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AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 9 May 2008 at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Paul Wickenden**

Telephone **(01622) 694486**

Tea/Coffee will be available from 9.30am outside the meeting room

Membership (17)

Conservative (12): Lord Bruce-Lockhart (Chairman), Mr Chell, Mr Cope, Mr Crowther, Mr Curwood, Mr Davies, Mr Hirst, Mrs Hohler, Mr Horne, Dr Robinson, Mr Tolputt and Mrs Tweed

Labour (4): Mr Fittock (Vice Chairman), Mrs Angell, Ms Harrison and Mrs Rowbotham

Liberal Democrat (1): Mr Daley

UNRESTRICTED ITEMS

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

Item No		Timings
1.	Substitutes	10.00 – 10.10 am
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes – 28 March 2008 (Pages 1 - 10)	
4.	Monitoring of outcomes from conclusions and recommendation of previous Health Overview and Scrutiny Committee meetings (Pages 11 - 32)	10.10 – 10.20 am

5.	Working Group – Healthcare Commission Core Standards (Pages 33 - 48)	10.20 – 10.30 am
6.	Draft Work Programme for June 2008 to April 2009 (Pages 49 - 54)	10.30 – 10.40 am
7.	Healthcare services in Dover (Pages 55 - 62)	10.40 – 11.40 am

Liz Shutler, Director of Strategic Development, Howard Jones, Director of Facilities, East Kent Hospitals NHS Trust, Lynne Selman, Director of Citizen Engagement, Sheila Pitt, Head of Practice-based Commissioning, and David Meikle, Director of Finance, Commissioning and Performance, Eastern and Coastal Kent PCT, will be in attendance for this item.

11.40 – 11.55 am (BREAK)

8.	*Our NHS, Our Future – Next Stage Review* (Darzi Review) (Pages 63 - 74)	11.55 am – 12.55 pm

Stephanie Hood, Director of Strategy and Communications, and David Mallett, Assistant Director, "Fit for the Future", South East Coast Strategic Health Authority, will be in attendance for this item.

9.	Timetable for Foundation Trust status applications by trusts in Kent and Medway (Pages 75 - 78)	12.55 – 1.05 pm
10.	Conclusions and Recommendations	1.05 – 1.15 pm
11.	Date of next programmed meeting – Friday 13 June 2008 at 10.00am	

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

Thursday 1 May 2008

Please note that any background documents referred to in the accompanying papers may be 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 at Sessions House, County Hall, Maidstone on Friday 28 March 2008

PRESENT: Lord Bruce-Lockhart (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr M J Fittock, Ms A Harrison, Mr C Hibberd (substitute for Mrs S C Hohler), Mr G A Horne, MBE, S J G Kowaree (substitute for Mr D S Daley), Mr R A Marsh, Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed

OTHER MEMBERS PRESENT: Mr G K Gibbens (Cabinet Member for Public Health) and Mr W V Newman

OBSERVERS: Mr R Appadoo, Mr J Cunningham, Mrs A Evennett, Mr R Kenworthy, Mr J Larcombe, Mrs A Loveday, Mrs F Witherden (Patient and Public Involvement Fora)

IN ATTENDANCE: Mr P D Wickenden, Overview, Scrutiny and Localism Manager, Dr D Turner, Research Officer to the Health Overview and Scrutiny Committee, and Mrs C A Singh, Democratic Services Officer (Overview and Scrutiny)

UNRESTRICTED ITEMS

11. Minutes

RESOLVED: that the Minutes of the meeting held on 8 February 2008 were correctly recorded and that they be signed by the Chairman.

12. Health services in Dover

(Item 4)

The Chairman introduced this item, noting that a formal referral had been received from the Patient and Public Involvement Forum (PPIF) for the Eastern and Coastal Kent PCT. Although the Forum would be disbanded, along with all other PPIFs, after 31 March 2008, he hoped that this formal referral would still be dealt with by the Committee.

The Chairman suggested that he, the Vice Chairman and the Liberal Democrat Spokesman needed to discuss the Committee's future work programme. It might be necessary to set up working groups if the Committee was to keep to half-day meetings, as agreed previously.

The Committee agreed to the Chairman, the Vice Chairman and the Liberal Democrat Spokesman meeting to discuss the way forward.

13. Healthcare Commission Annual Health Check

Dartford and Gravesham NHS Trust

(Item 5 – Mr M Devlin, Chief Executive, and Ms S Acott, Director of Performance and Service Development and Director Lead for Governance, Dartford and Gravesham NHS Trust were in attendance for this item at the invitation of the Committee)

(1) The Chairman introduced Mr Devlin and Ms Acott and thanked them for attending. He felt that it would be helpful if they both outlined where they felt the Trust had made the most progress over the past year and where they had made the least progress.

(2) Mr Devlin advised that the Trust had been looking to make a Core Standards declaration of "Fully met" ("Compliant" in respect of all Core Standards) for 2007–8. In 2006–7 there had been two areas relating to equality and diversity where the Trust had not performed adequately, leading it to declare itself "Not met" in respect of Core Standard C07e. Mr Devlin advised that information was now available in a wider range of languages and more patient information on disability had been published on the Trust's website. He advised the Committee that the Trust was now compliant in respect of this Core Standard, having been so since the middle of 2007–8, but it would not be able to declare itself "Fully Met", for that particular element as it had not been compliant for the whole year. However, given this was the only lapse and had been addressed within year, the Trust would be making an overall Core Standards declaration of "Fully met" for 2007–8.

(3) Nevertheless, the Trust had not deteriorated in any respect and they were happy with the progress that had been made.

(4) Mr Devlin conceded that in the first half of the year there had been more cases of MRSA than there should have been. But there had been an improvement over the past four months. Mr Devlin reminded the Committee that this was one of the best hospitals in the south east of England.

(5) In response to whether the self assessment by Trusts for the Annual Health Check was similar to the system used in schools, Mr Devlin advised that the Quality of Services element of the Annual Health Check was based on performance against targets (which was measured objectively) and performance against Core Standards, rated by Trusts' self-assessments, backed up by random inspections conducted by the Healthcare Commission.

(6) In response to a question on the Trust now being in surplus and having no budgetary problems, Mr Devlin advised the Committee that the Trust had achieved annual surpluses for two years in a row: £¼ million in 2006–7 and £½ million in 2007–8. He predicted that in 2008–9 there would be a surplus of £1 million, The Trust had a historic deficit of £1 million, which was being cleared by these in-year surpluses and would be completely cleared in 2008–9. The Trust's Use of

Resources score in the Annual Health Check should on this basis move from "Fair" to "Good" in 2008–9.

(7) A Member asked whether the Trust was compliant with Core Standards in respect of the provision of dental services and diabetes services. Ms Acott explained that the Trust was not responsible for the provision of primary care dentistry. However, oral surgery was provided at the Darent Valley site by Medway Trust and this service was fully compliant with Core Standards. With regard to diabetes services, these were excellent and compliant with Core Standards.

(8) A Member asked how the needs of ethnic minority patients were being met in respect of dietary requirements and languages. A question was also asked about how the Trust ensured that older patients were eating their meals. Mr Devlin said that the PPIF had been critical of catering arrangements in its third-party commentary for the 2006–7 Annual Health Check, but was more positive this time.

(9) The new catering contract was successful and this had been verified by the Trust Board. On the issue of ensuring that older people ate their meals, Mr Devlin explained that any patient needing assistance with eating was served their meal on a red tray (instead of the usual blue tray), so that staff, including support staff, could help them. Regarding language difficulties, Mr Devlin said that the Trust now had interpreters available. He added that 30% of the Trust's staff were from ethnic minority backgrounds, meaning that a wide variety of languages was spoken among staff.

(10) In response to a question about the Trust's seeking Foundation Trust status, Ms Acott explained that the Trust had not yet put its application before the Department of Health. This had been put back from December 2007 as the Trust's level of MRSA infection had been higher than it had wanted – and the Department of Health had "raised the bar" on infection control. MRSA rates were now better so the Trust was more confident about taking its application to the DoH. It would first be submitted to the South East Coast Strategic Health Authority at the end of March 2008.

(11) Responding to a question about numbers of cases of Clostridium difficile, Ms Acott advised that the Trust's position in this regard had been consistently good for some time. Regarding cases of MRSA, under current NHS targets the Trust was not allowed more than twelve cases in 2007–8. Ms Acott thought that the timetable for achieving Foundation Trust status was about right – Foundation Trust status would be achieved in the next six months.

(12) In response to a question about pharmacy services, Mr Devlin advised that the Trust was trying to improve dispensing arrangements by setting up a pharmacy outlet for patients who were being discharged.

(13) Mr Devlin said he was puzzled to hear that the quality of diabetes services had been queried by the West Kent PPIF. Ms Acott said that she was aware that a camera used for diabetic retinopathy screening had not been working, but this was

not a fundamental issue. She explained that the diabetic retinopathy screening service was being provided by a team from the Paula Carr Trust.

(14) Responding to a question about the cost of the Trust's Private Financial Initiative (PFI) contract, Ms Acott said that this did not impact on service delivery.

(15) A Member asked how it was that the Trust had only been rated "Fair" for Use of Resources in the Annual Health Check for 2006–7 when it had actually achieved a surplus in that year. Mr Devlin advised that, under the Healthcare Commission's rating system, having run up a deficit in 2005–6, the Trust needed to achieve a surplus in two consecutive years before it could be rated "Good" for Use of Resources. This would happen in 2007–8. Regarding the PFI contract, Mr Devlin said that this did have the virtue of protecting funds allocated to services such as catering, as he was not able to raid budgets that were set under the PFI contract. It could be argued that it was an expensive contract – but it did mean that the Trust was able, for instance, to offer a good, diverse catering service.

(16) A Member asked whether the Health Overview and Scrutiny Committee's minutes were forwarded, as a matter of course, to the Healthcare Commission and if not, why not. The Overview, Scrutiny and Localism Manager advised that the minutes were not forwarded to the Healthcare Commission. The Commission would not be able to process all the minutes of all the Health Overview and Scrutiny Committees in the country. Instead, it relied on the third-party commentaries that the committees submitted each year as part of the Annual Health Check process, commenting on Trusts' performance against Core Standards. In order to be able to provide these commentaries, the Committee needed to build up an evidence base throughout the year. The Chairman agreed that the Committee needed a stronger evidence base to allow it to contribute to the Annual Health Check process. The Kent Local Involvement Network and Healthwatch would be important sources of information and feedback from patients about local NHS services.

(17) The Chairman thanked Mr Devlin and Ms Acott for the information that they had given the Committee.

Maidstone and Tunbridge Wells NHS Trust

(Item 6 – Mr Glenn Douglas, Chief Executive, and Ms Christina Edwards, Acting Chief Nurse, Maidstone and Tunbridge Wells NHS Trust were in attendance for this item at the invitation of the Committee)

(1) The Chairman introduced Mr Douglas and Ms Edwards and thanked them for attending. He then asked them to outline where the Trust had made the most progress and where the Trust had made the least progress.

(2) Mr Douglas said that 2007–8 had been a strange year for the Trust, because of the Healthcare Commission's investigation of the outbreaks of Clostridium difficile at the Trust's hospitals and the consequences of this. However, he was confident that the Trust would be able to make a declaration of "Fully met" in respect of Core Standards for 2008–9. He said that good progress had been made on MRSA, with the Trust being one of the best performing on this. With regard to Clostridium

difficile, the Trust had achieved all its targets and had in fact considerably undershot, with a steady decrease in cases even though the level of infection in the community was rising. Mr Douglas tabled a list of the Core Standards that the Trust would be declaring it had failed to meet, stating that the Trust would be one of the worst in the country in this respect. However, he explained that, given the amount of scrutiny that the Trust had been under lately, it needed to be "squeaky-clean". So where there was any doubt at all about compliance with a Core Standard, the Trust was making a declaration of "Not met". He emphasised that this did not mean that the Trust was a "basket case". The Cancer Centre at Maidstone was among the best in the country and consistently exceeded its targets. Genito-urinary Medicine had achieved 100% of its access targets. At the same time, some other Trusts' declarations, while not untruthful, could be described as optimistic.

(3) A Member welcomed Mr Douglas's honesty and openness, and asked what was being done to prevent bed-blocking – particularly in respect of tariff unbundling to allow more use to be made of community hospital beds.

