



## AGENDA

### HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 13th June, 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 9.45 am outside the meeting room*

#### Membership (17)

- Conservative (12): Lord Bruce-Lockhart (Chairman), Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr D A Hirst, Mrs S V Hohler, Mr G A Horne MBE, Mr R J Parry, Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed
- Labour (4): Mr M J Fittock (Vice Chairman), Mrs C Angell, Ms A Harrison and Mrs E D Rowbotham
- Liberal Democrat (1): Mr D S Daley

#### **UNRESTRICTED ITEMS**

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

<b>Item No</b>		<b>Timings</b>
1.	Substitutes	10.00 – 10.10 am
2.	Declarations of interests by Members in items on the agenda for this meeting	
3.	Minutes – 9 May 2008 (Pages 1 - 48)	
4.	Monitoring of outcomes from conclusions and recommendations of previous Health Overview and Scrutiny Committee meetings (Pages 49 - 70)	10.10 – 10.20 am

5. Application for Foundation Trust status by Kent and Medway NHS and Social Care Partnership Trust (Pages 71 - 78) 10.20 – 11.35 am

*Erville Millar, Chief Executive, Kent and Medway NHS and Social Care Partnership Trust, and Steve Leidecker, Director of Operations, Adult Social Services, will be in attendance for this item.*

**This item will include a break, 11.00 – 11.15 am**

6. GP-led Health Centres (Pages 79 - 92) 11.35 am – 12.35 pm

*Lynne Selman, Director of Citizen Engagement and Communications, Eastern and Coastal Primary Care Trust, and Julia Ross, Director of Civic Engagement and Bill Millar, Assistant Director of Primary Care, West Kent Primary Care Trust, will be in attendance for this item.*

7. Accessing Healthcare – establishment of Select Committee (Pages 93 - 98) 12.35 – 12.50 pm

8. "Fit for the Future" Workstreams – including decision on joint scrutiny of Urology plans with Medway HOSC (Pages 99 - 104) 12.50 – 1.00 pm

9. Date of next programmed meeting – Friday 18 July 2008 at 10.00 am

### **EXEMPT ITEMS**

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

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

**5 June 2008**

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

## KENT COUNTY COUNCIL

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### 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 9 May 2008

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

OTHER MEMBERS PRESENT: Mr G K Gibbens (Cabinet Member for Public Health) and Dr M R Eddy (Leader of the Opposition)

OBSERVERS: Ms J Bentley, Mr G Bridgland (KCC), Ms R Brough (Dover District Council), Ms M Graham (Kent Messenger), Mr R Hansell, Mrs W Hansell (Eythorne Parish Council), Mr R Kenworthy, Mr J Larcombe (West Kent PCT Health Network), Cllr D Lloyd-Jones (Dover District Council), Ms P Major, Ms N Miller (KCC), Mr A Sencicle, Ms L Sencicle, Ms D Smith, Ms J van Ruyckevelt (West Kent PCT)

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

#### UNRESTRICTED ITEMS

**15. Minutes – 28 March 2008**  
(Item 3)

RESOLVED: that the minutes of the meeting held on 28 March 2008 were correctly recorded and that they be signed by the Chairman.

**16. Monitoring of outcomes from conclusions and recommendation of previous Health Overview and Scrutiny Committee meetings**  
(Item 4)

Members welcomed the draft rolling action sheet that had been prepared, while making a number of suggestions regarding improvements to the format and topics that had been omitted.

RESOLVED: that an updated version of the rolling action sheet should be considered at each meeting of the Committee as a standing item.

**17. Working Group – Healthcare Commission Core Standards**  
(Item 5)

- 1) Dr Robinson reported on the Working Group of Members that had met on 25 April to speak to NHS colleagues from a number of trusts about their Core Standards declarations. A summary of the information gathered at this meeting was before the committee, along with a similar summary relating to the full Committee meeting on 28 March.

- 2) Dr Robinson said that a lot of useful information had been gleaned, providing the Committee with baseline data for the process of preparing third-party commentaries for the next Annual Health Check. The Committee would need to ensure that it was gathering evidence-based information for this purpose throughout the course of the coming year.
- 3) A Member suggested that, when the Committee was scrutinising the work of a local NHS body, it might meet in the actual area concerned. The Chairman suggested that the Committee would also need to involve Members of the County Council in each area in the process of gathering information for third-party commentaries on local NHS trusts.

RESOLVED:

- a) retrospectively to agree to the setting up of the Working Group that considered the self-declarations of the six remaining Trusts on 25 April 2008 – with similar arrangements to be made regarding the gathering information for third-party commentaries in respect of 2008–9; and
- b) to note the information set out in the summaries of the Working Group meeting on 25 April 2008 and the Committee meeting on 28 March 2008.

**18. Draft Work Programme for June 2008 to April 2009**

*(Item 6)*

- 1) The Committee had before it a draft Work Programme, covering the period from June 2008 to April 2009.
- 2) The Chairman referred to the intention that the Committee would consider, on 28 November 2008, a report on criteria and policy for assessing future reconfigurations and rationalisations of NHS services. He thought this would entail making recommendations to the Cabinet and possibly also the County Council itself.
- 3) The Chairman also referred to the intention that the Committee would consider, in December 2008, a report on NHS funding and delivering value for money in Kent – possibly prepared with assistance from an external organisation, such as the King's Fund.
- 4) The Chairman reported that he, along with the Overview, Scrutiny and Localism Manager, and Graham Gibbens, the Cabinet Member for Public Health, had met the Chief Executive of the Council to discuss the resourcing of the Committee. The Chief Executive had given an assurance that resources would be made available to the Committee to support both these substantial pieces of work.
- 5) Members discussed various aspects of the proposed Work Programme that was before them.

RESOLVED: to agree the draft forward Work Programme for June 2008 to April 2009, while recognising that it was not wholly fixed, and might well require revision in practice.

**19. Healthcare services in Dover**

*(Item 7 – 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, were in attendance for this item at the invitation of the Committee.)*

- 1) The Committee had before it a copy of a letter from the Patient and Public Involvement Forum for Eastern and Coastal Kent PCT, formally referring to the Committee the matter of healthcare services in Dover (dated 5 February 2008), along with a paper, setting out the reasons for referral, that was sent to the PCT (on 20 December 2007) and an annotated version of the paper, containing the PCT's responses. These papers are attached to these minutes as Appendices 1 and 2.
- 2) The Chairman reported that he had received a letter from Gwyn Prosser, the Member of Parliament for Dover and Deal, stating that he would have liked to attend the meeting, but was unable to do so, due to the lack of notice given. Mr Prosser had also gained the impression that he would not have been allowed to speak if he had attended the meeting.
- 3) The Chairman said that he wished to apologise to Mr Prosser and emphasised that local Members of Parliament were always welcome to attend and speak at meetings of the Committee. Copies of Mr Prosser's letter were circulated to Members.
- 4) Lorraine Sencicle, formerly a member of the Patient and Public Involvement Forum for Eastern and Coastal Kent Primary Care Trust, addressed the Committee, at the Chairman's invitation. Ms Sencicle said it had been stated that the basis for the Dover Project was the White Paper *Our health, our care, our say*. She believed that applying the principles of the White Paper to healthcare services in Dover must mean the establishment of a community hospital in the town – not a cottage hospital or a polyclinic. Funding had been made available for community hospitals, but Eastern and Coastal Kent PCT and East Kent Hospitals Trust had not put in a bid for this.
- 5) Ms Sencicle said that Dover was entitled to a community hospital providing: outpatient clinics; diagnostic services; phlebotomy; chemotherapy; physiotherapy; occupational therapy; renal dialysis; podiatry; orthopaedics; a Minor Injuries Unit, open from 6am to 9pm, seven days per week; day surgery; in-patient observation beds; intermediate care beds; end-of-life care; and other services.
- 6) Reg Hansell also addressed the Committee at the Chairman's invitation. He said that Dover lacked hospital services and had poor transport links to other areas where these were being provided. Buckland Hospital was "dying from a thousand cuts".
- 7) Mr Hansell read out a message from Gwyn Prosser MP, supporting enhanced facilities at the Buckland Hospital site. He also read out a message from Charlie Elphicke, the Conservative Prospective Parliamentary Candidate for Dover and Deal, saying that he fully supported the idea of a community hospital in Dover,

with an Emergency Care Centre similar to that existing at the Kent and Canterbury Hospital.

