AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Monday, 27th July, 2009, at 1.30 pm
Council Chamber, Sessions House
County Hall, Maidstone

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

Tea/Coffee will be available from 1:15 pm

Membership

Conservative (11):	Mr G A Horne MBE (Chairman), Mr G Cooke, Mr B R Cope, Mr M C Dance, Mr K A Ferrin, MBE, Mr J A Kite, Mr R L H Long, TD, Mr A Sandhu, MBE, Mr C P Smith and Mr A Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4)	Cllr Ms A Blackmore, Cllr M Lyons, Cllr Mrs J Perkins and Cllr Mrs M Peters

UNRESTRICTED ITEMS

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

Item

1. Substitutes
2. Election of Vice Chairman
3. Declarations of Interests by Members in items on the Agenda for this meeting.
4. Minutes of the meetings held on 20 March and 25 June 2009 (Pages 1 - 10)
5. Audiology updates (Pages 11 - 18)
6. Delayed transfers of care updates (Pages 19 - 34)
7. Kent Local Involvement Network (LINk) (Pages 35 - 44)

   John Cunningham, Chair of Governors' Group LINk and Graham Hills, Director Kent and Medway Network Ltd will be in attendance for this item.
8. The future direction of the Health Overview & Scrutiny Committee (to follow)
9. Date of next programmed meeting – Wednesday 2 September 2009 at 1:30 pm

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

17 July 2009

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 20 March 2009.

PRESENT: Mr B R Cope (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A D Crowther, Mr D S Daley, Mr C G Findlay, Ms A Harrison, Mr W A Hayton (Substitute for Mr R Tolputt), Mrs S V Hohler, Mr M J Northey, Mr R J Parry, Ms B J Simpson, Dr T R Robinson, Mrs E D Rowbotham, Cllr Ms A Blackmore, Cllr R Davison (Substitute for Cllr Mrs M Peters) and Cllr M Lyons.

ALSO PRESENT: Mr R A Marsh, Cabinet Member for Public Health

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

UNRESTRICTED ITEMS

18. Minutes - 9 January and 6 February 2009
(Item 3)

RESOLVED that Minutes of the meetings held on 9 January 2009 and 6 February 2009 are correctly recorded and that they be signed by the Chairman.

19. Medway NHS Foundation Trust
(Item 4)

(Lois Howell, Company Secretary and Linda Dempster, Head of Infection Control were in attendance for this item)

(1) In response to a question about whether there was an issue around public perception of the Trust, particularly people in those areas most likely to use the Trust's services, the Trust acknowledged that getting the right message out to the public was a challenge but that the Trust did have a very good communications team.

(2) In response to a question about infection control, the response was that for infection control the team were working towards a level of zero tolerance. In recent years the issue of infection control and its profile had been substantially raised and the public's awareness of its importance recognised.

(3) The targets for infection control which had been put in place had really helped the Infection Control Team within the Medway NHS Trust, but there were also a number of other areas which needed to be addressed.

(4) In response to a question relating to the Trust declaring on the Health Care Commission Core Standards for 2007/08 that the Trust had not met the requirements for decontamination the response was that it was not an issue of patient safety but related to some of the facilities that the Trust had during that year which prevented the Trust from declaring that it was compliant with this standard.

(5) The area that was non-compliant was the cold sterilisation facility for endoscopes. A brand new unit had been established and so this year the Trust were able to declare in their self assessment that they were compliant.

(6) In answer to a question about infection control and MRSA, Mrs Dempster responded that MRSA screening took place for all admissions and screening of in-patients also took place every week. She informed the Committee that this was a credit to the Microbiology Unit at the Trust who had looked carefully at the way they worked and increased the number of tests that they conducted from 1,000 to 17,000.

(7) In answer to a question about the policy on 'bare arms below the elbow', Mrs Dempster answered that the Trust had a stringent performance management regime. It was Trust policy that staff were 'bare below the elbows'. This had strengthened the infection control policy. All staff from the cleaner to the Chief Executive were empowered, as were the public, to challenge anyone who was found not adhering to this policy. There had been no need to date to taken any formal disciplinary action against any member of staff not adhering to the policy.

(8) A question was asked about an item within the papers before the Committee which indicated that the Healthcare Commission had undertaken a review at the Trust in January 2009 and whether the outcome of that inspection had been received from the Healthcare Commission. In response, the Committee were advised that the official feedback had not been received but the initial feedback had been very positive.

(9) In answer to a question as to why silver was used in catheters or central lines, Mrs Dempster responded that this was proven to reduce infection for patients.

(10) Acknowledging that bacteria was everywhere, a question was asked about the cleaning of trolleys and whether the paper medical notes used by professionals were cleaned and what the risk was. In response, Mrs Dempster said bacteraemia was the real risk, but in all cases it was about assessing the real risk and how that risk could be reduced. Hand hygiene was key. Bacteria can be found on notes, door handles, anything that is touched. It was important that professionals washed their hands immediately before dealing with a patient. Mrs Dempster said while notes could be seen as a perceived risk, she did not consider that there was a real risk relating to the notes.

(11) In answer to a question about infection control, and control of the wards, the answer given was that Ward sisters have control of the ward, which means they had ownership and power of what happens in the ward in terms of performance management. There was a direct line of performance management up to the Director of Nursing and onwards to the Board. The Board looked at the policy safety for each of the wards, including looking at issues of uniform, policy, considering whether there were any problems of skill mix for each of the wards which would then be addressed.

(12) In answer to a Member's question, relating to infection control targets and how they are set, the response was that the targets are initially set by the Government, but then the South East Coast Strategic Health Authority issued a 'stretched target' to each Trust.

(13) This was demonstrated by the number of cases of MRSA that were expected across the health economy this year and the stretch target that the Strategic Health

Authority had imposed. The Trust would be expected to reduce the total of 63 cases in any one year by a further 10% this year based on outturn.

(14) The Committee were informed that following each case of infection, thorough investigation was undertaken to ensure that from the Medway NHS Trust's point of view, the risk was being reduced.

(15) Exploring this issue of zero tolerance further and stretch targets, the representatives of the Trust acknowledged that it would be harder and harder to achieve zero cases and percentages become less meaningful. The only appropriate response was to look at each incidence of infection on a case by case basis.

(16) In answer to a question about whether staff were screened for MRSA, Mrs Dempster answered that this would not be practical as staff could present for a shift and be totally clear of any MRSA, but on leaving that shift they could be positive or vice versa.

(17) She added that in terms of training, by the following week, i.e. the last week in March, 100% of the staff should have been trained.

(18) With regard to student nurses, Mrs Dempster said that part of the training took place in university and part within the hospital setting. Within the first week of being employed by the hospital, nurses were trained on the basic skills and they had to demonstrate that they had the competencies to undertake those basic tasks effectively. The Trust had gone back to basics in terms of hygiene and she said that there was now an ethos within the Trust of checking that people were competent in terms of changing beds, drips procedures etc. The danger had been over the last 30 years that once a student nurse had been trained, there was an assumption that they were competent. All staff were now assessed for their competency. In terms of infection control specifically, there was a necessity not only for clinical staff but also for non-clinical members of the Board and Executive Directors to take a refresher course each year.

(19) Mrs Dempster added that people would be suspended without pay if they had not undertaken this mandatory training. This is a new policy coming in from April 2009.

(20) In response to a question about whether the Trust used agency staff, Mrs Dempster said there had been some agency staff utilised recently in Accident and Emergency, but over and above that, they had their own bank of staff which were used.

(21) Asked about compliance with anti-bacterial prescribing, Mrs Dempster said that all prescribers of drugs had to go on training and all junior doctors were trained as part of their initial induction. The Trust had clear guidelines about prescribing, and how antibiotics were to be prescribed.

(22) The amounts of antibiotics on each ward were audited and regular reports were made to the Governors Risk Committee for assessment. If it was acknowledged that there was over-prescribing on a particular ward, this would be addressed. In addition, the Risk Committee would be given additional reports if there was an outbreak of, for example, C Difficile.

(23) The Committee noted that on display on each ward were statistics relating to the number of breaches of hand hygiene, bed sores, 'slip, trip and falls', unclean commodes

etc. This really focussed staff minds to ensure that all these basic issues were attended to and embarrassment avoided. This was also available for the public to see.

(24) Asked about whether the Committee would get to know what was going on within the Foundation Trust, as many of the meetings took place in private, the response was that Board papers were published on the website and Minutes were made available following those meetings.

20. Kent & Medway NHS & Social Care Partnership Trust
(Item 5)

(Erville Millar, Chief Executive and Donna Eldridge, Assistant Director of Nursing/Director of Infection and Prevention Control were in attendance for this item)

(1) Mr Millar informed the Committee that Donna Eldridge's role as Assistant Director of Nursing/Director of Infection and Prevention Control was a recent appointment to the Trust in the last year.

(2) In response to a question raised by a Member regarding the Annual Health Check results for 2007-08 Mr Millar explained that the Trust had 'not met' the standards for infection control because the Board did not begin receiving regular reports on the issue until August of that year and so were not compliant for the full year. Reports had been received by the Board prior to this, but not in the proper form.

(3) Ms Eldridge explained how a process was triggered around infection control, if a patient presented with diarrhoea and sickness. The assumption was always made that this was Norovirus and dealt with accordingly unless and until tests showed otherwise. A deep clean takes place 48 hours after the last symptom has presented itself. No cases of MRSA has been caused by the Trust but some patients colonised with MRSA had been transferred in. No cases of MRSA bacteraemia had even been transferred in either.

(3) In answer to a question from a Member about the process for reporting incidents to the Board, the response was it was a responsibility of the ward matron to report either in person or e-mail to the Infections Prevention and Control Team who would also report to the Board. Mr Millar added that when the Board received a report they would follow up the incident.

(4) In answer to a question about an incident which had occurred in one of the Trust's establishments in Thanet where an outbreak of infection had occurred, the answer was that there were always meetings to discuss with staff an outbreak of infection when it occurred. What had happened in this case in Thanet was not that the member of staff was refusing to wipe down an area, but a case of not having sufficient knowledge about what should be wiped down and how.

(5) Ms Eldridge displayed to the Committee a check list which all staff worked to regarding infection control. The Trust worked closely with the Primary Care Trusts, (the Commissioners) and Acute Hospital Trusts on infection control issues.

(6) Asked the question of how people's attention were focussed on infection control when the primary need for a patient for the Trust was mental health, the Trust representatives acknowledged that was extremely difficult especially in dealing with

older adults who were suffering from Dementia. However, the Committee were advised that frontline staff were all trained in hand hygiene.

(7) In answer to a question about whether the Trust employed agency staff, the answer was that the Trust did not tend to, and if they did require any such staff they were NHS Professionals which is an NHS agency that trains staff on infection control.

(8) Turning to another case study contained within the papers which had been presented to the Committee was a case of a patient who was infected with HIV who had a sexual relationship with another patient. A Member asking the initial question about this incident was concerned that other patients were unaware that this person was HIV positive because of issues of confidentiality and for this reason needed to be monitored. The member was concerned that the Trust could be open to criticism.

(9) There followed a lengthy debate on this one particular case, but within the current legislative framework, the Trust had dealt with the incident appropriately.

(10) Asked how long it took between a sample being taken from a patient and the results being known, the response was that in instances of vomiting and diarrhoea, the results would be returned from the laboratory within 48 hours.

(11) Asked about the reporting process for infection control, the response was that it was down to the modern matrons, and if there was a need for onward reporting to the Infection Control Team and ultimately to the Trust Board.

(12) In answer to a question about training for nurses, the Trust responded that they worked closely with the universities and they spoke about the importance of their 'bare below the elbow' policy, and keeping uniforms pristine clean. They totally agreed with the Member asking the question, but it was also about appropriate lifestyles and standards in terms of hygiene.

(13) Referring to two other cases in the pack that Members had before them, the Trust responded by explaining the standard procedure when an incident occurred and the extra measures that had been taken.

(14) Asked about the length of stay and the correlation with MRSA, the Trust responded that it did not keep those statistics.