(4) Mr Douglas advised that tariff unbundling was a complex issue, and that there had in the past been a degree of suspicion between the Trust and West Kent PCT, with each being suspected of wanting to dump costs onto the other. He admitted that the Trust had placed patients into nursing home beds in order to alleviate pressure on acute beds. The Trust was all too well aware of the infection-control risks of putting beds too close together; and the PCT had been reluctant to reopen closed community hospital beds.

(5) Mr Douglas said that his chief concern was to see that hospital beds were freed up. Whether this was done by patients going into community hospital beds or into nursing home beds was a secondary issue. Pressure had been put on the PCT to reopen community hospital beds, but he was not in a position to influence how the PCT dealt with this.

(6) A Member put it to Mr Douglas that lack of finance seemed to underlie all the issues that the PPIF had raised in its third-party commentary for the Annual Health Check. He replied that it didn't feel that way at the Trust. They had now considerably increased spending on nursing. There had been a recruitment freeze to hit financial targets; staffing levels on wards had been inadequate; and there had been too much reliance on bank and agency staff. However, this situation had now ended. Ms Edwards added that a lot of additional nurses had been appointed since November 2007. The Trust would soon be up to the staffing level recommended by the Healthcare Commission. Recruitment was made more difficult for the Trust by the fact that it was near to the London weighting area, where staff could make more money.

(7) A Member said that service provision should drive the Trust, not financial issues; and stated that too many trained nurses were being poached by the Australian healthcare system. Mr Douglas responded that the Trust was obliged, like all parts of the NHS, to make efficiency savings. Ms Edwards said that the NHS in the South East had a lower rate of staff turnover than elsewhere (partly because it was

a more rural area, meaning people tended to move around less). The sickness rate among nurses was lower too. She said that it was mainly young trained nurses who went to work in Australia – but they often came back. And it should be remembered that the NHS had taken nurses from other countries, many of whom had returned home with better skills, thereby improving nursing standards in their own countries.

(8) A Member asked what the outcome had been in the cases of those members of staff who had recently been suspended by the Trust for poor practice in relation to infection control. Mr Douglas replied that two members of staff had been dismissed and two had been given warnings. Senior nurses were now taking more responsibility, which was key. Also, maintenance staff were now under pressure from nursing staff to maintain high standards of cleanliness.

(9) Responding to a question about setting up stroke units, Mr Douglas said that he was absolutely committed to seeing such units at both the Kent and Sussex Hospital and Maidstone Hospital. The unit at the Kent and Sussex would be open in June 2008. At Maidstone a "virtual unit" was being created and staff were being recruited. A solution was being identified and this would be achieved. He urged Members to visit the Trust's hospitals and see how they were doing. He added that the Trust was looking to set up its own patient panel, using the expertise of former PPIF members.

(10) A Member advised that a relative of his was currently in Maidstone Hospital. He had been very impressed with the standard of cleaning and the care his relative was receiving. However, on one occasion during visiting hours he had found his relative sitting in a chair completely naked. Ms Edwards apologised for this occurrence and explained that the Trust still had a long way to go. Staff were under a lot of scrutiny and the majority did a good job. The Member's complaint would be followed up, as all complaints were. The Trust welcomed complaints as a means of improving services.

(11) The Chairman thanked Mr Douglas and Ms Edwards for answering the Committee's questions so straightforwardly.

Eastern and Coastal Kent PCT

(Item 7 – Lynne Selman, Director of Citizen Engagement and Communication, Karen Benbow, Assistant Director Assurance, and Debra Vidler, Head of Standards and Better Health, Eastern and Coastal Kent PCT, were in attendance for this item at the invitation of the Committee)

(1) The Chairman introduced Ms Selman, Ms Benbow and Ms Vidler and thanked them for attending. He asked them to detail where they felt there had been progress and where they felt there had been a lack of progress. Ms Selman explained that the PCT had come into existence quite recently, following the merger of five predecessor PCTs, which had had differing levels of compliance with Core Standards. The PCT's rating against Core Standards mostly related to the services that it provided itself, but a few related to its performance as a

commissioner of services. In future the PCT would be rated much more on its commissioning function.

(2) Ms Benbow reported that the PCT's position had improved greatly. In the 2006–7 Annual Health Check it had been rated "Weak" on Quality of Services and "Fair" on Use of Resources. For 2007–8, the PCT was predicting that it would be rated "Fair" on Quality of Services and "Good" on Use of Resources. The PCT was expecting to declare itself "Compliant" in respect of 79% of Core Standards – as against 34% in 2006–7. At the present moment, the PCT had "Not met" or had "Insufficient assurance" in respect of eight Core Standards, but it expected to be able to declare itself "Compliant" in respect of some of the latter at the end of 2007–8. Ms Benbow explained that successful efforts had been made during the year to harmonise a number of policies and procedures across the five predecessor PCT areas. She advised that the PCT had been the subject of a Healthcare Commission visit during the year regarding its complaints procedures and there had been good progress following this. Progress had also been made on clinical and corporate governance structures, and on medicines management. There were two standards in respect of which the PCT would be declaring "Not met" at the end of the year: C9, regarding records management; and C13c, regarding the treatment of patient information in a confidential manner.

(3) A Member said that many patients felt they were unable to complain about the service provided by their GP as they feared being discriminated against as a result. Ms Selman responded that GP services were not directly provided by the PCT, as GPs were independent contractors, but the issue of complaints procedures should be picked up through the PCT's annual Quality and Outcomes Framework visits to practices. The PCT also encouraged the formation of practice groups, to give patients a voice.

(4) Responding to a question about the Hygiene Code and infection control, Ms Vidler said that the Healthcare Commission's report on the Clostridium difficile outbreaks at Maidstone and Tunbridge Wells Trust had been "a wakeup call". Appropriate plans had already been in place in respect of community hospitals, with significant improvements in implementation. These plans were now much more detailed and subject to a higher level of scrutiny. The PCT would, though, have to declare "Insufficient assurance" in respect of Core Standard C11b, as it had been lacking a system to monitor uptake of statutory and mandatory training by staff.

(5) A Member raised the issue of inequalities in service provision, in relation to Core Standard C18, and the extent to which Swale in particular was underserved. Ms Selman responded that investment was being made in services in Swale and other areas of underprovision. Health and Wellbeing Groups had been set up across each of the district council areas covered by the PCT, with an Executive Director leading each of them. She pointed out that in some respects, Swale actually had better services than other areas, for instance as regards audiology. Meeting this Core Standard was about having systems in place to allow the PCT to identify underserved areas and act accordingly – this did not mean that all areas were well-served at the current moment in time.

(6) A Member asked about the scoring system used for the Annual Health Check, which appeared to mean that it took a long time before any improvement in performance was reflected in the PCT's rating. Ms Benbow agreed that the scoring system was quite complicated. The Annual Health Check gave a retrospective annual rating made up of a number of elements. There was some provision for the PCT to declare itself "Compliant" in respect of a Core Standard for the whole year having achieved compliance during the course of the year. The PCT was expecting to be subject to a risk-based inspection by the Healthcare Commission over the summer, having moved from "Weak" to "Fair" in its self-assessment on Quality of Services.

(7) A question was asked about the apparent lack of adequate procedures for managing the discharging of patients from acute care, at Medway Maritime Hospital, into intermediate care, to which the PPIF had drawn attention in its third-party commentary for the Annual Health Check. Ms Selman responded that there was a national contract covering this area, to which the PCT was adding requirements regarding the quality of information provided on discharge.

(8) A question was asked about the PCT's apparent slowness in rectifying disparities between services in Swale and those elsewhere, and lack of information on how investment in Swale had been spent, which had also been referred to by the PPIF. Ms Selman replied that about £1m of additional funding had been invested in Swale GP services, and money had been provided for new intermediate care services and other services, in order to rectify past underinvestment in the area.

(9) A Member asked that the responses on these points be given in writing to the PPIF, which had raised them in its third-party commentary. Ms Selman explained that the commentary was not addressed to the PCT, but was intended for the Healthcare Commission as part of the Annual Health Check process. However, the PCT would be happy to provide a written response if the PPIF wished.

(10) The Chairman asked about the matter of insufficient co-ordination and communication between the PCT and the Trust, which had been raised. Ms Selman said this related to discharging patients from Medway Maritime Hospital into community care. She said that the PCT was conscious that there needed to be more and better communication between the Trust and the PCT in this regard.

(11) The Chairman thanked Ms Selman, Ms Benbow and Ms Vidler for their encouraging report and for attending the meeting.

Conclusions and Recommendations
(Item 8)

(1) The Chairman suggested that, rather than the Committee now deliberating at length on what it had heard, a very full minute of the meeting should be prepared to allow matters to be taken forward – perhaps by submitting the minutes to the Healthcare Commission, as Member had suggested. He thought there needed to be a discussion about how the Committee handled the Annual Health Check process next year, perhaps by means of a sub-committee. It was pointed out by a

Member that the Committee had still to hear from a number of local NHS organisations regarding their Annual Health Check declarations. The Chairman suggested there were various ways in which this might be addressed during April.

(2) The Chairman emphasised that, as the Committee had previously agreed, there should be a regular agenda item looking at what progress had been made on recommendations that it had previously made.

(3) The Chairman informed the Committee that the external review panel regarding the planned reconfiguration of services by Maidstone and Tunbridge Wells Trust was due to be convened in May 2008. The Trust had indicated in April 2007 that a nominated Member of the HOSC might be allowed to observe the panel's deliberations in order to be assured of the efficacy and robustness of the external review process. The Chairman proposed, and it was agreed, that the Committee should appoint one member of the Committee to the External Review Panel and the nominee report back to this Committee.

14. Update on Local Involvement Network (LINk)
(Item 9 – report by Mr G K Gibbens, Cabinet Member for Public Health)

(1) A Member asked Mr Gibbens about the County Council's proposed Healthwatch scheme and whether the Committee would get a chance to scrutinise the plans for this. The Chairman said he thought that Healthwatch could play an important role in supporting the work of the Committee. However, it was not on the agenda for this particular meeting.

(2) Mr Gibbens explained that it had been intended the Kent LINk would be operational by 1 April 2008, as provided for in the legislation governing LINks. However, this had not proved possible. The County Council had only learned in December 2007 how much money it was going to receive to fund the LINk (£492,000 in the coming year, rising by £1,000 over the next two years). Because of the high value of the contract for the LINk host organisation, the council was obliged to go through the EU tendering process, which took 39 days. Expressions of interest had been received in late January and early February; and tenders were due back by 8 April. He emphasised that Kent was no further behind, or forward, than any other large local authority involved in this process. Those authorities that had pressed ahead were Unitary Authorities, which were not covered by the EU process due to the smaller size of their LINk budgets. An update meeting had been held with voluntary groups on 30 January 2008 at Lenham; as a result, 58 volunteers had expressed an interesting in joining a LINk working group. Transitional arrangements would be effective from 1 April. It was expected that the awarding of the contract for the LINk host organisation would come to Cabinet in June 2008. Meanwhile, various sub-groups of the 58-strong working group were being created, around particular issues. The host organisation and the LINk would be made aware of all the legacy issues left behind by the PPIFs when they were abolished after 31 March 2008.

(3) The Chairman, on behalf of the Committee, formally thanked the PPIFs for their work and their huge contribution to the NHS in Kent. Mr Gibbens, on behalf of the

County Council, echoed the Chairman's thanks and said he hoped former PPIF members would continue to be involved in health issues in the county.

(4) A Member asked how the transitional arrangements would work, particularly in regard to social care matters, where there was a clear potential conflict of interest if the County Council was to temporarily fulfill the role of the LINk. He also asked what would happen to the funding allocated to the LINk during the transitional period. Mr Gibbens replied that expert help would be sought during the transitional period. This was anticipated to last for three months, but the County Council would not be taking a commensurate amount (one quarter) of the annual funding allocation for the LINk (£492,000). It would only be seeking to cover its costs. This would mean that the host organisation would effectively receive a cash bonus for funding the LINk when it was set up in June. Mr Gibbens accepted that there was a potential conflict of interest in respect of social care matters during the transitional period. Consequently, care was being taken, at both Member and officer levels, to ensure that those involved with setting up the LINk were not directly involved in discharging the council's social care functions.

