KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held in the Council Chamber at Sessions House, County Hall, Maidstone on Friday 8 June 2007.

PRESENT: Mr A R Chell (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr M J Angell, Mr A D Crowther, Mr D Daley, Mr D A Hirst, Mr G A Horne, MBE, Mr I T N Jones (substituting for Ms A Harrison), Mr J London (substituting for Ms B Simpson), Mr W Newman (substituting for Mrs E Rowbotham), Mr M Northey (substituting for Mr R Tolputt).

OTHER MEMBERS PRESENT: Mr G Gibbens, Mr P Lake.

OBSERVERS: Mr R Appadoo (West Kent Primary Care PPIF), Ms C Swann (Kent and Medway Mental Health and Social Care PPIF), Mr D Easton (East Kent Hospitals PPIF) and Mr J A Ogden DL (Chairman of KCC Standards Committee).

IN ATTENDANCE: Dr D Turner, Research Officer to the NHS Overview and Scrutiny Committee, and Ms D Fitch, Assistant Democratic Services Manager (Policy Overview).

UNRESTRICTED ITEMS

28. Membership

It was noted that Mr J A Davis had replaced Mr C Hibberd, and Ms B J Simpson had replaced Mrs P A V Stockell as Members of the Committee.

29. Minutes

RESOLVED that the Minutes of the meeting held on 11 May 2007 were correctly recorded and that they be signed by the Chairman.

30. Matters arising relating to the Minutes

1. Business Plan for the Private Finance Initiative (PFI) – Pembury (Minute No. 25 of 11 May 2007)

(i) Mr Crowther stated that there was a chapel on this site that had served the hospital for many years. It was proposed to demolish this and use the space for car parking. English Heritage had now listed the building and he believed that the Committee should express its support for the retention and protection of this building. The Chairman said that clarification would be sought from the Trust and fed back to Members.

2. Maidstone and Tunbridge Wells PPI Forum

(ii) Mr Fittock mentioned a letter from the Maidstone and Tunbridge Wells PPI Forum relating to the meeting on 11 May 2007 and asked how the Committee would be dealing with it. Mr Chell stated that he had not seen the letter but that he would talk to Mr Fittock outside of the meeting about this.

3. Local Involvement Networks (LINks)

(iii) Mrs Angell stated that it was important for the Committee to be kept informed about developments regarding the introduction of LINks.

(iv) Mr Chell confirmed that there would be a full report on LINks on the agenda of the July meeting.

4. Community hospitals in west Kent

(v) Mrs Angell expressed regret that a stakeholder meeting in relation to the review of community hospitals in west Kent had been held on the afternoon of the County Council meeting on 17 May and, therefore, it had been difficult for Members to attend. Mr Chell stated that the community hospitals review would be on the agenda for the next meeting of the Committee. The good news arising from the review was that it was planned to retain all the community hospitals in west Kent.

31. Urgent Business

The Chairman stated that he was of the opinion that the committee should receive representations about the renaming of the Minor Injuries Unit at Edenbridge and District War Memorial Hospital as a matter of urgency, as this change had already been made and, therefore, it was not appropriate to leave this item until the next meeting.

32. StourCare Out-of-Hours service

(Peter Robinson, Eastern and Coastal Kent Primary Care PPIF, Jayne MacDonald, Head of Primary Care and Community Contracts, and Lynne Selman, Director of Citizen Engagement and Communications, Eastern and Coastal Kent PCT, were in attendance for this item)

(1) Mr Robinson set out the background to the StourCare Out-of-Hours service and the change to the contract, which had been the subject of a recent review after six months of operation. He stated that joint working between the Forum and the NHS Overview and Scrutiny Committee had led to a satisfactory outcome. He made the Committee aware that there would be a full review of the Out-of-Hours Service in late 2007 or early 2008 for the PCT area and the existing contract had, therefore, been extended to the end of May 2008. He stated that he believed the PPIF and the NHS Overview and Scrutiny Committee should be involved in this review at an early stage.

(2) Ms Jones stated that, as a result of the work of the PPIF, there had been a renegotiation of the contract between the PCT and StourCare and a satisfactory result for the public in the area had been achieved. She highlighted the fact that the PCT was part

of the national pilot for the Urgent Care Review programme. Work on this had started and the PPIF had a representative on the Project Board.

(3) In relation to engaging with the public and organisations, Ms Selman stated that the PCT was setting up a "virtual panel" across the PCT area to use for consultation for the Urgent Care pilot. This was a key part of their ongoing work.

(4) The Chairman expressed the Committee's thanks to Mr Robinson for the detailed piece of work that the PPIF had undertaken and stated that this was a good example of PPIFs being the "eyes and ears" of the NHS Overview and Scrutiny Committee.

(5) RESOLVED that the update on StourCare Out-of-Hours Service be welcomed and noted.

33. Renaming of the Minor Injuries Unit at Edenbridge and District War Memorial Hospital

(Dr A Russell, Chairman of the League of Friends of Edenbridge and District War Memorial Hospital, and Julian Ross, Director of Public Engagement and Sharon Jones, Director of Community Services, West Kent PCT, were in attendance for this item)

(1) A petition from the League of Friends of Edenbridge and District War Memorial Hospital regarding the Minor Injuries Unit at the hospital (attached as Appendix 1 to these Minutes) was tabled, along with information supplied by West Kent PCT (attached as Appendix 2). The Chairman welcomed Dr Andrew Russell to the meeting and invited him to address the Committee. Dr Russell made the following points:-

- The Minor Injuries Unit at Edenbridge had been a nurse-led unit for the past nine years and had worked satisfactorily.

- On 24 May the West Kent PCT at their Board meeting had decided, on safety grounds, that the unit should be renamed a "Treatment Clinic" with immediate effect.

- A consultation period on the future of the Clinic was due to run from 2 July for three months and he expressed concern that the name change had occurred one month before the official consultation period had started.

- The PCT had given the reason for the renaming as the low throughput of patients, which did not give staff adequate exposure to all types of case for the safety of patients.

- He made the point that there had never been any question of poor safety; the unit had a 100% safety record, with no complaints.

- He highlighted the important support given to the unit by Dr Julian Webb, the A&E consultant who covered this unit and others in the area. He audited the unit's work regularly and visited the unit weekly to discuss the work with nurses; in the view of Dr Webb, the unit was safe.

- The nurses at the unit rotated with colleagues at the Sevenoaks Hospital Minor Injuries Unit and, therefore, saw the same case-mix.

(2) In conclusion, Dr Russell stated that he believed that the name change at this time, before a consultation on possible closure of the Unit, would lead people to believe that the Minor Injuries Unit had already ceased to exist. This would prejudice the consultation that was about to take place and, therefore, was unfair. He suggested that the question of the final closure of the Unit might be a subject for further consideration by the NHS Overview and Scrutiny Committee.

(3) Ms J Ross was invited to speak and stated how disappointed she was that the good news in relation to community hospitals had been overshadowed by more minor issues. She made the following points in relation to the Minor Injuries Unit at Edenbridge:-

- The PCT had taken legal advice and they had the right to change the name of the unit.

- Out of the 11 patients a day that were seen in the unit, 50% were sent by GPs for re-dressings or Electrocardiograms (ECGs). ECGs had actually already been paid for in the General Medical Services contract and did not need to be provided in a Minor Injuries Unit.

- The issue was not the safety of the current service. Rather, there was a risk in retaining the name “Minor Injuries Unit” that, if a patient were to present with a serious injury, the service would not be able to cope, given that it was not used to such cases. The name “Treatment Clinic” was a more accurate reflection of the service actually being provided.

- The PCT would be going out to consultation on the future of the renamed Treatment Clinic.

- The PCT had data from 2004 and the numbers using the unit had not changed. Although it had the support of the local community, it was not a well-used facility.

- It should be noted that the outcome of the review of community hospitals was: to keep all six hospitals; to re-open those beds that had been closed in recent years; and to bid for national capital funding. This new investment would include modernising the x-ray facilities at Edenbridge.

- Another contentious issue that had arisen was the matter of possibly transferring the Renal Dialysis Unit to Tonbridge Cottage Hospital. This would be going out to consultation. On the whole, the outcome of the community hospitals review was very good news – and the controversy around the small changes at Edenbridge and Tonbridge should not be allowed to obscure this.

(4) Ms S Jones stated that she had a clinical background and a passion for community hospitals. She corrected the statement made by Dr Russell regarding Dr Webb, the A&E consultant. Dr Webb was not clinically in charge of the Minor Injuries Unit at Edenbridge:

he only audited clinical notes, not the actual work of the unit. Only 9–11 patients a day used the unit, and 50% of them attended to have their dressings changed; this was not a proper workload for qualified nurses. There was not the throughput of patients at Edenbridge to consolidate training and there were problems getting nurses to work there. She said, from a personal point of view, that if she were a Nurse Practitioner she would not stay in that unit. There was actually only one member of staff who rotated between Edenbridge and Sevenoaks Hospital. She stated that there was no one definition of a Minor injuries Unit. When the Healthcare Commission and PriceWaterhouseCooper had audited emergency units, they had broken them down into three types. Type 1 was a full A&E unit; Type 2 saw at least 20,000 patients a year; and Type 3 saw at least 10,000 patients a year. Edenbridge was seeing just 3,000 patients a year and, as such, did not even count as a Type 3 facility. In changing the name of the unit at Edenbridge, the PCT was merely calling it what it really was – which was a Treatment Clinic.

(5) The Chairman stated that he welcomed the result of the community hospitals review overall. Members made a number of points in response to what they had heard and Ms Ross responded.

(6) RESOLVED that

(i) the presentations and discussions be noted;

(ii) the next meeting of the NHS Overview and Scrutiny Committee would consider West Kent PCT's community hospitals review in its totality.

34. Vice-Chairman in the Chair

Mr Fittock, Vice-Chairman, took the Chair for the remainder of the meeting, as the Chairman had to leave early, for which he apologised.

35. General Pharmaceutical Services

(Mike Keen, Chief Executive of the Kent Local Pharmaceutical Committee, Professor John Butler, the Chairman of Kent and Medway Pharmaceutical Regulations Committee, Julia Ross, Director of Civic Engagement, West Kent PCT, Jayne Macdonald, Head of Primary Care and Community Contracts, Eastern and Coastal Kent PCT and Anne Bretherton, Chief Pharmacist, West Kent PCT, were in attendance for this item)

(1) The Chairman welcomed Mr Keen to the meeting and invited him to give his presentation. Mr Keen's presentation (attached as Appendix 3) covered the following:-

- What is a Local Pharmaceutical Committee?
- Where does it draw its powers from?
- How does pharmacy help to improve services to patients?
- How does pharmacy help public health?
- What is control of entry?

(2) Professor Butler from the Kent and Medway Pharmaceutical Regulations Committee, the body responsible for awarding contracts to applicants for pharmacies,

explained that the number of pharmacies in Kent and Medway over the past 15 years had remained approximately the same. However, the location of the pharmacies had changed; and large pharmacy companies had taken an increased share of the market. There was a tendency to have more pharmacies in supermarkets and also to move pharmacies out of high streets and to co-locate with doctors' surgeries, which ran in parallel with the increase in the redevelopment/relocating of doctors' surgeries. Professor Butler explained that in rural areas under regulations it had been possible since 1982, with consent, for doctors to dispense, as often in these areas it was not commercially viable for pharmacists to operate.

(3) Ms Bretherton stated that in Kent the PCTs were looking at formally setting in place a Clinical Governance Framework based on the national programme. East Kent PCT had the responsibility to carry out the performance monitoring visit. In West Kent every pharmacy had a visit and pharmacist would go on the visit with a lay Member. This visit would be pre-arranged and anything arising from it would form part of an action plan. PCTs gave pharmacies help and support so that they could address any issues identified as requiring action. In relation to a question on counterfeit drugs, she stated that the PCT had no influence as this was a national problem. In relation to unused drugs, Ms MacDonald and Ms Bretherton stated that they headed teams of Prescribing Advisors who visited GP practices and supported GPs. Members asked a number of questions, and received responses, regarding the following points:-

- As regards the regulation of pharmacists, it was explained that they had a professional code of ethics and that their professional body, the Royal Pharmaceutical Society of Great Britain, played a regulatory role (although the regulatory and representative functions of the Society were to be separated under planned reforms to the regulation of healthcare professionals).

- All pharmacies had to agree their opening hours with the contracting PCT. New pharmacies had to specify their total opening hours and their core contract hours, which had to be at least 40 hours per week. When the Pharmaceutical Regulations Committee received an application, the applicant usually offered to open in excess of 40 hours, but contractors were able to withdraw from any commitment to provide additional hours (with three months' notice). The Committee could only accept the hours that were being offered – if the pharmacy did not offer to open on Saturdays or Sundays, or in the evening, then they could not be forced to do so. Given a choice of applicants in the same area, the Committee would choose the one offering the greater coverage, other things being equal.

- One of the problems with the regulatory system was that it was reactive. Pharmacists chose where they wished to provide services and there was no direct means of directing provision at underserved areas. PCTs worked to try and develop local pharmacy services where there were gaps. There were certain areas where pharmacists would not find it attractive to open up a pharmacy; on the other hand there were others areas that were "over-pharmacied" – for example, Westwood Cross Retail Park in Thanet, which did not necessarily need the four pharmacies that it had.

- The Galbraith Inquiry, which was looking at the NHS pharmacy "control of entry", was due to report before the end of June (although the report itself might not actually be published). This could lead to further reforms in the "control of entry" mechanism.

- The provision of "advanced" and "enhanced" services by community pharmacists was a cost-effective way of providing medical help and advice in the community.

- PCT prescribing advisors went round to every GP practice, to provide unbiased evidence on drugs, thereby acting as a counterweight to the targeting of GPs by pharmaceutical companies. GPs valued this advice.

(4) The Chairman thanked the presenters and representatives from the PCTs for attending the meeting and giving Members an interesting overview. He stated that the NHS Overview and Scrutiny Committee hoped to be able to contribute to the discussion about the future of the "control of entry" regulations following the Galbraith Inquiry.

(5) RESOLVED that the presentations and discussions be noted.

36. Infection Control

(Rose Gibb, Chief Executive, Amy Page, Service Improvement Director, Maidstone and Tunbridge Wells PCT, James Nash, Director of Infection Prevention and Control, East Kent Hospitals NHS Trust, Mark Devlin, Chief Executive and Iris Smith, Director of Infection Control, Dartford and Gravesham NHS Trust and Helen Goodwin, Head of Governance and Risk with Kath Hughes, Modern Matron for Infection Control, Medway NHS Trust were in attendance for this item)

(1) The Committee received presentations from each of the Acute Hospital Trusts across Kent and Medway regarding the processes and procedures that they had put in place concerning infection control and the incidence of hospital-acquired infection within each Trust (attached as Appendix 4). Members' questions were answered by PCT colleagues.

(2) In response to a question from a Member, Ms Hughes undertook to provide Members with data showing the numbers of patients that had contracted *Clostridium difficile* and MRSA, expressed as a proportion of the total number of patients treated.

(3) RESOLVED that health colleagues be thanked for their informative presentations.

37. Public Health Strategy for Kent

(Meradin Peachey, Director of Public Health, and Mark Lemon, Policy Manager, KCC Department of Public Health were in attendance for this item)

(1) Mr Gibbens introduced the latest draft of the Public Health Strategy for Kent, which had been circulated to key stakeholders for comment and discussion before being taken to a meeting of the full County Council on 24 July 2007. Ms Peachey stated that she was pleased the Committee were looking at this. It was an opportunity for the PCTs and KCC to clarify what they meant by public health. The strategy set out six key outcomes for all partners to focus on. Some of the targets were already part of the Local Area Agreement

for Kent. Mr Lemon emphasised that the document was work in progress and, even when agreed, it would still be work in progress, as the strategy would continue to evolve and develop. After the County Council meeting on 24 July 2007 the document would go out to public consultation.

(2) Members made the following comments on the document:-

- It would be helpful to have more discussion in the document on food – for example, the importance of adequate information being shown on food packaging, so that informed choices could be made; and also the need for information about how to find healthy, local food.

- In relation to obesity, the "pleasure principle" was important: a healthy diet and lifestyle needed to be presented as enjoyable.

- It was noted that KCC's Environment and Regeneration Directorate had set a good example of encouraging staff to take exercise in an enjoyable way.

- The Healthy Schools programme was acknowledged as another good example of promoting healthy lifestyles.

- The Alcohol Abuse Select Committee's recommendations would feed into the next version of the Strategy, which was due to be published in October 2008.

- Members were pleased to see that mental health was included in the document.

- It was noted that a lot of work had been done to reduce teenage conception rates.

- Members who sat on Local Strategic Partnership Boards would find it helpful to have advice about how to challenge other organisations to ensure that they were working along the lines set out in the strategy. It was noted that once the document had been agreed, there would be discussions with the Local Strategic Partnerships and district authorities.

- The challenges around health inequalities were starkly illustrated by the different life-expectancy rates found in geographically adjacent wards in some parts of the county.

- It would be useful to have a map of the county illustrating the different indices, so that the various aspects of health inequalities could be visually presented.

- It was noted that Environmental Health, which was a district council function, was key to public health – but it was important to look at major public health issues where all local authorities could make a big difference to a large number of people. One of the main issues that district councils wanted action on was air-quality improvement.

- It was noted that the County Council was a major player in relation to public health and had the opportunity to have a very powerful lobbying voice but it was important to be very careful about which issues were selected for lobbying.

- It was suggested that establishing "excellence in public health" awards for organisations could be considered.

(3) An undertaking was given that as part of the consultation on this document, it would go to PPIFs.

(4) RESOLVED that the latest draft of the Public Health Strategy for Kent, and comments made by Members of the Committee, be noted.

38. Fit for the Future - Update

(1) Tabled at the meeting was a paper from Ms J Ross, Director of Civic Engagement for West Kent PCT, which set out the current situation regarding Fit for the Future (attached as Appendix 5). Work on Fit for the Future was continuing, with the health economy across Kent and Medway on track to deliver a formal update for all stakeholders in July. At an extraordinary County Council meeting on 24 July 2007, the PCTs would have an opportunity to share more detail about next steps regarding Fit for the Future and there would be an opportunity for Members to speak to a range of clinicians and staff about the service improvements that were planned. Once the public document was published, there would the opportunity for a full discussion with the Committee and to discuss in detail about what would happen next in west Kent.