21. South East Coast Ambulance Service NHS Trust
(Item 6)

(Mr A Cashman, Assistant Director of Service Development was in attendance for this item)

(1) Mr Cashman advised the Committee of the acronyms which had been used in the report.

(2) In response to a question about training Mr Cashman explained that the expectations on ambulance staff had increased over the years. They had moved to a Foundation Course which took up to three years. Year one in university and year two and three mixed between operational and classroom based training.

(3) Mr Cashman explained to the Committee the role of the patient transport staff and how their skills had also increased, for example in terms of first aid, administering oxygen, defibrillation etc.

(4) The South East Ambulance Service also worked closely with the voluntary agencies including the Red Cross and the St John's Ambulance.

(5) The South East Coast Ambulance provided facilities for accident and emergency as well as some patient transport services. There were however a whole raft of patient transport providers. The Ambulance Service worked closely with the Acute Trusts, Primary Care Trusts and the Mental Health Trusts.

(6) The Ambulance Service did support the Red Cross and St Johns Ambulance in dealing with some of their training, but questions specifically about their training would need to be addressed to those two organisations.

(7) In answer to a question about the challenges for staff in the Ambulance Service, Mr Cashman said that any change was challenging and the performance standards for the Ambulance Service were extremely rigorous. During the past Winter this had been very difficult. He added that the Chief Executive of the service believes that embedded in the culture of the service is a strong patient focus and he was adamant that operational staff delivered the service appropriate to the patients needs.

(8) In response to a question about the "Make Ready System", Mr Cashman responded that the existing estate was very old and not always appropriate so the Trust had been finding new sites and developing the "Make Ready System". There were sites in Hastings and Chertsey, Mr Crowther commended Members to visit one of these "Make Ready Systems" having recently visited the Hastings site, and seen a number of ambulances arriving and turning round as quickly as possible to then move onto a new call and patient having been thoroughly cleaned.

(9) Several Members of the Committee having had recent personal experience of the service commended the service.

(10) Questioned about the performance report and the difference of levels between for example, Kent and Hampshire, Mr Cashman responded that the figures relating to Hampshire were only a small part of that county, which the South East Coast Ambulance Service covered, i.e. the Blackwater Valley.

(11) Asked about how a person's entitlement to patient transport services was assessed, the answer was that this was based on need.

22. Local Involvement Network (LINk)
(Item 7)

Mr J Fletcher, Governor, Kent Local Involvement Network and Mr Graham Hill, Director, Kent and Medway Networks Limited were in attendance for this item)

(1) Mr Daley asked colleagues from the Local Involvement Network whether they would consider looking as part of their programme at the issue of pain clinics, bearing in mind the report of the Chief Medical Officer published on Monday, 16 March 2009.

Colleagues from the LINk acknowledged that they would take this message away to other involved with the LINk.

(2) In answer to a question about whether infection control was better in United States of America or in the United Kingdom, Mr Fletcher said that he was not sure whether that was the case.

(3) LINk representatives responded that they would be preparing third party commentaries to the 24 Health Care Commission Core Standards but this would be a "quick and dirty" process.

(4) The LINk were working closely with a number of voluntary organisations across the county who had expressed surprise that they had not been asked for such information before, but of course this was leading to much more anecdotal evidence.

(5) Colleagues of the LINk referred to the re-designing of the main entrance at Medway Hospital and a decision then took place about the use of hand gels and the number of entrances to acute hospital sites. This was of concern to the LINk.

(6) Responding to a question about how the LINk was being publicised, (with one Member identifying that on a recent visit to her GP's surgery, the information still available in the surgery related to the Patient and Public Forums which had now been abolished), the answer was that the LINk now had 443 members, including some very new members. There was a good spread of members across the county. The LINk did have a number of items of publicity material and they were looking at how the County Council could help them with distribution methods. The representatives of the LINk commented on the issues around the policy of disinfecting commodes and toilets and gave their view on how they can influence the Secretary of State for Health.

(7) The representatives also agreed with comments made relating to the cleanliness of magazines, toys, food being taken in hospital by visitors and the policy of being bare below the elbows.

(9) One Member commented that the acronym LINk was not very explicit and he advocated that the LINk needed to publish what their purpose was as swiftly as possible.

23. Health Care Commission Core Standards - "Third Party Commentaries"
(Item)

(1) The Committee had at the last three meetings been gathering evidence from each of the Trusts on the various aspects of compliance with the Hygiene Code to enable it to prepare third party commentaries to be submitted by the Trusts with the self declarations against the Department of Health Core Standards.

(2) The Committee noted that third party commentaries are valued by the Healthcare Commission for the additional information they provide about the performance of NHS Trusts and form part of the evidence that goes towards the Annual Health Check. Health Overview and Scrutiny Committees are one of the main sources of third party commentaries along with Strategic Health Authorities and Local Involvement Networks (LINkS). Third party commentaries that are submitted through a declaration made by a Trust are made publicly available.

(3) The evidence and background information received by the Committee at its last three meetings now needed to be digested quickly and third party commentaries prepared in accordance with the Healthcare Commission's timetable. Trusts must submit their declarations between 15 April 2009 and midday, 1 May 2009.

(4) The approval was therefore sought and given by the Committee to delegate authority to prepare these third party commentaries in consultation with the Chairman, Vice-Chairman and Liberal Democrat Spokesman of the Committee. The third party commentaries would be circulated to all Members of the Committee so that individual Members could contribute to this process.

Recommendation

(5) RESOLVED that delegated authority be given to the Overview, Scrutiny and Localism Manager in consultation with the Chairman, Vice-Chairman and Liberal Democrat Spokesman of the Committee, to agree the third party commentary for inclusion in each Health Trusts self assessment which they are submitting to the Health Care Commission by the end of April 2009.

24. Date of next programmed meeting – Friday 1 May 2009 at 10:00 am
(Item 8)

(1) The Committee noted that the next meeting of the Committee was scheduled for Friday, 1 May 2009. Suggestions for inclusion on the agenda at that meeting was a presentation on the First Responders Scheme operating in the rural parts of Dover in Aylesham and other surrounding villages, and for the Committee to be given in a presentation about the Stroke Care Pathways.

(2) The Committee agreed that the Chairman, Vice-Chairman and Liberal Democrats Spokesperson would consider suggestions for inclusion on the programme and make a decision on 24 March 2009 as to whether the meeting of 1 May was to go ahead.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 25 June 2009.

PRESENT: Mr L Christie (Substitute for Mrs E Green), Mr G Cooke, Mr B R Cope, Mr D S Daley, Mr M C Dance, Mr K A Ferrin, MBE, Mr G A Horne MBE, Mr J A Kite, Mr R L H Long, TD, Mr A Sandhu, Mr C P Smith and Mr A Willicombe

IN ATTENDANCE: Mr P Sass (Head of Democratic Services and Local Leadership)

UNRESTRICTED ITEMS

1. Membership
(Item 1)

The Committee noted its membership as set out below:-

Conservative (10): Mr G Cooke, Mr B R Cope, Mr M C Dance, Mr K A Ferrin MBE, Mr G A Horne MBE, Mr J Kite, Mr R L H Long TD, Mr A Sandhu, Mr C Smith, Mr A Willicombe

Liberal Democrat (1): Mr D S Daley

Labour (1): Mrs E Green

2. Election of Chairman
(Item 3)

RESOLVED that Mr G A Horne MBE be elected Chairman of the Committee.

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Audiology Update

Background – Extract from Minutes relating to Meeting of 6 February 2009.

13. Audiology Update
(Item 4)

(1) Following the Committee's previous consideration of Audiology Services across Kent, the two Primary Care Trusts for the administrative county of Kent had been written to ask for an update on the progress in implementing some of the views expressed by the Committee when it had previously considered Audiology Services including the future plans for the audiology service.

(2) Within the papers for the meeting, were two updates from both Eastern and Coastal Kent and West Kent Primary Care Trusts.

(3) The Chairman indicated that should Members have any questions that they wished to raise with the two PCT's who were not present to respond to any questions, then these questions should be forwarded to the Research Officer to the Health Overview and Scrutiny Committee or the Overview and Scrutiny Localism Manager. As a consequence the following additional questions were raised by Members of the Committee:-

a. Given the importance of testing the hearing of newborns, can the PCTs provide further information on any newborn hearing screening programmes they have and how many children are being screened?

b. What provision is made for testing military personnel returning from conflict situations and are they given priority?

c. Can NHS West Kent clarify the situation regarding patients in the Dartford, Gravesham and Swanley areas? Your report refers to additional capacity extending capacity for patients in the Maidstone and Tunbridge Wells areas, but what about those patients who have audiology services provided by NHS Medway? Does the statement that patients across West Kent are assessed within 6 weeks and treated within 18 weeks include patients in north Kent?

d. Can NHS Eastern and Coastal Kent name the sites from which Hearbase operate in Folkestone, Ashford, Canterbury and Dover?

e. What provision exists for GPs to carry out hearing tests and what encouragement is there for GPs to advertise hearing tests?

f. Can the PCTs provide more information about progress in searching for willing providers as well as what plans are in place to ensure audiology services are sustainable in the future?

g. What plans are there for encouraging "high street audiologists" in the same way as there are high street opticians?

h. What public education campaigns around the dangers to hearing exist aimed at young people?

i. What plans are being made to provide services in Kent so that Kent patients do not have to travel to London hospitals?

j. The reports suggest that adult audiology serviced in Swale are provided by NHS Eastern and Coastal Kent and paediatric audiology services in the same area are provided by NHS West Kent. Can the trusts provide assurances that this does not create confusion in the provision of services?

NHS
Eastern and Coastal Kent

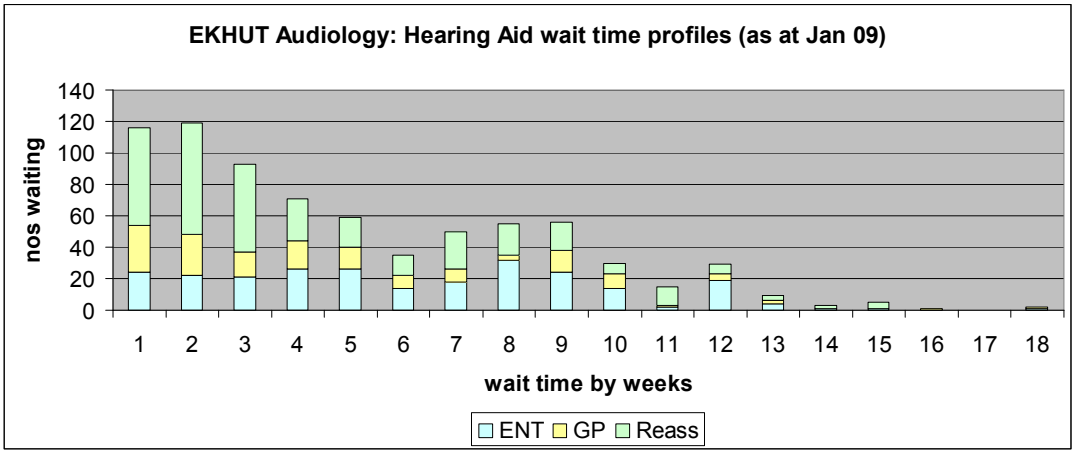
Audiology Services in East Kent briefing paper March 2009

Following an update made at the HOSC meeting of 6th February, this paper is intended to give an additional update on the services currently provided by the Audiology Service commissioned by NHS Eastern and Coastal Kent. It addition it sets out to answer the supplementary questions asked by the HOSC committee.

Current position:- East Kent Hospitals University Foundation Trust (EKHUFT)

As at the end of January 2009, NHS Eastern and Coastal Kent have 748 patients waiting for audiology services at East Kent Hospital University Foundation Trust (EKHUFT). All patients are on an 18 week pathway and will be seen within that time frame unless they choose to extend their pathway through exercising their own personal choice. The average wait for audiology at EKHUFT is now 10 weeks from referral through to the fitting of a hearing device.

Figure 1 waiting list profile at EKHUFT



Current waiting times for patients seen by an audiologist working in a community setting remain at an average of 4 weeks from referral.