(5) Another Member asked what consideration had been given to publicity and promotion of the LINk to the general public, and asked what signposting role the LINk would play. Mr Gibbens replied that efforts had been made, including through voluntary groups, to make as many people as possible aware of the LINk. As regards signposting, he said that the LINk would certainly be involved in playing this role.

(6) A Member said she was very concerned about PPIF legacy issues and continuity between the PPIFs and the LINk. At the same time, there had to be a broadening of the scope of public and patient involvement beyond the PPIFs' base, so as better to reflect the diversity of the community in Kent. She asked why it was taking so long to get the LINK set up. Mr Gibbens reiterated that the County Council had been unable to begin the tendering process for the host organisation until the DoH had notified the level of funding available – and this had not happened until December 2007. Other County Councils had found themselves in the same situation. Mr Gibbens agreed that the LINk must have as broad a base of involvement as possible. He had been disappointed that there had not been any representation from the gypsy and traveler community at the meeting in Lenham – although they had been invited. The County Council would do all it could to ensure broad involvement. The tender document for the host organisation stipulated that it was expected to ensure this happened.

By: Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – Friday 9 May 2008

MONITORING OF OUTCOMES FROM CONCLUSIONS AND RECOMMENDATIONS OF PREVIOUS HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETINGS

Introduction

1. Members will recall that it has been agreed a standing item should be before the Committee at each of its meetings to consider how NHS Trusts, Adult Social Services or the team supporting this Committee have taken forward conclusions and recommendations from the Committee's discussions on issues which have been before it. The Appendix sets out the matters on which the Committee has arrived at conclusions and recommendations in the past year and the outcomes of actions taken.

Information/Feedback

2. A number of recent conclusions and recommendations have only been taken up with NHS colleagues in the past week, so I would expect further replies and information to be available to the Committee at its June meeting.

Recommendations

3. The Committee is asked to note the report.

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Kent County Council

Health Overview and Scrutiny Committee

ROLLING ACTION SHEET

Ask for: Angela Evans

Telephone: 01622 221876

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
23 March 2007 – 17	Cancer Services	All acute Trusts	*RESOLVED:- that the Committee should continue to monitor the development of cancer services across Kent and Medway.*	Ongoing	
23 March 2007 – 18	Proposed Whitstable Polyclinic	- Eastern and Coastal Kent PCT - East Kent Hospitals NHS Trust	*RESOLVED:- that the development of a polyclinic at Whitstable be kept under review; and that the Committee welcome the proposed joint modelling by all the partners on the proposed project so that a reassessment of the project proposals could be reviewed before decisions were taken.*	Ongoing	Proposal scrutinised by Canterbury City Council Health Scrutiny Panel on 26 July 2007

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
14 December 2007 – 72	Audiology	- Eastern and Coastal Kent PCT - East Kent Hospitals NHS Trust - Kent Adult Social Services - Maidstone and Tunbridge Wells NHS Trust - Medway NHS Foundation Trust - West Kent PCT	*The Committee concluded that:-* *(a) further work needed to be done to inform the public of the new services being provided by Clinicenta;*	April 2008	
			(b) work needed to be undertaken on transport issues in relation to accessibility of healthcare services (the Committee noted that this was a piece of work that it had set aside for a Topic Review Select Committee to undertake early in the New Year);		
			(c) the issue of the Joint strategic Needs Assessment should be picked up by the Health Overview and Scrutiny Committee in conjunction with both Health and Adult Social Care colleagues;		
			(d) Public Health colleagues should ensure (possibly using Kent TV) that the public were made aware of the risks to their hearing posed by prolonged exposure to loud music;		
			(e) data collection and collation for audiology services must be improved, to enable commissioners to commission services effectively;		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
			(f) it needed to be recognised that dealing with a patient with audiology needs was about more than just fitting a hearing aid;		
			(g) patients were entitled to copies of their audiograms;		
			(h) audiology should be recognised as an important service in the strategic plans of the Primary Care Trusts;		
			(i) Hi-Kent Kent provided a valuable and well-respected service;		
			(j) further work should be undertaken by the Primary Care Trusts and others to see whether it might be feasible to provide audiology services through "High Street" practitioners (along the same lines as dental and optical services);		
			(k) the Healthcare Commission Annual Health Check should take account of RTT waiting times for audiology services;		
			(l) a written report on audiology services should be received by the Health Overview and Scrutiny Committee every four months;		
			(m) audiology patients should be subject to an automatic recall;		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
			(n) as there had been no audit of audiology needs across the population of Kent, this needed to be undertaken as a matter of urgency;		
			(o) patients should be encouraged to return hearing aids where they were no longer required or are not being used;		
			(p) PCTs and others needed to consider carefully the mental health needs of people with hearing impairment.		
			RESOLVED that:- *(a) the conclusions of the Committee be conveyed to all those identified as having matters to take forward; and*		
			(b) the Committee would expect an update on how these issues were being dealt with when it received the first written review of audiology services in four months' time.		Topic scheduled for HOSC meeting, 13 June 2008
14 December 2007 – 73	Dentistry	- Eastern and Coastal Kent PCT - West Kent PCT	*Having heard and received responses to its questions, the Committee reached the following conclusions:* *a) The Committee welcomed the reported interest shown by dentists in taking up NHS contracts. The PCTs were asked to give further consideration to the*	April 2008	

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
			way that they communicated with the public and patients, particularly around charges for dental services. It was felt by the Committee that there was a perception that the public did not know what they are expected to pay and this might be exacerbating health inequalities by discouraging the less well-off from seeking treatment.		
			b) The Committee would recommend that there was an independent audit undertaken of dentistry provision across the county. The Committee would also welcome quarterly reports being made available to it regarding NHS dentistry provision.		
			c) Details of unmet need for dentistry across the county should be made available in the Primary Care Trusts' Local Delivery Plans. The Committee would welcome details of how many NHS dentists there were in total and where they were situated across the county.		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
			RESOLVED:- *(a) That the conclusions of the Committee be drawn to the attention of health colleagues; and*		
			(b) that a progress report on how the Committee's views were being taken forward should be made available to the Committee in four months' time.		Topic scheduled for HOSC meeting, 18 July 2008
11 January 2008 – 79	Mental health	- Kent Adult Social Services - Kent and Medway NHS and Social Care Partnership Trust - Medway PCT	*Recommendations arising from the Health Overview and Scrutiny Committee meeting on 11 January 2008, agreed by the Vice-Chairman, the Conservative Group Spokesman and the Liberal Democrat Group Spokesman:* *a) that the Committee needed to stay abreast of progress on the Action Plan for implementing the recommendations of the Carers in Kent Select Committee report;*		
			b) that the Committee must keep up-to-date with implementation of KCC's Young Carers Strategy "Invisible People";		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
			c) that the Committee must decide whether it wished to respond to the consultation on the Partnership Trust's application for Foundation Trust status;		Topic scheduled for HOSC meeting, 13 June 2008
			d) that submitting third-party commentaries for the Healthcare Commission's Annual Health Check was core business for the Committee;	30 April 2008 (Healthcare Commission deadline for receipt of Core Standards declarations and third-party commentaries)	Minutes of HOSC meeting on 28 March 2008 sent to Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust, and Eastern and Coastal Kent PCT for submission to Healthcare Commission with Core Standards declarations

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
			e) to welcome NHS colleagues' undertaking to provide details about the level of funding for mental health services and how it was allocated, to enable the Committee to identify any gaps;		
			f) to request from NHS colleagues a simple explanation of how the various types of mental health service (CRHT, Community Health Mental Health teams, etc.) all fitted together, with a brief summary of the role played by each;		
			g) that the Committee should consider the feasibility of a "one-stop shop" approach to hospital admission, which had been mentioned in evidence;		
			h) to welcome NHS colleagues' undertaking to provide the Committee with a full beds schedule for all 46 of the Partnership Trust's wards;		Information received from Kent and Medway NHS and Social Care Partnership Trust, 21 April 2008

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
			i) to investigate arrangements in A&E departments regarding service users who present with mental health issues, and whether a more consistent approach, based on best practice, was needed;		Information received from Kent and Medway NHS and Social Care Partnership Trust, 21 April 2008
			j) to look further at the issue of training for GPs, the police, ambulance staff and firefighters as regards dealing with mental health service users;		
			k) to examine further the question of out-of-hours services, particularly in respect of service users presenting with less serious conditions, such as personality disorders;		
			l) that there was a need to look at the issue of less well-off service users experiencing difficulty accessing services due to lack of transport;		
			m) to pursue the matter of providing better information for the public (through means including Kent TV) about mental health services and how to go about accessing them;		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
			n) to acknowledge the valuable role of the voluntary sector in the mental health field;		
			o) that an independently chaired event should be arranged for all mental health services stakeholders, including the voluntary sector, to explore how to work together more effectively to improve services across Kent and Medway.		
28 March 2008 – 13	Healthcare Commission Annual Health Check	All trusts	*The Chairman suggested that, rather than the Committee now deliberating at length on what it had heard, a very full minute of the meeting should be prepared to allow matters to be taken forward – perhaps by submitting the minutes to the Healthcare Commission, as Member had suggested. He thought there needed to be a discussion about how the Committee handled the Annual Health Check process next year, perhaps by means of a sub-committee. It was pointed out by a Member that the Committee had still to hear from a number of local NHS organisations regarding their Annual Health Check declarations. The Chairman suggested there were various ways in which this might be addressed during April.*	30 April 2008 (Healthcare Commission deadline for receipt of Core Standards declarations and third-party commentaries)	Minutes of HOSC meeting on 28 March 2008 sent to Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust, and Eastern and Coastal Kent PCT for submission to Healthcare Commission with Core

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
					Standards declarations; Working Group meeting held on 25 April 2008, to discuss with other trusts their declarations
28 March 2008 – 13	Reconfiguration of services	Maidstone and Tunbridge Wells NHS Trust	*The Chairman informed the Committee that the external review panel regarding the planned reconfiguration of services by Maidstone and Tunbridge Wells Trust was due to be convened in May 2008. The Trust had indicated in April 2007 that a nominated Member of the HOSC might be allowed to observe the panel's deliberations in order to be assured of the efficacy and robustness of the external review process. The Chairman proposed, and it was agreed, that the Committee should appoint one member of the Committee to the External Review Panel and the nominee report back to this Committee.*	May 2008	PCT advised as follows on 17 April 2008: "As the external panel is composed of clinical experts that have been charged to review the proposals for rota changes, accreditation compliance and clinical safety, and commend its

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
					views to the PCT Board, it is by nature small and technically qualified to perform this. Members are Professor Cobb, an external Director-level Surgical Nurse, the PCT's Medical Director and a member of the Maidstone LMC [Local Medical Committee, representing local GPs]. It may therefore be more helpful if a presentation of

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken
					the outcome of their views, as will be made to the PCT Board, is also made to the HOSC, at the appropriate time.”

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With regards to your request for a response to the actions, points and views expressed in the minutes of the meeting of the HOSC held on 11 January 2008, I have detailed below the Trust's response to issues we believe require further comment:

- ***Minute number 79 (2i): "It was stated that, in some parts of Kent, A&E mental health liaison nurses were employed, with access to CRHTs to make an assessment of a patient if necessary"***

  East Kent A&E Liaison Service – offers a rapid assessment service for people with mental health problems who use an Accident and Emergency [A&E] Department in East Kent (William Harvey Hospital, Queen Elizabeth the Queen Mother [QEQM] Hospital and Kent and Canterbury Hospital). The service operates seven days a week, 09.00 – 00.00 hours. It includes eight members of staff (1 x Nurse Band 7, 7 x Nurse Band 6).

  Medway A&E Liaison Service – there is no dedicated A&E Liaison Service in Medway. However the Medway Assessment and Short Term Treatment [MASTT] team have responsibility for this function and interface very closely with Crisis Resolution Home Treatment [CRHT] team when acute care is the required intervention. MASTT operates twenty-fours hours a day, seven days a week.

  West Kent A&E Liaison Service – in Dartford, Gravesend and Swanley [DGS] there is 1 whole time equivalent [wte] A&E Liaison post, that operate 09.00 – 17.00 hours Monday to Friday providing cover to the Darent Valley Hospital A&E. The post is presently based in the DGS CRHT.

  In Maidstone there are 2 wte A&E Liaison posts, which operate 09.00 – 17.00 hours Monday to Friday, providing cover to the Maidstone Hospital A&E and medical Wards. The posts are based at Priority House and come under Maidstone CRHT management.