(2) RESOLVED that the report be noted.

39. Date of Next Programme Meeting

It was noted that the next programmed meeting of the Committee would be held on Friday 20 July 2007 at 10.00 am, with the venue to be confirmed.

Appendix 1

Petition to the NHS Overview and Scrutiny Committee of Kent County Council by the League of Friends of Edenbridge and District War Memorial Hospital

Subject of the Petition

1. On May 24 the West Kent Primary Care Trust Board announced that the Minor Injury Unit (MIU) at Edenbridge Hospital should be renamed as a treatment clinic with immediate effect for safety reasons;
2. The PCT should consult on the closure of the Treatment Clinic, currently the MIU
3. The PCT should provide a redressing clinic for 1 to 2 days a week for existing patients until such time as current patients are discharged when it should cease; and
4. That new redressing patients are redirected to other services.

In subsequent discussion with the PCT it is confirmed that the proposed new Treatment Clinic will continue to function as the present Minor Injuries Unit during the consultation period commencing July 2nd.

Thus the only substantive change during the consultation period is one of name but not of function. This change is recommended by the PCT Board on grounds of the alleged safety of the patients.

The patients are alleged to be at risk because the number of patients seen is deemed to be too low to maintain the competence of the Emergency Nurse Practitioners who staff the unit.

The grounds for objection to the name change before the consultation period

1. If the unit continues to function as previously during the consultation period there is no reason to change the name.
2. The present Minor Injury Unit has a 100% safety record and has been running as a nurse led unit since 1998. There has never been a complaint from the public.
3. The Consultant Surgeon in clinical charge is very supportive of the unit, visits weekly to see patients and staff and carries out a regular audit of the work.
4. No arguments of substance have been advanced to justify the renaming of the unit without due consultation.
5. The inevitable consequence of a change of name without consultation will lead members of the public to believe that the Minor Injury Unit has ceased to exist. This could adversely affect the availability and operation of the unit during the consultation period.
6. A proper consultation can only take place in relation to the entirety of the Board's decisions and not part only.
7. The name should not be changed prior to consultation taking place.

Dr Andrew Russell, Chairman, League of Friends

June 5 2007

Summary for NHS Overview and Scrutiny Committee 8 June 2007

Edenbridge Minor Injuries Unit

1. Definition of a Minor Injury Unit

There is no one definition of a Minor Injuries Unit. The Health Care Commission, working with Price Waterhouse Coopers, undertook reviews of all A&E units during 2004/5. These were mandatory audits carried out in acute trusts and PCTs that delivered significant levels of A&E services. This included nurse led Minor Injury units and walk in centres. They defined them as type 1, 2 and 3. Types 1 are those units with access to a full range of specialist departments, such as eye departments and children's A&E departments. Type 2 included Gravesham Community Hospital as it treats 20,000 patients a year whilst type 3 included those minor injuries units departments where the level of attendances were more than 10,000 patients per year. Whilst Gravesham and Sevenoaks MIUs were included in these audits the Edenbridge Minor Injuries Unit was excluded by the auditors as its attendances were deemed too low. Therefore, in this context, it can be argued that Edenbridge MIU was not regarded as an MIU.

The PCT has also assessed the access criteria and key characteristics of both minor injuries units and walk in centres across England. The following seem to be common features in all minor injury units and are also reflected in a Kings Fund Document on Walk in Centres.[1]

- *Initial Point of Contact*. Patients attend with new unforeseen health problems to the unit as the first point of contact. They are not referred to the unit by another service;
- *Immediate Access*. Patients require neither appointment nor referral;
- *No or limited follow-up care*. Treatment or advice is given for the presenting problem. If further care is needed patients are advised and redirected to attend the appropriate services;
- *No substitution of care*. Minor Injuries Units are not substitutes for care that is provided elsewhere.

2. Observations

It appears that the Edenbridge Minor Injuries Unit is working outside these criteria as patients are often referred to the unit, there are high levels of follow up care given and a primary care treatment/redressing service makes up a significant part of its activity. In all these aspects it is an outlier when compared to the other units. Therefore it is the PCT's view that this service is not serving its primary function of a MIU and should be renamed as a treatment/redressing service. This is not changing the service that it provides, but giving it a name that more accurately describes the service offered. Legal advice was taken prior to this action being instigated.

[1] Mountford L, Rosen R (2001) '*NHS Walk-in Centres in London An initial assessment'*, Kings Fund

3. Activity Levels

To provide care safely, health care professionals need to treat a critical mass of patients to be able maintain their skills. This argument would apply even in a health system with unlimited resources. The strategic review looked at the statistics for average attendances at a range of MIUs and took note of the Healthcare Commission report previously mentioned. On the basis of this and the professional judgement of the members of the management team responsible for clinical governance an MIU would need to see a minimum of 20-30 appropriate patients per day to be clinically viable. Edenbridge falls far short of these levels.

On average Edenbridge MIU sees between 9 – 11 patients a day. It has recently increased up to 14 patients a day but often a service under scrutiny will gain a temporary increase in activity. Up to 50% of these are for redressings that could be undertaken in a clinic or GP practice environment. These also do not require to be undertaken by an Emergency Nurse Practitioner. A local GP practice also sends patients to the unit for ECGs whereas it is more usual (and we would argue better for the patient) for these to be undertaken at the practice.

There has been concern that the opening hours limit the number of patients attending the unit. Modelling the peak activity times against the other three units the PCT manages (Sevenoaks, Gravesend and the Urgent Care Centre at Darent Valley Hospital) it is clear that mornings (9 – 12) and early evenings (4 – 7) are the busiest times. However looking at the data opening the unit for longer hours would only mean an increase of 3 – 5 patients a day and would require a disproportionate increase in staffing costs. Also as up to 50% of attendees at Edenbridge MIU are for redressings, only 1 to 3 of these patients would be true MIU attendees.

It has been suggested to the review team that the Minor Injuries Unit should provide leg ulcer care on behalf of a local practice. However, it is not normal practice for a minor injuries unit to provide this service and is outside the key characteristics of an MIU as described above. Redressings and leg ulcer care also do not require an emergency nurse practitioner. The Minor Injuries Unit would not be functioning appropriately.

Another issue that has been raised is that the unit is not effectively advertised and so unknown by the local population. This is incorrect. The unit is advertised on websites, in directories, and in neighbouring cottage hospitals. Also we had 140 people attending a stakeholder workshop in April who were all aware of the unit. The unit has come under scrutiny in 2002 and 2004 and on these occasions up to 4,000 people have expressed their views on the unit. Therefore it is well known locally.

Concerns had been expressed that the threat to the MIU was as a result of financial considerations. While it is the PCT's duty to ensure that it obtains value for money, as we have shown the reason for these recommendations are clinically based.

COMMUNITY HOSPITAL MIU ATTENDANCES

COMMUNITY HOSPITALS	ATTEND per DAY	ATTEND per MONTH	ATTEND per YEAR
Cromer Hospital	25	173	>9,000
Weymouth Hospital	43	1,333	16,000
St Albans Hospital	27	834	10,000
Orsett Hospital (Thurrock)	36	1108	13,300
North Cambridgeshire Hospital	33	1000	12,000
Royal Victoria Infirmary Newcastle	19	583	7,000
Trafford Hospital	27	808	9,700
Uckfield Hospital	33	1000	12,000
Crowborough Hospital	11	333	4,000
Chippenham Hospital	79	2416	29,000
Withernsea Hospital	16	475	5,700
Southmead Hospital (Bristol)	55	1666	20,000
Stratford (Warwicks) Hospital	23	691	8,300
Mendip Hospitals	26	800	9,600
Panteg Hospital (Gwent)	27	833	10,000
St Mary's Hospital (Portsmouth) [includes Walk-in Centre)	137	4166	50,000
Grinden Lane Primary Care Centre (Sunderland)	55	1666	20,000
Average (minus highest and lowest)	**35**	**1026**	**12773**

Figures assume opening 365 days per year.

8 June 2007

West Kent Community Hospital Review

Conclusions & Recommendations

1. Introduction

This document brings to the PCT Board the recommendations of the review team looking into the future of our Community Hospitals.

The purpose of this report is to provide a summary for the PCT Board concerning:

- THE OUTCOME OF THE REVIEW OF THE COMMUNITY HOSPITALS;
- TO OUTLINE THE STRATEGIC REVIEW DOCUMENT;
- The key recommendations of the review;
- TO SEEK APPROVAL OF THE RECOMMENDATIONS OF THE REVIEW.

The review has taken a long time to complete and it is recognized that this has been an unsettling period for stakeholders – particularly for staff who have been concerned about their futures. The executive management team is grateful for the contributions made by stakeholders and appreciative of the patience shown. There are some significant findings arising which would probably not have come to light without such a comprehensive exercise.

If the recommendations are supported, public consultation will be needed regarding:

- the closure of the Minor Injuries Unit at Edenbridge and District Memorial Hospital
- The reprovision of the Livingstone Hospital.

2. Summary of Key Proposals

- There is a significant degree of variation in practice throughout the 6 community hospitals. By adopting best practice consistently in all of them, particularly with a focus on active rehabilitation, we expect to make major improvements to the quality of care provided while at the same time improving efficiency and cost effectiveness.
- Based on an exercise to model the need for community hospital beds, the current open bed base would be sufficient were all community hospitals currently operating in the optimum way. However, since they are not, it will be necessary to reopen 18 beds in the short term to meet demand.
- As services evolve over the next 3-5 years, it will be necessary to reopen all the existing closed beds. While these will not all be required in the short term, we propose to open them in advance of need just as soon as the revised models of service are put in place and staff recruited.
- Not surprisingly, there is strong and widespread support within the area for our community hospitals. This is shared by our executive team as we see community hospitals as being a key component of our strategy to provide more care for people more locally.
- There is a need for all the hospitals in the south of the area to remain in place and continue to provide the majority of services as at present, though many of these

services will need to be modernized. We plan to make a number of investments in these to augment service.

- The fabric of the Livingstone Hospital in Dartford no longer meets modern requirements. A cost benefit analysis of refurbishment, reprovision or rebuilding will need to be done. The working assumption, subject to the cost benefit analysis and a full business case, is that reprovision may be the most likely option. However, the model of care provided at the Livingstone is excellent despite the challenging physical environment and will be retained in whatever the physical manifestation of the successor building.
- The MIU at Edenbridge Hospital is not clinically viable and should be closed.

3. Background & Context

The former PCTs in South West Kent and Maidstone Weald commissioned a review of their community hospitals in August 2006. The scope of the review originally focused on the four community hospitals in the south of the PCT area. However the formation of West Kent PCT on 1st October 2006 resulted in 2 more community hospitals being part of the PCT and so the scope was expanded. Originally, the review had an emphasis on the financial aspects of the community hospitals. However the brief was made more extensive and comprehensive to ensure that it was patient focused, considered quality, efficiency, effectiveness and sustainability of the services. These areas were placed at the heart of the review.

Most of the PCT's community hospitals pre-date the NHS and were established and/or have benefited from local benefactors. One was built with local donations as a war memorial. The PCT recognizes that its community hospitals have a civic importance for communities and that there is a strong sense of local ownership. However, the current locations reflect history rather than an overall plan. To some extent the services currently provided in community hospitals also reflect history as much as strategic planning.

4. Principles

THE FOLLOWING PRINCIPLES SET THE CONTEXT FOR THE REVIEW:

- West Kent PCT has a challenging financial position. The community hospital review is set within this context. Affordability and sustainability are key to the future of the community hospitals.
- However it was equally important to ensure that the following were also core to the review:

    - Safety & Governance
    - Quality
    - Efficiency
    - Quality of environment
    - Equity

Considerations of privacy and dignity, infection prevention and control were intrinsic to the Safety & Governance and Quality of environment.

5. Findings

5.1 Patients in community hospitals need high quality care that gets them well as quickly as possible to enable them to return home and to families. There are real dangers for patients remaining in hospital beds for longer than necessary. There are unnecessary variations in the average length of stay in the community hospitals. There is also potential to improve the efficiency in the use of community hospital beds by improving the average stay to 18 days. This requires an active rehabilitation focus which will be necessary if the PCT is to deliver the service modernisation required by our aspiration for many more people to be cared for in local settings. The current range varies from 26 to 18 days once long stay patients, such as continuing care patients, are excluded. Therefore the community hospitals need to improve efficiency and the throughput of patients to allow an increase in capacity. The PCT has a range of adult community health services that can provide care in the patient's home to allow this to happen. The PCT is also about to commence a review of adult community health services to ensure that it is well placed to support the improvement in the average length of stay in the community hospitals.

Not all of the hospitals were able to demonstrate that they have written and agreed admission and referral criteria, operational policies and a modern set of service standards. It is essential that each hospital has these written and agreed as well as a service level agreement against which they are performance managed.

Further work can also be undertaken to use the day centres more effectively and efficiently. This would mean that some patients could be offered day care to provide for their health needs rather than being admitted to a community hospital bed. This is particularly the case for those who need rehabilitative care.

5.2 The PCT needs to ensure that all the community hospitals implement the best practices as advised by the Department of Health and the Chief Nursing Officer of England. These include The Essence of Care and the Chief Nursing Officer's 10 Key Roles for Nurses and 10 Key Roles for Allied Health Professionals. 'The Essence of Care' has been designed to support the measures to improve quality set out in 'A First Class Service' and is an important part of implementing clinical governance at a local level. The benchmarking process outlined in 'The Essence of Care' helps practitioners to take a structured approach to sharing and comparing practice, and enables them to identify best practice and to develop action plans to remedy poor practice. The 10 key roles empower nurses and allied health professionals to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs. At present the implementation of both of these has not been systematic or even (in the case of the Essence of Care) implemented at all in some of the community hospitals. Implementation of these would help to ensure that the effectiveness and efficiency of the services is consistent across the PCT area. They would also be used as the tools that would ensure that the National Service Frameworks for Older People and Long Term Conditions are consistently implemented and evidenced in all the community hospitals. This would include the following:

- Performance data on activity, length of stay, skill mix levels, costs and standards of care;
- An agreed number of clinical and documentation audits;
- The clinical audits focussed upon evidence based care;
- A programme for the Essence of Care will be implemented and monitored;
- Yearly benchmarking exercises.

Each hospital should have its own governance framework based on the models that have already been put in place within the PCT. Each hospital should have its own governance group with terms of reference that covers:

- Patient care issues such as complaints, falls, infections;
- Essence of Care and other benchmarks
- Sharing lessons learnt from incidents elsewhere in the PCT;
- Checking that clinical supervision is in place and is being effective;
- Organization and delivery of care is evidenced based.

5.3 The 6 community hospitals have 177 beds of which 115 are currently open. The modelling has shown that if we were more efficient we currently have the correct number of beds open for the current and future population growth. Our future plans for services closer to local communities will allow for the prospect of the PCT making greater use of community hospital beds and facilities – providing the care is up to date, the standards are high and the costs are economic. Whilst we still have work to do to agree the balance between inpatient beds and other services it is clear that we need to provide these beds more efficiently. The modelling we have done is based on improving our average length of stay to 18 days. The current range varies from 26 to 18 days once long stay patients, such as continuing care patients, are excluded. Whilst the current model of care is not as efficient as it could be, it is clear that there is enthusiasm, vision, expertise and commitment by the staff in the care and expertise that they provide.

5.4 The PCT needs to make its services affordable and it appears that there are variations in the costs of running the community hospitals. This seems mainly to be a variation in skill mix with some hospitals having a high level of registered nurses and a low level of band 2 and 3 nurses i.e. support staff or “health care/rehabilitation assistants”. There are also apparent differences in the cost of hotel services and in particularly catering costs. It is planned that further work will be undertaken once the Head of Facilities management is in post to understand this across the three current providers within the PCT area.

5.5 Edenbridge Minor Injuries Unit

5.5.1 Definition

There is no one definition of a Minor Injuries Unit. The Health Care Commission, working with Price Waterhouse Coopers, undertook reviews of all A&E units during 2004/5. These were mandatory audits carried out in acute trusts and PCTs that delivered significant levels of A&E services. This included nurse led Minor Injury units and walk in centres. They defined them as type 1, 2 and 3. Types 1 are those units with access to a full range of specialist

departments, such as eye departments and children's A&E departments. Type 2 included Gravesham Community Hospital as it treats 20,000 patients a year whilst type 3 included those minor injuries units departments where the level of attendances were more than 10,000 patients per year. Therefore, whilst Gravesham and Sevenoaks MIUs were included in these audits the Edenbridge Minor Injuries Unit was excluded by the auditors as its attendances were deemed too low.

During this process the PCT has assessed the access criteria and key characteristics of both minor injuries units and walk in centres across England. The following seem to be common features in all minor injury units and are also reflected in a Kings Fund Document on Walk in Centres.[2]

- *Initial Point of Contact***.** Patients attend with new unforeseen health problems to the unit as the first point of contact. They are not referred to the unit by another service;
- *Immediate Access***.** Patients require neither appointment nor referral;
- *No or limited follow-up care*. Treatment or advice is given for the presenting problem. If further care is needed patients are advised and redirected to attend the appropriate services;
- *No substitution of care***.** Minor Injuries Units are not substitutes for care that is provided elsewhere.

5.5.2 Observations

It appears that the Edenbridge Minor Injuries Unit is working outside these criteria as patients are often referred to the unit, there are high levels of follow up care given and a primary care treatment/redressing service makes up a significant part of its activity. In all these aspects it is an outlier when compared to the other units. Therefore it is the PCT's view that this service is not serving its primary function of a MIU and should be renamed as a treatment/redressing service.

5.5.3 Activity Levels

To provide care safely, health care professionals need to treat a critical mass of patients to be able maintain their skills. This argument would apply even in a health system with unlimited resources.

The strategic review looked at the statistics for average attendances at a range of MIUs and took note of the Healthcare Commission report previously mentioned. On the basis of this and the professional judgement of the members of the management team responsible for clinical governance an MIU would need to see a minimum of 20-30 appropriate patients per day to be clinically viable. Edenbridge falls far short of these levels.