Current position:- Medway Foundation Trust

Medway Foundation Trust remain a key provider of audiology for Swale patients, referral into the service is made either directly into audiology for those patients over 65 years of age or through an ENT pathway for all other patients.

The current wait for an ENT 1st appointment is 5 weeks, onward referral into audiology if it is required is 4 weeks. In addition to the provision Swale GPs are able to access an

audiologist placed by ECKPCT at Sittingbourne memorial medical practice this is accessible through local choose and book with current waits of a maximum of 6 weeks.

Supplementary questions following February update

1. Given the importance of testing the hearing of newborns, can the PCTs provide further information on any newborn hearing screening programmes they have and how many children are being screened?

The newborn hearing screening programme within NHS Eastern and Coastal Kent is well established and follows national guidelines. Over the last year the number of babies on the programme was 7334.

Please see appendix 1 for an outline of the screening pathway

2. What provision is made for testing military personnel returning from conflict situations and are they given priority?

Although the DOH has issued a paper on priority treatment for ex servicemen (*meeting the healthcatre needs of Armed Forces Personnel their families and veterans*). This covered specialist care outlining the services provided at hospitals with which the MOD has a contract. Audiology was not covered in this document and as such testing is offered through our current acute and community teams (current waits are outlined above)

3. Can NHS Eastern and Coastal Kent name the sites from which Hearbase operate in Folkestone, Ashford, Canterbury and Dover?

Hearbase operate from the following locations:-

Hearbase Ltd 140 Sandgate Road Folkestone CT20 2TE	Hi Kent 46 Northgate Canterbruy CT1 1BE	Kenneth Bird Opticians 7 Park Place Ladywell Dover CT16 1DF	St Stephens Medical Centre St Stephens walk Ashford TN23 5AQ

In addition to the above, Hearbase are also offering services at the Spencer Wing at Queen Elizabeth the Queen Mother Hospital in Margate.

4. What provision exists for GPs to carry out hearing tests and what encouragement is there for GPs to advertise hearing tests?

Currently GP's do not carry out hearing tests, but patients with hearing difficulties are offered a choice firstly as to whether they would like the opportunity of having an audiometry test and secondly as to where they would like to have that test carried out.

5. Can the PCTs provide more information about progress in searching for willing providers as well as what plans are in place to ensure audiology services are sustainable in the future?

As commissioners we continue to proactively search for interested willing providers to declare their ability and desire to provide services in the future and extend choice for patients. As we establish the future levels of demand we will be working in partnership with all interested parties and stakeholders to establish a platform for sustainable services across the economy, and in addition to this will ensure that services are established in rural and hard to reach areas.

6. What plans are there for encouraging "high street audiologists" in the same way as there are high street opticians?

High street audiologists are encouraged to tender for NHS work through the "Supply to Health" website as and when commissioners identify the need for additional providers. ECKPCT plan to advertise shortly for increased audiology provision in some hard to reach areas (i.e. Tenterden and New Romney)

7. What public education campaigns around the dangers to hearing exist aimed at young people?

The Lead Commissioner for Head and Neck Services within NHS Eastern and Coastal Kent is planning to carry out social marketing work alongside Public Health experts and with the Communications team "HOUSE" initiative specifically to educate teenagers over the dangers of playing music and games through personal sound systems (IPODs) at too loud a volume highlighting the long term damage that can be caused by this behaviour.

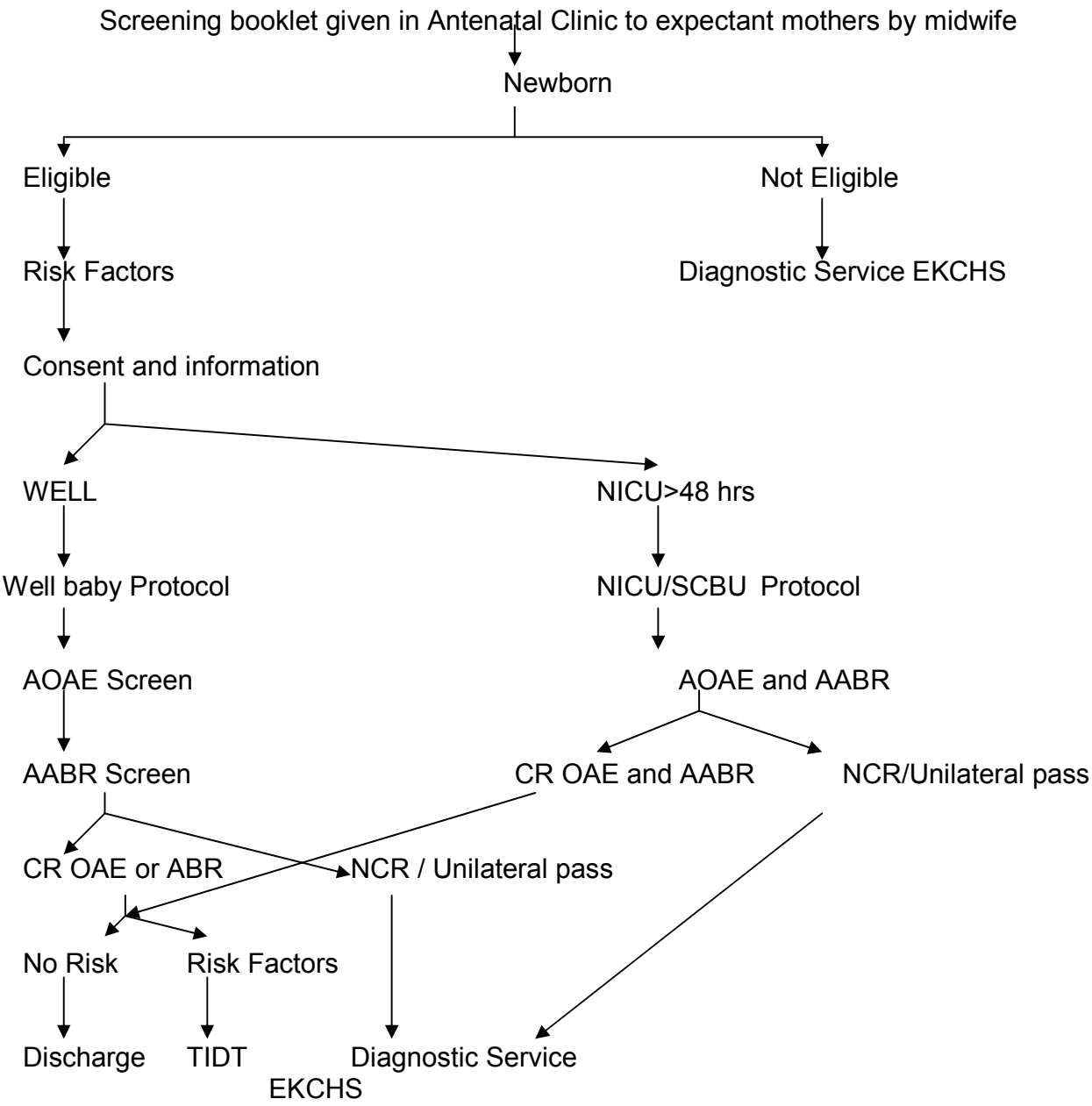
8. What plans are being made to provide services in Kent so that Kent patients do not have to travel to London hospitals?

We have had significant success in providing audiology services closer to home, this means that patients would only travel to London for their treatment if they chose to do so. As such Eastern and Coastal Kent patients are able to choose London providers as a choice option , however a full range of audiology services are fully available through our local acute provider supplemented by community and private audiologists.

9. The reports suggest that adult audiology serviced in Swale are provided by NHS Eastern and Coastal Kent and paediatric audiology services in the same area are provided by NHS West Kent. Can the trusts provide assurances that this does not create confusion in the provision of services?

Whilst paediatric audiology services for Swale patients are largely provided through NHS West Kent, we have been working with EKHUFT to establish opportunities to offer their services as a choice option. Further work is being done to establish options for outreach by EKHUFT into the Swale area. However to assure that the current approach does not lead to confusion, robust adherence to patient pathways is endorsed through communication to General Practitioners and performance monitoring by commissioners is being put into place.

Appendix 1



Diagnostic test currently done by ENT dept, with appointment of Paediatric Audiologist the test will be done under EKCHS along side the Audiological Physician's clinic.

<u>Diagnostic Service</u>

- ABR pass, if click 35 dBnHL and tone pip 40 dBnHL (BC if indicated)
- ABR optional for well babies OAE bilateral pass is sufficient (2 octave=>6 dB)
- Tympanometry high frequency (if less than 4 months old)

NHS
West Kent

West Kent Primary Care Trust
Wharf House
Medway Wharf Road
Tonbridge
Kent
TN9 1RE

Telephone: 01732 375200
Fax: 01732 362525

Paul Wickenden
Overview, Scrutiny and Localism Manager
Kent County Council
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Sessions House, County Hall
Maidstone, Kent
ME14 1XQ

25 March 2009

Dear Paul

Health Overview and Scrutiny Committee – Audiology Updates

Further to your letter of 3rd March 2009, please find below further details on audiology to answer the committee's questions:

1. Newborn Hearing Screening within West Kent offered screening to 1080 babies in December 2008. This included babies born at Medway Hospital who are mainly Medway and Eastern & Coastal babies. As a programme we are now offering screening to all eligible babies.
2. There is provision for testing military personnel returning from conflict in a timely manner via services provided at Medway Foundation Trust and Maidstone and Tunbridge Wells NHS Trust. Within Medway Foundation Trust, these patients would normally be seen by ENT in the first instance to establish whether there were any conditions requiring immediate surgical intervention but a hearing test would be performed in the audiology clinic. Maidstone and Tunbridge Wells NHS Trust has confirmed that military personnel are prioritised and treated as appropriate.
3. We can confirm that Dartford, Gravesham and Swanley patients receive audiology services, provided by Medway Trust, at Gravesham community hospital and Darent Valley Hospital. These patients are receive a hearing assessment within 6 weeks and are treated within 18 weeks
4. NA
5. Currently GPs do not carry out hearing tests. However, Clinicenta are currently considering providing each surgery that uses their service with handheld initial testers.
6. We have a collaborative approach between the PCT and Maidstone and Tunbridge Wells NHS Trust to establish how a patients needs are met in the best place by the best person. Meetings are shortly to take place to discuss sustaining audiology services and the future of where this service may be best provided, which could be "high street audiologists". We have already used a range of high street providers to assess and treat our patients and we will continue to do so when there is a need. We may move to an any willing provider model in the future, when current contracts expire, and of course 'high street audiologists' will be free to apply for consideration
7. As per question 6

8. Currently the PCT has no public education campaigns in place; however Hi Kent is a member of RNID and actively supports their campaigns, such as the latest campaign 'Don't Stop the Music', so are helping them to get their message out in Kent. In addition, Hi Kent is in the process of acquiring funding for a research project into this issue. They intend to carry out research over the next year with a view to publicising our findings during Deaf Awareness Week in May 2010. We also intend to give a series of talks on the findings to Kent schools reaching as many young people as possible.
   The PCT will need to consider public education on use of for example ipods- which could be done via our volunteer organisations such as Hi Kent, RNI, as the Hi Kent response suggests.
9. Patients currently do not have to travel to London Hospitals for audiology services as hearing assessment and fitting of hearing aids are provided at Maidstone, Kent and Sussex, Sevenoaks, Darent Valley and Gravesham Community hospitals, a service is also provided at Preston Hall Maidstone. A patient, however, may choose to have an appointment in London as outlined in the PCTs Free Choice Strategy.
10. Medway Foundation Trust provide some of the adult services in Swale under a block contract with NHS Eastern and Coastal Kent. Paediatric services are provided in Swale by West Kent Children's Hearing Services based at Preston Hall.
    The adult service at Medway Hospital will see children for specialist testing that cannot be provided by the children's service. This is undertaken by the Consultant Audiological Physician and includes taking impressions for all the paediatric earmoulds.

I hope this addresses the Committee's queries, if you require any further information please don't hesitate to contact me.