  In South West Kent there is 1.60 wte A&E Liaison posts, that operate 09.00 – 17.00 hours Monday to Friday, and provide cover to the Kent and Sussex Hospital A&E and Medical Wards. The posts are based in the Kent and Sussex Hospital A&E and come under South West Kent CRHT management.

  Outside of 09.00 – 17.00 hours Monday to Friday, assessments are completed in the A&E by the Junior Doctor On Call and a member of the CRHT Team.

- ***Minute number 79 (3k): "In responding to a question about bed numbers, Mr Millar said that the Partnership Trust had 46 wards in total and promised to make available to the Committee a full beds schedule"***

  Appendix B, embedded in this letter, provides the detail requested.

- ***Minute number 79 (3m): "The often long and drawn-out process of trying to get someone with severe mental health problems "sectioned" was highlights. A multiplicity of agencies were involved and they needed to work together to achieve a quick, speedy and satisfactory outcome. one of the issues was that the police in these situations would only attend when they had resources available. It was***

important that colleagues in the health Service engaged with the police and ambulance service to ensure that adequate assistance was given by the police when it was required"

The Out of Hours Approved Mental Health Act Assessment Service was moved to the Trust on 3 December 2007. Since that time we have been working hard to establish positive relationships with our colleagues with both the Police and Ambulance Service and additionally with different professionals within the Trust. Margaret Vickers (Associate Director of Social Care) who managers the service has now met with both Roy Kingston (Kent Police) and Paul Barratt (Head of Non Emergency Ambulance Services). The Social Care Management Team has worked consistently with the Crisis Teams within the Trust to develop positive support for these assessments from staff. Overall feedback from professionals in the Trust has been positive about the new arrangements, which have led to approximately 50% more Mental Health Act Assessments being completed out of hours.

Previously these assessments would have had to wait over night for day teams to assess or, in the case of Section 136s, the patient would have been discharged without having been seen by a Social Worker.

We continue to depend on good support for our conveyancing from the Police and Ambulance Service and although we are establishing positive relationships with them, there are still difficulties in them responding as quickly as is desirable for service users in these critical situations. This is as a result of the skeleton service that they have available over night. Peter Hasler (Director of Nursing and Modernisation / Interim Director of Operations) and Lauretta Kavanagh (Director of Commissioning Medway PCT) are now looking into purchasing their own conveyancing service with specific requirements from Kent and Surrey Ambulance Trust.

APPENDIX B

Kent and Medway NHS
NHS and Social Care Partnership Trust

Full Beds Schedule as at 21 April 2008

Location	Ward	Bed Type & Numbers
Ashford (William Harvey Hospital)	Edgehill	Adult x 19
	Newington	Adult x 19
	Scarburgh	Adult x 19
	Winslow	Older Peoples x 20
Canterbury (St Martins)	Anselm Admission Ward	Adult x 18
	Cranmer	Older Peoples x 15
	Dudley Venerables Unit	Adult Psychiatric Intensive Care Unit [PICU] x 08 Adult x 04
	Edmund	Older Peoples (Female) x 15
	Ramsey	Older Peoples (Male) x 15
Dartford (Darent Valley Hospital)	Jasmine Centre	Older Peoples Organic x 10
Dartford (Greenacres Site)	Little Stone Lodge	Older Peoples Continuing Care x 20
	Rosewood Lodge	Adult Rehabilitation x 12
Dartford (Little Brook Hospital)	Amberwood	Adults (Female) x 16
	Birch	Older Peoples Functional x 16
	Willow Suite	Adult PICU (West Kent and Medway) x 12
	Woodlands	Adults x 16

Location	Ward	Bed Type & Numbers
Dartford (Tarenfort)	Marle	Forensic Learning Disability x 10
	Riverhill	Forensic Learning Disability x 10
Maidstone (Fant Oast)	Fant Oast	Child and Adolescent x 07
Maidstone (Priority House)	Amherst	Adults (Maidstone) x 17
	Brocklehurst	Adults (South West Kent) x 17
	The Orchards	Older Peoples x 25
Maidstone (Red House)	Red House	Eating Disorder x 06
Maidstone (111 Tonbridge Road)	111 Tonbridge Road	Adult Rehabilitation x 09
Maidstone (Trevor Gibbens Unit)	Bedgebury	Forensic Pre-Discharge Secure (Male) x 05
	Emmetts	Forensic Rehabilitation (Male) x 16
	Groombridge	Forensic Sub-Acute (Male) x 11
	Hucking	Forensic Pre-Discharge Low Secure x 04
	Penshurst	Forensic Acute (Male) x 11
	Scotney	Forensic Intensive Care Unit [ICU] (Male) x 04
	Walmer	Forensic (Female) x 11
Margate (Westbrook House)	Ogden Wing	Older Peoples (Continuing Care) x 10
Gillingham (Medway Hospital)	Emerald	Adult Acute x 24
	Newhaven Lodge	Adult Rehabilitation x 8
	Ruby	Adult (Female) x 18
	Sapphire	Adult High Dependency x 10
Sevenoaks (Darent House)	Darent House	Neuro-Rehabilitation & Neuro-Psychiatry x 10

Location	Ward	Bed Type & Numbers
Swale (Frank Lloyd)	Heartsdelight / Highstead / Rowena / Southlands	Older Peoples Assessment and Treatment x 10 Older Peoples Continuing Care x 26
Thanet	Elmstone	Adult x 14
	Sevenscore	Older Peoples x 16
	Woodchurch	Adult x 05
	Woodchurch	Older Peoples x 10
Tunbridge Wells (Highlands House)	Leedham	Older Peoples x 14

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By: Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – Friday 9 May 2008

Subject: **Working Group – Healthcare Commission Core Standards**

Introduction

1. (1) At the Committee's last meeting, consideration was given to three of the declarations by Trusts against the Healthcare Commission Core Standards for the period 1 April 2007 to 31 March 2008.

(2) The draft minutes of the last meeting, to be approved by the Committee today, were sent to each of the Trusts concerned, for inclusion in their declarations – which had to be with the Healthcare Commission by Midday on Wednesday 30 April 2008.

Remaining Trusts

2. (1) No firm decision was taken at the meeting on 28 March 2008 for dealing with the remaining Trusts. I therefore sought the views of the Chairman.

(2) The Chairman suggested that a small group should be convened to consider the remaining Trusts' declarations. An informal Working Group, comprising Dr Robinson (substituting for Lord Bruce-Lockhart), Mr Marsh, Mr Fittock and Mr Daley, met on Friday 25 April 2008.

(3) The Working Group concluded that it did not have any substantive evidence that would enable it to submit, on behalf of the Committee, useful third-party commentaries that could add value to the Healthcare Commission's Annual Health Check process. However, the Working Group did feel that the exercise had been extremely useful in providing the Committee with a baseline, against which evidence can be gathered on an ongoing basis by the Committee throughout the forthcoming year, enabling third-party commentaries to be made by the Committee in April 2009.

(4) Attached as an Appendix is a table which sets out the information gleaned by the Working Group. I have also extracted similar information from the minutes of the meeting which looked at three of the Trusts' declarations on 28 March 2008; the table containing this is attached too. These documents will form the basis of a database against which the questions will be asked by the Committee on the Core Standards as they engage with Trusts throughout the year.

Working Group

3. (1) The Working Group covered much in a short space of time (six Trusts were seen in two-and-a-half hours). If work is to be conducted by small groups of Members, those Members could have the opportunity to

become very knowledgeable on specific areas. However, it is important that information from small groups is widely disseminated among other Members of the Committee/Council.

(2) The transparency of the work of the Committee is fundamental and so it needs to take place in public.

(3) Significant working in this way will require additional resources if it is to be sustainable.

Recommendations

4. The Committee is asked to:

(a) Retrospectively agree to the setting up of the Working Group that considered the self-declarations of the six remaining Trusts on 25 April 2008; and

(b) note the information set out in the Appendix.

Health Overview and Scrutiny Committee
Working Group on Healthcare Commission Core Standards
25 April 2008

Trust	Core Standard discussed	Declaration	Information gleaned
Medway Foundation Trust (Andy Horne, Chief Executive; Helen Goodwin, Head of Governance)	**C4e** *Health care organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.*	Not Met	Changes in regulations and clinical practice mean that more clinical waste is being generated, segregated into more waste streams. The Foundation Trust is declaring itself Not Met, due to system failures identified by the Environment Agency in November 2007. These failures are mainly about flaws in the documentation and audit trails (consignment notices) on the part of the waste management contractors. The contract is held by a consortium of all trusts in Kent and Medway. This problem affects all other trusts, as members of the waste consortium; and the fault is in the service provided by the contractor, rather than in the Foundation Trust itself. While the Foundation Trust is declaring itself Not Met against C4e for the third year running, this is down to a range of issues, each of which has been resolved in turn.
	C4c *Health care organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.*	Not Met	The Foundation Trust is declaring itself Not Met due to the delayed introduction of a centralised cold sterilisation unit. The level of clinical activity is rising, necessitating more facilities. The unit will be installed and, in the meantime, rigid endoscopes are being used for gynaecological investigations. £700,000 has been invested in equipment for the new unit.

Trust	Core Standard discussed	Declaration	Information gleaned
	C4a *Health care organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA.*	Compliant	The Foundation Trust is declaring itself Compliant, having met the standards set out in the Hygiene Code. The Foundation Trust is planning to redevelop all its medical wards, which will increase bed capacity, thereby helping to isolate outbreaks of infection. Screening of patients for MRSA is being undertaken, and elective and emergency patients are being separated.
	C9 *Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.*	Compliant	The Foundation Trust is declaring itself Compliant, but there are concerns about the organisation of the paper unified healthcare record and other matters. There are big plans for the improvement of records management, involving transfer to an off-site location. The Foundation Trust has a medium-term plan (within five to 10 years) to go over to an electronic records system. All incidents involving loss of data or breach of patient confidentiality are captured by an incident-logging process and an audit is conducted.
West Kent PCT (Molly Clark, Project Manager for Governance; Anne Carroll, Assistant Director, Clinical Governance)	**C7e** *Health care organisations challenge discrimination, promote equality and respect human rights.*	Not Met	A policy has been formulated covering both these Core Standards, but it has yet to be finalised. A conference for this purpose is being held on 16 June 2008.

Trust	Core Standard discussed	Declaration	Information gleaned
	C18 *Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.*	Not Met	The Patient and Public Involvement Forum for the PCT raised concerns about the inadequacy of dental services across the whole of the West Kent area, as well as inequalities in service provision within the area. The Forum also visited Livingstone Community Hospital at Dartford and noted the lack of written material in ethnic minority languages, as well as the lack of translation services for patients who did not have a good understanding of English.
	C23 *Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.*	Not Met	An external review has revealed significant lapses in respect of sexual health and smoking. A new strategy and action plan are being put in place.
	C5c *Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work.*	Insufficient Assurance	The PCT believes that this updating of skills and techniques is probably happening, but there is a lack of evidence to show this. A new software system is being implemented that will allow managers to map staff training and identify areas needing attention. A staff skills audit and training needs analysis have taken place. Clinical staff have a professional responsibility to undertake continuing professional development. The Quality and Outcomes Framework review should pick up shortcomings in GP practices.

Trust	Core Standard discussed	Declaration	Information gleaned
	C8b *Health care organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.*	Insufficient Assurance	
	C9 *Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.*	Insufficient Assurance	The PCT has had to work to make records management policy consistent, following the merger in 2006 of its three predecessor PCTs, which had varying policies.
	C13c *Health care organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary.*	Insufficient Assurance	

Trust	Core Standard discussed	Declaration	Information gleaned
	C4a *Health care organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA.*	Compliant	The PCT has three locality-based community infection control nurses, who work with care homes and primary care practitioners. A root cause analysis is undertaken whenever community-acquired Clostridium difficile is present in a patient admitted to hospital. Monthly surveillance reports are produced and a postcode analysis of patterns is undertaken. Advice is given to GPs on microbiological analysis and the excessive use of antibiotics is discouraged. The PCT attends acute Trusts' infection control meetings.
South East Coast Ambulance Service NHS Trust (Andy Cashman, Service Development Manager)	**C5b** *Health care organisations ensure that clinical care and treatment are carried out under supervision and leadership.*	Insufficient Assurance	This Core Standard is not entirely appropriate to Ambulance Trusts, given the way in which their staff work. Systems have been put in place since the creation of the Trust in 2006, but they are still not fully embedded. A traditional apprentice-style training model has been replaced by a degree programme based in key skills and competencies. Clinical staff are now registered healthcare professionals and required to undertake continuing professional development. Control room staff do not need to be trained clinicians; but they are all trained and have some level of clinical knowledge.
	C4a *Health care organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA.*	Compliant	Ambulances are now cleaned and prepared in "Make ready centres" by dedicated teams. Clinicians do, though, still have responsibility for rubbing down hard surfaces between patients and maintaining good infection control practices. All invasive equipment (such as needles) is single-use. Disposable linen is used.