- 8) Mr Hansell also read out a message from Dr Joe Chaudhuri, of the Dover and Aylesham Practice-based Commissioning Consortium, explaining that the Consortium would be working with the PCT to commission services closer to home.
- 9) Cllr David Lloyd-Jones, of Dover District Council's Scrutiny Committee, addressed the Committee at the Chairman's invitation. He explained that his committee was conducting its own scrutiny on the issue of healthcare services in Dover. While he could not report on the outcome of this, as it would not be concluded until July, he could say that there was great public unrest and anger in Dover caused by fear that the town's hospital was going to disappear.
- 10) David Meikle Director of Finance, Commissioning and Performance, Eastern and Coastal Kent PCT, explained that the PCT recognised the work done under the heading of the Dover Project had been narrow in perspective. The PCT was now working with the local Practice-based Commissioning cluster and developing a Joint Health Needs Assessment.
- 11) In May 2008 the PCT would be discussing with GPs the "first cut" of a plan for enhanced local services, and discussing with East Kent Hospitals Trust how those services could be delivered. One of the main issues that needed to be considered was the buildings that would be used to deliver services.
- 12) Howard Jones, Director of Facilities for East Kent Hospitals Trust, explained that the Trust had come up with two options for the future of the Buckland Hospital site:
  - a general upgrade of the site, at a cost of £8 million;
  - the construction of a new building, at a cost of £11 million.
- 13) The Trust was currently discussing with Dover District Council other possible estate options in the area. Late July / early August had been set as the deadline by which the options for consideration should be set.
- 14) A consultancy report, by G V A Grimley Ltd, had been prepared regarding the possible disposal of Buckland Hospital and the construction of a new healthcare facility in Dover.
- 15) The market value of the Buckland site had recently been estimated at between £3 million and £4 million. The figure of £16.6 million, which had been quoted in the briefing paper provided to Members, was the "book value" for the site given by the District Valuer, not the market value. The site was not a "cash cow" for the Trust.
- 16) A Member pointed out that the Committee would need detailed information in order to be able to undertake scrutiny of the options that were to be considered. Sheila Pitt, Head of Practice-based Commissioning at Eastern and Coastal Kent PCT, said that the details were still being worked on and would be available by the end of June 2008, once they had been agreed by the PCT Board.

- 17) Mr Meikle said that the PCT welcomed scrutiny and criticism in the interests of improving services. A commitment was given to bring a detailed financial appraisal, with fully costed proposals, to the Committee for scrutiny.
- 18) Mr Jones said that the Trust would share detail as it became available. Plans for the options involving the Buckland site were currently being drawn up by architects for the Trust.
- 19) A Member asked whether the detailed options could come before the Committee for consideration in June or July 2008. The Chairman agreed that the detailed options should come before the Committee but said no guarantee could be given regarding when this would be.
- 20) Lynne Selman, Director of Citizen Engagement for Eastern and Coastal Kent PCT, assured the Committee that Practice-based Commissioning plans would be the subject of patient and public engagement and consultation, as well as coming before the Committee.
- 21) Responding to a question about the availability of adequate resources, Liz Shutler, Director of Strategic Development for East Kent Hospitals Trust, said that resources were not an issue for the Trust; Dover was a priority. The Board did want to reinvest in services, either at the Buckland site or an alternative Dover location, as the existing estate was not good enough.
- 22) Mr Meikle emphasised that the local Practice-based Commissioning cluster was committed to seeing a full range of diagnostic and other services available in Dover. Account was being taken of the voice of local GPs.
- 23) Ms Shutler said the Trust was planning to reprovide all services currently provided at the Buckland site. Practice-based Commissioning plans were currently awaited; if GPs wanted additional services to be provided, that would then have to be discussed.
- 24) A Member queried how services would be provided locally during rebuilding work at Buckland Hospital, if that option were to be adopted.
- 25) Another Member praised the quality of services at the Community Hospital in Deal (the Victoria Hospital), which was a refurbished building.
- 26) Responding to a question about public consultation, Ms Selman said that the PCT wanted to involve people all the way through the process of planning new services in Dover.
- 27) A Member queried whether it was an appropriate use of NHS money to have architects working on plans for the Buckland site when no decision had yet been made on which option to pursue.
- 28) Mr Hansell mentioned the availability of a site at Whitfield that he thought would be superb. Mr Jones said that the Trust did not think that a site at Whitfield would be suitable.

RESOLVED unanimously, on the motion of Dr Robinson, seconded by Mr Marsh, that:

*The Health Overview & Scrutiny Committee of KCC strongly recommend & support E K Hospitals Trust working closely with the ECK PCT & Dover District Council to locate a central site in Dover for the Community Hospital Services for the population of Dover & the surrounding areas.*

*This proposal to be delivered to the EKHT by the end of August 2008. This third option to be considered & evaluated alongside options 1 & 2 concerning the Buckland Hospital Site.*

**20. Our NHS, Our Future – Next Stage Review (Darzi Review)**

*(Item 8 – Stephanie Hood, Director of Strategy and Communications, and David Mallett, Assistant Director, “Fit for the Future”, South East Coast Strategic Health Authority, were in attendance for this item at the invitation of the Committee.)*

- 1) Stephanie Hood, Director of Strategy and Communications for South East Coast Strategic Health Authority, gave the Committee a presentation on the development of the South East Coast element of *Our NHS, Our Future – Next Stage Review* (the Darzi Review). Slides from the presentation are attached to these minutes as Appendix 3.
- 2) The Chairman thanked Ms Hood for her presentation. He emphasised it should not be forgotten that the South East, despite being an affluent region overall, still had real problems of deprivation.
- 3) A number of Members raised the question of polyclinics and the impact that these would have on local GP surgeries. Ms Hood responded that the work being undertaken in South East Coast around the Darzi Review was bottom-up and clinically led. It reflected what local people had told the NHS and was not being dictated from the centre. Whilst Lord Darzi had proposed a network of polyclinics for the NHS in London, this was not a blueprint for the rest of the country. Where polyclinics were proposed, it was to provide additional services, not to replace existing ones. And the Committee needed to focus on the ends that the NHS was trying to achieve, rather than on the means being employed.
- 4) Regarding GP-led health centres, which had been described as polyclinics, Ms Hood accepted that PCTs were being required to introduce these – but there would only be one in each PCT area. These would provide additional services, targeted at underdoctored areas, and it would be down to PCTs to carry out appropriate consultation over their introduction.
- 5) David Mallett, Assistant Director for “Fit for the Future” at South East Coast SHA, responded to a question about whether polyclinics might destabilise acute service providers by taking patients, and therefore funding, away from them. He said that the intention was now to deliver care locally both because this was cheaper and because it provided better access for patients. The NHS was now in financial surplus, having put an end to the “boom and bust” of the past, and this would enable some money to be taken out of the acute sector. Financial modelling had shown that, under Payment by Results, it would be possible to take marginal amounts of activity out of the acute sector without destabilising acute Trusts. There was no threat to the financial sustainability of any hospital in Kent and Medway, or anywhere else, caused by shifting activity into the community.