Yours sincerely

Steve Phoenix
Chief Executive

Delayed Transfers of Care Update

Background – Extract from Minutes relating to Meeting of 6 February 2009.

Extract from minutes of meeting 17 October 2008:

(55) RESOLVED That the Chairman and Spokesmen would agree recommendations based on the issues raised during the discussion.

The following recommendations on the issue of delayed transfers of care following the meeting of the Health Overview and Scrutiny Committee on 17 October 2008:-

1. The Committee congratulates social services and the NHS on their partnership working in tackling delayed transfers of care and, once the different pilots have been fully assessed, the Committee asks that the Trusts and KASS look at the possibility of spreading best practice across the whole county, as well as looking closely at best practice in other areas of the country.

2. The Assessment Beds Pilot in East Kent has the full support of the Committee and requests an update by July 2009 containing an evaluation of the pilot and details as to how it has been taken forward.

3. The Committee supports the aims of the Discharge Planning Pilot in West Kent and requests an update by July 2009 containing an evaluation of the pilot and details as to how it has been taken forward.

4. The Committee commends the establishment of a joint agreement on non-weight-bearing patients in West Kent and asks to be informed by the three parties involved whether, at the end of its first year of operation, it will be continued.

5. The Primary Care Trusts in Kent and KASS shall be asked to provide a yearly written update to the Committee containing the numbers of community, nursing and residential beds available to people in Kent so as to provide information on capacity in the county.

6. The Committee shall request further information from KASS and NHS Trusts in Kent regarding existing patient advocacy service provision.

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Eastern and Coastal Kent

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31 March 2009

Mr P Wickenden
Overview, Scrutiny & Localism Manager
Democratic Services & Local Leadership
Sessions House
County Hall
Maidstone
Kent ME14 1XQ

Dear Paul

I refer to your letter of 26 January 2009 and would like to respond with particular reference to your request regarding further information regarding patient advocacy service provision.

Independent Complaints Advocacy Service (ICAS)
Section 12 of the Health and Social Care Act 2001 places a duty on the Secretary of State for health to make arrangements to provide Independent Advocacy Services to assist individuals making complaints against the NHS. The Independent Complaints Advocacy Service (ICAS) supports patients and their carers wishing to pursue a complaint about their NHS treatment or care. This statutory service was launched on 1 September 2003 and provides a national service delivered to agreed quality standards.

For the South East area the service is provided by South East Advocacy Projects (SEAP). Complainants who contact the Customer Services Team at the PCT are provided with information about ICAS. Those who may have a communication difficulty are always actively urged to make use of the ICAS whose services are outlined in the attached leaflet.

Patient Advice and Liaison Service
PALS has been in place nationally since 2002. It is their remit to help and support people and to empower them to take actions and decisions based on options suggested.

Each health trust has its own PALS which is primarily telephone based, although in East Kent, PALS for NHS Eastern and Coastal Kent is established in a readily accessible health shop in Canterbury. In the acute hospitals there are signs, posters and volunteers to help or alternatively to signpost to people more qualified to answer specific queries. PALS may also be contacted via email, letter or fax.

Recently the Patient Advice and Liaison Service in the East Kent Hospitals Trust merged with their Complaints Department to become the Patient Experience Team. A similar merger took place within NHS Eastern and Coastal Kent. The two services are now known collectively as Customer Services but PALS retains its individual branding. Every NHS professional should know about and be able to signpost to PALS. Leaflets are available in GP surgeries, pharmacies, dental practices, libraries etc. Contact details are available in Health News, Yellow Pages and the local NHS website.

I trust this provides the information you are looking for but please contact me should this not be the case.

Kind regards

Yours sincerely

Glynis Alexander

Glynis Alexander
Deputy Director of Communications

cc Ann Sutton
Tristan Godfrey

NHS
Eastern and Coastal Kent

Urgent Care Commissioning
Commissioning Directorate
Templar House, Tannery Lane
Ashford, Kent, TN23 1PL

Tel: 01233 658473
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19th June 2009

Paul Wickenden
Overview, Scrutiny & Localism Manager
Kent County Council – Legal & Democratic Services
Sessions House
County Hall
Maidstone
Kent ME14 1XQ

Dear Paul,

Assessment Beds Pilot – Eastern and Coastal Kent

I am writing in response to your letter send earlier this year requesting an update by next month on the evaluation of the Assessment Beds Pilot and details of how this work is being taken forward.

Please see attached paper which gives an overview of the pilot and its evaluation. The paper also summarises some of the processes that are now being incorporated into the new Transfer of Care Pathway that is currently being developed. This pathway will be commissioned over the coming months, builds on the learning of the pilot and will include joint health and social care (whole systems) responsibilities along the patient pathway to prevent delayed transfer of care.

The recently completed NHS Eastern and Coastal Kent Urgent Care Commissioning Strategy (2009-2013) firmly outlines that one of its many commissioning intentions is to improve transfers of care.

If you need any further information in relation to this work please do let me know.

Yours sincerely

Zoe Fright
Senior Lead Commissioner Urgent Care

NHS

Eastern and Coastal Kent
Community Services

NHS
Eastern and Coastal Kent

Assessment Beds Pilot
Evaluation and Way Forward
(Report for Health Overview and Scrutiny Committee)

Introduction & Context

Joint approaches to admission and discharge planning is key to ensuring that people move from and to the most appropriate setting at the point they are medically fit to do so. The planning of a patients discharge should happen at the point they are admitted and systems need to be in place to effectively 'in-reach' into acute hospitals to identify which patients may benefit from Intermediate Care to assist with reducing delays.

The (DOH 2003) in their document *Discharge from Hospital: pathway, process and practice* suggest that practices and processes must be in place to ensure the best outcomes and maximize independent living for all adults discharge from acute settings. It should be understood that:

"*Many people admitted to hospital fear the experience of hospitalization and of losing their autonomy; they want to return to their previous lives as soon as possible and every effort should be made to help them do so.*" and "*Acute hospitals should only be used for the delivery of services that cannot be provided as effectively elsewhere in the health service, social care or housing system.*" DOH (2003: 6)

Older people make up a large number of those whose discharge is delayed whilst awaiting other services, the Audit Commission (2000) report *The Way to go Home: Rehabilitation and Remedial Services for Older People* suggested that once a patient's medical condition has stabilised the full range of hospital services is not always needed and intermediate care could be used instead.

Discharge planning remains problematic and an area of concern despite much research and government legislation. Increasingly there is incentive and emphasis on managing acute hospital beds, targets to meet in accident and emergency departments and reduction in delayed transfers of care. At a nursing level the discharge planning process is not well understood and there is a need to educate nurses in the principles of the discharge planning process. Furthermore by having an 'in-reach' into acute hospitals identifying which patients may benefit from Intermediate Care may assist in reducing the length of patient stay.

The "Assessment Bed Pilot" was undertaken as part of the Urgent Care Programme. The aims of the pilot were as follows:

- Utilise community hospital beds / Kent Adult Social Services Registered Care Centre beds across East Kent, to support appropriate discharge from acute hospital beds when a patient is medically fit for transfer;
- Reduce the number of reportable delayed transfers of care;
- Facilitate improved patient outcomes;
- Reduce institutionalisation rates.

The Pilot was tested across the Canterbury locality and covered the following sites:

Eastern and Coastal Kent
Community Services

- Kent and Canterbury Hospital;
- Whitstable and Tankerton Community Hospital;
- Queen Victoria Memorial Hospital in Herne Bay;
- Ladesfield Registered Care Centre in Whitstable;
- Kiln Court Registered Care Centre in Faversham.

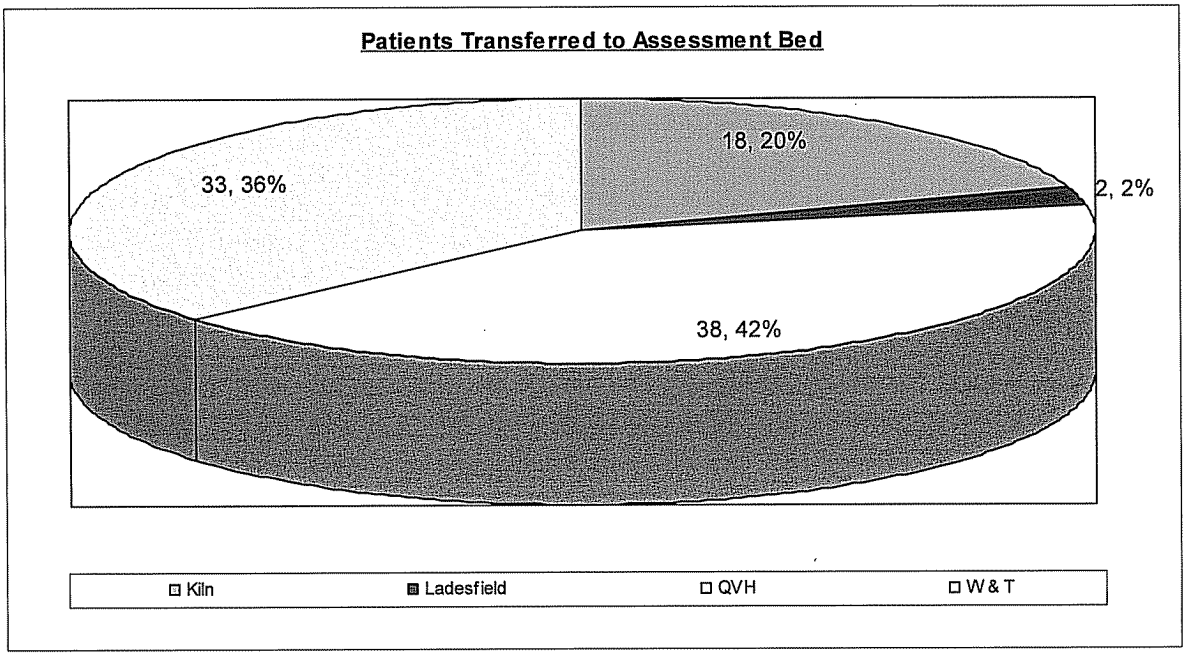
Pilot timeframes

- The Pilot ran for a 24week period from Monday 25th February to Sunday 10th August 2008.

The following outcomes were achieved as a result of this pilot in accordance with the stated aims.

a) AIM: Utilisation of community hospital beds / Kent Adult Social Services Registered Care Centre beds across East Kent, to support appropriate discharge from acute hospital beds when a patient is medically fit for transfer.