On average Edenbridge MIU sees between 9 - 11 patients a day. It has recently increased up to 14 patients a day but often a service under scrutiny will gain a

[2] Mountford L, Rosen R (2001) '*NHS Walk-in Centres in London An initial assessment'*, Kings Fund

temporary increase in activity. Up to 50% of these are for redressings that could be undertaken in a clinic or GP practice environment. These also do not require to be undertaken by an Emergency Nurse Practitioner. A local GP practice also sends patients to the unit for ECGs whereas it is possible that these could be undertaken at the practice.
There has been concern that the opening hours limit the number of patients attending the unit. Modelling the peak activity times against the other three units the PCT manages (Sevenoaks, Gravesend and the Urgent Care Centre at Darent Valley Hospital) it is clear that mornings (9 – 12) and early evenings (4 – 7) are the busiest times. However looking at the data opening the unit for longer hours would only mean an increase of 3 – 5 patients a day and would require a disproportionate increase in staffing costs.

It has been suggested to the review team that the Minor Injuries Unit should provide leg ulcer care on behalf of a local practice. However, it is not normal practice for a minor injuries unit to provide this service and is outside the key characteristics of an MIU as described above. Redressings and leg ulcer care also do not require an emergency nurse practitioner. The Minor Injuries Unit would not be functioning appropriately.

Concerns had been expressed that the threat to the MIU was as a result of financial considerations. While it is the PCT's duty to ensure that it obtains value for money, as we have shown the reason for these recommendations are clinically based. The Edenbridge service is not expensive to run and its unit costs are within the expected range.

5.6 There is an opportunity to provide a new service at Tonbridge Cottage Hospital for renal dialysis patients. This arises from the desire of Guys & St Thomas's NHS Trust to relocate from the Pembury site. Work has been ongoing to confirm the viability of this proposal, which also envisages an increase in provision from 14 to 20 units.

5.7 Edenbridge Hospital: The current x-ray facility is close to the end of its useful life and is in serious need of upgrading if the facility is to meet the challenge of expansion envisaged in this paper.

5.8 Livingstone Hospital: The service model in place at the hospital is modern and up -to-date and has been commended by the NHS National Director for Older People.

The main estates problems are concentrated at the Livingstone Hospital where inpatient facilities are based in the original hospital building. Although it is notionally a 38 bedded inpatient unit on the ground floor layout restricts the practical use to 30 beds and has done for some time. The inpatient unit was extended in 2002 but still provides cramped working and unacceptable patient care conditions. The beds are too close together and breach infection control guidelines. At present this risk is minimised by not using all the beds but even this measure is inadequate.

5.9 The NHS run day centres should be remodelled so that they maximise their potential. Any patient not requiring clinical care should be discharged. The current provision is focussed on social activities rather than healthcare.

5.10 Quality of the Environment

Despite the age of 5 of the 6 community hospitals, the problems associated with the current buildings are perhaps not as significant as may be expected. The overall backlog maintenance figure of £500k is relatively low. The bed pan washers in all of the community hospitals need to be replaced immediately. This is an urgent infection prevention and control measure.

Sevenoaks Hospital: The biggest cost will be the refurbishment of the kitchen at Sevenoaks. It is recommended that a decision as to whether to refurbish this or not will depend on the outcome of the review of the hotel services. A capital bid will be developed for 2007 to further develop and improve the infra structure of Sevenoaks Hospital.

6. Detailed Recommendations

6.1 The PCT should implement modern service models, appropriate to individual need across all sites.

6.2 All sites should develop a range of operational, clinical, professional and managerial policies consistent with national and local best practice.

6.3 Current beds should be reopened in a phased manner once new service models are in place and recruitment is completed. There are other dependent factors, for example, if we are successful in a capital bid for Sevenoaks Hospital we will need to keep some or all of the ward space available for decanting.

6.4 The PCT should aim to open the all the beds at Edenbridge and Hawkhurst Hospitals within three to six months. Seven beds at Sevenoaks will also be opened within the same timescale. The timetable for the remaining beds at Sevenoaks will be subject to the outcome of the capital bid (see below) as if that is successful it will be used as decanting space and in any event are not currently essential.

6.5 Further work should be undertaken within the next twelve weeks with Guys and St Thomas's NHS Trust on the development of the potential renal dialysis unit at Tonbridge Cottage Hospital. The trust is looking to relocate the unit currently at Pembury and increase the dialysis units from 14 to 20 for the local population.

6.6 A capital bid should be made in 2007 for Sevenoaks Hospital. The bid should aim for improvements in:

- outpatients
- ward areas
- rehabilitation facilities
- MIU

6.7 Edenbridge MIU:

- The MIU service should be renamed as a treatment clinic with immediate effect for safety reasons
- The PCT should consult on the closure of the treatment service, currently the MIU
- The PCT should provide a redressing clinic for 1 to 2 days a week for existing patients until such time as current patients are discharged when it should cease
- That new redressing patients are redirected to other services

6.8 Edenbridge X-Ray

A capital bid should be made to replace and upgrade the current x-ray facility.

6.9 Livingstone Hospital

Although the hospital has a successful model of care in place the building no longer meets modern requirements. A cost benefit analysis of refurbishment, reprovision or rebuilding should be commissioned.

The working assumption, subject to the cost benefit analysis and a full business case is that reprovision may be the most likely option with a dedicated 'Livingstone Unit' run and managed by PCT staff on the Darent Valley or Gravesham Hospital sites.

6.10 The PCT should work with local voluntary groups to reprovide current day centre activity.

6.11 The PCT should do further work to assess the value for money of the hotel services. The PCT has three providers and a significant variance in the costs of the service.

6.12 There is a mixed model of medical cover across the hospitals and the PCT should work with GPs and practice based commissioners on this service.

Appendix 3

Providing NHS Pharmacy Services in Kent

Michael Keen,

Chief Executive Kent Local Pharmacy Committee

Local Pharmacy Committees

Topics I intend to cover today:

- What is a Local Pharmaceutical Committee?
- Where does it draw its powers from?
- How does pharmacy help to improve services to patients?
- How does pharmacy help public health?
- What is "Control of Entry?"

How Does Pharmacy Help Improve Services to Patients?

- Working with PCTs, providing commissioned services
- Ensuring equitable access to services
- The role of providers and types of pharmacy providers

Pharmacy and Public health?

- Providing a minimum standard of quality and monitoring through the national pharmacy contract
- NHS and Local Authorities working together – where does pharmacy fit?
- The Commissioning Framework for Health and Wellbeing
- The range of skills and services available

What is "Control of Entry?"

- How did we get to where we are?
- Possible reforms
- What does the public want?

Conclusion

We have today covered:

- Local Pharmaceutical Committees
- Pharmacy's role in improving services to patients
- Pharmacy and public health
- Control of entry

This is a very brief summary of where we are. Where do we go from here!

Appendix 4

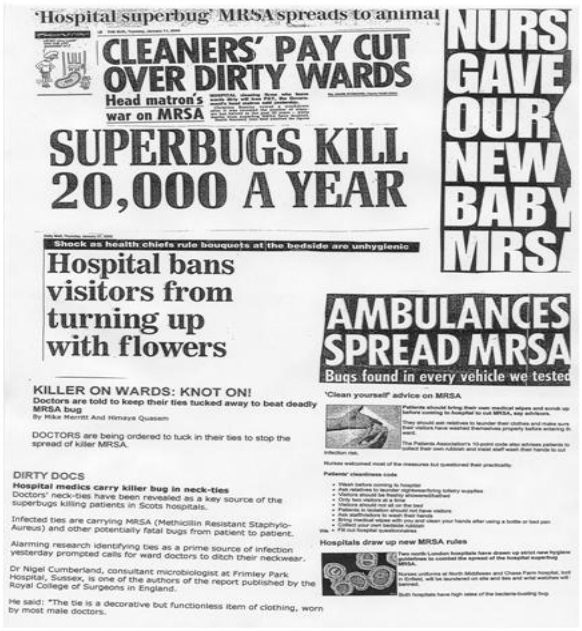
"There remains the question whether at some future date the control of hospital cross-infection will have reached such a level of effectiveness that there will no longer be a place for an Infection Control Sister in General hospitals.

A similar argument that bacteriologists would become unnecessary in hospitals because of the advent of antibiotics was a familiar one about 1945 but is rarely heard today.

The future of hospital cross-infection is impossible to predict, but its present toll of misery is such that it would seem wiser to contemplate any measure that might reduce its incidence than to worry unduly about the possibility of an unemployed ICS at some future time."

Moore. B. Control of Infection (1961)
The *employment of a Senior Member of the Nursing Staff as a member of the Infection Control Team in General Hospitals.*

45 years later



'Hospital superbug' MRSA spreads to animal

CLEANERS' PAY CUT OVER DIRTY WARDS

Head matron's war on MRSA

SUPERBUGS KILL 20,000 A YEAR

NURS GAVE OUR NEW BABY MRS

Shock as health chiefs rule bouquets at the bedside are unhygienic

Hospital bans visitors from turning up with flowers

AMBULANCES SPREAD MRSA

Bugs found in every vehicle we tested

KILLER ON WARDS: KNOT ON!

Doctors are told to keep their ties tucked away to beat deadly MRSA bug

By Mike Merritt And Himaya Quasem

DOCTORS are being ordered to tuck in their ties to stop the spread of killer MRSA.

DIRTY DOCS

Hospital medics carry killer bug in neck-ties

Doctors' neck-ties have been revealed as a key source of the superbugs killing patients in Scots hospitals.

Infected ties are carrying MRSA (Methicillin Resistant Staphylo-Aureus) and other potentially fatal bugs from patient to patient.

Alarming research identifying ties as a prime source of infection yesterday prompted calls for ward doctors to ditch their neckwear.

Dr Nigel Cumberland, consultant microbiologist at Frimley Park Hospital, Sussex, is one of the authors of the report published by the Royal College of Surgeons in England.

He said: "The tie is a decorative but functionless item of clothing, worn by most male doctors.