- 6) Mr Mallett added, regarding polyclinics, that they were intended to enhance GP services, not to replace them. In any case, GP practices were not the NHS's to close – they belonged to GPs as independent contractors.
- 7) Responding to a question about maternity services, Mr Mallett said that, across South East Coast, consultant cover on maternity wards ranged between 15 hours per week and 40 hours per week. In the short-term, it was intended to provide 40 hours' consultant cover per week everywhere, rising to 50 hours' cover in the medium term and 60 hours' cover in the longer term. In achieving this, there was an issue regarding the number of consultants available to staff the necessary rotas. He emphasised that, where there was not consultant cover, middle-grade doctors and midwives were still present.
- 8) On the issue of partnership working between health and social care, Ms Hood agreed that this was very important. She said that Lord Darzi had visited West View Hospital at Tenterden and said that the hospital had the best joint working between health and social care that he had ever seen. Best practice was going on in such places, and it had to be spread.
- 9) Responding to a question about the cost of public consultation around the Darzi Review, Ms Hood said that this expenditure did not come from the budget for care of patients – and she would not apologise for asking people's views.
- 10) A Member asked about protocols regarding the distance travelled, and time taken, in transporting patients to receive emergency care. Mr Mallett said that in a few clinical instances there was guidance on maximum time taken in getting a patient to emergency care. However, in the main there was no evidence to support the intuitive view that shorter times produced better clinical outcomes. There was really good evidence to show that the key factor in producing better clinical outcomes was getting the patient to a centre of excellence – regardless of how long it took.
- 11) Regarding end-of-life care, Ms Hood said that it was not being suggested that everyone had to die at home. The intention was to allow people to die where they wanted. Mr Mallett added that currently 55% of people died in acute hospitals, and that people did not get the choice of alternative options (including hospices) early enough.
- 12) In response to a question about the dignity of patients and the persistence of mixed-sex wards, Ms Hood said that it was intended to address this issue.
- 13) Ms Hood thanked a Member for raising the issue of the NHS failing to support young carers; this was just the sort of feedback that was needed.
- 14) Responding to a question about personal budgets in the NHS, Mr Mallett said that there was a move to this, in line with the choice and patient empowerment agenda. Where such budgets were provided, patients would be able to choose to spend them on NHS care, social services care or third-party care.

**21. Timetable for Foundation Trust status applications by trusts in Kent and Medway**  
*(Item 9)*

The Committee had before it a progress report on Foundation Trust status applications, provided by South East Coast SHA. It was noted that the Committee had earlier agreed, as part of its Work Programme, to consider the application by Kent and Medway NHS and Social Care Partnership Trust on 13 June 2008.

RESOLVED: that the Foundation Trust progress report be noted.

# Eastern and Coastal Kent

## Patient Public Involvement Forum



5 February 2008

Paul Wickenden  
Overview and Scrutiny Manager  
Legal and Democratic Services  
Sessions house  
County Hall  
Maidstone  
Kent  
ME14 1XQ

Dear Paul

### **Dover Health Care**

You will be aware that the Eastern and coastal Kent PPI Forum has become increasingly concerned over the last year about the provision for health care in the Dover district. Despite extensive meetings and discussions concerning this, we do not seem to be any nearer a clear direction for the way forward than we were a year ago. At the meeting on 13 December the Forum expressed a wish to refer the matter to Kent Health Overview and Scrutiny Committee, and sent a detailed document to the PCT covering the history of the project and our concerns. The PCT responded to this document, and this response was discussed at the forum meeting on 31 January. Representatives of the PCT and the EKHT attended the meeting, and they were able to respond to further questions from the forum members. Following a lengthy discussion of all the problems around health care provision for the Dover area, the Forum agreed unanimously that we wish to refer the matter for review by Kent HOSC.

We enclose the submission that was sent to the PCT in December with the comments from the PCT included. We also include correspondence between the Forum and the PCT and any relevant reports.

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Cont'd.

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*All correspondence should be addressed via:*

**Kent & Medway Networks Ltd**  
Office Hours: Monday - Friday 8.30am - 4.30pm  
Unit 24, Folkestone Enterprise Centre, Shearway Road, Folkestone, Kent, CT19 4RH  
Tel. No: 01303 297050 Fax No: 01303 297069 Email: janine@kmn-ltd.co.uk

The Forum would also like to express our concern that the protracted decision making process with regard to Dover health care may illustrate a lack of strategic direction across the PCT area which could affect the development of modern health and social care services for the people of this community.

Yours sincerely



Janet Bentley

Enc

Cc

Nadeem Aziz, Chief Executive Officer Dover District Council  
Stuart Bain, Chief Executive Officer, East Kent Hospitals NHS Trust  
Candy Morris, Chief Executive Officer, South East Coast SHA  
Alan Stibbs, Dover Practice Based Commissioning Consortium  
Ann Sutton, Chief Executive Officer, Eastern and Coastal Kent PCT  
Paul Watkins, Leader Dover District Councillor

# Eastern and Coastal Kent

## Patient Public Involvement Forum



20 December 2007

Ann Sutton  
Chief Executive  
Eastern and Coastal Kent PCT  
Trust Headquarters  
Brook House  
John Wilson Business Park  
Reeves Way  
Whitstable  
CT5 3QT

Dear Ann

### **Dover Health Care**

The PPI Forum has become increasingly concerned over the last year about the provision for health care in the Dover district. Despite extensive meetings and discussions concerning this we do not seem to be any nearer a clear direction for the way forward than we were a year ago. At the meeting on 13 December the Forum expressed a wish to refer the matter to Kent Health Overview and Scrutiny Committee. I attach the document which will form the basis of the submission and will be presented for agreement by the Forum at the next meeting which is on 31 January. If the Forum is in agreement, this will be sent to the HOSC, along with all the relevant papers and correspondence that we have had concerning Dover issues.

If the PCT would like to comment on the document, may we please have the reply by 23 January, in order that the document and PCT comments may be included in the papers for the 31 January meeting? Members of the forum will then consider whether or not to refer the matter to Kent Health Overview and Scrutiny Committee.

I apologise for the tight time scale for this, but you will appreciate that the Forum has a limited time in which to take this matter forward, and also have to accommodate the Christmas holiday break.

I look forward to receiving your comments.


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**All correspondence should be addressed via our Forum Support Organisation:**

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Yours sincerely,



*JP* Janet Bentley  
Chair  
Eastern & Coastal Kent Patient and Public Involvement Forum

Enc

Cc Lynne Selman, Director of Citizen Engagement, E&CK PCT  
Paul Wickenden, Kent County Council Health Overview and Scrutiny Committee  
Howard Jones, Facilities Manager, East Kent Hospital Trust  
Alan Stibbs, Dover Practice Based Commissioning Consortium  
Nadeem Aziz, Chief Executive Officer, Dover District Council  
Paul Watkins, Leader Dover District Councillor

# Eastern and Coastal Kent

## Patient Public Involvement Forum



<b>Report:</b>	Dover Health Care
<b>Date:</b>	20 December 2007

1. The Patient and Public Involvement Forum (PPIF) has become increasingly concerned over the last year about the provision of health care in the Dover district. There are many groups involved:

- East Kent Hospital Trust (EKHT)
- Eastern and Coastal Kent NHS Primary Care Trust (ECK-PCT)
- Buckland Hospital Steering Group (BHDSG)
- Dover Project Steering Group (DPSG)
- Practice Base Commissioning Group Consortium
- Dover District Council – Dover Pride Project (DDC-DPP)
- Kent County Council – Social Services

These are required to plan and provide health care services in compliance with the Government White Paper, Our Health, Our Care Our Say, published in January 2006, (hereafter referred to as the White Paper). The PPIF are not sure where the different groups stand with each other, but we consider that the Dover health services are deteriorating and therefore the patients and public are being disadvantaged.

2. The strategic directions of the White Paper, has three simple themes (Chapter 1):

- Putting people more in control of their own health and care.
- Enabling and supporting health, independence and well being.
- Rapid and convenient access to high quality, cost-effective care.

The focus is on the need to move care closer to patients and make it better value for money. Chapter 6 paragraph 38 states that *"We intend to fulfil the manifesto commitment to help create an even greater range of provision and further improve convenience, we will over the next five years develop a new generation of modern NHS community hospitals. These state-of-the-art centres will provide diagnostics, day surgery and outpatient facilities closer to where people live and work."* Within the White Paper there are a wide range of services to be offered by the Community Hospital which includes:

- Speedy access to diagnostic facilities;
- Elective day and outpatient surgery;
- In-patient beds for step-up and step-down care;
- Social Service one-stop shop;

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- Urgent care during the day and co-ordinating 'out of hours' care at night.
- Renal Dialysis
- Mental Health Service
- Podiatry, Occupational Therapy, Physiotherapy and other similar ancillary services
- Sexual Health Service
- Long Term Disability Care
- End of Life Care

The White Paper is clear that the accessing of services should be given prominence (paragraphs 6.63-70) and that this should be at a "reasonable cost, in reasonable time and with reasonable ease."