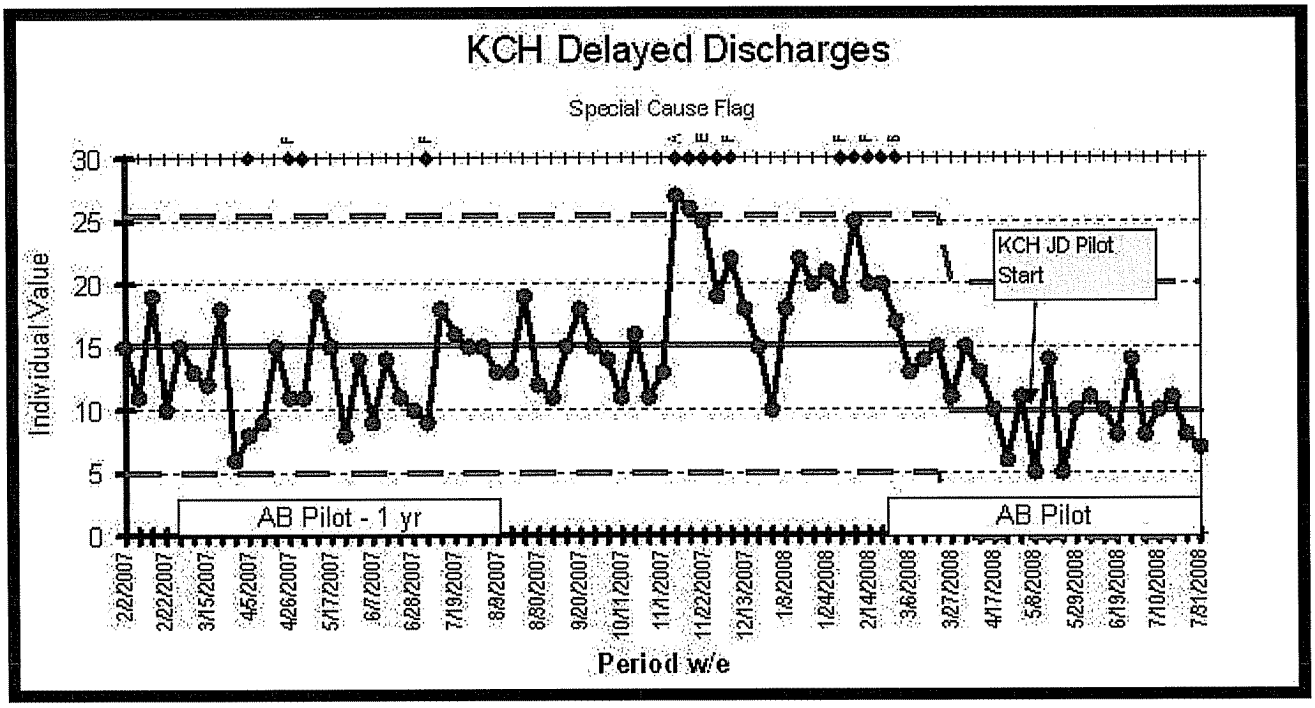
During the 24 weeks of the pilot 105 patients were accepted for transfer from the acute site at KCH to Assessment Beds in Community Hospitals and Care Centres. Of this number 91 (87%) were actually transferred to the sites shown below. All these patients would have remained at the acute site, although medically fit for discharge. Patients were transferred to Community Hospital beds prior to the pilot via other processes, and under different medical cover arrangements.



b) AIM: Reduction in the number of reportable delayed transfers of care.

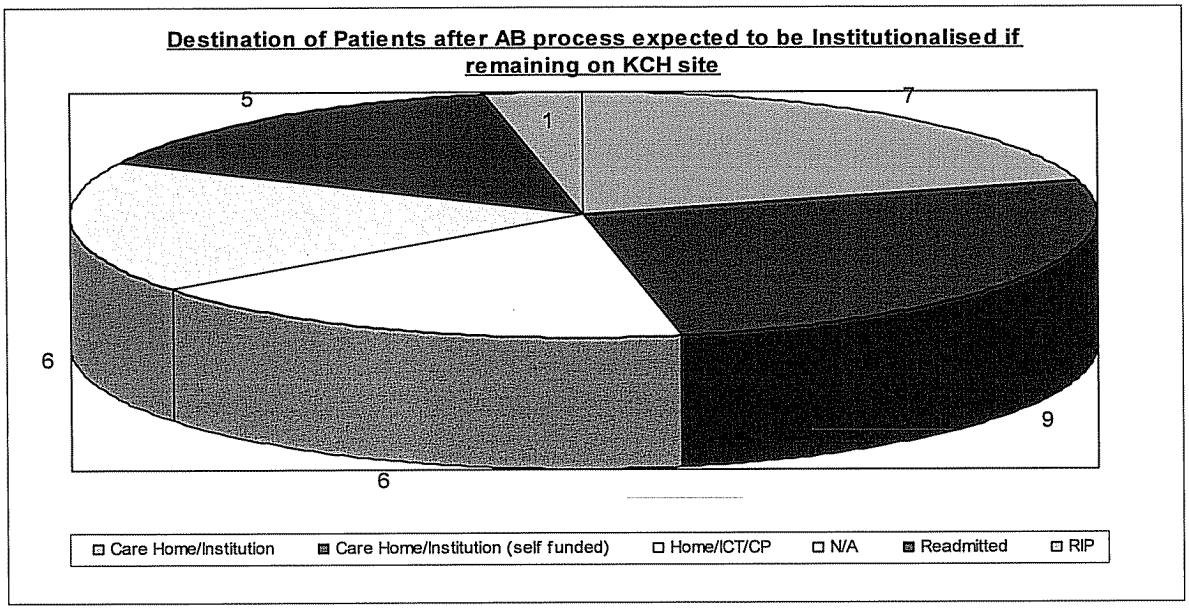
The numbers of Delayed Discharges at KCH has reduced from around 20 delays per week at the start of the pilot to an average of 10 per week (as shown by the green line) at the end of the pilot. Delays have reduced in the categories of choice and assessment. Of particular note are the self funding clients who often become a delay under choice health. Self funders were not excluded from access to assessment beds. The category of assessment has seen

reduced in as much as the assessment beds have provided opportunity to move some patients who have complex, fluctuating needs out of the acute setting. Being able to use the beds flexibly has definitely had an impact on delays, as has being able to transfer people from EEC and CDU, so that they do not even get into the main hospital system. It does have to be acknowledge that a number of changes occurred around about the same time. The introduction of a care management turn around team at the front door, and the discharge facilitation team (dedicated ICT lead nurse and care manager) started on the same day as the assessment bed pilot. In addition the Joint discharge team approach commenced within a few weeks, where early discussion about potential delays took place.



c,d) AIM: Facilitation of improved patient outcomes
AIM: Reduction in Institutionalisation Rates

34 of the patients who completed the Assessment Beds Pilot process had an expected discharge destination of a care home or other residential institution. Had the Pilot not been in place, therefore, all 34 of the patients, whose outcomes following the pilot are displayed below, would have been institutionalised. The chart shows that 6 of these patients (18%) were able to return home with an ICT care package, showing an improved outcome for these patients. N/A signifies that these patients (6) had yet to complete the pilot process to date.

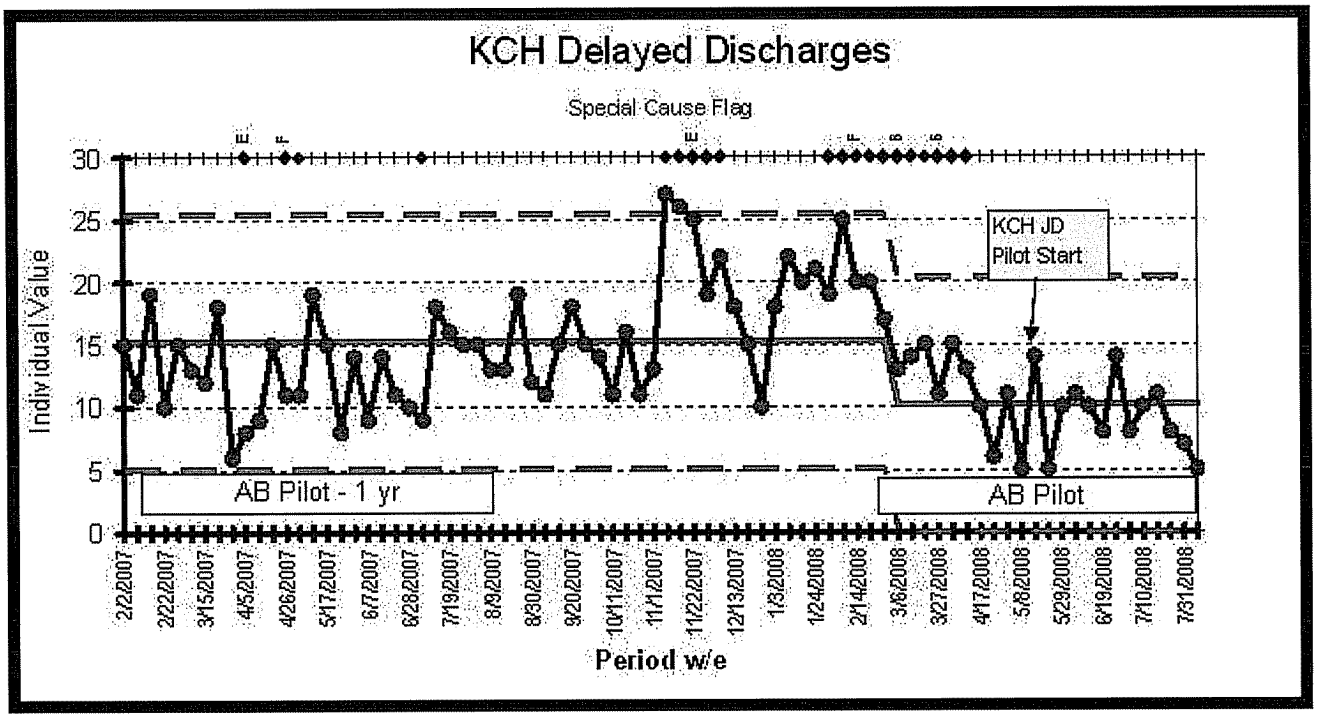


27 of the patients who completed the Assessment Beds Pilot process had an expected discharge destination of Home with a level of ICT care. Had the Pilot not been in place, therefore, all 27 of the patients, whose outcomes following the pilot are displayed below, would have been discharged home and a care package arranged. In addition, these discharges may have caused delays in the patients discharge whilst an appropriate care package was arranged.

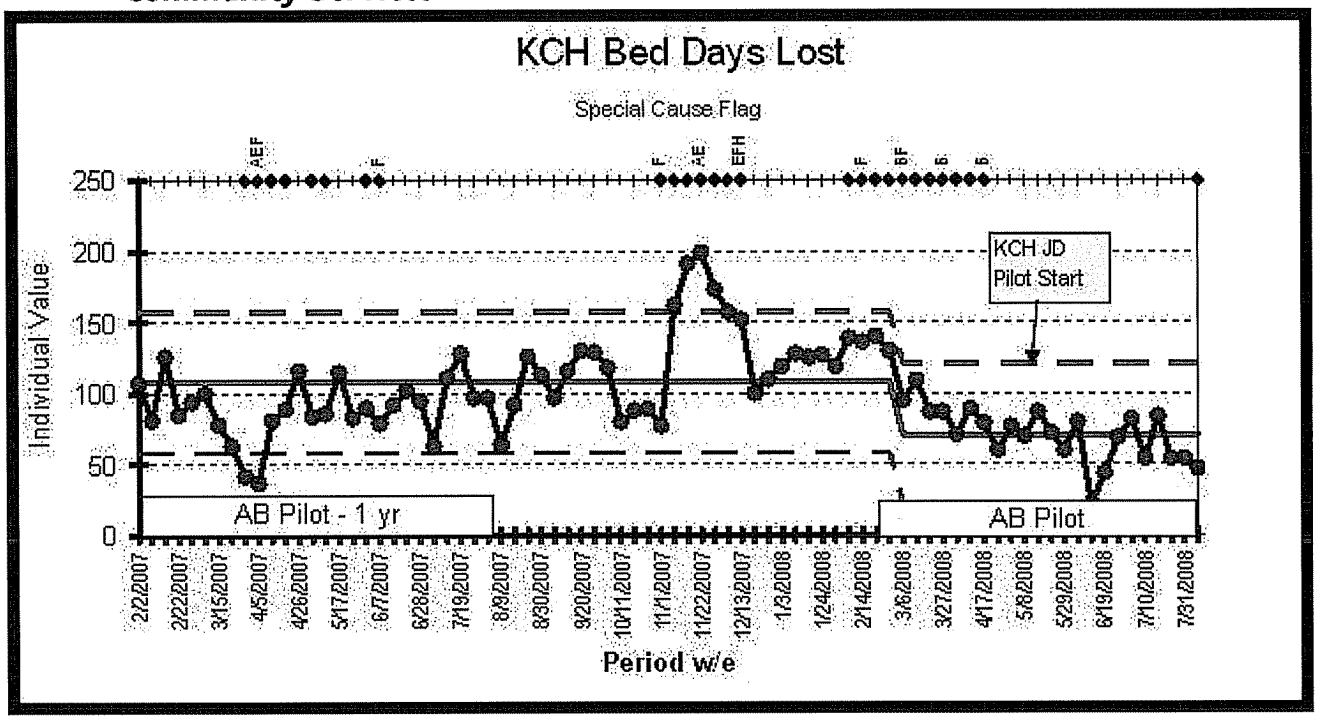
DTOC/Delayed Discharges/Bed Days Lost

The 24 week pilot period is indicated by the [AB Pilot] box. The equivalent period last year is indicated by the [AB Pilot – 1 yr] box. The KCH Phase of the Integrated Discharge pilot runs concurrently with the AB pilot as indicated.