Trust	Core Standard discussed	Declaration	Information gleaned
	C7e *Health care organisations challenge discrimination, promote equality and respect human rights.*	Insufficient Assurance	The Trust employs a member of staff for external liaison on equality and diversity issues, but that member of staff was not in place throughout the year.
Kent and Medway NHS and Social Care Partnership Trust (Erville Millar, Chief Executive)	**C7e** *Health care organisations challenge discrimination, promote equality and respect human rights.*	Not Met	The Trust will in future ensure that race equality impact assessments are conducted and published in respect of its policies.
	C8b *Health care organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.*	Not Met	The Trust will in future implement policies to ensure that staff from black and minority ethnic groups have opportunities for personal development – targeted where appropriate.
	C16 *Health care organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.*	Not Met	The Trust already provides information for patients and the public in five languages, but it will need in future to use a broader range of languages and make the material more readily available.

Trust	Core Standard discussed	Declaration	Information gleaned
	C17 *The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.*	Not Met	The Trust will need in future to develop good processes to show that it involves and consults a wide range of groups, including members of black and minority ethnic communities, regarding the planning of services.
	C18 *Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.*	Not Met	The Trust needs to do more to ensure that information is readily available for all sections of the community to allow them to access services easily.
Medway PCT (Natalie Davies, Company Secretary)	**C1a** *Health care organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.*	Not Met	The PCT is now compliant in this regard, but has only been so from September 2007. This in-year lapse related only to the process for less serious incidents. The process for dealing with Serious Untoward Incidents was in place throughout the year.
	C5a *Health care organisations ensure that they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.*	Insufficient Assurance	While the process to assess conformity with NICE Technology Appraisals is in place, there is not an audit trail to demonstrate that an action plan has been completed in respect of each and every Technology Appraisal.

Trust	Core Standard discussed	Declaration	Information gleaned
	C5d *Health care organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.*	Insufficient Assurance	A detailed clinical audit plan has been agreed within the PCT and many clinical audits have been completed. However, not all services are able to show that they have completed all the mandatory audits.
	C7e *Health care organisations challenge discrimination, promote equality and respect human rights.*	Not Met	The PCT has not been meeting all of the requirements regarding the assessment of the effect of its policies on minority groups. The PCT failed to update its race equality scheme and to complete equality impact assessments on its Board papers – these failures are now being rectified. A Diversity and Equality Manager is being appointed. The PCT aims not only to meet the minimum standard but to become a centre of excellence in this regard.
	C18 *Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.*	Not Met	
	C11b *Health care organisations ensure that staff concerned with all aspects of the provision of health care participate in mandatory training programmes.*	Not Met	This relates to non-clinical training (e.g. fire safety). Mandatory training sessions have been provided, but attendance levels have not been satisfactory. The PCT needs to ensure that both staff and managers recognise this training as a priority.

Trust	Core Standard discussed	Declaration	Information gleaned
East Kent Hospitals Trust (Julie Pearce, Director of Nursing, Quality and Midwifery)	**C4e** *Health care organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.*	Not Met	There were two or three breaches of standards during the year, meaning that the Trust has to declare itself Not Met. This was mainly due to the inadequacy of the contract specification that had been drawn up by the Kent waste consortium. There are some internal issues too. A business case is being developed for a dedicated waste manager. There is a training issue around the separation and segregation of waste. The policy regarding hazardous waste disposal needs to be reviewed.
	C7e *Health care organisations challenge discrimination, promote equality and respect human rights.*	Compliant	Additional evidence has been sought, in particular regarding whether or not there was a “glass ceiling” affecting black and minority ethnic staff, and the Trust is satisfied that it is Compliant.

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Health Overview and Scrutiny Committee
28 March 2008

Trust	Core Standard	Declaration	Information gleaned
Dartford and Gravesham NHS Trust (Mark Devlin, Chief Executive, and Susan Acott, Director of Performance and Service Development and Director Lead for Governance)	**C7e** *Health care organisations challenge discrimination, promote equality and respect human rights.*	Not Met	Information is now available in a wider range of languages and more patient information on disability had been published on the Trust's website. Interpreters are also available. Consequently, the Trust is now Compliant in respect of this Core Standard, but it has only been so since the middle of 2007–8
	C15 *Where food is provided, health care organisations have systems in place to ensure that:* *a) patients are provided with a choice and that it is prepared safely and provides a balanced diet; and* *b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.*	Compliant	The Patient and Public Involvement Forum for the Trust was critical of catering arrangements in its third-party commentary for the 2006–7 Annual Health Check, but it has been more positive this time. The new catering contract is successful and this has been verified by the Trust Board. Any patient needing assistance with eating is served their meal on a red tray (instead of the usual blue tray), so that staff, including support staff, can help them.
	C4a *Health care organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA.*	Compliant	The Trust's position regarding Clostridium difficile has been consistently good for some time. Regarding cases of MRSA, the Trust achieved its target of not more than 12 cases in 2007–8.

Trust	Core Standard	Declaration	Information gleaned
	C6 *Health care organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.*	Compliant	The Patient and Public Involvement Forum for West Kent PCT has reported that the Trust's Diabetes Team has been unable to afford a repair to one of its three special digital cameras, causing the service to be cut by a third and putting patients at risk. The Trust is aware that a camera used for diabetic retinopathy screening has not been working, but insists this is not a fundamental issue. The diabetic retinopathy screening service is being provided by a team from the Paula Carr Trust.
Maidstone and Tunbridge Wells NHS Trust (Glenn Douglas, Chief Executive, and Ms Christina Edwards, Acting Chief Nurse)	**C4a** *Health care organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA.*	Compliant	Good progress has been made on MRSA, with the Trust now being one of the best performing on this. With regard to Clostridium difficile, the Trust has achieved all its targets and has in fact considerably undershot, with a steady decrease in cases even though the level of infection in the community is rising. Two members of staff have been dismissed for poor practice in relation to infection control and two have been given warnings. Senior nurses are now taking more responsibility, which is key. Also, maintenance staff are now under pressure from nursing staff to maintain high standards of cleanliness.
Eastern and Coastal Kent PCT (Lynne Selman, Director of Citizen Engagement and Communication, Karen Benbow, Assistant Director Assurance, and Debra Vidler, Head of Standards and Better Health)	**C9** *Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.*	Not Met	The PCT is unable to track systematically a patient who is being treated by more than one PCT provided service.

Trust	Core Standard	Declaration	Information gleaned
	C13c *Health care organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary.*	Not Met	Two significant lapses have been identified. An information governance pack has been produced and sent to all staff; and an extensive staff training programme is being implemented.
	C11b *Health care organisations ensure that staff concerned with all aspects of the provision of health care participate in mandatory training programmes*	Insufficient Assurance	The PCT has been lacking a system to monitor uptake of statutory and mandatory training by staff.
	C18 *Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.*	Compliant	The Patient and Public Involvement Forum for the PCT has raised the issue of lack of services in the Swale district. Investment is being made in services in Swale and other areas of underprovision. About £1m of additional funding has been invested in Swale GP services, and money has been provided for new intermediate care services and other services, in order to rectify past underinvestment in the area. Health and Wellbeing Groups have been set up across each of the district council areas covered by the PCT, with an Executive Director leading each of them. In some respects, Swale actually has better services than other areas, for instance as regards audiology. Meeting this Core Standard is about having systems in place to allow the PCT to identify underserved areas and act accordingly – this does not mean that all areas are well-served at the current moment in time.

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By: Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – Friday 9 May 2008

DRAFT WORK PROGRAMME FOR JUNE 2008 TO APRIL 2009

Introduction

1. (1) The Committee will recall that, when it considered the report on refocusing the Committee in September 2007, one of the key objectives was to agree a work programme for the forthcoming year.

(2) The report in September identified some key components of the work programme including:-

(a) in April each year, submitting third-party commentaries on trusts' performance against Core Standards for the purposes of the Healthcare Commission's Annual Health Check; and

(b) in the autumn and early in each New Year, scrutinising the Operating Plans for each of the Primary Care Trusts.

Draft Work Programme

2. (1) The Chairman of the Committee has recently met with the Chairmen and Chief Executives of the two Kent Primary Care Trusts to consider those issues which are considered important for inclusion in the Draft Work Programme of the Committee. This followed a meeting at which Dr Robinson (on behalf of the Chairman), Mrs Rowbotham (on behalf of Mr Fittock) and Mr Daley were present to input topics for inclusion in the programme.

(2) The outcome of those discussions is a draft Work Programme for the period June 2008 to April 2009, which is attached as an Appendix to this report.

(3) The draft Work Programme is only indicative of the issues/items already known to the Committee. It does not take into account any unplanned items, such as referrals from the Local Involvement Network (LINK) or matters arising from complaints to Kent Health Watch or Patient Advice and Liaison Services.

(4) The Work Programme will be submitted to the Committee for its approval in April each year.

Recommendations

3. The Committee is asked to agree the draft Work Programme for June 2008 to April 2009.

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Draft Forward Work Programme for the Health Overview and Scrutiny Committee, 2008–9

Meeting date	Topic(s)	Witness(es)
13 June 2008	Foundation Trust status application by Kent and Medway NHS and Social Care Partnership Trust	• Kent and Medway NHS and Social Care Partnership Trust
	Diabetes services	• Eastern and Coastal Kent PCT • West Kent PCT
	Accessing healthcare	
	Audiology	• Eastern and Coastal Kent PCT • West Kent PCT
18 July 2008	East Kent Older People's Mental Health Strategy	• Eastern and Coastal Kent PCT • East Kent Hospitals NHS Trust • Kent and Medway NHS and Social Care Partnership Trust
	Dentistry	• Eastern and Coastal Kent PCT • West Kent PCT
	GP-led health centres ("Darzi clinics")	• Eastern and Coastal Kent PCT • South East Coast Strategic Health Authority • West Kent PCT
5 September 2008	Trusts' and PCTs' performance management of delivery plans, targets and priorities 2008–9 – including health inequalities	• Dartford and Gravesham NHS Trust • Eastern and Coastal Kent PCT • East Kent Hospitals NHS Trust • Kent and Medway NHS and Social Care Partnership Trust • Maidstone and Tunbridge Wells NHS Trust • Medway NHS Foundation Trust • Medway PCT? • South East Coast Ambulance Service NHS Trust • West Kent PCT

Meeting date	Topic(s)	Witness(es)
	Public Health	• Eastern and Coastal Kent PCT • KCC Public Health Department • West Kent PCT
17 October 2008	Community pharmacy services and prescribing (including availability of medical drugs in Kent)	• Eastern and Coastal Kent PCT • Kent Local Pharmacy Committee • West Kent PCT
	Briefing on progress with PCTs' Operating Plans and budgets 2009–10	• Eastern and Coastal Kent PCT • West Kent PCT
28 November 2008	Receive report to enable HOSC to establish criteria and policy for assessing future reconfigurations / rationalisations of NHS services (including access to health care and advantages of local services, balanced against economies of scale and specialist services) – to make recommendations to Cabinet / Council	
	Scrutiny of PCTs' Strategic Commissioning Plans	• Eastern and Coastal Kent PCT • West Kent PCT
December 2008	Receive report (by King's Fund?) on NHS funding and delivering value for money in Kent	

Meeting date	Topic(s)	Witness(es)
9 January 2009	Scrutiny of PCTs' draft Operating Plans and budgets 2009–10	• Eastern and Coastal Kent PCT • West Kent PCT
6 February 2009		
20 March 2009	Third-party commentaries on Core Standards for Healthcare Commission Annual Health Check 2008–9	• Dartford and Gravesham NHS Trust • Eastern and Coastal Kent PCT • East Kent Hospitals NHS Trust • Kent and Medway NHS and Social Care Partnership Trust • Maidstone and Tunbridge Wells NHS Trust • Medway NHS Foundation Trust • Medway PCT? • South East Coast Ambulance Service NHS Trust • West Kent PCT
24 April 2009	Receive reports on Public Health and Healthy Living, including key performance indicators	• Eastern and Coastal Kent PCT • KCC Public Health Department • West Kent PCT

Other topics:

- Kent Adult Social Services
- Learning Disability services
- Coronary Heart Disease services (covered by Fit for the Future?)
- Stroke services (covered by Fit for the Future?)
- Public health issues: obesity, smoking cessation, diabetes, etc.
- Reducing health inequalities
- Role of independent Sector providers
- Child and Adolescent Mental Health services

Other issues to be taken on board:

- Flexibility needs to be built into the programme, to allow responsiveness to unforeseen issues
- Unknown number of referrals from Kent Local Involvement Network and Kent Healthwatch
- Member induction and development programme
- Interrelationship with Children's Services and Adult Social Services

Briefing note on Buckland Hospital and health services in Dover

Background

Buckland Hospital is a small former acute hospital at Coombe Valley Road, Buckland, Dover, run by East Kent Hospitals NHS Trust.