3. However, the White Paper warns that, "Some community hospitals are currently under threat of closure, as PCTs consider the best configuration of services in their area. Where these closures are due to facilities that are clinically not viable or which local people do not want to use, then local reconfiguration is right. However, we are clear that community facilities should not be lost in response to short-term budgetary pressures that are not related to the viability of the community facility itself." (White Paper paragraph 6.42).

4. The PCT Dover Project, covers Dover and surrounding villages (hereafter referred to as Dover) and by its own admission, is based on the recommendations of the White Paper. At the time of publication Dover's health service providers were EKHT and the PCT. The configuration of the latter was different to that of today (see paragraph 10). They were under Government pressures in order to achieve financial balance. The history of Buckland Hospital, Dover (BHD), following WWII, was that it was one of three separate sites offering the town a comprehensive hospital service. In the 1970's rationalisation with refurbishment put all the services on the BHD site, and eventually the other two hospitals were sold with the promise that a new state-of-the-art hospital. This was one of the outcomes of the Consultation Tomorrow's Health Care 1988-1989 This did not happen but BHD did become part of the headquarters of the EKHT.

5. Following NHS reorganisation although the headquarters were moved elsewhere the BHD site was given Community Hospital Status by the Department of Health (DPSG minutes 10.03.2006 p 4). This meant that the East Kent Coastal PCT were obliged "to demonstrate to the Strategic Health Authority that they have considered all options on new pathways." (DPSG minutes 10.03.2006 p 4). During March 2006 a risk-costs assessment (relative amount required to bring the buildings up to standard) on the fabric and structure of BHD was carried out. Each building was assessed and ranked A-D in accordance with Department of Health Estates definitions: A = Low risk-costs, to D = High risk-costs with 'x' added to buildings ranked C or D when structural improvements are either impractical or too expensive. In the event only two areas of BHD were designated DX, Matron's House and Pathology. The rest of BHD was classed as B or C but would require £4,842k to bring it up to standard. The value of the land and buildings (operational use), as at 31.03.2006, was given at: Land = £4,201k and buildings £12,447k (FOA- EKHT 25.07.2006).

6. The Dover Project revolved around a Consultation document (DP-Consultation), drawn up by the DPSG, a body on which there was/is no elected representatives, and covered 11 service areas. Specific questions pertaining to the locations of services were not included, just referring to a central Dover location (DPSG 11.05.2006 p 2). A presentation was made to the KCC Scrutiny Committee (27.04.2006), when it was

understood that only the Neuro-rehabilitation would be relocated outside of Dover and therefore was to be treated as a separate issue with separate consultation procedure. The actual areas covered in the Consultation document were:

- Care of the Elderly;
- GP Services;
- Dental Services;
- Pharmacy Services;
- Optician Services;
- Minor Injuries;
- Outpatient Services;
- Children's Services in the Community;
- Children's Day Wards;
- Midwifery Services;
- Improving Health and Well Being.

The list above omits key services envisaged in the White Paper - see paragraph 2 above. Although transport issues were not included in the main body of the Consultation document this was given as one of the areas that respondents may wish to comment on, at the end.

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- 20.06.2006 ( 23 people attended);
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was noted in the Consultation Outcome Report (DP – Outcome) of 22 09.2006, that a number of petitions (over 15,000 locals had signed one), and polls had been undertaken by individual members of the public, political groups and the Dover Express during the consultation period. However, although they were acknowledged, the DPSG did not include these in the findings, (DPSG 12.09.2006 p2).

9. The number of official questionnaires distributed was 4,800 (DP - Outcome paragraph 27) the number returned was 888 (18.5%). Although not stated how many were disregarded (see paragraph 8 above) the Service area with the most responses, GP Services – 740; indicates that 20% were not taken into account. However, the final part of the questionnaire did allow people to comment and the issues raised, (DP-Outcome paragraph 48) were:

- i. Transport - access and frequency of public transport, eligibility to access NHS transport, cost of travelling to acute hospital sites outside of Dover.
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- v. Strong support for the preservation of Buckland Hospital.
- vi. Location of services - central position on a good bus route.

10. Close on the heels of the completion of the Dover Project the PCT, which had overseen the Dover Project, amalgamated with its neighbours to become the Eastern and Coastal Kent NHS Primary Care Trust (ECK-PCT). The PPIF (PCT) was reconfigured to match this change. For the remainder of the local Community expressed increasing concerns about the continuing reductions of services available at BDH and lack of information on the future of their health services. The only sign of an alternative venue for Dover's hospital services was the PCT owned Health Centre, Maison Dieu Road, which had been recently refurbished. The Health Centre does not comply in size or capability of a Community Hospital as described in the White Paper.

11. In February 2007 the PPIF (PCT) raised a number of concerns with the ECK-PCT appertaining to continuing decrease in services provided in Dover (06.02.2007). Not satisfied with the answers the Dover Project was discussed at the PPIF (PCT) Forum in April. There it was agreed to invite the ECK-PCT to present progress plans for Dover health care at the East Kent Coastal Locality meeting 04.06.2007. In the meantime, (16.05.2007), the Dover Project - Next Step (DP – Next Step) was accepted by the ECK-PCT Board. The document included the implementation of the White Paper and the recommendations of the DP-Outcome (paragraph 9 above). The stated agreed key principles within which the Dover Project outcomes were to be developed were (DP-Next Step paragraph 3):

- 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.

However, there was little to indicate to the general public where Dover's health services would be based and what form they would take.

12. The PPIF (PCT) Locality meeting (04.06.2007) was held in Dover's Town Hall and attended by about 200 local people. The meeting was attended by three ECK-PCT

Board Directors; two Senior Officers from EKHT and chaired by PPIF (PCT) Chairman, Janet Bentley. Both local papers, Dover Express and Dover Mercury (07.06.2007) and Radio Kent covered the meeting and in their reporting, all were in accord that the people of Dover were uncertain and therefore unhappy about the future of their health services. In reply to a letter from the PPIF (PCT), the ECK-PCT (06.07.2007) said that, "a health needs assessment was undertaken as an early piece of work to support the Dover Project initiative." later in the same paragraph "In addition the PCT wishes to take into account ... accessibility and transport." and "work with DDC as the local structural planning lead and others to ensure we identify a viable and sustainable site." Sites identified were:

- Buckland Hospital,
- Dover Health Centre - as part of the proposals for the Mid Town area;
- Connaught Barracks;
- Whitfield,
- Western Docks
- Coombe Valley.

This is at variance with DDC – DPP, "a new Community Hospital in a central location." The letter also stated that the DPSG, included a PPIF (PCT) member, who would "visit the sites and hear about the planning implications of developing on the sites ... The outcome of these visits will be reported to the PCT Board at its meeting in September."

13. Both the PPIF (EKHT and ECK-PCT) have been reassured, at successive BHDSG meetings, that current services (whatever that might mean) provided by BHD would remain in Dover. No statement has been made as to what these services will be with the exception of Day Hospital. We have also brought to the attention of the ECK-PCT issues including: Outpatients; Minor Injuries Unit (MIU); Transport; Intermediate Care and Mental Health; all of which are discussed below under separate sub-headings. The PPIF have also raised a number of issues to which we are awaiting replies, Cancer, Podiatry and Endoscopy. Regarding the latter, we understand that there is uncertainty over the reinstatement of endoscopy, the reasons given are staffing problems and also patients from outside Dover are not willing to attend BHD (BHDSG 01.10.2007).

13 i. Outpatients. The DP-Next Step, in line with the White Paper, states, "these should be located near to the patients' homes and that they would continue to be provided at BHD. Outpatient referral letters would ensure that patients who live in the Dover area are given appointments at BHD." However, it was apparent that increasingly fewer patients were being seen at BHD, which was confirmed by the ECK-PCT own statistics:

- Between 2002-2006 an average of 39,000 people had been seen at BHD outpatients
- In 2006-7 only 30,809
- From April to September 2007 only 13,345.