- The numbers of delayed discharges and bed days lost as a result of delayed transfers of care **have reduced significantly from the beginning of the pilot, both at KCH and across all EKHT sites.** The 24 week period covered by the [AB Pilot] box illustrates the reduction from 20 at the start of the pilot (25th Feb) to 7 during the week ending 31st July. However the equivalent period last year (covered by the 16 week [AB Pilot – 1yr] box) shows a similar reduction during this time. This could be considered a seasonal variation, and not attributable to the AB pilot, however the reduction seems to have been sustained, and we also know there have been changes in the types of delay. The step-down as shown by the red dashed lines also coincides with the start of the AB pilot, and not with the start of the KCH JD Pilot.



The number of Bed Days lost at KCH and across all EKHT sites shows a sustained reduction from the start of the Pilot as shown in the step down on the 2 charts below. The equivalent period last year also shows an initial sharp reduction though the number of days lost then returned to average levels at the end of the 24 week period.


KCH Bed Days Lost
Special Cause Flag
Individual Value
250
200
150
100
50
0
KCH JD
Pilot Start
AB Pilot - 1 yr
AB Pilot
2/2/2007
2/22/2007
3/15/2007
4/5/2007
4/26/2007
5/17/2007
6/7/2007
6/28/2007
7/19/2007
8/9/2007
8/30/2007
9/20/2007
10/11/2007
11/1/2007
11/22/2007
12/13/2007
1/3/2008
1/24/2008
2/14/2008
3/6/2008
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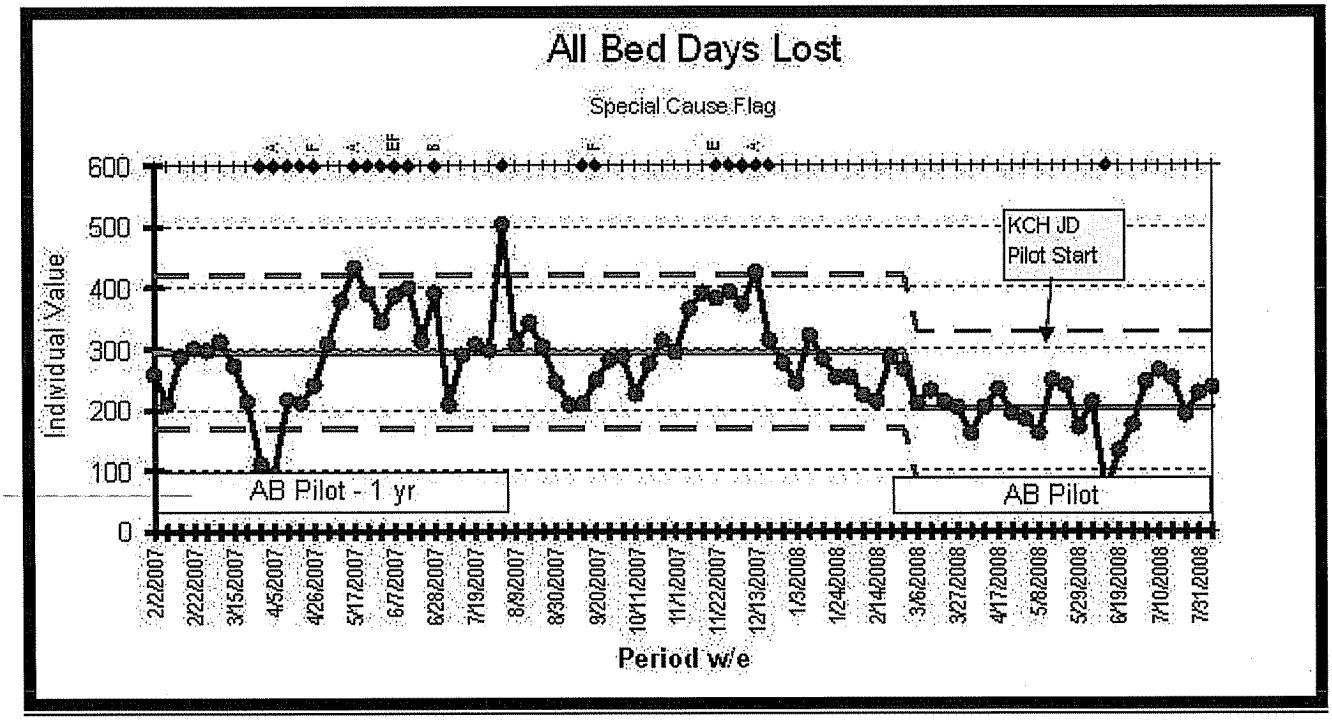
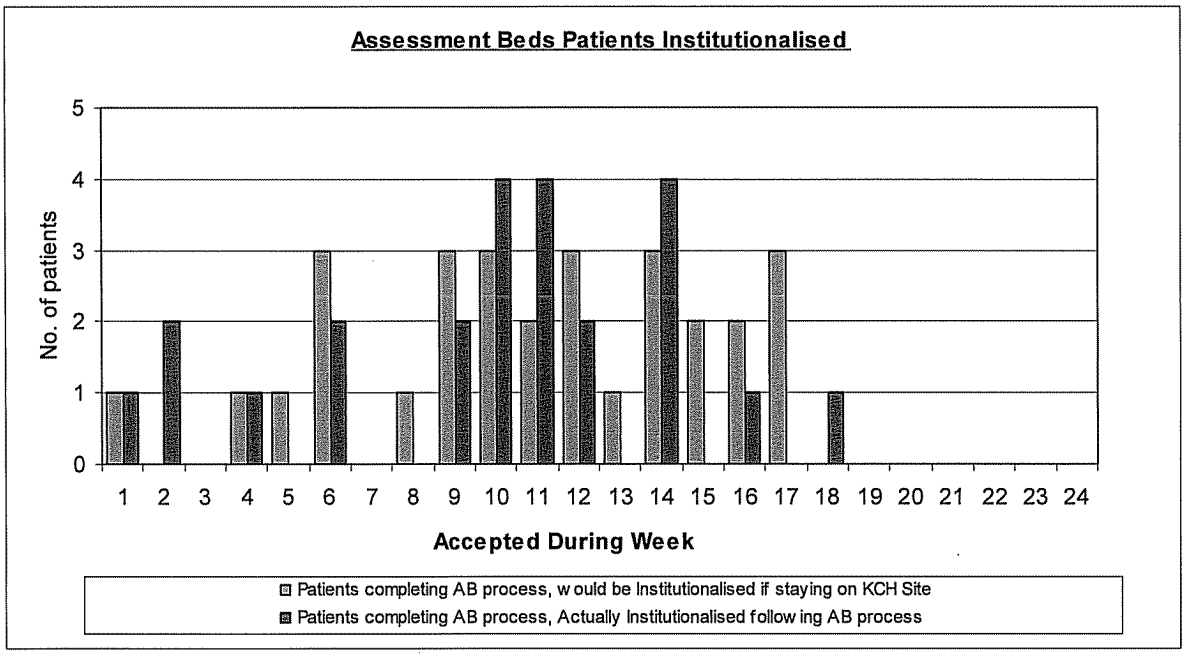
4/17/2008
5/8/2008
5/29/2008
6/19/2008
7/10/2008
7/31/2008
Period w/e

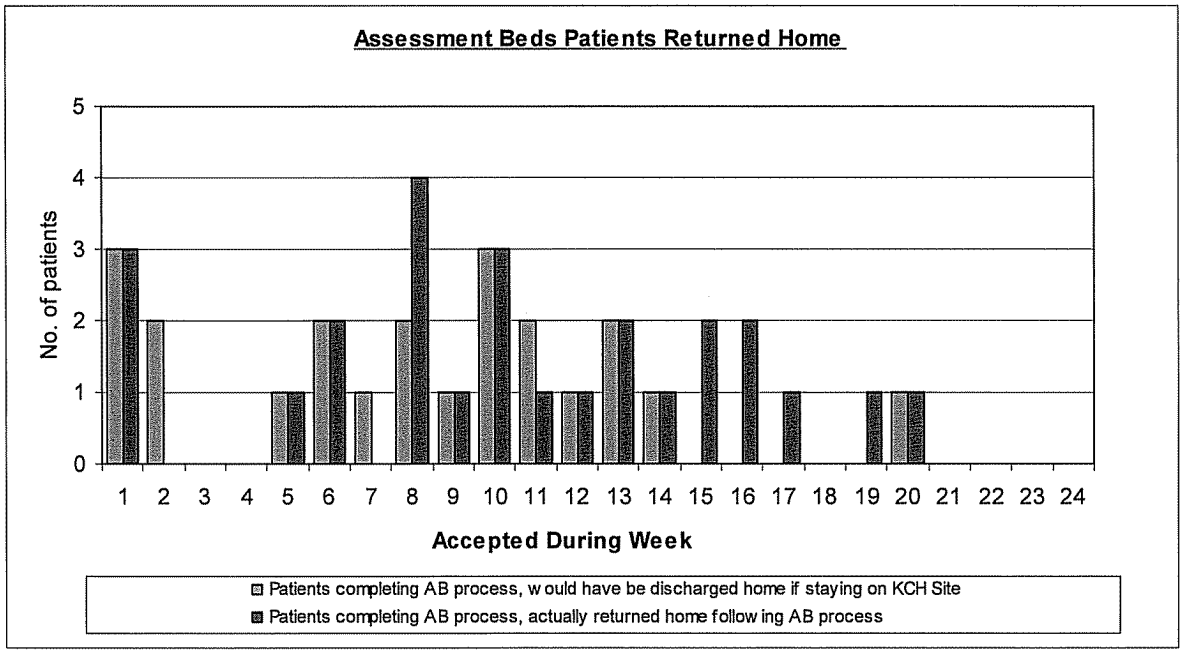

All Bed Days Lost
Special Cause Flag
Individual Value
600
500
400
300
200
100
0
KCH JD
Pilot Start
AB Pilot - 1 yr
AB Pilot
2/2/2007
2/22/2007
3/15/2007
4/5/2007
4/26/2007
5/17/2007
6/7/2007
6/28/2007
7/19/2007
8/9/2007
8/30/2007
9/20/2007
10/11/2007
11/1/2007
11/22/2007
12/13/2007
1/3/2008
1/24/2008
2/14/2008
3/6/2008
3/27/2008
4/17/2008
5/8/2008
5/29/2008
6/19/2008
7/10/2008
7/31/2008
Period w/e

Outcomes of those in Assessment Bed Process

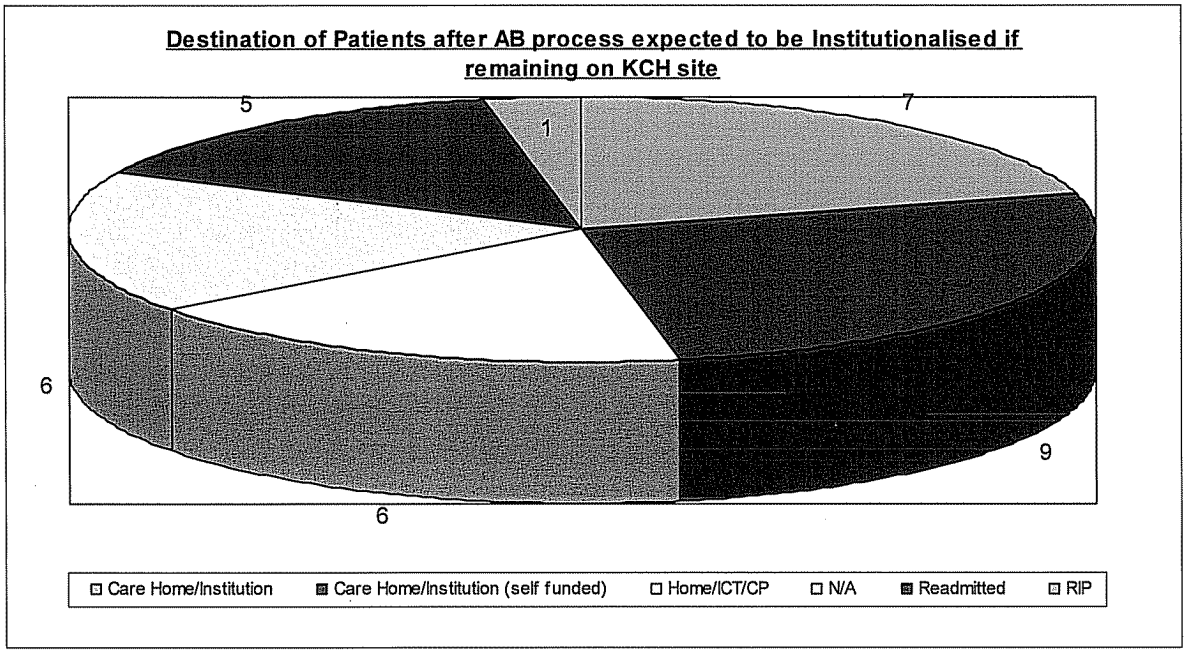
As a result of the assessment beds pilot, 5 patients who would have been placed into a care home setting were able to return home, with a level of ICT input. 5 patients who would have been placed into a care home setting were re-admitted.