The building in which the hospital is housed was originally a Workhouse, built in 1836. It was taken over by the NHS in 1948 and eventually (with the closure of two other local hospitals) became the sole NHS hospital in Dover, serving as the local district general hospital.

In recent years a number of services have been withdrawn from Buckland Hospital – including the Accident and Emergency department, which has been replaced by a nurse-led Minor Injuries Unit (open seven days a week but not 24 hours a day). Patients from the Dover area requiring A&E services now have to travel to the William Harvey Hospital at Ashford, the Kent and Canterbury Hospital or the Queen Elizabeth The Queen Mother Hospital at Margate.

Buckland Hospital does, however, continue to provide a range of outpatient services and some inpatient services. It currently houses:

- the specialist East Kent Neurorehabilitation Unit (providing rehabilitation services for people with Epilepsy, Multiple Sclerosis, Motor Neurone Disease, Parkinson's Disease or traumatic brain injury);

- the award-winning Dover Family Birthing Centre (which offers expectant mothers the option of a birthing pool);

- the Dunkirk Renal Satellite Unit (providing haemodialysis services for kidney patients).

The Dover Project (2006)

In July 2005 the NHS Overview and Scrutiny Committee asked the local NHS to undertake a public discussion about the future of health services in Dover.

During January and February 2006, East Kent Coastal PCT and East Kent Hospitals Trust met various stakeholders, including the NHS Overview and Scrutiny Committee.

A 12-week public consultation by the PCT and the Trust about possible models of health and social care service delivery in Dover took place between June and September 2006 around the document *The Dover Project – Your Say*. This was a 20-page publication, outlining possible alternative models of provision for 11 service areas, with an accompanying response form to allow members of the public to indicate which options they preferred. Three public meetings were held as part of the consultation. While the consultation was concerned with services provided in Dover town, the consultation process was promoted across Dover district.

The NHS OSC considered this consultation on four occasions (on 30 March 2006, 12 May 2006, 22 September 2006 and 23 March 2007). Members were unanimously supportive of the way that The Dover Project was being undertaken.

The PCT and the Trust emphasised that the consultation was about services rather than buildings; the specific details of where services were to be provided would only be considered once the agreed Models of Care were clear. As such, the consultation was not directly concerned with the future of Buckland Hospital.

Nevertheless, many Dover residents, along with the local press and the town's MP, Gwyn Prosser (Lab.), were of the opinion that The Dover Project was an attempt to bring about the closure of Buckland Hospital by surreptitious means. East Kent Hospitals Trust was accused of wanting to sell off Buckland Hospital for housing development in order to bolster the Trust's financial position. A senior clinician at the hospital, Dr John Sewell, also queried the motives behind The Dover Project and argued in favour of retaining hospital services at the Buckland site.

During the consultation, the *Dover Express* conducted a poll, in which 2,229 people responded in favour of keeping the hospital open, with just seven against. Thirteen thousand signatures were collected on a petition to save the hospital, which was handed in at 10 Downing Street in September 2006 by Mr Prosser and local campaigner Pauline Major.

The leader of Dover District Council, Cllr Paul Watkins (Con.), was critical of Mr Prosser and the campaign to keep Buckland Hospital open. He argued that the poor quality of the antiquated estate at the hospital meant that it was no longer fit for the provision of modern healthcare.

A total of 888 response forms from the public were submitted during the consultation on The Dover Project (4,800 forms were distributed).

The preferred options for Models of Care arising from the consultation have been summarised by the PCT as follows:

- CARE OF THE ELDERLY – INTERMEDIATE CARE: Expand intermediate care services in a community setting, including local intermediate care beds which can be accessed according to need, and reduce the hospital based service.

- GP SERVICES: Keep GP practice based services as they are and also provide a broader range of services delivered in the practice.

- DENTAL SERVICES: Keep the balance between a regular dental provision and the dental access service as it is now providing an increase in overall provision with an emphasis on regular dental care.

- PHARMACY SERVICES: Expand the service provided by pharmacies to include services such as health care checks and additional 'over the counter' advice from the pharmacist.

- OPTICIAN SERVICES: Keep providing optician services the way they are at the moment.

- MINOR INJURIES: Develop a walk-in centre in central Dover offering a comprehensive range of services including minor injuries and minor illness.

- OUTPATIENTS – FIRST AND FOLLOW-UP APPOINTMENTS: More outpatient clinic appointments as close to home as possible – e.g. in a GP surgery or central Dover location.

- CHILDREN'S SERVICES IN THE COMMUNITY: Provide enhanced and specialist services from a central Dover location, whether this is dedicated to Children's Services or linked to other NHS provision. Low level and more generic services to be delivered in a range of community and NHS facilities.

- CHILDREN'S 'DAY WARD' SERVICES – AMBULATORY CARE: Continue to provide ambulatory care services in Dover and co-locate them with other Dover children's services on the same site such as radiology, minor injuries outpatients and some elements of community services.

- MIDWIFERY SERVICES: Make no changes and keep the birthing unit the way it is at the moment.

- IMPROVING HEALTH & WELLBEING – HEALTH PROMOTION: Focus delivering health promotion activities in partnership with non-health agencies, e.g. schools, community centres, leisure centres, supermarkets.

The questionnaire also included an open-ended "Other issues" section, to allow people to raise any concerns. The responses under this heading have been summarised by the PCT as follows:

- Transport – access and frequency of public transport, eligibility to access NHS transport, cost of travelling to acute hospital sites outside of Dover;

- Accessibility of buildings – child friendly environment, catering correctly for people with disabilities;

- Condition of buildings and their suitability to provide modern health care in a clean and safe environment;

- Opening hours – times of clinics, access to care outside of normal working hours;

- Parking at acute sites – cost of parking;
- Strong support for the preservation of Buckland Hospital;
- Location of services – central position on a good bus route.

East Kent Neurorehabilitation Unit

Between February and March 2007 a "focussed discussion" (not a consultation) took place on the future of the East Kent Neurorehabilitation Unit. Among the issues discussed was the possibility of moving the service from Dover to another location in East Kent. It is now intended that the Unit will relocate to the Kent and Canterbury Hospital during 2008. (Locating the service at Buckland Hospital when it was set up in 2001 was seen at the time as a temporary expedient.)

Inpatient wards for older people

Buckland Hospital's inpatient wards for older people were due to close by the end of October 2007. The wards were regarded as not fit for providing modern standards of care and had been superseded by community-based forms of intermediate care in the area.

Service delivery options

On 16 May 2007 the PCT Board approved a paper setting out emerging service delivery options that stemmed from The Dover Project. These options had been developed by planning leads in each of the service delivery areas, reporting to the Dover Project Steering Group (a multi-agency body, including KCC, the Patient and Public Involvement Forum for the PCT, the "Dover Pride" regeneration project and other stakeholders, meeting on a monthly basis).

The paper stated that the following key principles had been agreed by the PCT and the Trust for the development of Dover Project outcomes:

- to ensure that appropriate local services are developed in Dover for Dover people;
- to deliver local services in high quality environments;
- to develop a clear vision in respect of the Buckland Hospital site;
- to deliver local services through skilled and motivated staff.

Critical issues affecting the development of the service delivery options were:

- future strategic direction for the Hospitals Trust and the PCT – including the Trust's intention to remove inpatient beds from Buckland Hospital;

- commissioning issues – relating to the commissioning plans of the Dover and Aylesham Practice-based Commissioning Group;

- estates and property – particularly regarding the future of the Buckland Hospital site, given that "A hospital estate built over 100 years ago with numerous poor-quality additions can not provided the patient environment that meets the required standards for privacy, dignity and appropriate clinical adjacencies".

Buckland Hospital Steering Group

A Buckland Hospital Steering Group was then set up, meeting every two months under the chairmanship of Howard Jones, Facilities Director of East Kent Hospitals Trust.

It was proposed that services would continue to be provided from Buckland Hospital for at least four more years – but the age and quality of the estate made it impossible to continue providing services indefinitely in the buildings that currently existed on the site.

It was proposed to retain the Renal Satellite Unit in Dover, although not necessarily at the Buckland site.

Any decision on the future overall configuration of services in Dover, and what was to be done with the Buckland Hospital site, was to be made in the context of "Dover Pride", in which Eastern and Coastal Kent PCT is an active partner.

It was argued by some (e.g. Dr Sewell) that it would be more efficient to co-locate services at a single location in Dover, rather than scattering them across satellite sites – so there should continue to be a hospital in the town, either at the Buckland site or some other location.

Patient and Public Involvement Forum referral to Health Overview and Scrutiny Committee

On 13 December 2007 the Eastern and Coastal Kent Patient and Public Involvement Forum (PPIF) discussed and agreed a document (drafted by PPIF member Lorraine Sencicle) expressing concern about the future of health services in Dover.

On 20 December the document was sent to Eastern and Coastal Kent PCT, which then responded to the points in it. The PPIF was not satisfied with the PCT's responses and agreed at its meeting on 31 January 2008 to refer the matter to the Health Overview and Scrutiny Committee.

The PPIF document stated that "we consider that the Dover health services are deteriorating and therefore the patients and public are being disadvantaged". The Dover Project failed to deal with the actual location of services, and the PCT and the Trust are failing to explain what services will be provided and where, all the while running down Buckland Hospital.

The PCT's response was that The Dover Project was concerned with services rather than buildings and that detailed consideration was now being given to options for the actual provision of services.

The Trust, meanwhile, was working on a Strategic Outline Case that would satisfy agreed criteria for access and affordability. It was clear that Buckland Hospital in its present form was not sustainable in the longer term – the issue was whether the site would be redeveloped in some way or services would be reprovisioned elsewhere in the Dover area.

More recently a new campaign in support of keeping hospital facilities at the Buckland site has been set up, led by former County Council Member Reg Hansell. This supports the view taken by the PPIF (which was abolished, along with all other PPIFs, at the end of March 2008).

The Trust's Proposals

The Trust has now completed its strategic options appraisal. The outcome of this is that it intends to develop two options into full business cases. These are:

1) to refurbish part of Buckland Hospital, so that the facilities are fit for purpose – this would mean an investment of just over £8 million;

2) to provide a new building on the Buckland site, at a cost of around £11 million.

These options have been agreed by the Trust's Chief Executive's Group, Clinical Management Board, Strategic Development Committee and, most recently, the Board. The necessary capital expenditure is being built into future plans and architects are being engaged to work on the options.

The Trust has given Dover District Council and the PCT until August 2008 to come up with an alternative solution, based in central Dover, which can then be assessed against the two options for the Buckland site.

If it is decided not to redevelop the Buckland Hospital site for healthcare services, any proceeds from the sale of it (most likely to a housing developer) will go substantially to the Trust (or entirely to it, if the Trust has become a Foundation Trust by the time of the sale).[1]

[1] Disposal of NHS property is governed by the Department of Health's Estate Code. The Code aims to ensure that the use of NHS estate will "improve the health and well-being of the population through the resources available" by requiring NHS Trusts to use their estate "efficiently, effectively and strategically". Trusts can retain some of the proceeds of sales of land and buildings – up to £1 million for most Trusts and up to £5 million for top-performing Trusts. Proceeds above these thresholds are made available for use within the wider local health economy, apparently at the discretion of the relevant Strategic Health Authority. These rules, however, don't apply to Foundation Trusts, which are able to keep the proceeds of estate sales in their entirety. The estimated value of the Buckland Hospital site is £16.6 million (£4.2 million for the land and £12.4 million for the buildings).