Further, it was argued and accepted at the BHDSG meeting of 01.10.2007, that under the new Consultant Contract, time travelling was classed as patient time, therefore consideration would need to be given to:

Patient to Consultant > Patients seen;

Consultant to Patient < Patients seen;

This means that it is financially expedient for the Trust if patients to travel to see the Consultant. Of note, the Highways Agency, only weeks before, pointed out to EKHT who were applying for more parking facilities at William Harvey Hospital (WWH) - where most Dover outpatient's are seen - that the EKHT should have a 'more robust green policy.' (ECK-PCT 14.09.2007)

13ii. MIU. The hours of the MIU, which had previously been 12/24 7/7, was reduced in May 2007 to 9/12 and often it is not open at weekends or bank holidays. This was brought to the attention of the ECK-PCT by the PPIF (PCT) as being at variance with the recommendations of the DP-Next Step. The PPIF (PCT) were told that *"the local Practice Based Commissioning consortium to consider commissioning an extended minor illness service in addition which would also be provided on the Buckland Hospital site,"*(06.07.2007), but the situation has not changed.

13 iii. Transport. It was stated in the White Paper, (paragraphs 6.63-70), that accessibility to services should be at a *"reasonable cost, in reasonable time and with reasonable ease."*

- It has already been noted, in paragraph 7 above, that Dover contains some of the worst areas of deprivation in the county and according to the KCC:
  - 26% of households in the Dover area do not have a car/van (Kent average 21.6%);
  - 44.9% have one such vehicle - which, in all probability, will be used by the household provider;
  - 29.1% (Kent average 34.7%) have two or more vehicles.
- Overall, the journey by bus to WHH (the cheapest option) is typically 6 hours. At night, when public transport ceases, and for ambulant patients who are being admitted early in the morning, for day surgery, the cost of taxi is about £70 for a one way journey. Patients living in the surrounding villages are faced with correspondingly longer journey times and expense. Relatives who wish to visit hospital patients are also faced with these problems.
- A recent study in the Emergency Medicine Journal has found that the risk for the unconscious, those who have chest pains or respiratory problems, rises by 1% for every six miles from the acute hospital centre. Dover's nearest acute service is twenty miles away, farther for those living in the surrounding areas.
- The town already is the busiest passenger port in the World and has a successful cruise liner terminal, yet the road access and egress to/from Dover is vulnerable to blockage by lorry traffic, during inclement weather and industrial disputes.

These and associated issues have been brought up by the PPIF (PCT), by correspondence (14.08.2007, 06.09.2007, 29.10.2007); the Joint Sandwich and Dover West Neighbourhood Forum 06.09.2007; the DPSG and the BHDSG. The replies have been less than satisfactory.

13 iv. Intermediate Care. This has also been a concern of the PPIF (PCT) to which we have been told that, *"8 recuperative care beds at Cornfields residential care home and 2 at Alexander House. If needed Dover residents will also be able to access intermediate care beds at Deal Hospital,"* (17.07.2007). The DDC Scrutiny (Community and Regeneration) Committee (DDC –SC) were told by Officers of the ECK-PCT (04.09.2007), that Dover patients can access the 36 intermediary care beds for use by at the Royal Victoria Hospital - Deal, but went on to say that, *"Deal hospital services would be under review, and like the Dover Project that would be about services as opposed to buildings."* PPIF members report that prior to the closure of beds at the Royal Victoria Hospital, Folkestone, they were told that Folkestone patients would be able to access intermediate care beds at BDH.

The written ECK-PCT Intermediate Care Service Model, December 2006, adapted from the Kings Fund document 'Developing Intermediate Care', on p5 states: *"Intermediate Care is not marginalising older people from mainstream services."* Albeit, the rest of the document makes numerous references to 'older people' and with regards to costs and savings (page 16), only those over 65 years were considered. Further, the paper only

looks at costs in relation to the ECK- PCT of which investment was envisaged at £3,482.657 across the Trust while general savings, are given as £1,310,496.96p. Costs and benefits to the patient and their family were not taken into account.

13v. Mental Health. The White Paper gives Mental Health as a key component to be considered in the provision of health care. According to the NHS Statistics, Dover people have a greater than average (England) vulnerability to mental illness, yet mental health was not included, or even mentioned, in the Dover Project Consultations. Nonetheless, is a concern to the PPIF (PCT). On 19 October 2007, our Chairman, Janet Bentley, wrote to the PCT asking for a list of GP's specialising in Mental Health in the Dover area. In line with statutory requirements a reminder was included that a reply was expected within 20 working days. At the time of writing, this had not been received.

14. To conclude, the White Paper envisages the Acute Hospital sector to be supported by state-of the art Community Hospitals close to people's homes. In the context of this the PPIF recommends to the KCC Health and Scrutiny Committee that the health service for Dover should be provided in line with the White Paper, local services for local people, including:

- A Community Hospital as envisaged by the White Paper.
- Services provided in an appropriate high quality environment.
- A clear vision from relevant health authorities to achieve this.
- Clear communication to the local community including their involvement in the development of services.

PPIF (PCT): 19 December 2007a

**Abbreviations:**

BHD: Buckland Hospital, Dover

**BHDSG: Buckland Hospital Steering Group**

DDC-DPP: Dover District Council Dover Pride Project

DDC –SC: Dover District Council Scrutiny (Community and Regeneration) Committee

DP-Consultation: Dover Project Consultation

**DP – Next Step: Dover Project: Next Step Document 16.05.2007**

DP – Outcome: Dover Project: Outcome Document 22.09.2006

DPSG: Dover Project Steering Group

ECK-PCT: Eastern and Coastal Kent NHS Primary Care Trust

EKHT: East Kent Hospital Trust

PCT: Primary Care Trust

White Paper: Government White Paper, Our Health, Our Care Our Say, January 2006

WWH: William Harvey Hospital



# Eastern and Coastal Kent

## Patient Public Involvement Forum



The PCT response to the items raised are shown below in *blue / italics and blue / underline*. (*this update is as at Jan 08*)

1. The Patient and Public Involvement Forum (PPIF) has become increasingly concerned over the last year about the provision of health care in the Dover district. There are many groups involved:

- East Kent Hospital Trust (EKHT)
- Eastern and Coastal Kent NHS Primary Care Trust (ECK-PCT)
- Buckland Hospital Steering Group (BHDSG) – *led by the East Kent Hospitals Trust\**
- Dover Project Steering Group (DPSG)
- Practice Base Commissioning Group Consortium
- Dover District Council – Dover Pride Project (DDC-DPP)
- Kent County Council – Social Services

These are required to plan and provide health care services in compliance with the Government White Paper, Our Health, Our Care Our Say, published in January 2006, (hereafter referred to as the White Paper). The PPIF are not sure where the different groups stand with each other, but we consider that the Dover health services are deteriorating and therefore the patients and public are being disadvantaged.

- *\* N.B. The Buckland Steering group chaired by the Director of facilities is part of the East Kent Hospital Trust's agenda and not separate from it.*

2. The strategic directions of the White Paper, has three simple themes (Chapter 1):

- Putting people more in control of their own health and care.
- Enabling and supporting health, independence and well being.
- Rapid and convenient access to high quality, cost-effective care.

The focus is on the need to move care closer to patients and make it better value for money. Chapter 6 paragraph 38 states that *"We intend to fulfil the manifesto commitment to help create an even greater range of provision and further improve convenience; we will over the next five years develop a new generation of modern NHS community hospitals. These state-of-the-art centres will provide diagnostics, day surgery and outpatient facilities closer to where people live and work."* Within the White Paper there are a wide range of services to be offered by the Community Hospital which includes:

- Speedy access to diagnostic facilities;
- Elective day and outpatient surgery;

- In-patient beds for step-up and step-down care;
- Social Service one-stop shop
- Urgent care during the day and co-ordinating 'out of hours' care at night.
- Renal Dialysis
- Mental Health Service
- Podiatry, Occupational Therapy, Physiotherapy and other similar ancillary services
- Sexual Health Service
- Long Term Disability Care
- End of Life Care

The White Paper is clear that the accessing of services should be given prominence (paragraphs 6.63-70) and that this should be at a *“reasonable cost, in reasonable time and with reasonable ease.”*

3. However, the White Paper warns that, *“Some community hospitals are currently under threat of closure, as PCTs consider the best configuration of services in their area. Where these closures are due to facilities that are clinically not viable or which local people do not want to use, then local reconfiguration is right. However, we are clear that community facilities should not be lost in response to short-term budgetary pressures that are not related to the viability of the community facility itself.”* (White Paper paragraph 6.42).