'Clean yourself' advice on MRSA

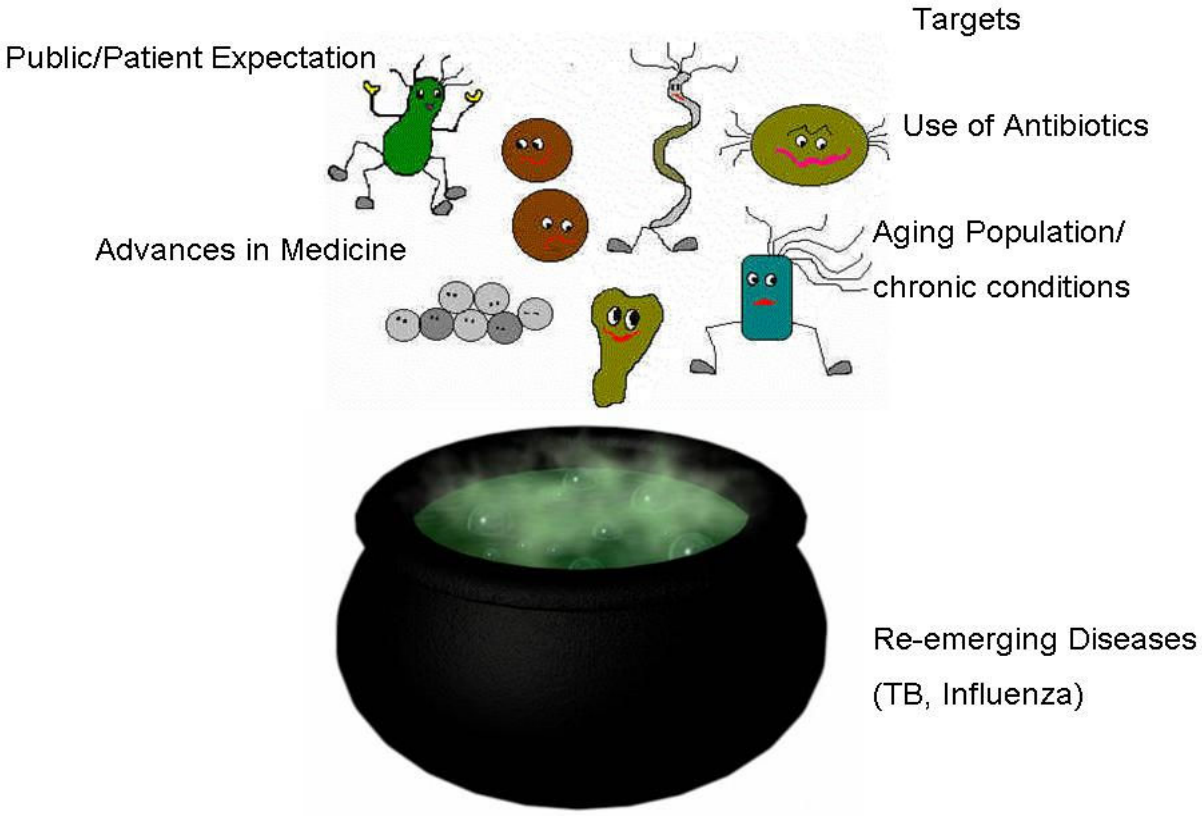
Hospitals draw up new MRSA rules

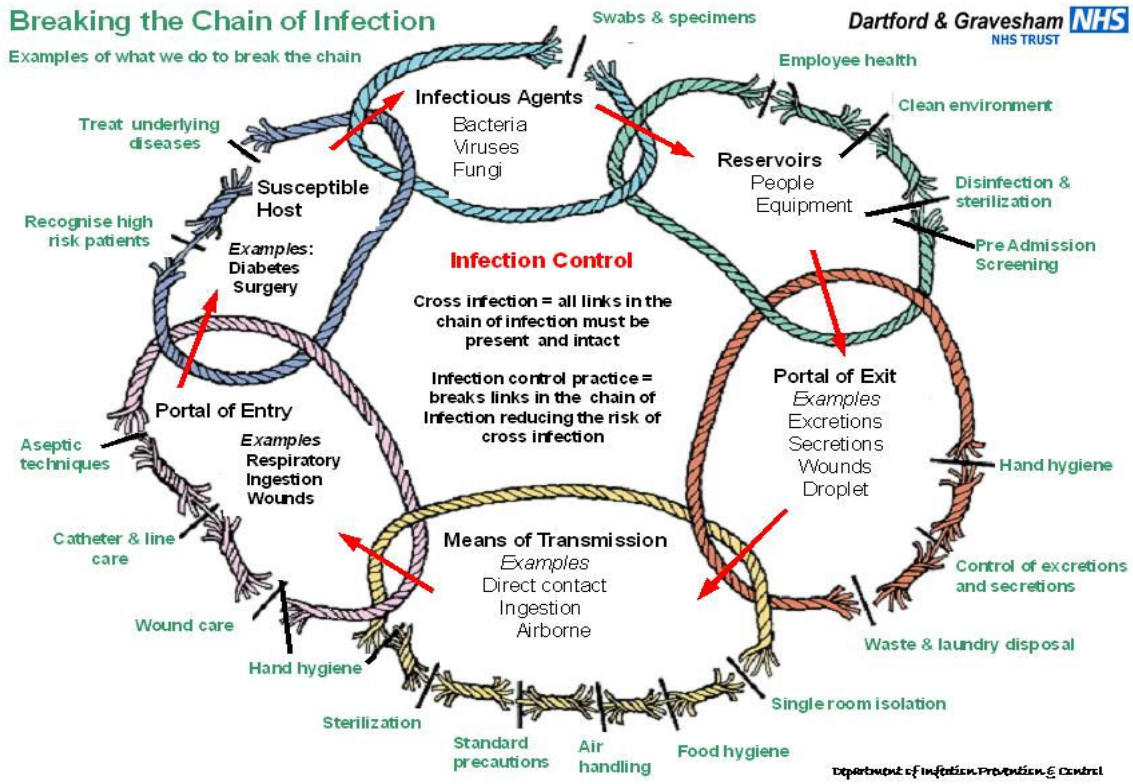
NEW NHS SUPERBUG IS WORSE THAN MRSA

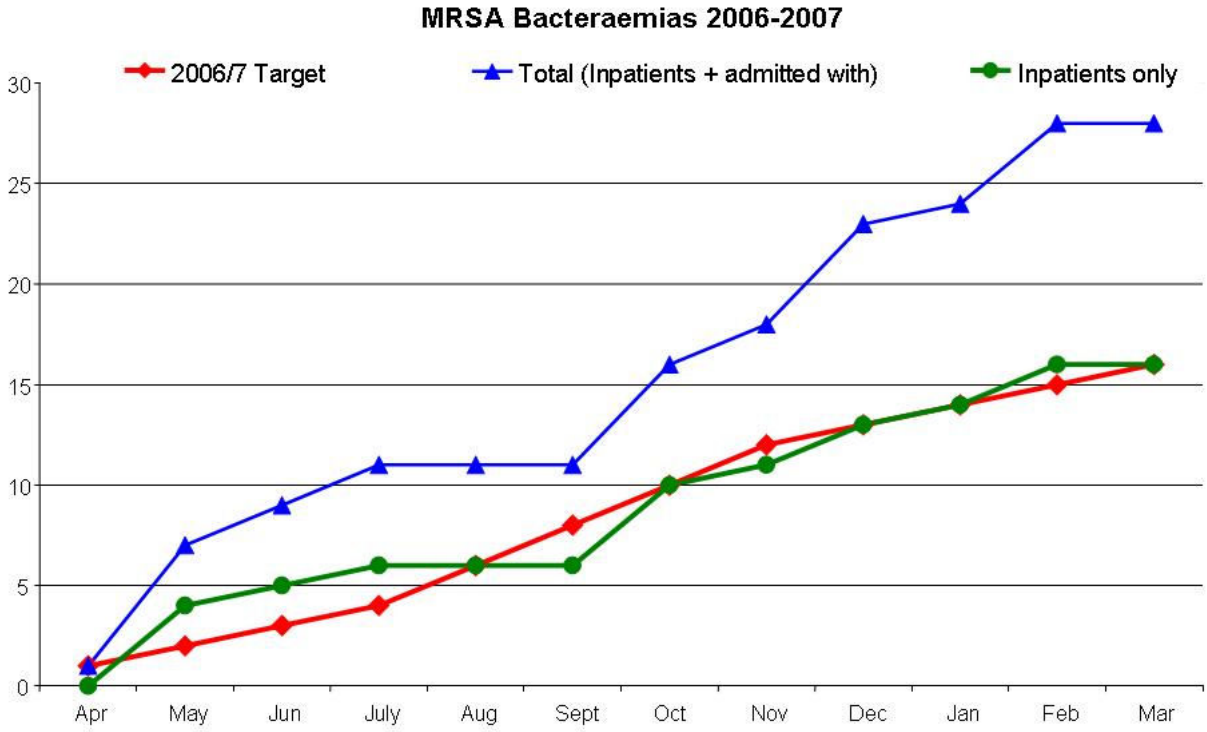
12 KILLED BY A NEW HOSPITAL SUPERBUG

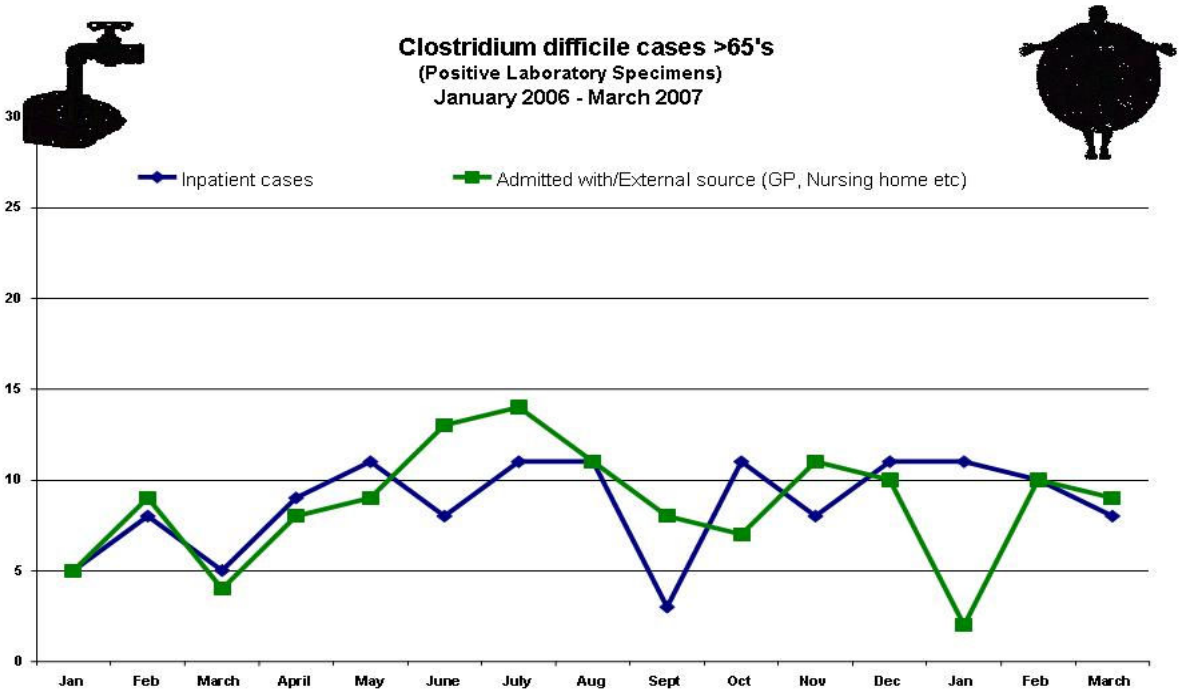
12 DIE IN JUST ONE NHS HOSPITAL

The deadly new bug stalking our wards

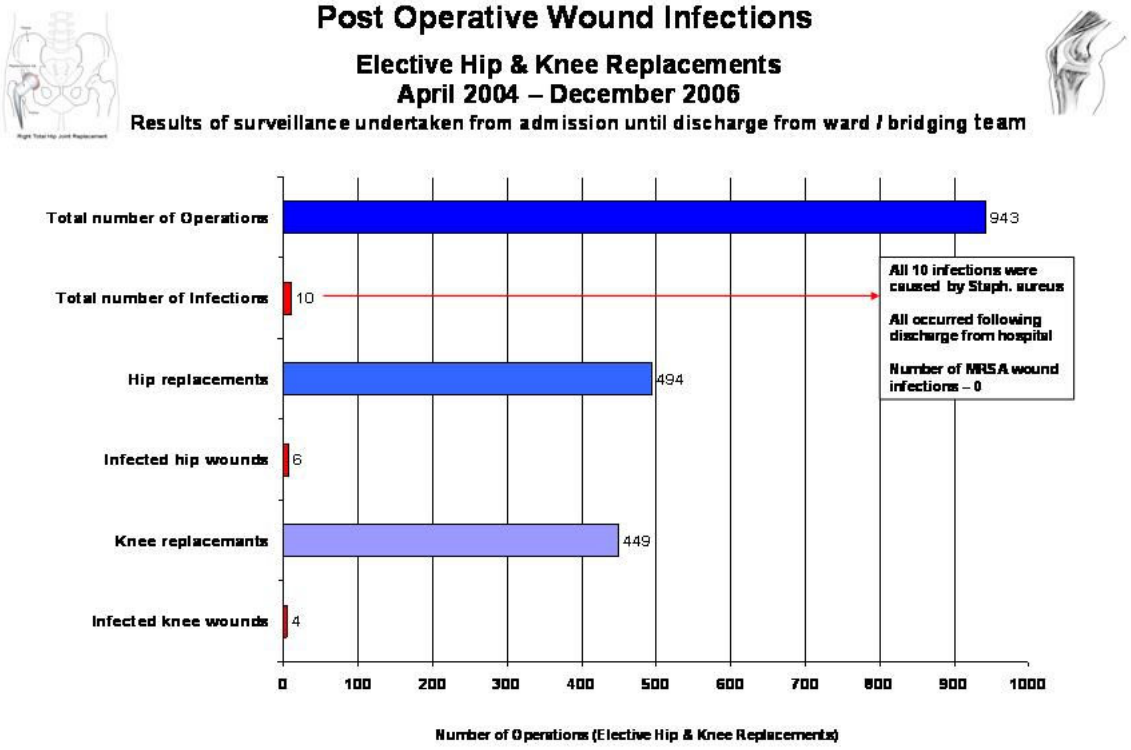



Breaking the Chain of Infection
Examples of what we do to break the chain
Dartford & Gravesham NHS
NHS TRUST
Swabs & specimens
Employee health
Clean environment
Disinfection & sterilization
Pre Admission Screening
Hand hygiene
Control of excretions and secretions
Waste & laundry disposal
Single room isolation
Food hygiene
Air handling
Standard precautions
Sterilization
Hand hygiene
Wound care
Catheter & line care
Aseptic techniques
Recognise high risk patients
Treat underlying diseases
Infectious Agents
Bacteria
Viruses
Fungi
Reservoirs
People
Equipment
Susceptible Host
Examples:
Diabetes
Surgery
Infection Control
Cross infection = all links in the chain of infection must be present and intact
Infection control practice = breaks links in the chain of infection reducing the risk of cross infection
Portal of Exit
Examples
Excretions
Secretions
Wounds
Droplet
Portal of Entry
Examples
Respiratory
Ingestion
Wounds
Means of Transmission
Examples
Direct contact
Ingestion
Airborne
Department of Infection Prevention & Control


MRSA Bacteraemias 2006-2007
2006/7 Target
Total (Inpatients + admitted with)
Inpatients only
30
25
20
15
10
5
0
Apr
May
Jun
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar



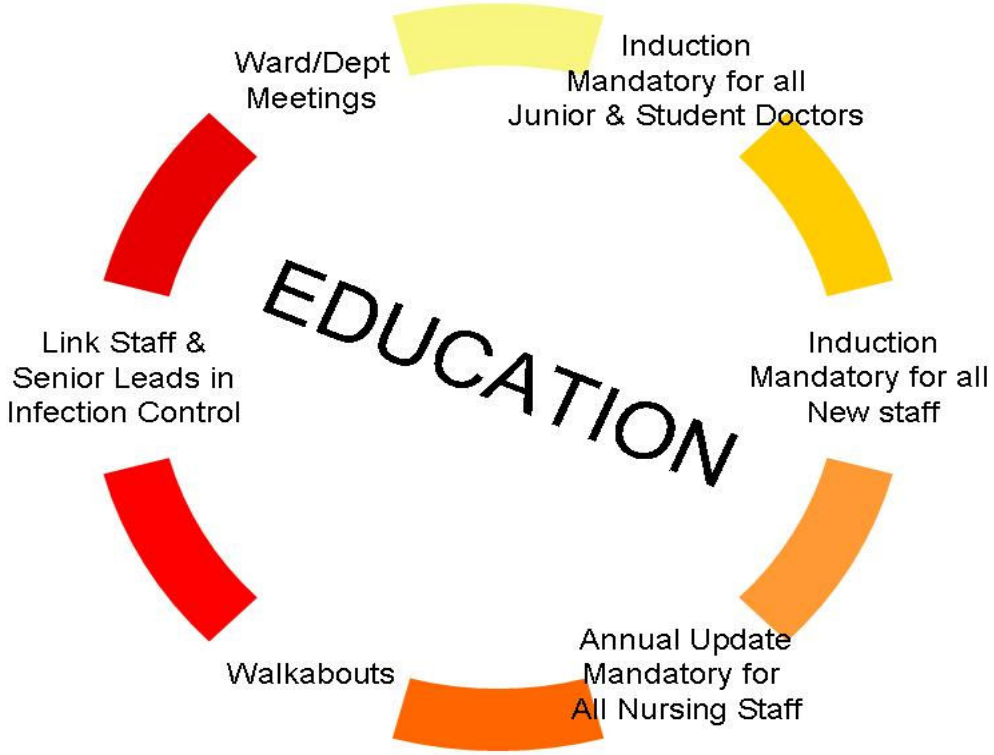
Notes: We have not had any identified cases of type 027 (Hypervirulent strain of Clostridium difficile)
From April 2007 we will be reporting all positive laboratory specimens irrespective of age 2



Results of the Third Prevalence Survey of Healthcare Associated Infections in Acute Hospitals 2006
Published February 2007

Prevalence Rate	National	Darent Valley Hospital
	8.19%	5.2%

Infection type	National Rate	Darent Valley Hospital Rate
MRSA	1.28%	0.3%
Clostridium difficile	1.98%	1.5%
Norovirus	0.74%	0.0%
Surgical site	1.27%	0.9%
Urinary tract	1.80%	0.6%
Pneumonia	1.27%	1.8%
Gastrointestinal	2.02%	0.9%
Lower respiratory tract	0.55%	0.6%
Primary bloodstream	0.62%	0.3%



What are we doing about MRSA and other infections?

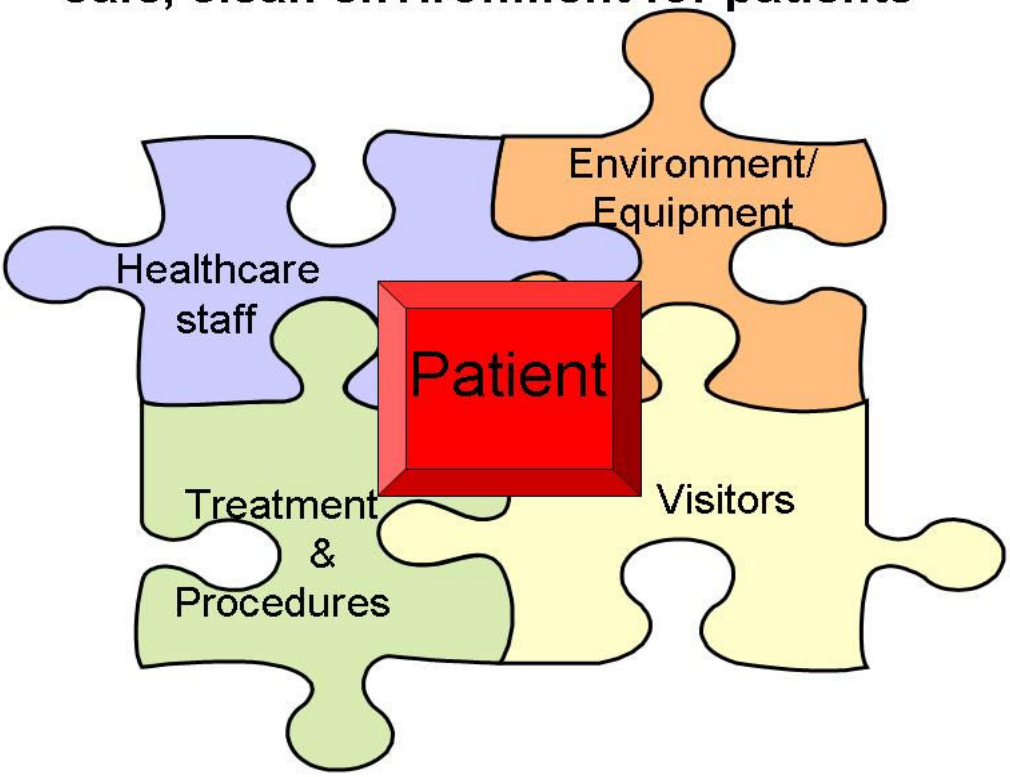
Hand hygiene (Staff, Patients and Visitors)



Clean environment & equipment


Prudent use of antibiotics

Working as a TEAM to provide a safe, clean environment for patients



East Kent NHS Trust
Infection Control

end of year report
April - 2006-07

James Nash
Director Infection Prevention and Control
Sue Roberts
Deputy Director Infection Prevention Control

Topics for discussion

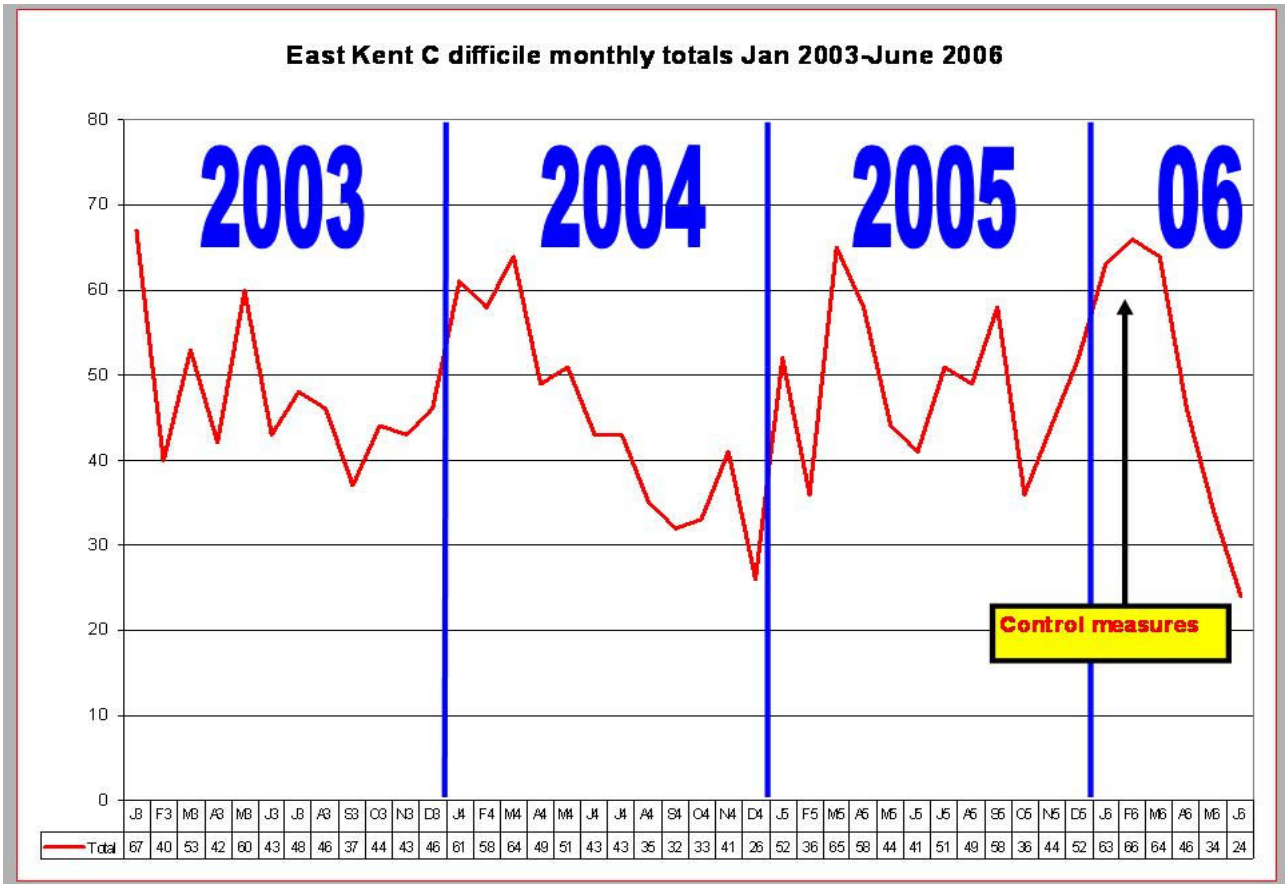
- Restructuring Infection Control
- Clostridium difficile
- MRSA bacteraemia (DH targets)

Clostridium difficile

- Important cause of diarrhoea and colitis
- Mainly in patients receiving antibiotic therapy
- Elderly hospital patients vulnerable
- The new hypervirulent strain (O27)