A refurbished or rebuilt hospital at the Buckland site would not have any inpatient beds, other than maternity beds, and would not function as a district general hospital with an A&E department.

David Turner

Research Officer, Health Overview and Scrutiny Committee

30 April 2008

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Our NHS, Our Future – Next Stage Review (The Darzi Review)

Background Briefing

Lord Darzi

Ara Darzi holds the Paul Hamlyn Chair of Surgery at Imperial College London, and is an Honorary Consultant Surgeon at St Mary's Hospital and the Royal Marsden Hospital.

His main clinical and academic interest is in minimally invasive therapy ("keyhole" surgery), including the use of surgical robots and image-guided surgery.

Prof Darzi was knighted in December 2002. In June 2007 he was made a member of the House of Lords and appointed Parliamentary Under Secretary at the Department of Health, as part of Prime Minister Gordon Brown's "government of all the talents" initiative.

Healthcare for London: A Framework for Action **(The London Darzi Review)**

In December 2006 NHS London, the Strategic Health Authority for the capital, asked Prof Darzi to develop a strategy for the NHS in London for the next five to ten years.

His report, *Healthcare for London: A Framework for Action*, was published in July 2007. It took as its starting point the following principles:

- Services should be focused on individual needs and choices.
- Services should be localised where possible, or regionalised where that improves the quality of care.
- There should be joined-up care and partnership working, maximising the contribution of the entire workforce.
- Prevention is better than cure.
- There must be a focus on reducing difficulties in accessing health and healthcare across London.

On this basis, the report proposed the following changes in the pattern of service delivery:

- centralisation and the creation of networks for the treatment of major trauma, heart attacks and strokes;
- a shift of routine diagnostic procedures and outpatient appointments out of large hospitals and into new "polyclinics";
- increased use of the day-case setting for many procedures;

- centralisation of more specialised in-patient care into large hospitals.

A London-wide public consultation was conducted from November 2007 to March 2008. An analysis of consultation responses will be published on 6 May 2008. London Primary Care Trust Boards will then consider the proposals and in June 2008 a Joint Committee of PCTs will meet in public to agree recommendations for health strategy in London over the next 10 years.

A paper that was recently put before the Board of NHS London suggested that there may be "insufficient leadership capacity and capability in primary care trusts and allied NHS organisations" in London to deliver Lord Darzi's recommendations.

Polyclinics

Lord Darzi argued that there was a need for a new kind of community-based care at a level between that of current GP practice and conventional acute hospitals – a need that could be filled by the creation of what he termed "polyclinics".

A polyclinic is a relatively small healthcare facility, serving a local community and hosting a wide range of health services – including some that have, within the NHS, traditionally been provided in acute (district general) hospitals.

Polyclinics have long been major features of healthcare systems in some countries. In the Soviet Union, the greater part of healthcare was provided through polyclinics that combined the role of a hospital outpatients department with that of a general medical practice and served populations of several thousand. This system (known as the Shemasko system) was a model for healthcare in other Communist countries. In Cuba, polyclinics serving populations of around 30,000 provide GP services and a range of specialties, as well as diagnostic services. Germany has some 400 polyclinics. These are mostly a legacy of the health system in the former East Germany – but new polyclinics have begun to be established as part of far-reaching healthcare system reforms.

The polyclinics envisaged by Lord Darzi could provide the following:

- GP services;
- community services;
- outpatient services;
- minor operations;
- urgent care;
- diagnostics;
- community mental health care;

- management of long-term conditions;
- pharmacies; and
- other primary care services, such as optical and dental services.

They could be combined with local authority services and leisure facilities; and they could be co-located with a hospital or free-standing in the community. Their size could allow them to offer extended opening hours.

On this model, polyclinics would become the site of most GP care. Those practices remaining separate from polyclinics could be networked with a polyclinic, allowing patients to use their extended facilities.

Lord Darzi envisaged that between five and 10 polyclinics would be established in the capital by 2009. He did not spell out the contractual arrangements under which they would be commissioned.

Our NHS, Our Future – NHS Next Stage Review, Interim Report

When Lord Darzi became a minister in June 2007 he was asked by the new Secretary of State for Health, Alan Johnson, to undertake a review of the NHS across the whole of England, with a view to producing a strategy for the next decade (effectively following on from the NHS Plan of 2000). He was tasked with producing an interim report within four months and the final report in 12 months (to coincide with the sixtieth anniversary of the creation of the NHS).

In October 2007 *Our NHS, Our Future – NHS Next Stage Review, Interim Report* was published. In it, Lord Darzi stated that the NHS should be:

- fair;
- personalised;
- effective;
- safe.

He thought the NHS needed to:

- focus on quality of care as well as capacity;
- be ambitious in responding to the aspirations of patients and the public for a more personalised service;
- ensure that change was animated by the needs and preferences of patients;
- support local change from the centre, rather than handing down instructions;

- make best use of resources to provide the most effective care, efficiently.

Lord Darzi advocated that certain immediate steps should be taken ahead of his final report:

1) implementing a comprehensive strategy for reducing health inequalities, as announced by the Secretary of State;

2) embedding patient choice within the full spectrum of NHS-funded care, going beyond elective surgery into new areas such as primary care and long-term conditions through:

    a. the investment of new resources to bring new GP practices (provided by traditional independent practitioners or by new private providers) to local communities where they are most needed, starting with the 25% of PCTs with the poorest provision

    b. newly procured health centres in easily accessible locations, offering a range of convenient services for all local people, whether or not they are directly registered with GPs in these centres

    c. the introduction by PCTs of new measures to develop greater flexibility in GP opening hours including the introduction of new providers – so that, over time, the majority of GP practices will offer services in the evening or at the weekend;

3) the establishment of a Health Innovation Council, to be the guardians of innovation;

4) support for the National Patient Safety Agency in establishing a single point of access for frontline workers to report incidents ("Patient Safety Direct"); and the following measures to reduce further rates of healthcare-associated infections:

    a. legislation to create a new health and adult social care regulator (the Care Quality Commission) with tough powers

    b. powers for matrons to report concerns on hygiene direct to the new regulator

    c. the introduction of MRSA screening for all elective admissions in 2008, and for all emergency admissions as soon as practicable by 2010;

5) ensuring that any major change in the pattern of local NHS hospital services is clinically led and locally accountable by publishing new guidelines to make clear that:

a. change should only be initiated when there is a clear and strong clinical basis for doing so

b. consultation should proceed only where there is effective and early engagement with the public

c. resources are made available to open new facilities alongside old ones closing.

Lord Darzi announced that groups of health and social care staff (over 1,000 people in total) would be established in every region of the country to discuss how best to achieve this vision across the following areas of care:

- maternity and newborn care;
- children's health;
- planned care;
- mental health;
- staying healthy;
- long-term conditions;
- acute care;
- end-of-life care.

Lord Darzi also asked the Chief Executive of the NHS, David Nicholson, to chair a national working group of experts to consider the scope, form and content of a possible NHS Constitution.

Equitable Access to Primary Medical Care programme

Following the interim report, the government declared its intention to implement Lord Darzi's proposals on access to Primary Medical Services through the "Equitable Access to Primary Medical Care" programme. This is an initiative to procure:

- over 100 GP practices in the 25% of PCTs that are the most under-doctored (38 in all – the only one in the South East Coast area is Medway PCT);
- the development of at least one "GP-led health centre" in each PCT area (there are 152 in total).

The health centres (which are being referred to as "Darzi clinics" or polyclinics) must:

- be in easily accessible locations;

- deliver core GP services;
- maximise opportunities to integrate and co-locate with other community-based services, including social care;
- be open between 8:00am and 8:00pm, seven days a week;
- offer both bookable GP appointments and walk-in services;
- provide services for both registered and non-registered patients.

The government has stated that additional funding for this procurement exercise (both GP practices and GP-led health centres) will be provided to PCTs from a new £250 million Access Fund, with the GP-led health centres costed by the DoH at around £790,000 each. Funds will be added to PCTs' allocations, on a weighted capitation basis – apparently with ringfencing.

It is being emphasised that this funding is for new capacity – not the expansion or replacement of existing surgeries or health centres. Investment must be for additional clinical capacity (i.e. extra GPs, nurses and support staff). And the procurement is for new and innovative services, not necessarily for new buildings or facilities.

PCTs will most likely be using the Alternative Provider Medical Services contracting route for this procurement, meaning that contracts could mostly, or entirely, go to corporate providers – although the DoH says that existing GPs must be able to compete on a "level playing field" with the independent sector.

Alliance Boots have said they could host all 152 of the GP-led health centres. Lord Darzi has reportedly held meetings with at least 15 potential private and voluntary sector providers of primary care services, including private healthcare providers such as BUPA, Netcare UK and Care UK, and High Street chemists Alliance Boots and Lloydspharmacy – with non-healthcare commercial organisations, such as Tesco, also "welcome to attend".

The DoH will not scrutinise individual plans or specifications but will ask Strategic Health Authorities (SHAs) to provide the necessary assurances. Progress will be monitored by the DoH on a monthly basis against "key milestones" deadlines – on an extremely demanding timescale for PCTs.

The DoH expects all the health centres to become operational between January and March 2009.

It has recently been reported in the *Health Service Journal* that Lord Darzi's final report will include a proposal that GPs should be charged whenever their patients access primary care through non-emergency use of an A&E department, or through a walk-in centre or minor injuries unit. GPs' representatives have argued that this would merely act as a disincentive for GPs to practice in areas with high levels of inappropriate A&E use – which tend to be socially deprived and underdoctored areas.

Individual budgets

Individual budgets for social care (now called "personal budgets"), in addition to direct payments, were first mooted in a January 2005 paper by the Prime Minister's Strategy Unit. The government announced that it would proceed with the development of individual budgets in the Green Paper *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England* (March 2005).

While direct payments only cover local authority social care budgets, individual budgets combine this money with that available from other public funding streams.

Service users eligible for these funds have a single transparent sum, equivalent to their total entitlement, allocated to them. They can then choose to take this money as a direct payment in cash, as provision of services, or as a mixture of both cash and services, up to the value of their total budget. As with direct payments, the social care element is subject to the usual policies regarding means-testing and charging. Unlike direct payments, individual budgets can be used for services provided in-house by local authorities.

In Lord Darzi's interim report he stated:

> *I have also been impressed by what I have heard about the introduction of individual budgets in social care linked to direct payments and individual budget pilots, which have clearly transformed the care of some social care users. From this, we need to learn how to support and allow eligible service users increasingly to design their own tailored care and support packages. This could include personal budgets that include NHS resources. As a first step, we will encourage practice-based commissioners to use NHS funds much more flexibly to secure alternatives to traditional NHS provision where this would provide a better response to an individual's needs, e.g. through respite care or support, installing grab rails to help maintain independence, self-monitoring equipment for people with long term conditions, supporting carers of terminally ill patients, and so on.*

In November 2007 this was explicitly endorsed by the NHS Chief Executive, David Nicholson, when he addressed the King's Fund:

> *I think we will see a move to more and more individual budgets involving allocation of resources - either yearly resources or episodic resources - to people, and what we will see coming with that is the need for a kind of brokerage, bringing people together and then buying on their behalf or commissioning on their behalf. I think we will see that. I think we should encourage it and develop it.*

In December 2007 *Putting People First* made explicit reference to Lord Darzi's comments on individual budgets in the NHS.

In January 2008 the Prime Minister, speaking to an audience of health professionals at King's College London said:

> *During 2008 we will bring forward a patient's prospectus that sets out how we will extend to all 15 million patients with a chronic or long-term condition access to a choice . . . Real control and power for patients, supported by clinicians and carers. And where it is appropriate, just as with personal care budgets for the 1.5 million social care users, it could include the offer of a personal health budget.*

In an interview with the *Sunday Telegraph* on 30 March 2008 Alan Johnson clearly stated his support for the idea of individual budgets in the NHS for patients with chronic conditions.

Given all of the above, it seems highly likely that proposals on individual budgets in the NHS will be contained in Lord Darzi's final report when it is published in early July 2008.