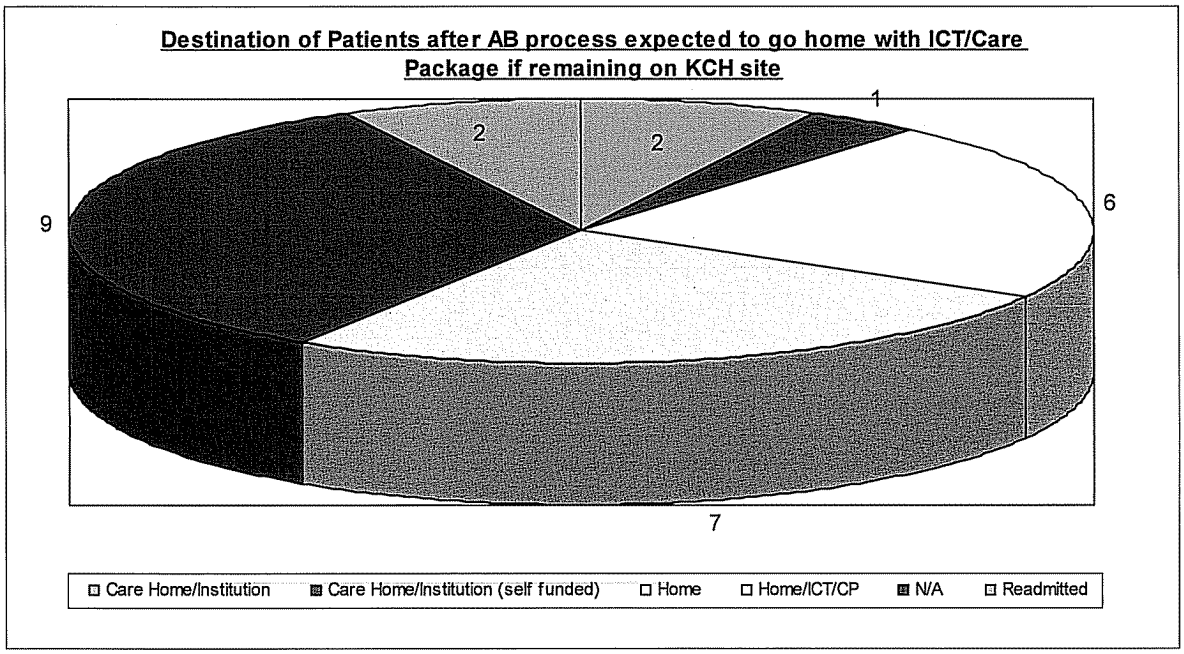
22 patients having completed the process would have returned home following discharge from KCH, 26 were actually able to return home following the AB process.



36 out of 91 patients going into an assessment bed were expected to enter a care setting while only 4 were expected to return home without ICT/CP input

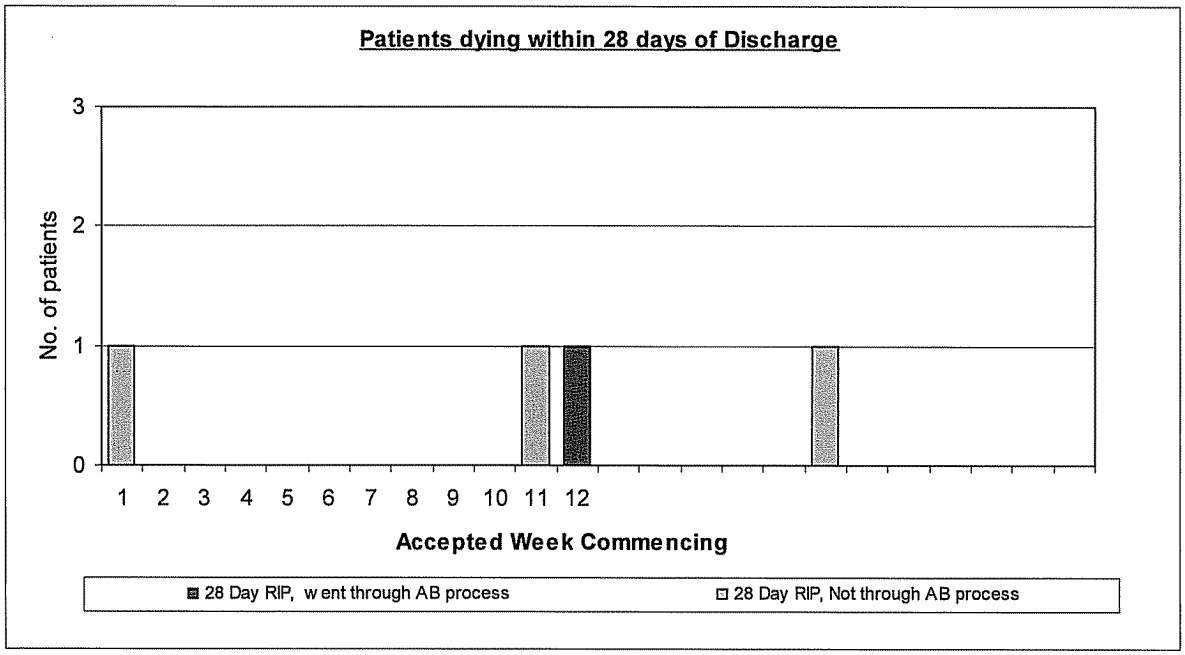


6 patients who would have previously required ICT/CP input at home were able to return home without this service. 3 of these patients was institutionalised. N/A = not completed AB process.



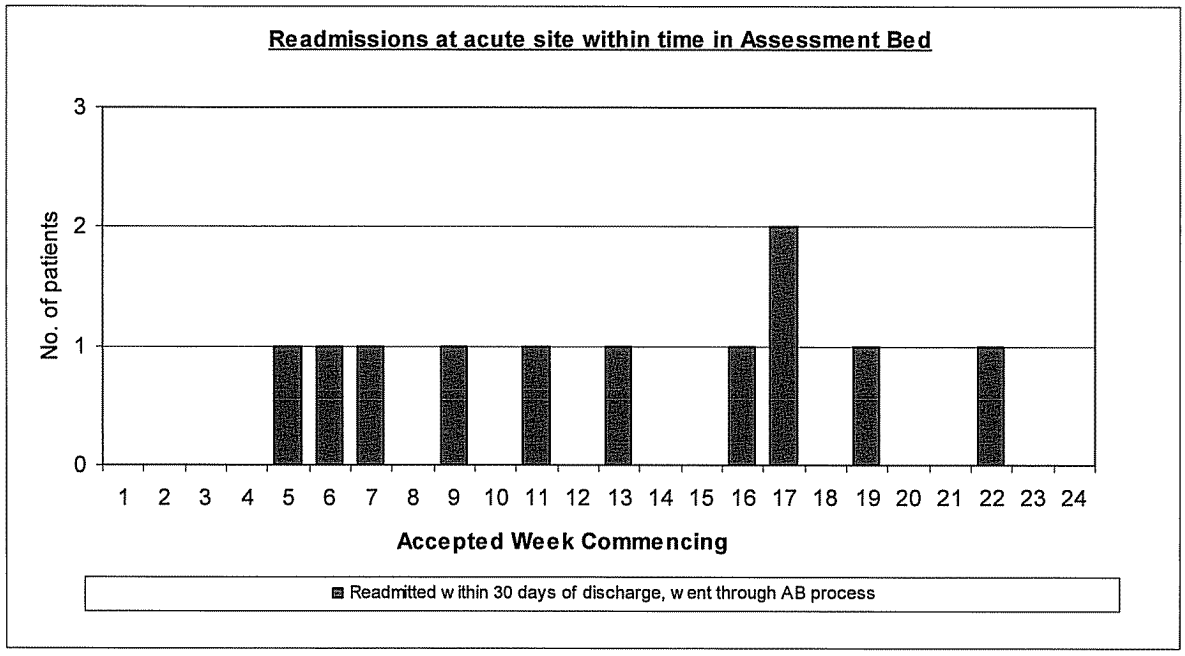
28 Day Mortality from date accepted for Assessment Bed

Across the pilot thus far there have been 4 deaths, 1 of which was within 28 days of acceptance. The latter patient was moved onto the Liverpool care pathway and remained at the community hospital.



30 Day Readmissions from date discharged from acute site

11 patients were readmitted. 1 patient was re-admitted due to bed closure at W&T, the others were readmitted as acutely unwell.



Progress since the Pilot

Following the success of the assessment bed pilot the operational process and patient categories have been further developed.

Given the pressures seen on acute hospital beds over the last winter the intention is to progress the following process:

- Attention will be primarily be focused on CDU / MAU and the medical wards by Social Services Care Managers and Intermediate Care Nurses proactively 'case finding' patients who are >75 years or complex <75 years.

- Orthopaedics and Surgical patients will enter the process by way of referral from the Matrons, Ward Managers or Care Manager, for the flowing reasons:
    - Patient has been slow to recover following a complication as a result of surgery;
    - Patients with a complicating condition i.e. Dementia;
    - Patients who cannot return home (where ever that might be) due to complexity of current condition and longer term needs that are indicating the outcome may be - home to Residential Home, Residential Home to Nursing Home, or fully funded NHS Continuing Care.

Patient Categories:

Category 1	Requiring Rehabilitation / Recuperation will go home	Following an acute episode provided either at home or step down into an Intermediate care bed if still requiring 24 hour supervision for assessment & rehabilitation home the definite discharge destination
Category 2	Requiring 24 hour care (residential) or a high level social care package to get home due to functional ability	Following an acute episode step-down into a community hospital bed or Intermediate care bed in a care home for assessment and rehabilitation to improve functional ability to go home rather than Residential care or home with a reduced care package or Residential Care rather than Nursing Care
Category 3	Requiring 24 hour nursing care (nursing or residential) as a result of an acute episode	For step down into a community hospital bed/care home at the point of medical fitness & MDT decision for progress to INP for nursing home care or fully funded NHS continuing care

- Patients to be actively 'case found' from CDU /MAU followed through the system if not able to be discharged after acute assessment, monitoring patients condition to enable early supported discharge or flagged to in-reach discharge team as potential for each of the 3 categories by the MDT/consultant/ward staff;
- Discussion with the Patient/family to agree to transfer into community setting;
- Simple transfer form / Intermediate Care Referral form to be completed as follows:

Simple Transfer Form	Home with Intermediate Care Step-down to Community Hospital
Intermediate Care Referral Form	OPDSU's & integrated care centres, Westbrook, Westview, Independent Care Homes

- Patients transfer to be arranged as soon as possible to the agreed destination – preferably morning or early afternoon but not after 4 pm.