Clostridium difficile
EKHT Annual report of 2005-06

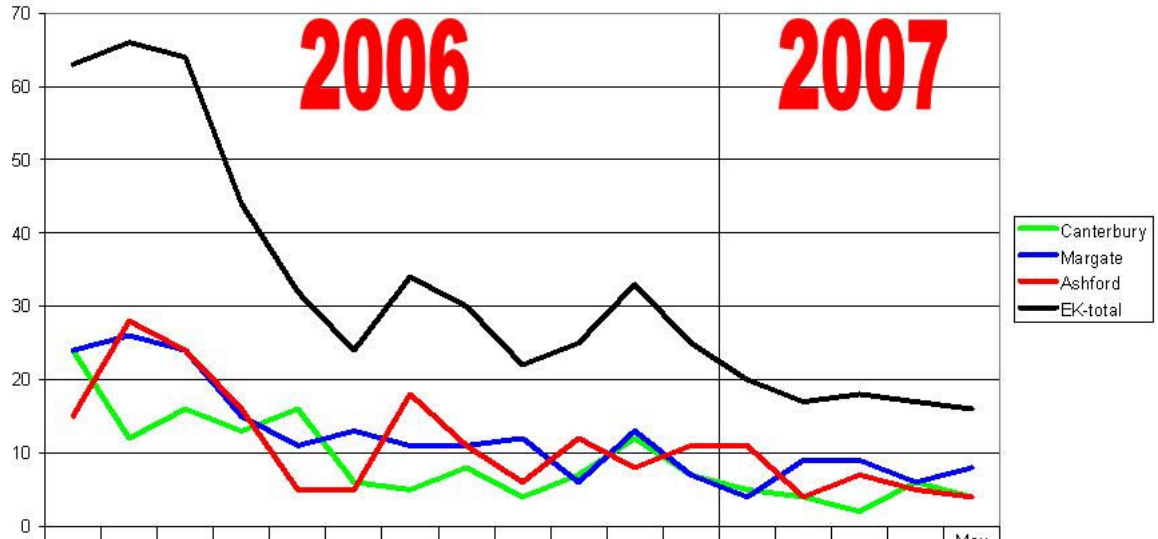
- Increased rate of C difficile Jan-Feb 2006
- O27 strain reported locally
- New infection control measures required
- Objectives for 06-07
  - Establish control over prescribing
  - Reduce rates of C difficile to < 15 cases/month/site


East Kent C difficile monthly totals Jan 2003-June 2006
2003
2004
2005
06
Control measures
80
70
60
50
40
30
20
10
0
J3 F3 M3 A3 M3 J3 J3 A3 S3 O3 N3 D3 J4 F4 M4 A4 M4 J4 J4 A4 S4 O4 N4 D4 J5 F5 M5 A5 M5 J5 J5 A5 S5 O5 N5 D5 J6 F6 M6 A6 M6 J6
Total 67 40 53 42 60 43 48 46 37 44 43 46 61 58 64 49 51 43 43 35 32 33 41 26 52 36 65 58 44 41 51 49 58 36 44 52 63 66 64 46 34 24

Sustained fall in 2007:

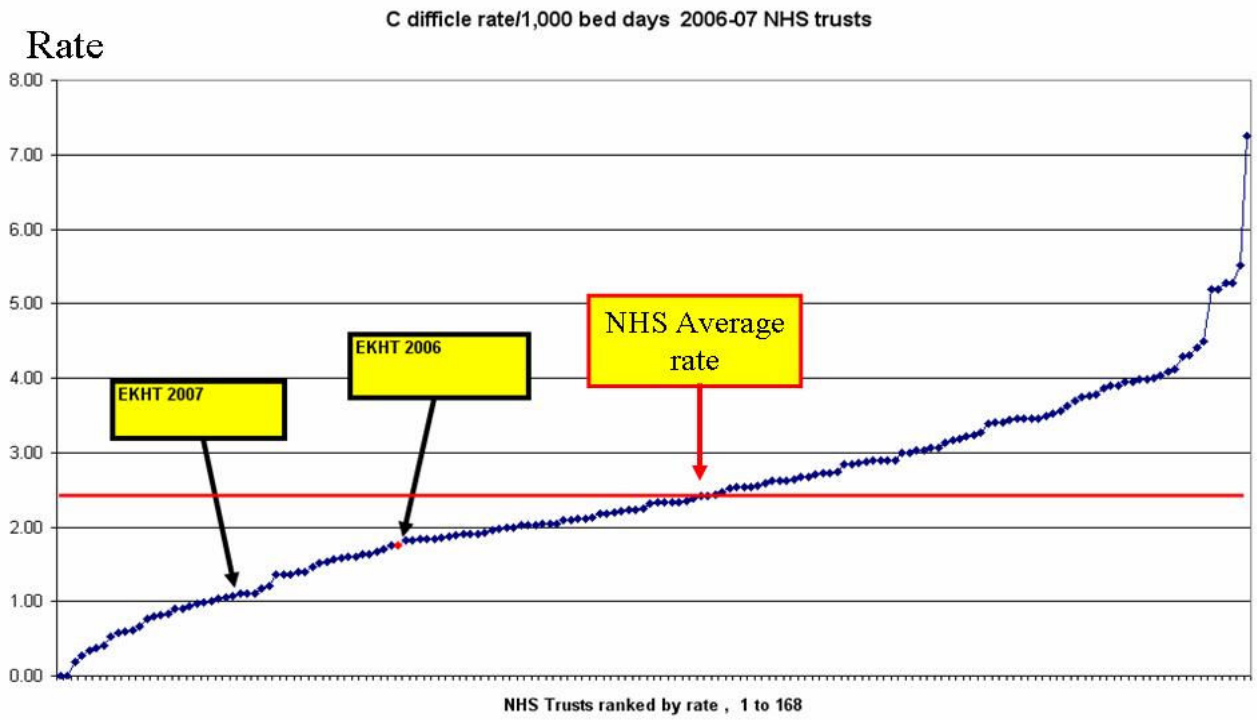
C difficile rate < 1.3 /1,000 bed days (NHS Average 2.4)

EKHT C difficile by hospital New cases by month and site May 2007



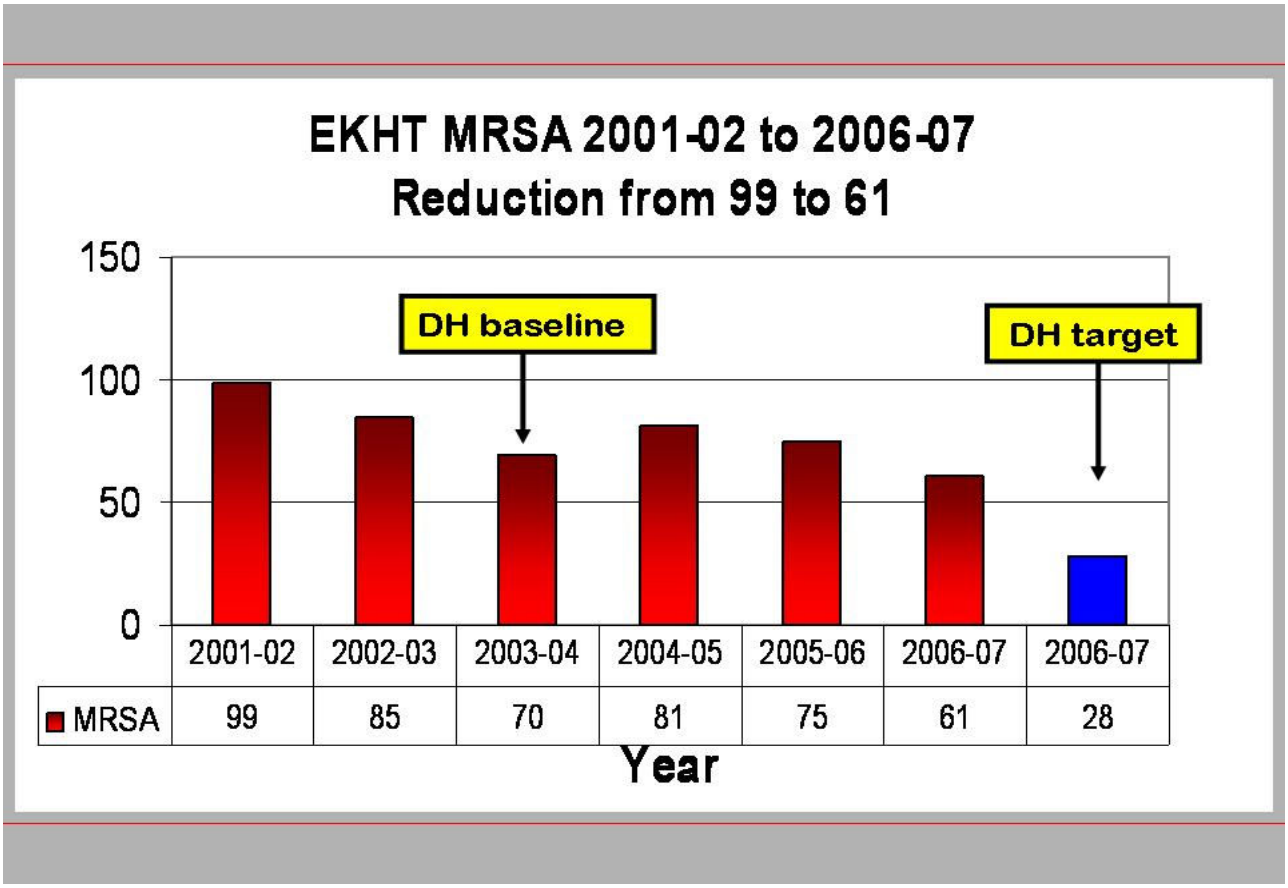
	6M1	6M2	6M3	6M4	6M5	6M6	6M7	6M8	6M9	6M10	6M11	6M12	7M1	7M2	7M3	7M4	May 07
Canterbury	24	12	16	13	16	6	5	8	4	7	12	7	5	4	2	6	4
Margate	24	26	24	15	11	13	11	11	12	6	13	7	4	9	9	6	8
Ashford	15	28	24	16	5	5	18	11	6	12	8	11	11	4	7	5	4
EK-total	63	66	64	44	32	24	34	30	22	25	33	25	20	17	18	17	16

EKHT C difficile rates were below the NHS average during 2006 and have fallen further during 2007



MRSA blood stream infections

- DH target is 60% reduction on figure for 2003-04



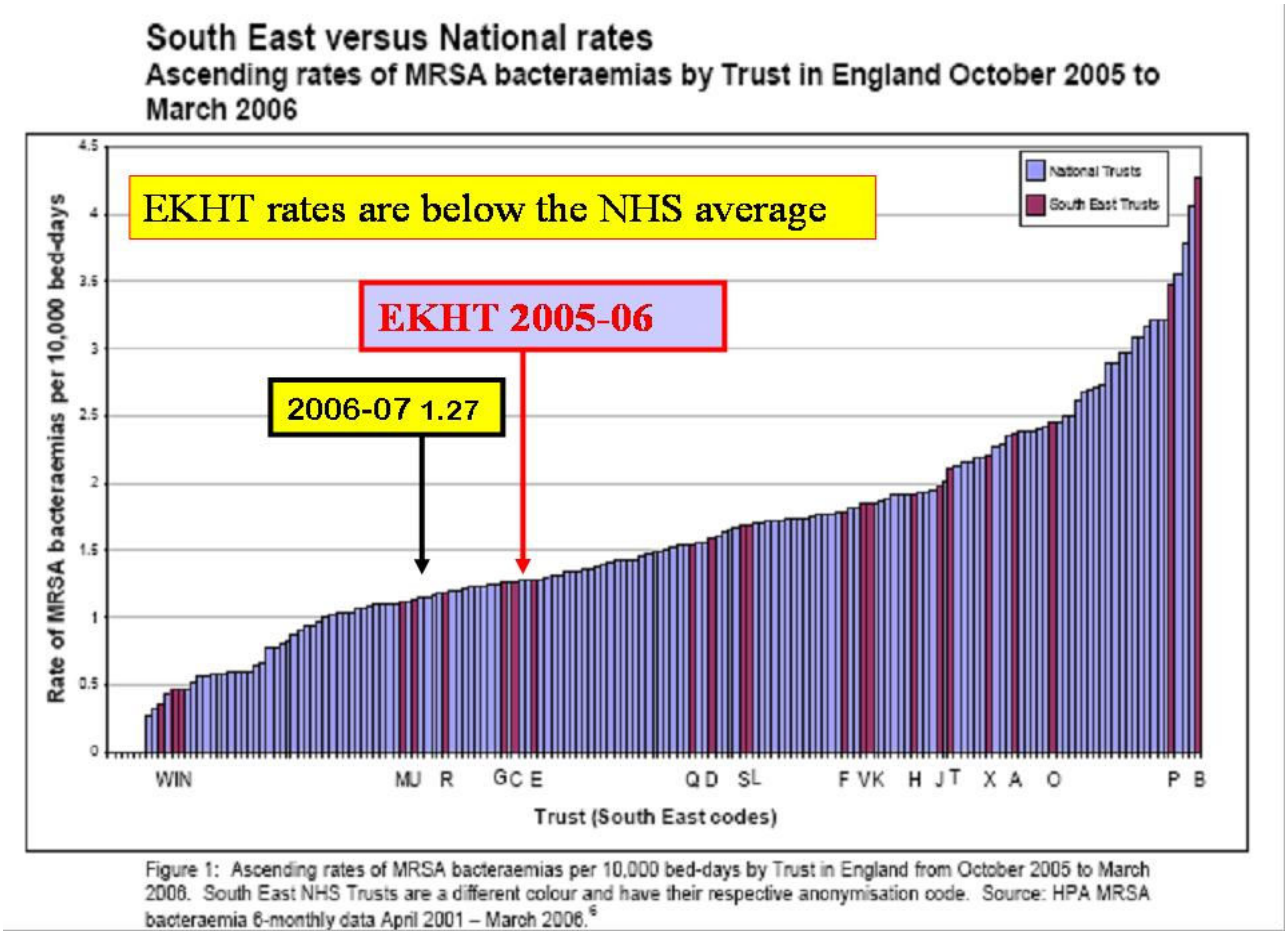


Figure 1: Ascending rates of MRSA bacteraemias per 10,000 bed-days by Trust in England from October 2005 to March 2006. South East NHS Trusts are a different colour and have their respective anonymisation code. Source: HPA MRSA bacteraemia 6-monthly data April 2001 – March 2006.[6]

MRSA EKHT

- MRSA rate is below average and falling
- But needs to fall further ....

MRSA control
lessons from Root Cause Analysis Jan-March

- Improved IV line care required
  - standardised IV line policies to be re-launched
  - improved training of junior hospital doctors
- MRSA screening lapses
  - Screening compliance to be performance managed at ward level
- False +ve results due to contamination
  - Blood culture collection protocols to be revised + improved training for staff

Summary

- Infection control has been restructured
  - "ownership" now at a ward level
  - Clinical infection control leads in place
  - Root Cause Analysis being used to identify why infections occur
- C difficile and MRSA rates below national average and continuing to fall

The Medway NHS
NHS Trust

Infection Control Update
June 2007

Kath Hughes
Infection Control Matron
Medway NHS Trust

MRSA Target

- The Trust has breached this target for 2006-7 we had 43 bacteraemias -Target was 29
- The target for 2007- 8 is **19**
- There is a comprehensive plan to achieve this for the coming year, as this includes patients admitted with infections this requires close collaboration with the PCT.

Key Actions to Reduce Infections include

- Compliance with hand Hygiene
- Infection Control training for all staff
- Compliance with the MRSA policy, including screening, isolation and treatment.
- Review of the management of all invasive devices and removal of IV,CVP urinary catheters ASAP
- Compliance with Antimicrobial guidelines
- Use of Central and peripheral line insertion packs to maintain asepsis and appropriate skin disinfection.
- Saving Lives High Impact Interventions to be applied to all relevant patients.

The Medway NHS
NHS Trust

Number of MRSA Bacteraemia Infections

2005/06 Trajectory												2005/06
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2	2	3	2	4	4	2	3	5	5	3	3	38

2005/06 Actual Data												2005/06
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
4	3	4	1	0	2	7	2	2	2	2	5	34

2006/07 Trajectory												2006/07
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1	2	2	2	3	3	1	2	4	4	2	2	28

2006/07 Actual Data												2007/08
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
4	2	4	6	8	4	2	5	2	3	1	2	43

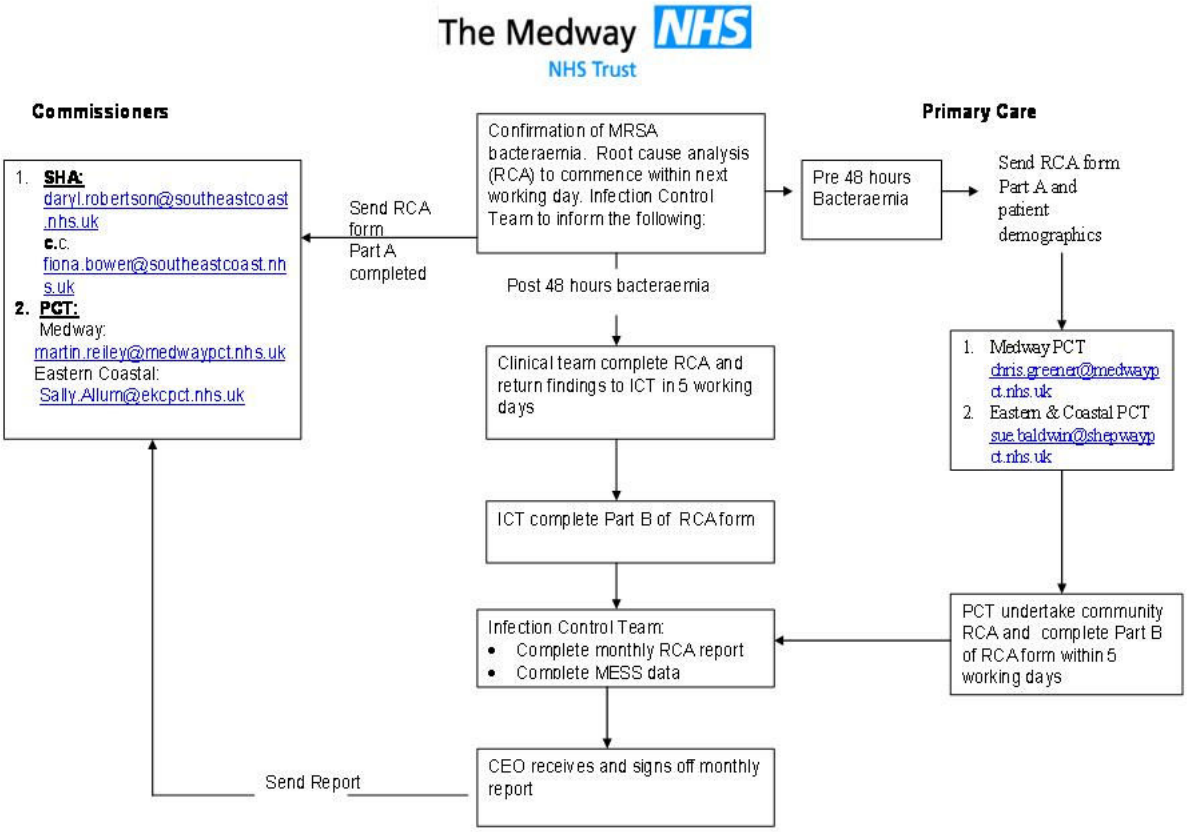
2007/08 Trajectory												2007/08
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1	1	1	1	1	1	2	2	3	2	2	2	19

2007/08 Actual Data												2007/08
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2	2											

Root Cause Analysis (RCA)

- Investigation is undertaken for all MRSA bacteramias. This is lead by the clinical team. Lessons learned are then reported.