- *The PCT has not closed facilities for the following financial reasons:*
  - *Many of the services described in the White paper are provided in local communities within hospitals at Margate, Canterbury and Ashford even though they may be regarded as 'acute' hospitals. The modern NHS works through co-ordinated clinical networks in a number of settings and does not confine itself to barriers created by physical sites.*

4. The PCT Dover Project, covers Dover and surrounding villages (hereafter referred to as Dover) and by its own admission, is based on the recommendations of the White Paper. At the time of publication Dover's health service providers were EKHT and the PCT. The configuration of the latter was different to that of today (see paragraph 10). They were under Government pressures in order to achieve financial balance. The history of Buckland Hospital, Dover (BHD), following WWII, was that it was one of three separate sites offering the town a comprehensive hospital service. In the 1970's rationalisation with refurbishment put all the services on the BHD site, and eventually the other two hospitals were sold with the promise that a new state-of-the-art hospital. This was one of the outcomes of the Consultation Tomorrow's Health Care 1988-1989 This did not happen but BHD did become part of the headquarters of the EKHT.

- *The Dover Project focussed, geographically on Dover Town. However, acknowledging that the services being consulted upon would be accessed by residents in the surrounding villages, the Dover Project consultation process was promoted across the Dover District area via Dover District Council's residents' newsletter.*
- *The investment in the NHS in East Kent over the last 10 years has been significant and cannot be compared to the service offered in the 1970's. Consider for example:*

- *MRI and CT scanners at 3 sites*
  - *Day surgery at 3 sites*
  - *A programme to deliver surgical activity within an 18 week programme*
  - *Angiography and angioplasty in East Kent*
  - *New Neonatal Care Unit and Special Care Baby Unit facilities*
  - *Renal services established in QEQM, WHH and Buckland for the 1<sup>st</sup> time.*
  - *The introduction of a comprehensive programme of clinical governance to safeguard patient care.*
  - *Over £50M invested in facilities in the last 8 years.*
  - *Investment in additional nurses and doctors.*
- *Buckland Hospital has never offered all the clinical services provided by the other 2 sites and there has never been a promise to build a new 'state of the art' hospital in the town. In the 1980's a former Regional Health Authority briefly considered replacing Buckland Hospital with a new facility at Whitfield in the early 1980's but it was not approved and instead some minor upgrading work was carried out. 'Tomorrow's Healthcare' did not even consider the future of Buckland Hospital as it was primarily concerned with the sustainability of services at Queen Elizabeth Queen Mother, Kent and Canterbury Hospital and William Harvey Hospital.*
  - *Half a dozen small offices were used at Buckland for a period of about 6 months as an interim HQ until offices were established at Kent and Canterbury Hospital.*

5. Following NHS reorganisation although the headquarters were moved elsewhere the BHD site was given Community Hospital Status by the Department of Health (DPSG minutes 10.03.2006 p 4). This meant that the East Kent Coastal PCT were obliged "to demonstrate to the Strategic Health Authority that they have considered all options on new pathways." (DPSG minutes 10.03.2006 p 4). During March 2006 a risk-costs assessment (relative amount required to bring the buildings up to standard) on the fabric and structure of BHD was carried out. Each building was assessed and ranked A-D in accordance with Department of Health Estates definitions: A = Low risk-costs, to D = High risk-costs with 'x' added to buildings ranked C or D when structural improvements are either impractical or too expensive. In the event only two areas of BHD were designated DX, Matron's House and Pathology. The rest of BHD was classed as B or C but would require £4,842k to bring it up to standard. The value of the land and buildings (operational use), as at 31.03.2006, was given at: Land = £4,201k and buildings £12,447k (FOA- EKHT 25.07.2006).

- *The condition survey work referred to was carried out on all hospital sites in the East Kent Hospitals Trust as part of the on-going estate management work to support investment plans and meet reporting requirements of the Department of Health and provide on-going information locally.*

6. The Dover Project revolved around a Consultation document (DP-Consultation), drawn up by the DPSG, a body on which there was/is no elected representatives, and covered 11 service areas. Specific questions pertaining to the locations of services were not included, just referring to a central Dover location (DPSG 11.05.2006 p 2). A presentation was made to the KCC Scrutiny Committee (27.04.2006), when it was understood that only the Neuro-rehabilitation would be relocated outside of Dover and therefore was to be treated as a separate issue with

separate consultation procedure. The actual areas covered in the Consultation document were:

- Care of the Elderly;
- GP Services;
- Dental Services;
- Pharmacy Services;
- Optician Services;
- Minor Injuries;
- Outpatient Services;
- Children's Services in the Community;
- Children's Day Wards;
- Midwifery Services;
- Improving Health and Well Being.

The list above omits key services envisaged in the White Paper - see paragraph 2 above. Although transport issues were not included in the main body of the Consultation document this was given as one of the areas that respondents may wish to comment on, at the end.

- *The Dover Project Steering Group included PPIF reps and there was/ is no obligation to include elected members. However, Dover District Council and Kent County Council Members were kept informed ahead of and throughout the consultation process*
- *The Dover Project consultation process ran for 12 weeks from 16 June – 8 September 2006. The Health Overview and Scrutiny Committee (HOSC) was consulted before the formal consultation process began at their meeting on 12 May 2006. Specific recommendations were made by HOSC to ensure that 'hard to reach groups' were consulted and that innovative methods were used to encourage as many people as possible to participate in the process. A presentation was also made to the HOSC at its meeting on 22 September 2006 to report on the outcome of the consultation process. At this meeting the PCT and East Kent Hospitals Trust were congratulated on the consultation process undertaken and the HOSC endorsed the recommendations that were presented. (Min no. 40(5) NHS OSC meeting 22 September 2006 refers)*
- *The service areas that were included in the consultation document were discussed with and agreed by local GPs before the consultation process began as key areas for consideration in line with local needs – January 2006*
- *The services highlighted in the White Paper are included as examples and are not a set prescriptive list.*
- *Strength of feeling from local Dover residents about local transport issues and shared concern from the PCT led to the PCT contributing £5k towards the development of Dover District Council's Transport Strategy. The Dover Neighbourhood Forum attended by PCT representatives also addressed key transport issues.*

7. At the time of the DP-Consultation, Dover's economy was in a chronic poor state, a situation, which has not changed. Five district council wards falling into the bottom 20% of most income deprived areas in the country. In order to combat this, Dover District Council (DDC) had launched the Dover Pride Project (DDC-DPP) to gain regeneration funding. Their submission included the building of more than 10,000 new family homes, to significantly increase working age population within the Dover locality, and "a new Community Hospital in a central location," was part of the remit.

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- *The "Dover Pride" initiative is a local regeneration project, which did not include healthcare as a key driver in its plans although health and well-being and health care estate will be a factor.*
- *It is important to reiterate that there will not be closures of facilities ahead of adequate re-provision which meets local health needs (e.g. provision of intermediate care outside a hospital setting).*
- *Department of Health "Community Hospitals" Funding is one route to support capital projects but is not the only route. Community Hospital funding requires the same thorough and detailed strategic business planning to be developed before an application can be considered, as any other capital funding route.*
- *East Kent Hospital Trust is considering all potential funding sources for the redevelopment of the Buckland site or a re-provision of a facility on an alternative site. The £750 million community hospital funding, launched last year, is being made available over a five year period.*

8. The Consultation period for the Dover Project ran from 16.06.2006 and 08.09.2006. Although the White Paper suggested that, *"People's voices – their opinions, preferences and views – need to be heard at a local level as that is where the vast majority of spending decisions are taken and where key priorities are set. They need to be heard in a variety of different ways"* (Paragraph 7.6). The only feedback that the DPSG took into account was the official questionnaires. These were issued with the Consultation Document. However, they did hold public meetings:

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- *The petition referred to was, on the future of the Buckland Hospital and was acknowledged and received at a public consultation meeting on the 6<sup>th</sup> of September and subsequently in a letter to Mr Prosser (MP) and Mrs Major (dated 4<sup>th</sup> October 2006). This letter clarified that the remit of the Dover Project consultation process was to make decisions on models of care which*

would inform the PCT's commissioning of services in the eleven areas of health and Social care covered by the Dover Project.