- Discharge from Domiciliary Rehabilitation/Recuperation/Step-down:
  - **Category 1 patients – at home/:** patients to continue rehabilitation /recuperation for an agreed period dependant on need once goals have been achieved patient must be discharged to allow continued through put;
  - **Category 1 patients – in step down:** patients to continue rehabilitation/recuperation with discharge planned with an EDD;
  - **Category 2 patients – in step down:** patients continue assessment and rehabilitation to attempt to improve functional ability to: reduce dependency on domiciliary care and therefore delay premature admission to long term care; prevent admission to long term care (residential) if possible supporting discharge home with a domiciliary care package or placement in Residential rather then nursing care;
  - **Category 3 patients – in step down:** patients to receive their individual needs portrayal (INP) within a step down environment to determine need for placement either in a n nursing home by KASS or fully funded NHS continuing care

These processes will be further defined through 'whole system' partnership working over the coming months and will be part of the newly commissioned 'Transfer of Care Pathway' (supported by additional community / Intermediate Bed Capacity as required). This commitment is outlined in the NHS Eastern and Coastal Kent Urgent Care Commissioning Strategy (2009-2013).

Improving Transfers of Care is a priority area and is recognised as essential to enable health and social care systems to effectively respond to winter pressures. A Joint Commissioner post is currently being recruited to work jointly with all agencies to develop integrated discharge planning processes and Intermediate Care services during 2009. Additional community bed capacity will be identified through a phased approach to enable timely discharges to and from the most appropriate setting of care.

Sue Baldwin, Associate Director of Nursing and Adult Clinical Services

Zoe Fright, Senior Lead Commissioner Urgent Care
June 2009

Your LINk for improving health and social care

www.thekentlink.co.uk

a LOCAL INVOLVEMENT NETWORK

16 July 2009

Report from Kent LINk to Kent Health Overview and Scrutiny Committee

Background

Local Involvement Networks (LINks) were set up in England from April 2008 to give communities a stronger voice in how their health and social care services are delivered. As independent networks of local people and groups, LINks will find out what people want, investigate issues and use their powers to hold services to account.

Key facts about LINks

The following are some of the key things to know about LINks:

- Every local authority with a responsibility for social services has a statutory duty to make arrangements for LINk activity to take place
- Kent County Council (KCC) has entered into a contract with Kent and Medway Networks Ltd to 'host' the Kent LINk until March 2011
- Anyone who lives, works or receives services in Kent can be part of the Kent LINk, as a LINk participant
- LINks are independent and not part of Government or accountable to the Local Authority or NHS. However, they have a duty to report to the Secretary of State for Health through their Annual Report
- LINks remit covers health and social care services in their area
- They have powers to enter and view services commissioned by the respective health and social care authorities, with the exception of children's services
- The remit of LINk includes independent providers of publicly funded services
- LINks has powers to:
    - Obtain information from health and social care commissioners
    - Issue reports and make recommendations and expect a response within a laid down time frame
    - Refer matters to the Council's Overview and Scrutiny Committees concerned with health and social care services
    - Enter certain services and view the care provided

Continued …

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E-mail: info@kmn-ltd.co.uk
Office Hours: Monday – Friday 8.30am - 4.00pm (Answerphone available out of office hours)

The Kent LINk

Following a transitional phase from April 2008, which was managed by KCC, Kent & Medway Networks Ltd was awarded the contract to 'host' the Kent LINk in July 2008. The Kent LINk became a legal entity at its launch on the 3 December 2008, when it endorsed its governance arrangements – these can be obtained on the LINk's website at www.thekentlink.co.uk . Since that time, the LINk has recruited over 550 LINk participants, 81 of whom are LINk participant organisations. The LINk held its first 'Annual' meeting in May 2009 at which it approved its first Annual Report, copies of which have been made available to members. At that meeting the LINk endorsed its work programme for 2009 / 2010, a copy of which is appended to this paper.

Conclusion

The relationship between the Health Overview and Scrutiny Committee of the Council and the Kent LINk is a complementary one and also there is a legal relationship with the HOSC in respect of referrals from the LINk.

a LOCAL INVOLVEMENT NETWORK

Nos	Title	Justification	Project	Who	Start	End
1.	Hygiene, Disinfection and Patient Experience in Hospitals	Effective hygiene is a major issue for all hospitals. Hospitals hygiene performance is recorded on a monthly basis and reports are monitored by the Care Quality Commission and Monitor. Investigation of hygiene in the NHS throughout Kent covering not only the acute hospitals in both East and West Kent but also the community hospitals and the ambulance service. The proposed subjects for the project include hand hygiene, disinfection and patient experience.	The Kent LINk project will be:- • to determine the policy on the use of hand hygiene for both East and West Kent. • to establish a compliance standard • to make unobtrusive observations of the use of selected dispensers • to make observations on a number of occasions throughout an agreed period	CB	01/09/09	31/12/09
2.	Hygiene, Disinfection and Patient Experience in Hospitals	It is important to establish the policy of disinfection. How is it done, what is used, how often it is done, what chemicals, if any are used and how it is monitored to ensure incidents of infections such as MRSA and Clostridium Difficile are reduced.	The Kent LINk project will be:- • to discuss with Infection Control departments their policies on the issues listed • to investigate frequency of deep cleaning, concentration of available chlorine in the made-up buckets, methods of making up the chlorine disinfectant and the frequency of renewal, monitoring surfaces for MRSA, monitoring the use of micro fibre cloths and mop heads and efficiency of micro fibre cloths.	CB	01/09/09	31/12/09

3.	Hygiene, Disinfection and Patient Experience in Hospitals	It is important to get an insight into cleanliness in hospitals from the perspective and experience of patients and their families and friends. For example; how often did medical staff use the bedside hand alcohol dispensers, did the cleaners work on all the surfaces within wards or were they selective, were beds cleaned between patients and how, how often were the commodes cleaned, how often were the toilets cleaned, did the bathrooms and toilets appears to be clean, did they smell fresh, how quickly was human excreta or blood cleaned up and how was this done, were they aware of disinfectant or detergent cleaning liquids being changed regularly, how often were door handles and other places frequently touched, cleaned, did those serving food show particular attention to hygiene.	The Kent LINk project will be:- • to carry out a survey of all LINk participants on their experiences of hospital cleanliness in Kent hospitals.	CB	01/09/09	31/12/09
4.	Transport to Hospital	With the increase in specialisation and concentration of services at fewer sites patients are facing longer, and, in some cases, more arduous journeys to hospital sites in Kent and Medway. Apart from the stress placed on patients, many of whom will be elderly, it is not known what impact this may have on morbidity, patient compliance and the rate of 'did not attends' for appointments	The Kent LINk project will be:- • to find out what systems trusts have in place to minimise transport problems for their patients, particularly with regard to the use of innovative approaches to addressing these problems, including working with partner organisations; • to see what level of consistency	CB	01/09/09	31/12/09

		or planned treatments.	exists between trusts in the provision they make for patient transport services, car parking, patients who find themselves stranded at A&E, links with community transport schemes and the quality of travel information given out to patients • to initiate a debate across Kent and Medway with a view to identifying best practice and promoting improved access to health services across the community of Kent.			
5.	Training and Supervision of Care Assistants	In April 2009 the BBC's Panorama Programme reported on an undercover investigation into standards of care which found levels of training given to care assistants amounted to little more training than they needed for a job in a burger bar. Staff reported that they had some caring experience but limited formal training. One assistant said she had training which consisted of four 20-minute DVDs and a tutorial lasting 90 minutes. A check with the Criminal Records Bureau is a legal requirement but one member of staff was allowed to work 14 shifts before she was cleared. The amount of time allocated to clients	The Kent LINk project will be:- • to find out what contracting and commissioning practices exist in Kent in relation to the provision of social care in people's homes • to compare those practices with best practice in this field.	EO	01/09/09	31/12/09

		was also limited and graphic accounts were given of how this impacted on clients. This was not limited to one Company. Research from the London School of Economics, commissioned by Panorama, found that 70% of home care is provided by the independent sector today and is worth £1.5 billion. The figure was just 2% in 1992. English local authorities spend around £22 an hour providing elderly care, but the independent sector provides it for around half that.				
6.	Stroke Services in Kent	Stroke is the 3rd biggest cause of death in the UK and the largest single cause of severe disability. Each year more than 110,000 people in England will suffer from a stroke which costs the NHS over £2.8 billion. (Source: Department of Health). The Government has launched a national stroke strategy to modernise services, deliver the newest treatments for stroke and aims to reduce the death rate from Stroke, Coronary Heart Disease and related diseases in people under 75 by at least 40 percent by 2010. A Stroke audit in the South East carried out last year highlighted four trusts as 'red light' hospitals in need of	The Kent LINk project will be:- • to find out what is being done in Kent and Medway to address shortfalls in stroke service provision • to raise awareness within the LINk of current initiatives underway to improve stroke services • to identify any impediments there may be towards achieving those aims.	EO	01/09/09	31/12/09

		improvement. They are: • The Princess Royal Hospital, Haywards Heath, Brighton and Sussex University Hospitals NHS Trust • The Dartford & Gravesham NHS Trust • Maidstone Hospital, Maidstone and Tunbridge Wells NHS Trust • The Kent and Sussex Hospital, Maidstone and Tunbridge Wells NHS Trust				
7.	NHS Trust in Kent and Medway	There is an ever increasing number of NHS trusts obtaining Foundation Trust status. This has already happened in East Kent and will, no doubt, also eventually happen in West Kent. There are considerable financial incentives for a Foundation Trust, in particular, selling services outside of the catchment area. In order to achieve Foundation status, a trust must have its accounts in credit. Many trusts have been in debit during the past few years and some of those who have achieved Foundation status have very quickly moved from debit to credit. Such cost saving could have serious implications for the patients served by the trusts.	The Kent LINk project will include:- • to monitor acute trusts, specifically East Kent University Foundation Trust, to ensure patients are not compromised as a result of Foundation Trust status being awarded • to review the operation of Foundation Trusts in Kent to ensure staff and patient complaints and views are taken into account – following the report into incidents in Mid Staffordshire.	CB	01/09/09	31/12/09

8.1	Getting the LINk involved in the commissioning arrangements for health and social care	It is important that the LINk, as a network of local people and voluntary sector organisations, is influencing decisions on health and social care services at the commissioning level and ensuring that local people can have their say and actually make a difference.	1. The Kent LINk project will be: • to work with a range of user groups in the NHS Eastern and Coastal Kent area with a view to influencing the NHS 'Vision' for commissioning community services for the period to 2014 • to use focus group methods • to host, in conjunction with NHS Eastern and Coastal Kent, a wash-up event with the purpose of defining the 'Vision'.	LM	20/07/09	29/08/09
8.2	Getting the LINk involved in the commissioning arrangements for health and social care	Ditto.	2. The Kent LINk project will be • to work with KCC's Adult Social Services in developing their Older Person's Strategy. In particular, to do so in relation to contracts the KCC has with Age Concerns in West Kent. In this context to examine the extent to which people are encouraged to be independent, are treated with dignity and respect, feel safe and secure and are encouraged to stay healthy • to use focus group methods to obtain the views of service users • to adopt mystery shopper technique to assess existing services provided at Age	EO	27/07/09	30/09/09

			Concern Day Centres.			
8.2	Getting the LINk involved in the commissioning arrangements for health and social care	Ditto	3. This Kent LINK project is to be commissioned by NHS Eastern and Coastal Kent and will seek to a establish a competition to celebrate the contributions that local voluntary and community groups are making to healthcare. This would involve: • Inviting nominations from LINk participant organisations • Setting a deadline for receipt of nominations • Establishing a Panel and criteria for making the award.	LM	01/08/09	30/09/09
11.	Annual Check by Care Quality Commission for Health & Social Care	The Care Quality Commission will be carrying out annual reviews on the standards of care being carried out across the county in health and social care establishments and services. The Kent LINk has an opportunity to put forward an independent commentary as part of this annual check.	The Kent LINk project will be:- • to work with the community and voluntary sector on arrangements for the next Care Quality Commission's Annual Check to enable the LINk to make a commentary.	All LDWs	01/10/09	31/03/10

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