- The PCT undertake the RCA for those samples taken within 48 hours of admission if there has been no previous admission the past month.



Clostridium difficile Toxin (CDT) Target

- New target set for CDT.
- Current rate of CDT for mandatory reporting is 1.99 per 1000 bed days.
- New target 1.75 per 1000 bed days
- This mandatory reporting includes people 65 years and over from all samples received in microbiology. Hence this includes GP and Community specimens.

The Medway NHS
NHS Trust

Mandatory Reporting of *Clostridium difficile* Toxin Diarrhoea Cases (Hospital and Community)

Year	2005/06												2005/06
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period	30	23	18	18	15	12	14	22	16	18	23	28	237 (2.20)

Year	2006/07												2006/07
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period	14	15	20	15	15	20	25	17	15	22	14	23	215 (1.99) to date

Year	2007/08 Trajectory												2007/08
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period - Trust	12	10	10	8	8	10	11	11	12	12	11	10	125
A&E and Community	6	6	4	4	4	6	5	5	6	6	5	6	63
Total	18	16	14	12	12	16	16	16	18	18	16	16	Overall Total = 188 (1.75)

Year	2007/08 Actual Figures												2007/08
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period - Trust	10	14											
A&E and Community	6	10											
Total	16	24											Overall Total =

Actual Data 2005/07 — Projected Data 2007/08 — Actual Data 2007/08

Medway NHS Trust rate of 1000 bed days:	January – December 2004	2.29
	January – December 2005	2.33
	January – December 2006	1.92

N.B. This is the same figure as the HPA mandatory reporting all patients 65 years and over, this is all samples sent to Microbiology including all community samples repeat samples on patients are counted again after 28 days. The rate is based upon 1,000 bed days using activity figure of 107,564 for 2004 (as per HPA).
February 2007

CDT Action Plan

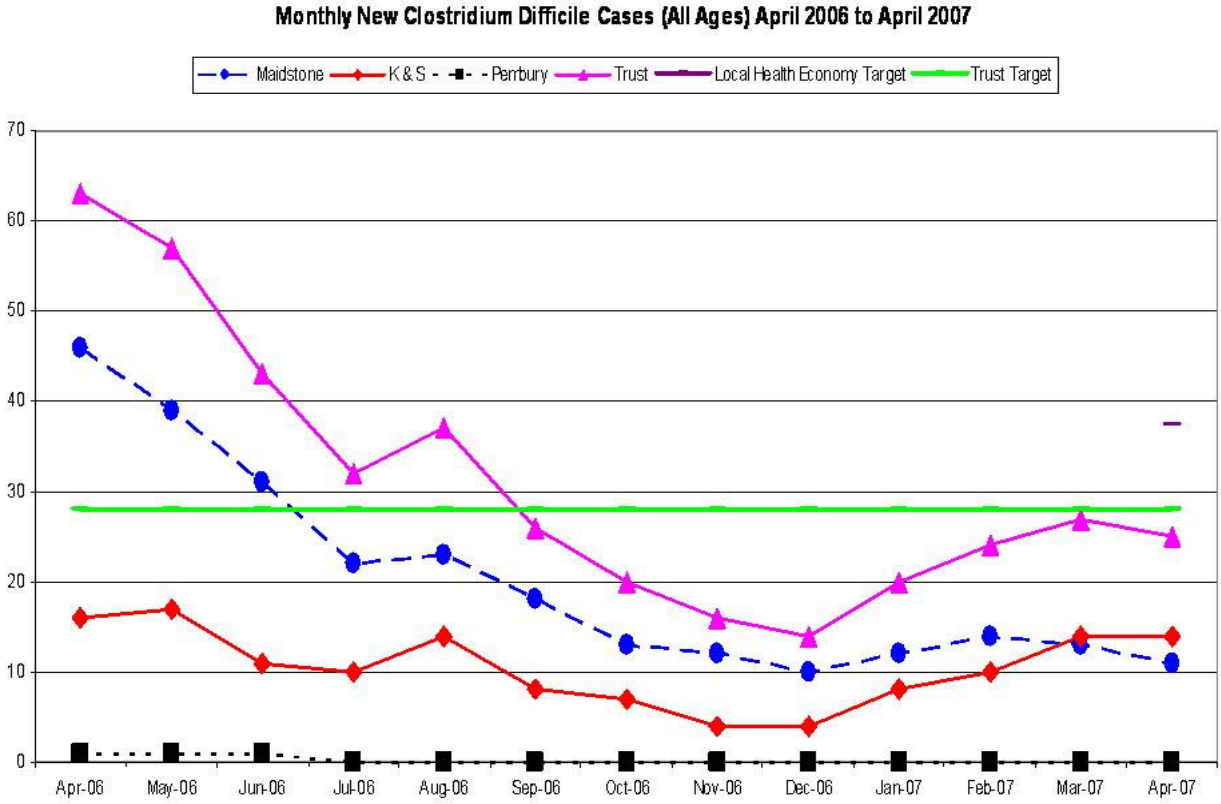
- Prudent antimicrobial prescribing
- Updated antimicrobial guidelines /restricted antibiotics
- Excellent hand hygiene Using soap and water for CDT patients NOT Alcohol hand rubs.
- Isolation of all cases in single rooms and adherence to IC precautions
- Treatment of cases with Metronidazole as first line treatment.
- Environmental cleaning and equipment cleaning to a high standard using Chlorine based product

Infection Control Progress within Maidstone & Tunbridge Wells NHS Trust

Gail Locock
Acting Director for Infection Prevention and Control

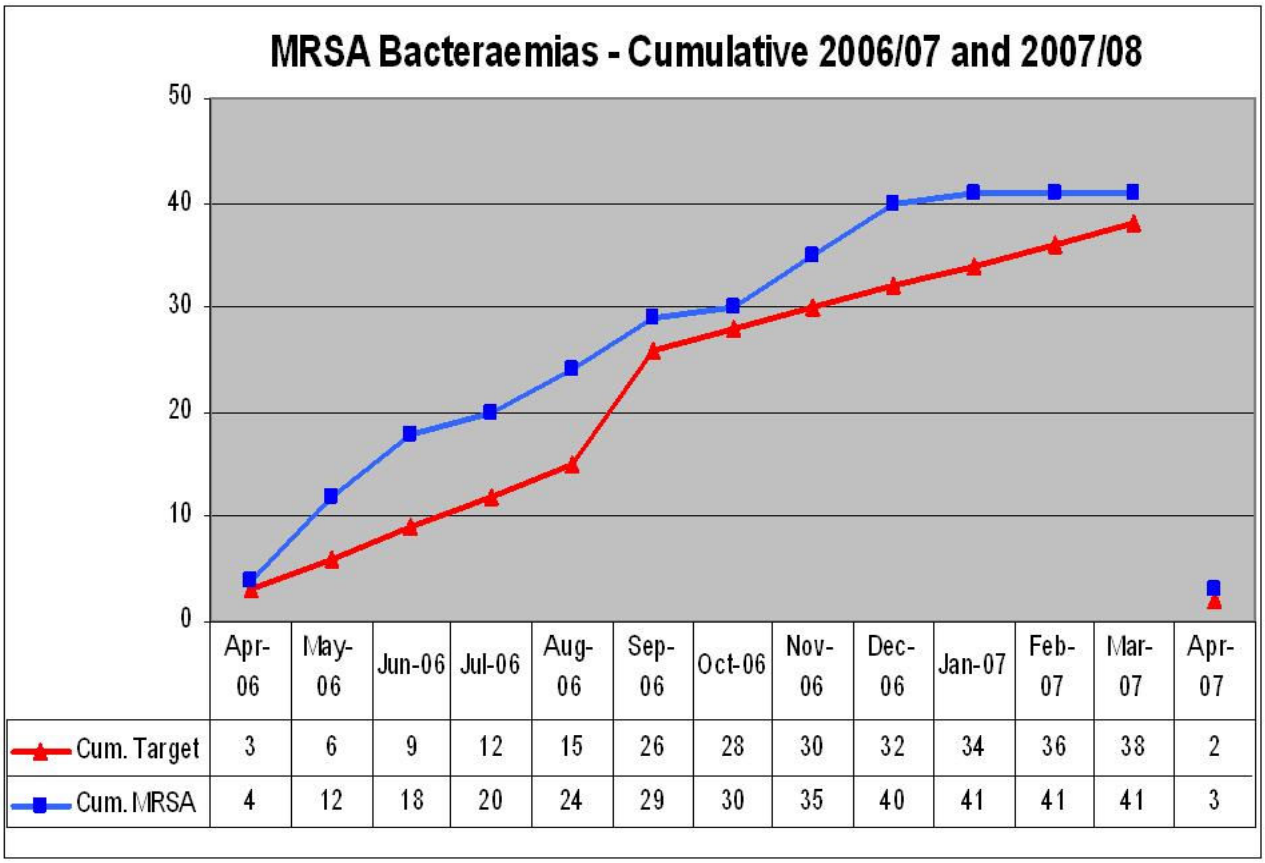
Outline of Presentation

- *Clostridium difficile* statistics
- MRSA Bacteraemia statistics
- Saving Lives Programme
- Clean Your Hands Campaign
- The Role of the Infection Control Link Nurse



MRSA Bacteraemia vs Projected Rates (06/07)

	Total Blood Cultures Processed	Total Positive Blood Cultures (All organisms)	Total MRSA Positive Blood Cultures	Hospital Acquired	Community Acquired	Projected MRSA Positive Blood Cultures
Apr	787	112	4	3	1	3
May	857	157	8	4	4	3
June	940	149	6	3	3	3
July	943	171	2	1	1	3
Aug	842	166	4	3	1	3
Sep	863	162	5	4	1	2
Oct	976	172	1	0	1	2
Nov	907	162	5	4	1	2
Dec	951	162	5	4	1	2
Jan	1038	202	1	1	0	2
Feb	938	170	0	0	0	2
Mar	920	155	0	0	0	2
Totals	10962	1940	41	27	14	38



	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07
Cum. Target	3	6	9	12	15	26	28	30	32	34	36	38	2
Cum. MRSA	4	12	18	20	24	29	30	35	40	41	41	41	3

Saving Lives 'A Delivery Programme to Reduce Healthcare Associated Infections, including MRSA'

Self Assessment:
"Balanced Score Card"

High Impact Interventions:

No 1. Preventing the risk of microbial contamination
No 2. Central venous catheter care
No 2b. Peripheral line care
No 2c. Renal dialysis bundle
No 3. Preventing surgical site infection
No 4. Care of ventilated patients
No 5. Urinary catheter care
No 6. Reducing the risk of infection from and the presence of *Clostridium difficile*

Clean Your Hands Campaign

- Instigation of Clinical Champions
- Increasing awareness with all staff and the general public
- Hand hygiene audits (observational and facilities) undertaken at ward level
- Floor and wall signage
- Use of light box for technique training
- Increased resources to improve facilities
- Will review Hand Hygiene Leaflet


STOP
CLEAN
YOUR HANDS


ATTENTION
Visitors
Please disinfect your hands prior to entering and before leaving this ward/department.
HELP US TO PREVENT INFECTIONS.
Pour Softalind® into the hollow of your dry hands.
Use the simple 6 step routine to rub the product thoroughly around your hands and wrists for 30 seconds.
Please supervise your children.
B BRAUN
CLEAN
YOUR HANDS


Staff Office
ATTENTION
Visitors
Please disinfect your hands prior to entering and before leaving this ward/department.
HELP US TO PREVENT INFECTIONS.
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Please supervise your children.
B. BRAUN

Improving Link Nurse Role

- Joined up working
- Increasing their contribution
- Training
- Auditing
- Cascade information
- Two-way process

Thank You for Listening

Appendix 5

Fit for the Future
Update for Health Overview & Scrutiny Committee
8 June 2007

Work on Fit for the Future continues, with the health economy across Kent & Medway on track to deliver a formal update for all stakeholders in July. The public document will describe the work that has been going on within and across health economies over the last year, including:

- Outcomes and key messages from the MORI social research and deliberative event
- Outcomes of local consultation with the public and partners
- Outcomes of the demographic and financial modelling that has been carried out to 2015/16 and the assumptions that we've built into our planning
- Why and what we'll be working on under the Fit for the Future banner both across Kent & Medway and within local health economies, including specific initiatives and next steps

The public document will describe an evolutionary process of modernisation and improvement for the local NHS, providing clarity about the areas we will be focusing on over the next year or so.

For West Kent key initiatives will include:

- Urgent Care – we'll be putting in place 'Urgent Care Centres' where primary care staff can provide a service for non-emergency attendances at A&E. We'll also be considering what more can be done in primary care settings (e.g. GP surgeries and high street pharmacies)
- Planned Care – we'll be looking at key areas where people can be diagnosed and treated in community settings closer to home and reviewing our adult community services to support this
- Maidstone & Tunbridge Wells NHS Trust – subject to the response of the Secretary of State we will be working with MTW to implement the outcomes of the recent Surgical & Orthopaedic Consultation
- Community Hospitals – following the recent review we will be re-vitalising all our community hospitals, including re-opening many of the closed beds, establishing the most modern models of care across all the hospitals and applying for capital funds to upgrade Sevenoaks Hospital and X Ray facilities at Edenbridge. We will also consult on the future of the service provided in the Minor Injuries Unit at Edenbridge, the potential to provide renal dialysis at Tonbridge and the refurbishment, re-building or reprovision of the Livingstone Unit in Dartford
- Children's Services – continuing implementation of the Health Visitors' Review and improving services for children and adolescents with mental health needs (CAMHS) in partnership with the Children's Trust
- Mental Health – we'll be redesigning the adult mental health pathway and improving services for older aged adults with dementia
- End of Life Care – we'll be reviewing the care that's available and working to provide more choice for people at the end of their life

Through all of this we will be continuing on-going discussions with the public and other stakeholders, and are in the process of setting up a Patient Advisory Group to work with us on reviewing and re-designing services. Any substantial variations in service will be subject to full and formal Section 7 consultation as deemed appropriate or necessary in discussion with the HOSC.

Across Kent & Medway we will be focusing on a number of high-level specialty areas (for example vascular and stroke services and trauma services). A major clinical event to support this work is scheduled to take place in July when the National Clinical Advisory Team will be coming to Kent to work with our most senior clinicians across the County. Again, outcomes of this work maybe subject to formal consultation.

At the Extraordinary Council meeting on 24th July in the afternoon we will be sharing more detail about Fit for the Future Next Steps and give councillors the opportunity to speak to a range of clinicians and staff about the service improvements we're planning.

I would value the opportunity for a full discussion with the HOSC, perhaps in September once the public document is published, to talk in more detail about what happens next in West Kent.