- *NHS Health and Overview Scrutiny Committee commended the consultation process at its meeting on 22 September 2006 and the “ Members were pleased that the PCT and the Hospitals Trust had taken on board the points that the Committee (at its meeting on 12 May 2006) had made in relation to consulting the public” – HOSC minutes 22 September 2006 refers.*

9. The number of official questionnaires distributed was 4,800 (DP - Outcome paragraph 27) the number returned was 888 (18.5%). Although not stated how many were disregarded (see paragraph 8 above) the Service area with the most responses, GP Services – 740; indicates that 20% were not taken into account. However, the final part of the questionnaire did allow people to comment and the issues raised, (DP-Outcome paragraph 48) were:

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- *Reconfiguration of the PPIF was a national requirement to reconfigure PPIFs to match PCT boundaries. In Eastern and Coastal Kent PCT however, it was agreed that former PCT groups would continue as locality sub-groups on an informal basis.*
- *The Dover Health Centre site is just one option if the detailed work currently being undertaken indicates that an alternative to Buckland solution would be the best way forward.*
- *It is widely acknowledged that the Dover Health Centre in its current form would not accommodate the community services that are currently provided at the Buckland Hospital and in the Health Centre itself. Whichever site or building is chosen, it would need to reflect PBC and local peoples' needs, future commissioning intentions and service provider needs.*

11. In February 2007 the PPIF (PCT) raised a number of concerns with the ECK-PCT appertaining to continuing decrease in services provided in Dover (06.02.2007). Not satisfied with the answers the Dover Project was discussed at the PPIF (PCT) Forum in April. There it was agreed to invite the ECK-PCT to present progress plans for Dover health care at the East Kent Coastal Locality meeting 04.06.2007. In the

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- 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.

However, there was little to indicate to the general public where Dover's health services would be based and what form they would take.

- *The PCT is committed to ensuring that local health services are made available for local people. However, it must be acknowledged that patients also have the right to more choice, through initiatives such as 'Choose and Book'. This means Dover people have a choice where they would like to receive treatment and in specific cases it may be more convenient not to be seen locally (e.g. if they work away from the Dover area). Similarly residents living outside Dover may put Dover as their first choice.*
- *The Dover Project consultation was commissioned to examine services not buildings. The next step was always going to be how and where the agreed services in Dover were to be physically placed and this is a role for the provider of those services. The East Kent Hospitals Trust as a major provider in the area is leading the Buckland Steering Group, which includes representatives from both the acute hospital and Eastern and Coastal Kent PPIFs.*
- *Additional commissioning resource, via the PCT, to be made available to:*
  - *lead Dover specific commissioning issues*
  - *define / refine commissioning intentions with PBC*
  - *relate this work with the estates strategy for Dover (PCT work being led by Jo Fox & also EKHT work re: Buckland Hospital)*
- *There may also be a need for an additional individual to project manage both King's Ave and Dover*
- *PCT will set up a group to oversee the above described actions along the lines of the Swale under doctored area.*

12. The PPIF (PCT) Locality meeting (04.06.2007) was held in Dover's Town Hall and attended by about 200 local people. The meeting was attended by three ECK-PCT Board Directors; two Senior Officers from EKHT and chaired by PPIF (PCT) Chairman, Janet Bentley. Both local papers, Dover Express and Dover Mercury (07.06.2007) and Radio Kent covered the meeting and in their reporting, all were in accord that the people of Dover were uncertain and therefore unhappy about the future of their health services. In reply to a letter from the PPIF (PCT), the ECK-PCT (06.07.2007) said that, "a health needs assessment was undertaken as an early piece of work to support the Dover Project initiative." later in the same paragraph "In addition the PCT wishes to take into account ... accessibility and transport." and "work with DDC as the local structural planning lead and others to ensure we identify a viable and sustainable site." Sites identified were:

- Buckland Hospital,
- Dover Health Centre - as part of the proposals for the Mid Town area;
- Connaught Barracks;
- Whitfield,
- Western Docks
- Coombe Valley.

This is at variance with DDC – DPP, “a new Community Hospital in a central location.” The letter also stated that the DPSG, included a PPIF (PCT) member, who would “visit the sites and hear about the planning implications of developing on the sites ... The outcome of these visits will be reported to the PCT Board at its meeting in September.”

- The sites referred to were part of early discussions and are areas that may be able to accommodate health care provision. The timescale referred to above was discussed but has slipped.
- As described previously, East Kent Hospitals Trust is presently writing a Strategic Outline Case (SOC), which will consider options for a long-term solution for siting healthcare services in Dover. All the sites mentioned will be commented upon in the SOC but the intention is to identify the most affordable and best fit solutions that can be concentrated upon by the Trust with the consultation of key stakeholders.

13. Both the PPIF (EKHT and ECK-PCT) have been reassured, at successive BHDSG meetings, that current services (whatever that might mean) provided by BHD would remain in Dover. No statement has been made as to what these services will be with the exception of Day Hospital. We have also brought to the attention of the ECK-PCT issues including: Outpatients; Minor Injuries Unit (MIU); Transport; Intermediate Care and Mental Health; all of which are discussed below under separate sub-headings. The PPIF have also raised a number of issues to which we are awaiting replies, Cancer, Podiatry and Endoscopy. Regarding the latter, we understand that there is uncertainty over the reinstatement of endoscopy, the reasons given are staffing problems and also patients from outside Dover are not willing to attend BHD (BHDSG 01.10.2007).

- The Intermediate Care community model is now in place for Dover. The impact of this community model is that there is no longer a requirement for inpatient intermediate care beds in Buckland Hospital. This service development is as per the agreed model of care from the Dover Project consultation process.
- The Buckland Steering Group agreed the Terms of Reference which have been drawn as wide as possible to embrace all the issues arising from the public consultation and day to day operational matters. The clear requirement is to provide the necessary facilities for those services, identified in the consultation process as a minimum. There are other services on the Buckland site which also need consideration.

13 i. Outpatients. The DP–Next Step, in line with the White Paper, states, “these should be located near to the patients’ homes and that they would continue to be provided at BHD. Outpatient referral letters would ensure that patients who live in the Dover area are given appointments at BHD.” However, it was apparent that

increasingly fewer patients were being seen at BHD, which was confirmed by the ECK-PCT own statistics:

- Between 2002-2006 an average of 39,000 people had been seen at BHD outpatients
- In 2006-7 only 30,809
- From April to September 2007 only 13,345.

Further, it was argued and accepted at the BHDSG meeting of 01.10.2007, that under the new Consultant Contract, time travelling was classed as patient time, therefore consideration would need to be given to:

Patient to Consultant > Patients seen;  
Consultant to Patient < Patients seen;

This means that it is financially expedient for the Trust if patients to travel to see the Consultant. Of note, the Highways Agency, only weeks before, pointed out to EKHT who were applying for more parking facilities at William Harvey Hospital (WWH) - where most Dover outpatient's are seen - that the EKHT should have a '*more robust green policy.*' (ECK-PCT 14.09.2007)

- *The East Kent Hospitals Trust will provide an update on attendance figures for Dover Outpatients before the PPIF meeting on 31<sup>st</sup>.*
- *The East Kent Hospitals Trust is working with the Highways Agency to update the present Green Transport Plan as part of an application to improve car parking. The aim is to consider principles that work to reduce the impact of cars on the hospital site and is not concerned with public transport investment or decisions related to clinical governance and services.*

13ii. MIU. The hours of the MIU, which had previously been 12/24 7/7, was reduced in May 2007 to 9/12 and often it is not open at weekends or bank holidays. This was brought to the attention of the ECK-PCT by the PPIF (PCT) as being at variance with the recommendations of the DP-Next Step. The PPIF (PCT) were told that "*the local Practice Based Commissioning consortium to consider commissioning an extended minor illness service in addition which would also be provided on the Buckland Hospital site,*"(06.07.2007), but the situation has not changed.