The extension of individual budgets to the NHS has been strongly advocated by a number of academics (including Prof Julian Le Grand, who was health policy adviser to Tony Blair during the latter's premiership), as well as by the Social Market Foundation and the Conservative Party.

It is argued that individual budgets in the NHS would:

- lead to greater personalisation of services;
- help overcome capacity constraints in the NHS;
- allow better coordination of care for individuals using multiple services;
- mean more transparency in the allocation of NHS funds;
- foster equity by allowing personalisation of services for NHS patients as well as private patients;
- deliver better value for money;
- lead to innovation and service development; and
- possibly improve health outcomes by helping people manage their own health better.

Individual budgets are in line with the government's introduction of market-style mechanisms into the NHS, through means such as Patient Choice.

The following have been identified as areas of NHS care in which individual budgets could be piloted:

- services for people with long-term conditions;
- mental health services;

- maternity services;

- expensive out-of-area placements;

- continuing nursing care (for instance, in the case of a patient with Alzheimer's Disease, an area that has been the subject of a legal test case about the limits of NHS funding, the Pointon case) – there are indications that this is the most likely candidate for a pilot of individual budgets in the NHS;

- services for learning disabled people (although, where such services are still within the NHS, they are increasingly being transferred to local authorities).

A radical version of individual budgets might go beyond this, with patients able to use sums of money, allocated to procedures under a national tariff, to choose from a range of providers.

It is unclear how exactly commissioning of services by patients using individual budgets would relate to other elements of NHS "system reform", particularly Practice-based Commissioning by General Practitioners and "world-class" (strategic) commissioning by Primary Care Trusts.

There are also questions around the possible impact of individual budgets on the work of the National Institute for Health and Clinical Excellence (NICE). NICE has a remit to evaluate the effectiveness and cost-effectiveness of clinical interventions and to issue guidance accordingly, helping to ensure that the NHS achieves value for money. Allowing patients to choose to spend NHS funds on treatments that have not been approved by NICE would appear to risk undermining the role of the Institute.

Some critics fear that individual budgets could actually work to compound the Inverse Care Law (that those who most need care are least able to access it) – contrary to claims made in support of the idea.

According to this view, market-type mechanisms tend most to empower those who have always done best out of the NHS and social care (the better off and less sick). At the same time, such mechanisms place service provision more in the hands of independent providers, who will want to concentrate on those communities, patients, conditions and procedures that yield the highest rate of return. The poorest and sickest will be least able to work the system to their advantage (especially without adequate "support brokerage" and "care navigation"); and they could suffer the most from the undermining of publicly-provided services.

Individual budgets also raise the possibility of breaching one of the NHS's core principles – that NHS money is never used to subsidise the purchasing of private care by the better off. Under Patient Choice, NHS patients can choose independent providers, but their care is still entirely on the NHS, wholly purchased by the NHS at its tariff price, with no "co-payments" by patients. A voucher system, such as individual budgets, could allow better off patients to

take NHS cash and use it, topped up with their own money, to buy private care not available to other NHS patients.

Allowing “co-payments” in this way could further be seen as potentially allowing *de facto* extensions of patient charging in the NHS (patient charges are currently confined to prescriptions, and to primary-care optical and dental services) – as indicated in *Our health, our care, our say*.

David Cameron’s speech to the King’s Fund

On 22 April 2008 the Leader of the Opposition, David Cameron, gave a speech to the King’s Fund in which he criticised government health policy, including the proposals that are emerging from the Darzi Review.

He argued that “The plan for a national network of polyclinics is the biggest upheaval in primary care since the creation of the NHS” and accused the government of wanting to “make GPs salaried employees of the state, and abolish small practices in favour of large multipurpose centres”. Mr Cameron continued:

> *The Government says that in London, most patients will be within a mile and half of a polyclinic. The people who need GPs the most are the elderly, those with small children and those with long-term conditions. Those are the people least able to get to a polyclinic, and least comfortable in a large impersonal institution. They like to rely on the doctor they know, at the end of their street, often in a building not much bigger than a house. They have a human relationship with their GP that they simply won't have with a member of staff at a polyclinic.*

He stated that, whilst not objecting to polyclinics in principle, he objected

> *to the principle of imposing them on local communities without public support and against the wishes of GPs themselves. Where they occur, they should occur naturally, as the voluntary combination of free agents - not as the latest structural re-organisation of the NHS. Lord Darzi, the health minister behind the polyclinics plan, has admitted that doctors will, effectively, be forced into polyclinics using the GP contract. It is quite wrong.*
>
> *If the Darzi plan is implemented a thousand GP surgeries are likely to close in London alone - that's three quarters of the total. Another 600 local surgeries will close across the country.*

House of Commons Opposition Day debate

On 23 April 2008 an Opposition Day debate took place in the House of Commons around an Opposition motion expressing concern "about the lack of empirical and clinical evidence for the establishment of polyclinics in every primary care trust" and opposing "the central imposition of polyclinics against local health needs and requirements". The Opposition argued that the government’s plans on polyclinics entailed the imposition of a “one-size-fits-

all" template across the country, threatening the future of family doctor services and undermining continuity of care.

The Secretary of State responded that "There is no national policy for replacing traditional GP surgeries with health centres or, indeed, polyclinics. There are no plans to herd GPs against their will, or the will of patients, into super-surgeries." Mr Johnson argued that the investment of £250 million in additional primary care for underserved areas should be welcomed. He stated that Lord Darzi's polyclinic plan for London was "not a blueprint for the rest of the country".

David Turner

(Research Officer, Health Overview and Scrutiny Committee)

30 April 2008

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NHS South East Coast

Foundation Trust progress report

The Foundation Trust (FT) application process has changed recently the SHA will now be taking the lead role in determining the readiness of Trusts for Foundation Trust authorisation rather than the Department of Health. The process the SHA are proposing enables both an improved quality of application and ensures that Trust Boards assess their state of readiness to achieve Foundation Trust licence, working collaboratively with the SHA.

The SHA will need to determine the overall potential readiness of each Trust in all areas, particularly as patient safety and service performance together with governance issues are likely to be as critical a factor as the financial performance.

REVISED PROCESS

The key components of the revised process are:

- There is a single robust framework that can be consistently applied
- There is a single evidence base that can support the nomination process
- There is explicit confirmation from the applicant Trust Board that the proposed time line to authorisation is achievable.
- There is ongoing engagement with the applicant up to the point of authorisation
- Trust readiness for Foundation Trust status is assured

Trusts with Monitor

- The revised process will apply to all Trusts except those that are already with Monitor, e.g. Surrey & Borders Partnership Trust.
- These Trusts will only need to come back into the process if, for any reason, they are rejected or deferred by Monitor.

Trusts currently in the Foundation Trust pipeline

- There are 5 Trusts that started their Foundation Trust application under the old process, all of whom have either been out to, or are currently in, public consultation. These Trusts are all at very different stages in the application process and agreement will be reached with each of those Trusts individually as to how assurance will be provided for each step of the new process and agreed timelines to F.T. authorisation.
- Meetings with each organisation are currently being held.

Trusts not yet in the Foundation Trust pipeline

- A new internal SHA process is currently being proposed to assess the readiness for Trusts to reach Foundation Trust status and the table at Annex 1 summarises the steps and timeline of that process.
- From the start of the process until reaching Monitor is a minimum of 9 months with a further 3 months for the Monitor assessment, giving a minimum of a year for Trusts to be authorised as an Foundation Trust.
- Following an introductory workshop, the process begins with agreement by the Trust CEO and Chair that their organisation is ready to begin the process and an indicative timeline agreed, depending on the state of readiness at that point.

- The timeline will set 2 key milestones, the initial Board to Board with the SHA and the expected date the application will go to the Secretary of State for onward submission to Monitor.
- The initial Board to Board with the SHA will be key to signalling that the Trust is in a state of readiness and can progress to public consultation and will be based on the information received from the Trust during that previous 16 weeks. This will be similar to the previous diagnostic but with a greater emphasis on being developmental.
- Following consultation and receipt of final documentation from the Trust, a second Board to Board is also proposed. This will be at the end of the process and will enable a review of final documentation following the public consultation and SHA sign off of final support. This final meeting could also include Monitor personnel and/or a current Foundation Trust CEO/Non-Executive Director to add further challenge.

Ambulance Trust

- The DH has established a separate process for Ambulance Trusts including a separate diagnostic process to be piloted during 2008. B

SHA TRUSTS

Trusts are listed below in chronological order within the Foundation Trust pipeline, setting out the progress to date and current issues. These dates are indicative as during the process nearly all Trusts have adjusted their timeframe to take account of alterations to the process, or because of other issues.

Medway – Wave 4 Authorisation by Monitor for Foundation Trust 1 April 2008

The Trust was authorised by Monitor to become a NHS Foundation Trust from 1 April 2008.

Surrey and Borders – Wave 6 (Earliest Authorisation by Monitor for Foundation Trust 1 May 2008)

The Trust is providing Monitor with assurance for a number of issues including the Month 11 financial position, Cost Improvement Programmes and the contractual position with the PCT.

Sussex Partnership – Wave 8 (Earliest Authorisation by Monitor for Foundation Trust 1 August 2008)

The SHA submitted the Trust's application to the DH together with the SHA Support Form to be considered at the DH Applications Committee in April 2008. The Trust currently has 3,000 public members in line with its plan. A Chair was appointed to the Trust on 1 April 2008 and the previous Chair has been appointed as a Non Executive Director.

Dartford & Gravesham –
Deferred Wave 7 (Earliest Authorisation by Monitor for Foundation Trust 1 October 2008).

The Trust plan, agreed with the SHA and DH, is to resubmit their application in April 2008 to the SHA and to the DH in May 2008, subject to achieving their MRSA target from December onwards, which is currently on track and the financial requirements. Further drafts of the documentation are currently being reviewed by the SHA and the DH before submission to the DH on 1 May 2008.

Kent & Medway Partnership – Earliest Authorisation by Monitor for Foundation Trust 1 December 2008

Public consultation ends in April 2008. The Trust has revised its previous timetable by two months and is planning on submission to the DH in August 2008. The Trust is currently working on its third draft of the documentation for submission to the SHA at the end of April 2008.

East Kent Hospitals – Earliest Authorisation by Monitor for Foundation Trust 1 December 2008
Public consultation ends in April 2008. The SHA and the Trust are currently working to a timetable that will see a submission to the DH applications committee at the beginning of August 2008

East Sussex Hospitals –
Deferred Wave 8 (Earliest Authorisation by Monitor for Foundation Trust 1 February 2009)
Since the Trust agreed with the SHA to defer their submission to the DH from Wave 7, an action plan has been progressing with the SHA regularly monitoring progress against the plan.

The Royal West Sussex NHS Trust
Worthing and Southlands Hospitals NHS Trust
Brighton and Sussex University Hospitals NHS Trust
The SHA reported to the DH that it considers Royal West Sussex NHS Trust, Worthing and Southlands Hospitals NHS Trust and Brighton and Sussex University Hospitals NHS Trust to be in a position to obtain NHS FT status by mid 2009. However, this is subject to the outcome of the Fit for the Future (FFF) programme.

Surrey and Sussex Healthcare NHS Trust
Maidstone and Tunbridge Wells NHS Trust
For Surrey and Sussex Healthcare NHS Trust and Maidstone and Tunbridge Wells NHS Trust, the SHA has moved authorisation dates for both organisations to mid 2010, to allow time for the Trusts to evidence sustainable improvement in both performance and finance.

Ashford & St Peters Hospitals NHS Trust
No date has been given for Ashford and St Peters to become a Foundation Trust in its own right as a merger/acquisition option was being worked up with Frimley Park Hospital Foundation Trust which has recently been discounted by both of the trusts.

Royal Surrey County NHS Trust
The SHA Board agreed to invite Royal Surrey County Hospital NHS Trust to complete Phase 1 of the SHA's Foundation Trust readiness assessment process. Phase 1 is the period up to the first Board to Board ahead of approving the Trust to go to public consultation.

South Downs Health NHS Trust
Until the future of this organisation in relation to Foundation Trust status has been decided, no date has been agreed.

South East Coast Ambulance Services NHS Trust
The DH is currently developing a diagnostic programme for ambulance trusts that will be piloted later this year and then rolled out across all other ambulance trusts. The Trust will be able to apply for NHS Foundation Trust from April 2009 and will be looking to do so as early as possible.

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