Julia Ross
Director of Civic Engagement
8 June 2007

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Kent and Medway NHS
NHS and Social Care Partnership Trust

The Partnership Trust
One Year On

20 April 2007

Erville Millar
Chief Executive

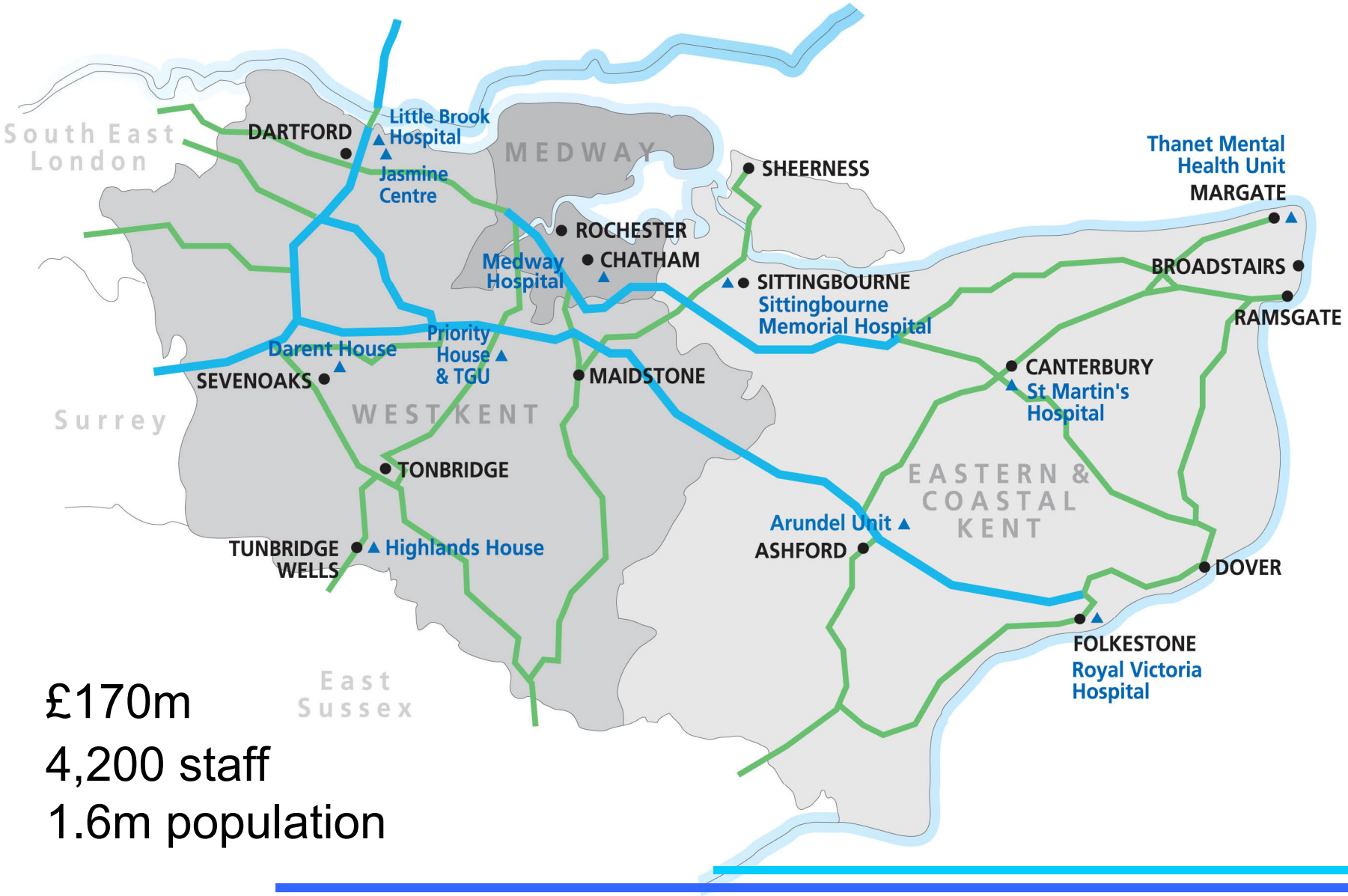
Kent and Medway NHS
NHS and Social Care Partnership Trust

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

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

NHS Overview and Scrutiny Committee Briefing Note

Community hospitals (West Kent)

✉ David.Turner@kent.gov.uk
☎ **(01622) 694196**

2 July 2007

General background

There are currently 332 community hospitals in England. They are often popularly known as "cottage hospitals" and many are located in smaller towns and rural areas – although there are also many in urban and suburban areas.

Community hospitals mostly pre-date the National Health Service, owing their origins to endowments from wealthy benefactors and public subscriptions; many were set up as war memorials. When the NHS was established in 1948, the community hospitals then existing were effectively gifted to the new service.

As a legacy of their charitable origins, many community hospitals often have strong voluntary Leagues of Friends that support them by raising funds and lobbying on their behalf.

NHS Primary Care Trusts are usually responsible for running community hospitals.

In recent years, the reconfiguration of NHS acute hospital services has been gathering pace, with the increasing centralisation of specialist services (including elements of emergency services), such that they serve catchment populations of around 500,000. As this occurs, some former district general hospitals (serving populations of around 250,000) are being downgraded, effectively becoming community hospitals. Such former acute hospitals tend still to be run by the NHS hospital Trusts that previously operated them as acute hospitals.

There is significant variety in the size of community hospitals and the scope of the services that they provide. The range of services provided in community hospitals can include all of the following (this is not an exhaustive list):

- diagnostic tests;
- preventative healthcare (including screening, advice and health promotion);
- day-case operations;
- outpatient clinics;
- intermediate care (to prevent unnecessary admission to an acute hospital bed, support timely discharge, reduce avoidable use of long-term care and maximise independent living);
- palliative/end-of-life care (helping patients with incurable conditions, including terminal illness);
- support for long-term conditions;
- rehabilitation services (supporting recovery from illness);
- urgent/unscheduled care (dealing with minor injuries and minor illnesses).

The services that community hospitals provide are often of particular importance for older people.

Community hospitals are greatly valued by their local communities for their convenience, accessibility, continuity and familiar, friendly atmosphere – as well as the sense of local ownership.

They tend to work closely with local GP practices and can provide a convenient base for Out of Hours primary-care services and community health professionals, such as health visitors, district nurses and midwives. They can also be a focus for the integration of health services with social-care provision.

As providers of intermediate care, community hospitals play an important role in freeing up both inpatient and outpatient resources in acute hospitals. “Step-down” beds allow patients to be discharged from acute hospitals even though they are not yet well enough to return home. “Step-up” beds allow patients to be admitted to hospital without taking up an acute-hospital bed. Community hospitals also save patients from having to travel in order to access hospital services.

Government policy
The importance of community hospitals in delivering healthcare locally was recognised in the *NHS Plan*, published in 2000.

In 2003, the Department of Health published a discussion document entitled *Keeping the NHS local – a new direction of travel*. This indicated that the government saw a continued important role for community hospitals as one of a number of ways of delivering “ambulatory care plus”.

At the 2005 general election, the Labour Party manifesto included the following promise:

> *To help create an even greater range of provision and further improve convenience, we will over the next five years develop a new generation of modern NHS community hospitals. These state-of-the-art centres will provide diagnostics, day surgery and outpatients facilities closer to where people live and work.*

In October 2005, the Secretary of State for Health, Patricia Hewitt, gave an undertaking that:

> *Through an initial £100m investment, we will build, rebuild or refurbish 50 new community hospitals in the next Parliament. Because community hospitals will be smaller, they can be sited closer to where people live and work. They will also reflect the latest standards of design and layout.*

The White Paper *Our health, our care, our say: a new direction for community services*, published in January 2006, clearly indicated that community hospitals would play an important part in the major shift of health services into primary care to which the government was committing itself. And it committed the government to fulfilling the manifesto promise regarding the creation of a new generation of community hospitals:

> *These will be places where a wide range of health and social care services can work together to provide integrated services to the local community.*

They will complement more specialist hospitals, serving catchment areas of roughly 100,000 people, but taking on more complex procedures, for example complex surgery requiring general anaesthetic or providing fully-fledged accident and emergency facilities.

The White Paper stipulated that:

PCTs taking current decisions about the future of community hospitals will be required to demonstrate to their SHA [Strategic Health Authority] that they have consulted locally and have considered options such as developing new pathways, new partnerships and new ownership possibilities. SHAs will then test PCT community hospital proposals against the principles of this White Paper.

The White Paper promised to make capital funding available for a "new generation of community hospitals and smaller facilities offering local, integrated health and social care services".

In February 2006, a letter to SHA Chief Executives from the Department of Health set out core expectations of local consultations (in accordance with Section 11 of the Health and Social Care Act 2001 – now Section 242 of the National Health Service Act 2006) regarding community hospitals. The letter indicated that the following questions should be posed in respect of any proposals for community hospitals:

Do the proposals fit with our commitment to invest an increasing proportion of NHS resources in providing care in community settings?

Do the proposals support the White Paper principles of providing modern health and social care in more local and community settings?

Do the proposals fit with the White Paper vision of a new generation of community hospitals, for example, giving scope for the provision of specialist care more locally such as diagnostics, day-case surgery and outpatients?

Are the proposals consistent with the White Paper goal of reducing unnecessary bed occupancies, eg for providing step-down rehabilitation beds in community hospitals?

The White Paper was followed in July 2006 by *Our health, our care, our community: investing in the future of community hospitals and services*. This outlined how the government planned to invest the promised capital funding – £150 million in each year over five years, amounting to £750 million in all. This scheme is known as "Central Capital Funding for Community Hospitals and Services".

The document recognised that community hospitals were in many cases operating in old buildings that were not adequate for delivering modern healthcare and that some brand-new community hospitals would have to be built. Also, new diagnostic equipment and other technology would have to be bought – possibly including equipment to allow services to be delivered to patients in their own homes.

It was stated that the new capital funding would be made available to PCT-sponsored

schemes “to support proposals involving the public and in some cases the independent sectors as part of a mixed programme of investment”. There would be no requirement to apply for this funding – it was intended to be an optional additional resource.

Investment proposals would have to demonstrate that they had met a set of principles set out in the document. These principles included goals set out in the White Paper:

- better prevention of, and earlier intervention in, disease;
- more choice and a louder voice for patients;
- tackling health inequalities and improving access to services;
- more support for people with long-term needs.

They also included the various strands of “system reform” that are bringing market-type mechanisms and outsourcing of service-provision into the NHS:

- Practice-based Commissioning;
- Patient Choice;
- a greater diversity of providers – including the for-profit and voluntary sectors;
- Payment by Results.

Regarding service-design, it was stipulated that plans must:

- be locally led;
- provide high quality services;
- re-design patient pathways;
- anticipate future needs as the population changes;
- adopt new technologies;
- plan across primary and secondary care;
- be affordable for the whole health economy;
- promote integrated service solutions;
- engage and harness the potential of staff;
- enable the transition of staff.

It was emphasised that PCTs must:

> *reconsider current proposals to close or reduce the scope of community hospitals if their only purpose is to make short-term financial savings. They cannot be supported on that basis and this has been made clear.*

Three investment models were set out for PCTs to choose from:

> *a. Public capital – using NHS capital directly.*
>
> *b. Local Improvement Finance Trust (LIFT) – an existing approach for bringing together public capital and independent sector expertise.*
>
> *c. Community Ventures – a new approach for capital investment not only in buildings or property but in services. This allows for the establishment of a joint venture between a PCT and a partner (which could be a third sector or private*

organisation). This joint venture company would be given capital. The Department of Health would retain a stake in the joint venture company's equity.

It is clear that the shift to primary care envisaged by the government entails a whole range of different models of service provision alongside traditional community hospitals/"cottage hospitals". These include GPs with Special Interests, walk-in centres, health-centres, polyclinics and domiciliary services. These could potentially all be run by a diversity of providers, including for-profit companies and the voluntary sector, in the context of a competitive NHS "market" in which patients are increasingly free to choose their provider.

There is plainly no set model for what services (if any) community hospitals will provide, how they will provide them or what catchment population they should serve. These are matters that PCTs are having to address, as the strategic commissioning bodies within the NHS. They are having to do so in the light of local circumstances (including financial issues) and taking account of the potentially powerful forces that are being unleashed by NHS "system reform".

Against this background, the definition of the term "community hospital", as it is now used by the Department of Health, has become very broad and flexible. The Health and Social Care Change Agent Team (which provides advice and support to health and social care communities on issues affecting the care of older people) states that "a community hospital is a 'service' not a building".

The Health and Social Care Change Agent Team's publication *Developing Community Hospitals: Models of Ownership – Options for Community Hospitals*, published in February 2006, describes a range of possible options for the ownership of community hospitals providing NHS services. These include ownership by:

- an NHS Trust (Hospital Trust, Foundation Trust or Health and Social Care Trust);
- a Primary Care Trust;
- clinicians working under a Specialist Provider Medical Services contract (an extension of the Personal Medical Services scheme for GPs, although this option does not actually require GP involvement);
- a non-profit independent provider (charity; voluntary organisation; "social enterprise");
- a for-profit independent provider (private company limited by shares; private company limited by guarantee; private unlimited company; public limited company, including community interest public limited companies);
- an independent provider working under an Alternative Provider Medical Services contract.

Despite the stipulation by the Department of Health that community hospitals must not be closed in order to make short-term financial savings, there remains widespread concern that this is exactly what is happening.

The Community Hospitals Association (CHA) claims that as many as a quarter of community hospitals are facing possible cuts in services or outright closure. A national campaign group called Community Hospitals Acting Nationally Together (CHANT) was formed in 2005 to draw together around 30 local groups that have been formed to oppose what they see as cuts in community hospitals. CHA and CHANT have identified the

following as factors in attempts by PCTs to cut community hospitals:

- the need to save money, in order to address deficits;
- the drive to provide more care in patients' homes (the feasibility of doing which on a large scale is disputed);
- the imperative to commission services from non-NHS providers (the for-profit and voluntary sectors).

The introduction of Payment by Results has caused financial problems for some community hospitals, due to the issue of "tariff unbundling". Under PbR, each "spell" of acute care is paid for by the commissioning PCT according to the relevant national tariff, set centrally by the Department of Health (based on average costs across the NHS, adjusted to allow for unavoidable regional variations in cost). Where a patient is discharged from an acute hospital into "step-down" care in a community hospital, the tariff has to be split ("unbundled"), so that the PCT can retain a portion of it to pay for that part of the patient's pathway being provided by the community hospital. The DoH has only recently begun to formulate national benchmarks for post-acute rehabilitation costs, in order to facilitate unbundling.

Any reductions in the availability of beds at community hospitals obviously raise concerns for acute hospital Trusts regarding "bed blocking" – and for local authorities with Social Care responsibilities as regards "cost-shunting".

Some campaigners in support of community hospitals see opportunities in NHS system-reform that might allow threatened hospitals to be kept in existence. It is argued that charities or companies might be formed to take over community hospitals (as indicated by the Health and Social Care Change Agent Team, there is a range of possible ownership options). These would then be able to secure income under the operation of Patient Choice, Practice-based Commissioning and Payment by Results.

As part of its "Productive Community Hospital" project, the NHS Institute for Innovation and Improvement commissioned a profiling project in respect of community hospitals throughout England, the results of which were published in March 2007. This found that, although the study had been carried out "during a time of radical change for Primary Care Trusts", there was "evidence of innovation and a clear commitment to service improvement" in community hospitals.

Community hospitals in West Kent

The following community hospitals are currently operated by West Kent PCT:

- Edenbridge and District War Memorial Hospital (17 beds);
- Gravesham Community Hospital, Gravesend (22 beds);
- Hawkhurst Hospital (23 beds);
- Livingstone Hospital, Dartford (38 beds);
- Sevenoaks Hospital (47 beds);
- Tonbridge Cottage Hospital (30 beds).

In early 2006, the Maidstone Weald and South West Kent PCTs (two of the predecessors of the present West Kent PCT) proposed that the four community hospitals in the south of West Kent should refocus their provision of services towards:

- accepting predominantly direct referrals from the community;
- providing continuing care and respite care (according to strict protocols);
- providing planned rehabilitation care (subject to contract negotiation to support timely discharge from hospital);
- providing intermediate care, including management of long-term conditions (according to agreed protocols).

These plans were explained to members of the NHS Overview and Scrutiny Committee at a briefing meeting held on 9 February 2006.

It was reported that, since July 2005, of the 117 beds in the four community hospitals in the south of West Kent, nine (eight at Sevenoaks and one at Edenbridge) had been temporarily closed as part of a package of cost-cutting measures.

It was planned to achieve the following temporary bed closures in February 2006:

- 15 beds at Tonbridge;
- seven beds at Edenbridge;
- 27 beds at Sevenoaks;
- six beds at Hawkhurst.

It was argued that these short-term, temporary measures had to be taken in the interests of the future viability of the community hospitals – as they would contribute to restoring the PCTs' financial stability. If the PCTs failed to address their financial problems, then more drastic measures, such as the permanent closure of one of the community hospitals, would have to be taken.

Faced with continued financial problems in the 2006–7 financial year, the Maidstone Weald and South West Kent PCTs formulated a Turnaround Plan in July 2006. At the same time, it was announced that a review of community hospitals would take place, separate from the Turnaround Plan, to consider the long term future of the community hospitals in the light of the January 2006 White Paper.

The consultancy firm Tribal was engaged to undertake this review. During the review, the PCTs worked with the Leagues of Friends at all four community hospitals concerned and held stakeholder meetings at each of the hospitals. The review was carried out in the autumn of 2006 and the stated intention was to bring forward proposals on which formal consultation would begin in early 2007.

The then Chief Executive of the PCTs, David Meikle, indicated that the future of Sevenoaks Hospital was secure. He said it was intended to make a bid for a share of the DoH's Central Capital Funding for Community Hospitals and Services in order to expand services at Sevenoaks. There was a widespread perception that services were to be concentrated at Sevenoaks and that the other three community hospitals were under threat of closure.

In February 2007, the Secretary of State for Health stated in a Parliamentary Answer that the review was likely to be completed in spring 2007. She said that the bed-closures in the community hospitals in the South of West Kent that had been made for financial reasons in

2006 would stay in operation pending the outcome of the review.

The Chief Executive of the Hospice in the Weald, John Ashelford, stated in February 2007 that the continued closure of beds at the Edenbridge and Tonbridge community hospitals had led to "bed-blocking" at the hospice, meaning that it was not always able to admit terminally-ill patients.

In spring 2007 it became clear that the PCT had decided to re-run the review, with a different focus. In March 2007, it was announced that a new review of community hospitals was being conducted (again by Tribal), this time also covering the two in the north of West Kent (at Gravesend and Dartford).

It was stated that an "enormous information gathering exercise" was being undertaken. This was looking at "geographic and transport considerations, the current hospital premises, the services offered in each of the hospitals and elsewhere in the community and the place of community care within the wider health service context". The emphasis on treating patients "closer to home" was noted as a key aspect of the "Fit for the Future" review of health services across Kent and Medway.

According to the PCT, there was to be "a change of emphasis from 'step down', where patients are transferred from the acute sector to community hospitals, to 'step up', whereby patients are referred to community hospitals by their GP or from acute hospital A&E departments".

It was noted that Livingstone Hospital in Dartford had been cited by the national older-persons "Czar", Prof Ian Phelp, as an example of best practice (in *A Recipe for Care – Not a Single Ingredient*, published in January 2007).

The Chief Executive of the PCT, Steve Phoenix, also stated in March 2007 that the 27 beds closed at Sevenoaks Hospital (in Holmesdale ward) were to be reopened, on an interim basis for six months in the first instance.

The outcome of the review was presented to the PCT Board on 24 May 2007. Its conclusions were as follows:

- Best practice must be generalised across the six community hospitals in West Kent.
- Eighteen beds (out of the 62 currently closed) must be reopened in the short term, to meet demand.
- Over the next three to five years, all the currently closed beds must be reopened.
- Community hospitals must be a key part of the PCT's strategy for providing more care closer to home.
- All the community hospitals in the south of West Kent must remain in place and continue to provide most of the services they already do (modernised in some cases); and investment must be made accordingly.
- The Livingstone Hospital buildings are out-of-date; but the hospital provides a model service and needs to continue doing so. The most likely solution is to "reprovision", *i.e.* to provide the service at an alternative location (rather than refurbishing the Livingstone Hospital, or building a new hospital on the same site). This will need to be looked at further; any proposed changes will be subject to formal consultation.
- The Minor Injuries Unit at Edenbridge Hospital is not clinically viable and needs to

close. This proposal will be subject to formal consultation.

The PCT decided immediately to rename the Edenbridge Minor Injuries Unit a “Treatment Centre”, on the basis that it was not actually functioning as an MIU. This decision proved controversial locally, being opposed by the hospital’s League of Friends, who regarded it as pre-empting the outcome of the consultation on the future of the unit.

The PCT also agreed that there was an opportunity for the renal dialysis service, provided by Guy’s and St Thomas’ NHS Trust, to be relocated from Pembury Hospital to Tonbridge Cottage Hospital – with an increase in provision from 14 units to 20. This too proved controversial, since it entailed the 15 temporarily-closed beds at the Cottage Hospital being taken over by the renal unit and, thereby, ceasing to be available for the provision of services specifically for local people.

Guy’s and St Thomas’ Trust has now decided that Tonbridge Cottage Hospital is not an appropriate location for the renal dialysis service and the PCT is considering alternative uses for the part of the hospital in which it was to have been housed. The PCT takes the view, in line with the review’s findings, that the 15 temporarily-closed beds at Tonbridge are effectively surplus to requirements – so some other use for the space concerned will have to be found. The new proposals should be considered and agreed by the PCT Board in July and put out to full public consultation later in the year. The 15 temporarily-closed beds will remain closed pending the outcome of the consultation.

In recent months, concerns have been expressed about the withdrawal from Gravesham Community Hospital of some outpatient services that have hitherto been provided there by Dartford and Gravesham acute Trust. The perception locally is that these services have been withdrawn from the Community Hospital and relocated at Darent Valley Hospital, the acute hospital that the Trust runs in Dartford. It has also been claimed that the motivation behind this has been primarily financial, resulting from the inflated costs that the local health economy has to bear in consequence of GCH and DVH having both been built under the Private Finance Initiative.

The NHS Overview and Scrutiny Committee dealt with this issue at its meeting on 9 March 2007. Representatives of the PCT and the Trust stated that the services in question were not being removed from Gravesham but would in future be commissioned by the PCT from local GP practices. This was stated to be in accordance with the principles set out in *Our Health, Our Care, Our Say*; it was denied that there was any financial motivation for the changes. Any gap in the local availability of services in Gravesham (causing patients to travel to Dartford) was only temporary, while new services were being established in the area.

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NHS Overview and Scrutiny Committee Briefing Note

Chronic Pain services

✉ David.Turner@kent.gov.uk
☎ **(01622) 694196**

2 July 2007

Background

Chronic pain can be defined as continuous or intermittent pain over a long period of time that persists beyond the normal period of healing. It is increasingly understood that it is a disorder in its own right (possibly a neurodegenerative disorder) that may result from a number of painful triggers – or may have no obvious precipitating cause. The condition affects a significant proportion of the population (21%, according to a survey by the British Pain Society in 2005) and, by definition, is incurable. Examples of potential triggers include:

- cancer
- lower-back injury or disorders
- arthritis (inflammation of the joints), including osteoarthritis
- recurrent headache, including migraine
- peripheral neuropathy (damage to the peripheral nervous system), including trigeminal (facial) neuropathy, diabetic neuropathies, postherpetic pain (following shingles), pain from multiple sclerosis and post-stroke pain
- conditions causing abdominal pain, such as chronic pancreatitis and bowel disorders
- conditions causing pelvic pain, such as endometriosis and interstitial cystitis
- other conditions, such as fibromyalgia, myofascial pain syndrome and complex regional pain syndrome

Lower-back pain in particular is a very common ailment, affecting large numbers and leading to the loss of many working days. The need to recognise psychosocial risk factors at an early stage cannot be understated. Increasingly, the importance of multidisciplinary pain management at an early stage for those at risk of a poor outcome is being emphasised. The Musculoskeletal Services Framework, published by the Department of Health in July 2006, provides a way of managing demand and treating most common painful conditions.

A range of therapies (surgical and non-surgical) for chronic pain is available, from both mainstream and complementary/alternative fields of medicine – supported by evidence bases of varying quality. Modes of treatment include the following:

- acupuncture
- Alexander Technique
- aromatherapy
- cordotomy (spinal-cord surgery) – for a very limited number of cancer patients with mesothelioma
- epidural steroid injections/facet joint injections/nerve root blocks
- opioid drugs
- psychological therapies/counselling/Cognitive Behavioural Therapy
- self-help programmes

- radiofrequency lesioning (burning of the nerves)
- SCENAR (Self-Controlled Energy Neuro-Regulation)
- Tai chi or exercise programmes/physical therapies
- TENS (Transcutaneous Electrical Nerve Stimulation)
- spinal cord stimulation
- intrathecal drug therapy (injecting drugs into the spinal canal)
- Pain Management Programmes (inpatient and outpatient)

Pain management services are mostly delivered in an acute hospital setting – in outpatient clinics, by inpatient ward referrals, and through oncology and palliative care services. It has been recommended that a minimum of one whole-time equivalent consultant (*i.e.* 10 Programmed Activities under the consultant contract) dedicated to chronic pain management is necessary for each population of 100,000 people. However, this seems to have been a somewhat arbitrary standard; and it has not been achieved widely (if at all).

Provision of pain management services within the NHS appears to be limited; and there seem to be significant variations in the extent and type of services offered across the UK. Surveys indicate that a majority of these services have waiting lists; waiting times vary widely and can be significant in some areas. In all but a few areas, the NHS does not keep any register of patients who require chronic pain management.

The effect of NHS system reform

NHS acute Trusts in England are now substantially being paid by commissioners on the basis of the Payment by Results (PbR) system – and will be more so in future. Under PbR, work is paid for through "cost and volume" contracts according to the actual number of episodes of care ("spells") provided. This is in contrast to the old system of block contracts, whereby commissioners paid for pre-determined volumes of work.

Under PbR, payment for each procedure is made according to a standard national "tariff", based on average costs across NHS providers. (There is some adjustment in the tariff to allow for unavoidable differences in costs between regions – using the same Market Forces Factor that is used to adjust funding allocations to Primary Care Trusts.) The tariff is structured around Healthcare Resource Groups (HRGs), which are used to classify together treatments, and types of case, that are clinically similar and that use roughly the same level of resources, taking account of diagnosis, the actual procedure involved and other variables (such as the patient's age).

It is intended that various types of clinical activity in the pain management specialty, including surgery, will be covered by PbR from 2008–9 (rehabilitation will be covered from 2009–10). A lot of work has already been done by Expert Working Groups (with input from the British Pain Society) to develop appropriate HRGs. National "Reference Costs" (derived from costs across acute Trusts) have been compiled for these, preparatory to tariffs being fixed. Providers, especially Foundation Trusts, are now beginning to record pain-management procedures and map them onto the appropriate HRGs.

Current national tariffs are only available at a very crude level. Where procedures and activities do not match the HRGs available, other HRGs are used if a match cannot easily be made. It depends on the coder and decisions made locally as to what is actually charged, since, in the absence of proper codes, it is open to interpretation.
Originally, under HRG version 3.5, there were four HRGs specifically for pain

management, namely:

Outpatient (Specialty Code 191) – First Attendance
Outpatient (Specialty Code 191) – Follow-up Attendance
A07 Intermediate Pain Procedures
A08 Percutaneous Image Controlled Pain Procedures

Concern was expressed over these original HRGs covering pain management on the grounds that:

- being so few in number, they involved bundling together treatments with a wide range of cost, meaning that the HRGs failed to reflect true costs in respect of the more expensive procedures carried out in the specialty;
- they required nearly all pain management activity to be described in terms of treatment rather than diagnosis;
- they did not allow complex cases (especially complex assessments) to be assigned a proper code;
- they failed to take proper account of non-surgical modes of treatment;
- they did not recognise pain management treatments carried out in an inpatient setting.

The Department of Health says that steps have been taken to address some of the issues relating to the coding of pain management. A new system of HRGs (HRG version 4.0) was introduced on 1 April 2007 and will form the currency for the national tariff from 2009–10. It includes six HRGs for pain management:

AB01Z Complex Neurosurgical Pain Procedures
AB02Z Complex Major Pain Procedures
AB03Z Complex Pain Procedures
AB04Z Major Pain Procedures
AB05Z Intermediate Pain Procedures
AB06Z Minor Pain Procedures

These will more accurately reflect the treatments that are undertaken, although their breadth and complexity are still not fully described. Reference costs will need to be derived on the outpatient work and the extent to which this can be done will depend on data returns from Trusts. Currently in many places tariffs are negotiated locally by commissioners to reflect the work and case-mix better – this is more likely in the more specialised centres.

Dartford and Gravesham NHS Trust
It has recently been reported that the Chronic Pain Management Clinic at Darent Valley Hospital has stopped taking new referrals from West Kent Primary Care Trust. Dartford and Gravesham NHS Trust is charging the PCT above the national tariff rate for the service; the PCT is not prepared to pay at this rate, and the Trust is not prepared to subsidise the service (although it is continuing to treat existing patients). The clinic is reported to be open on a part-time basis and to have significant waiting times.

The PCT is now commissioning services from other providers outside the area (obliging patients to travel some distance) and planning to provide some services locally in a primary-care setting.

East Kent Hospitals NHS Trust
The Chronic Pain Service provided by East Kent Hospitals NHS Trust is an outpatient service at the Trust's three main hospital sites. Therapies are provided by the service as follows:

Kent and Canterbury Hospital, Canterbury

- Acupuncture
- Alexander Technique
- Aromatherapy
- Counselling
- Patient support group
- SCENAR
- Tai chi
- TENS

Queen Elizabeth The Queen Mother Hospital, Margate

- Counselling
- Patient support group
- Reflexology
- Tai chi
- TENS

William Harvey Hospital, Ashford

- Acupuncture
- Counselling
- Patient support group
- Tai chi
- TENS

In addition, some of the therapies provided are offered on an outreach basis at the Royal Victoria Hospital in Folkestone and Buckland Hospital in Dover.

Patients can be referred to the Chronic Pain Service by their GP or from within the hospital system if they have already received treatment from the Trust for their condition.

The most recent Clinical Governance Report for East Kent Hospitals NHS (covering 2005–6) stated in respect of the Chronic Pain Service that:

- each site offered a different model of care to chronic pain patients, potentially resulting in inequity of provision;
- an increase in referrals had contributed to a lack of capacity within the service;
- there was a need to create extra capacity and expertise within primary care for high quality pain management.

It was reported that the Nurse Consultant for Chronic Pain, together with the PCT's Head of Commissioning and Service Redesign, had put forward a proposal for a "hub and spoke" model of care. This would allow most of the service to be delivered from primary care, freeing up capacity within the acute Trust to treat more complex cases. A pilot service had

begun, with the Nurse Consultant and a specialist chronic pain nurse running clinics and working one day a week in the PCT. A two-to-three-year plan was in place to develop the model to its full capacity.

The benefits of switching to primary care in this way were stated to be:

- shorter waiting times for treatment;
- improved access and choice;
- the development of support services that would help people;
- to live with their pain and improve quality of life;
- reduction in the number of referrals to secondary care.

It has recently been reported that services provided at the QEQM Hospital in Margate are to be transferred to the K&C Hospital in Canterbury.

Maidstone and Tunbridge Wells NHS Trust
Maidstone and Tunbridge Wells NHS Trust previously ran a Chronic Pain Unit at Maidstone Hospital. This was relocated to Pembury Hospital in September 2004, without consultation.

Since the Unit was moved, concern has frequently been expressed about the inconvenience and discomfort caused to patients in undertaking the lengthy journey from Maidstone to Pembury (around 15 miles). This involves using a poor-quality road connection and takes some time – using public transport (the Arriva No. 6 bus), it entails a round-trip journey time of around two hours (some chronic-pain patients who lack access to transport are taken in private cars by volunteer drivers).

The government stated in December 2004 that the Chronic Pain service provided at Pembury was significantly enhanced, as a result of £600,000 of additional resources being provided.[1]

Note
This briefing was prepared with assistance from Dr Cathy Price and Dr Joan Hestor of the British Pain Society.

[1] *Hansard*, House of Commons Debates, 2 December 2004, Col. 883.

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Item 7

By: Paul Wickenden, Overview and Scrutiny Manager

To: NHS Overview and Scrutiny Committee – 20 July 2007

Subject: Local Involvement Networks

Summary: To update the Committee on recent developments regarding Local Involvement Networks

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Introduction

1. (1) Members will recall that the Local Involvement Networks (LINks) proposals contained in the Local Government and Public Involvement in Health Bill propose to give the power to local authorities with social services responsibilities to establish a LINk. It will be for the local authority to procure a "host" organisation and it will be the host who is responsible for the establishment, maintenance and support of a LINk in the local authority area.

(2) The LINk will operate independently of the local authority, within its own governance structure and decision-making processes. The host will be accountable to the LINk.

Parliamentary timetable

2. (1) The Local Government and Public Involvement in Health Bill is currently under consideration by Parliament. The Department of Health have indicated that they cannot be sure when the Bill will receive the Royal Assent. Latest indicators are that it will be in the autumn (probably November).

(2) The current intention is that Patient and Public Involvement Forums will be abolished on 31 March 2008, with LINks coming into being on 1 April 2008.

The role of LINks

3. (1) Just to remind Members, the role of a LINk is proposed to consist of:-

- promoting and supporting the involvement of people in the commissioning and provision, and scrutiny of local care (i.e. NHS and Social Care) services;
- obtaining the views of people about their needs for, and their experiences of, local care services;
- enabling people to monitor and review the commissioning and provision of local care services;

- conveying people's views to organisations responsible for commissioning, providing, managing and scrutinising local care services; and
- recommending how care services can be improved.

Who is in a LINk and how are LINks constituted?

4. (1) A LINk will comprise an inclusive membership of user groups, local voluntary and community sector organisations, and interested individuals – but involvement will apparently not require formal membership.

(2) A LINk will need to be diverse and representative of all sections of the local population.

(3) LINks will need to have clear governance structures to make them accountable to their "membership" and the wider community.

Powers of LINks

5. (1) To enable them to influence the improvement of local services, LINks will have specific powers to:-

- enter specified types of premises and view the services provided (although the ability to exercise this power will be limited, as the government is concerned that LINks should not duplicate the work of the regulatory bodies for health and social care);
- request information and receive a response within a specified timescale;
- make reports and recommendations, and receive a response within a specified timescale; and
- refer matters to the relevant Overview and Scrutiny Committee and receive a response.

LINks "Early Adopter" projects

6. (1) The Committee will be aware that there are a number of "Early Adopter" projects. These are in the following local-authority areas:-

- Doncaster Metropolitan Borough Council;
- Dorset County Council;
- Durham County Council;
- Hertfordshire County Council;
- London Borough of Kensington and Chelsea;
- Manchester City Council;
- Medway Council.

(2) These projects are being led by the Commission for Patient and Public Involvement in Health.

(3) The Healthcare Commission has also been running two Patient and Public Engagement "test sites", in the North (Leeds and Bradford) and the South West (Plymouth and Exeter), which now appear to have been designated as additional Early Adopter projects.

(4) The purpose of the LINks Early Adopter projects is to provide information, advice and guidance to LINks, and organisations responsible for establishing, supporting and working alongside them, on how to maximise the effectiveness of LINks and relationships within them. The Early Adopters are assessing, testing and evaluating:-

- attracting and engaging participants;
- the LINk role and functions;
- LINks as organisations – form and governance;
- support required for a LINk (the host organisation);
- procurement and resourcing for a LINk;
- LINks relationships and accountability;
- understanding effectiveness;
- miscellaneous – training, developing protocols and processes, determining priorities.

Early messages from Early Adopter projects

7. (1) The following comments were presented to a recent Department of Health regional event on the early messages that Early Adopter projects had indicated.

- Flexibility to develop local models/approaches is exciting and challenging.
- Engaging with key stakeholders who will move things forward is critical.
- Creativity is needed to ensure engagement is inclusive and appropriate to the local population and is targeted at individuals as well as groups.
- How will LINks engage with Foundation, Ambulance, Mental Health and Children's Trusts, other specialist services and prisons?
- It is very important to ensure that the focus is on social care as well as health.
- There is a need to build on existing activity/networks/relationship LINks will not replace existing structures but must add value.
- There is a need to ensure that people already involved in Patient and Public Involvement activity are encouraged to get involved in LINks.

Parliamentary Health Select Committee

8. (1) Members will be aware that the Parliamentary Health Select Committee on Patient and Public Involvement was strongly critical of the government in its views and recommendations on LINks.

(2) However, from the Government's response to the Parliamentary Health Select Committee it clearly plans to go "full steam ahead" with the LINks proposal.

Key milestones

9. There are key documents that are expected to be published shortly. These are:-

- an easy-to-read guide to the proposals for the establishment of LINks, which should be available in the early part of July on the Centre for Involvement Network at www.nhscentreforinvolvement.nhs.uk;
- a model contract specification for the procurement of the host organisation;
- an interim document, following the regional events relating to the establishment of LINks, including informal discussions and the feedback from the Early Adopter sites on what an effective LINk might look like.

Funding

10. (1) A key issue for all local authorities with social services responsibilities will be the funding made available for the establishment of a LINk. Information about this is currently sketchy, but it is expected to be somewhere within the range of £100,000 to £150,000 per authority. The funding will be a targeted grant, based on a formula which we have yet to see.

(2) The funding of LINks will set a challenge for authorities regarding the administrative arrangement they would like to see in place.

Next steps

11. I will continue to keep the NHS Overview and Scrutiny Committee fully apprised of developments.

Recommendation

12. Members are asked to note the report

Paul Wickenden
Overview and Scrutiny Manager
Tel no: 4486
Email: paul.wickenden@kent.gov.uk

Background Information: *Include ALL background information taken into account in preparing the report. (This does not include previous Committee Reports)*