- *New opening hours for the Minor Injuries Unit were discussed at the Buckland Steering Group when PPIF members were present. The intention is to better match the limited opening hours to peaks and troughs in demand. The reduction in hours was a short term operational decision based on availability of staff.*

13 iii. Transport. It was stated in the White Paper, (paragraphs 6.63-70), that accessibility to services should be at a "*reasonable cost, in reasonable time and with reasonable ease.*"

- It has already been noted, in paragraph 7 above, that Dover contains some of the worst areas of deprivation in the county and according to the KCC:
- 26% of households in the Dover area do not have a car/van (Kent average 21.6%);
- 44.9% have one such vehicle - which, in all probability, will be used by the household provider;
- 29.1% (Kent average 34.7%) have two or more vehicles.

- Overall, the journey by bus to WHH (the cheapest option) is typically 6 hours. At night, when public transport ceases, and for ambulant patients who are being admitted early in the morning, for day surgery, the cost of taxi is about £70 for a one way journey. Patients living in the surrounding villages are faced with correspondingly longer journey times and expense. Relatives who wish to visit hospital patients are also faced with these problems.
- A recent study in the Emergency Medicine Journal has found that the risk for the unconscious, those who have chest pains or respiratory problems, rises by 1% for every six miles from the acute hospital centre. Dover's nearest acute service is twenty miles away, farther for those living in the surrounding areas.
- The town already is the busiest passenger port in the World and has a successful cruise liner terminal, yet the road access and egress to/from Dover is vulnerable to blockage by lorry traffic, during inclement weather and industrial disputes.

These and associated issues have been brought up by the PPIF (PCT), by correspondence (14.08.2007, 06.09.2007, 29.10.2007); the Joint Sandwich and Dover West Neighbourhood Forum 06.09.2007; the DPSG and the BHDSG. The replies have been less than satisfactory.

- *The NHS responsibility for transport is limited to:*
  1. *The provision of a Patient Transport Service for those patients who have a medical need and therefore meet the criteria for free transport.*
  2. *The payment of travel costs to those who receive benefits.*
  3. *Emergency transport provided by the Ambulance Service.*
  4. *We have set up a sub-group of the Urgent Care Board to develop an integrated transport strategy across the PCT, Health Trust, voluntary sector and Social Services. As a short-term measure we have provided emergency facilities for people taken to hospital by ambulance who are then unable to get home during unsocial hours.*

13 iv. Intermediate Care. This has also been a concern of the PPIF (PCT) to which we have been told that, *"8 recuperative care beds at Cornfields residential care home and 2 at Alexander House. If needed Dover residents will also be able to access intermediate care beds at Deal Hospital,"* (17.07.2007). The DDC Scrutiny (Community and Regeneration) Committee (DDC –SC) were told by Officers of the ECK-PCT (04.09.2007), that Dover patients can access the 36 intermediary care beds for use by at the Royal Victoria Hospital - Deal, but went on to say that, *"Deal hospital services would be under review, and like the Dover Project that would be about services as opposed to buildings."* PPIF members report that prior to the closure of beds at the Royal Victoria Hospital, Folkestone, they were told that Folkestone patients would be able to access intermediate care beds at BDH.

The written ECK-PCT Intermediate Care Service Model, December 2006, adapted from the Kings Fund document 'Developing Intermediate Care', on p5 states: *"Intermediate Care is not marginalising older people from mainstream services."* Albeit, the rest of the document makes numerous references to 'older people' and with regards to costs and savings (page 16), only those over 65 years were considered. Further, the paper only looks at costs in relation to the ECK- PCT of which investment was envisaged at £3,482.657 across the Trust while general

savings, are given as £1,310,496.96p. Costs and benefits to the patient and their family were not taken into account.

- *The establishment of the Intermediate Care Service in Folkestone and Dover is primarily concerned with providing patient care in the best setting and is not cost driven.*

13v. Mental Health. The White Paper gives Mental Health as a key component to be considered in the provision of health care. According to the NHS Statistics, Dover people have a greater than average (England) vulnerability to mental illness, yet mental health was not included, or even mentioned, in the Dover Project Consultations. Nonetheless, is a concern to the PPIF (PCT). On 19 October 2007, our Chairman, Janet Bentley, wrote to the PCT asking for a list of GPs specialising in Mental Health in the Dover area. In line with statutory requirements a reminder was included that a reply was expected within 20 working days. At the time of writing, this had not been received.

- *In response to the above, there are no GPs across the PCT area with a formal specialism in mental health. However, there are a number of GPs who have a keen interest in this area and have been actively involved in forums and groups looking at mental health issues. Also improved primary care access to support those with mental health, has lead to a recent significant improvement in the service.*

14. To conclude, the White Paper envisages the Acute Hospital sector to be supported by state-of the art Community Hospitals close to people's homes. In the context of this the PPIF recommends to the KCC Health and Scrutiny Committee that the health service for Dover should be provided in line with the White Paper, local services for local people, including:

- A Community Hospital as envisaged by the White Paper.
  - Services provided in an appropriate high quality environment.
  - A clear vision from relevant health authorities to achieve this.
  - Clear communication to the local community including their involvement in the development of services.
- *The PCT as a commissioner and the East Kent Hospitals Trust as the current provider have a responsibility to provide the agreed patient services in a quality environment which satisfies the criteria for access and affordability. The work being undertaken by the East Kent Hospitals Trust to produce a Strategic Outline Case (SOC) will demonstrate a commitment to this process and reflect that Buckland Hospital in its present form is not sustainable in the longer term. All key stakeholders will be engaged, as plans develop to ensure that future estates investment reflects patient and service provider needs together with future commissioning intentions.*

**NB: - Following paragraphs are based on Stuart Bain's most recent statement.**

*The range of services to be delivered has been agreed following public consultation (Dover project). The location in Dover that these services will be delivered remains to be decided.*

*The East Kent Hospitals Trust is concerned that the current buildings at Buckland Hospital do not provide a 'fit for purpose' 21<sup>st</sup> century environment for modern*

*healthcare and has therefore been considering how such facilities could be developed.*

*They are looking at two options for developing quality buildings on the Buckland Hospital site from which services can be provided. Their proposals are purely about the buildings and do not change Eastern and Coastal Kent Primary Care Trust's recommendations as to which health services should be provided in Dover.*

#### *Option 1*

*Carry out an extensive refurbishment of some of the existing estate, condensing the services housed at the hospital into a more efficient footprint and sell the remaining land.*

#### *Option 2*

*Build a new-purpose built facility on the current car park, refurbish the current Menzies ward and day hospital buildings and sell the remainder of the site.*

#### *Other potential options*

*The East Kent Hospitals Trust will work closely with the Eastern and Coastal Primary Care Trust and Dover District Council to see if any further options closer to the centre of Dover (Dover Health Centre site) can be developed.*

#### Abbreviations:

BHD: Buckland Hospital, Dover

**BHDSG: Buckland Hospital Steering Group**

DDC-DPP: Dover District Council Dover Pride Project

DDC –SC: Dover District Council Scrutiny (Community and Regeneration) Committee

DP-Consultation: Dover Project Consultation

**DP – Next Step: Dover Project: Next Step Document 16.05.2007**

DP – Outcome: Dover Project: Outcome Document 22.09.2006

DPSG: Dover Project Steering Group

ECK-PCT: Eastern and Coastal Kent NHS Primary Care Trust

EKHT: East Kent Hospital Trust


PCT: Primary Care Trust

White Paper: Government White Paper, Our Health, Our Care Our Say, January 2006

WWH: William Harvey Hospital

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# Healthier people, excellent care



## Stephanie Hood

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## NHS South East Coast facts & figures

### Vital statistics

- Circa 4 million population
- Affluent with strong economy
- One of the healthiest regions
- High life expectancy - by 2020 over-65s will increase by half and over-85s double
- Low rates of early death from circulatory disease and cancer – eg CVD mortality rates 40% lower in last 10 years
- Lifestyles associated with health risks are low

### Case for change

- 18 year gap between areas with the highest and lowest life expectancies
- Significant inequalities in early death rates for all the major killers
- Ageing population — challenges of 'young' and frail elderly
- Significant concentrations of health deprivation in coastal cities and towns, major inland urban centres, and some isolated rural areas
- The sickness absence rate is the joint second highest in England

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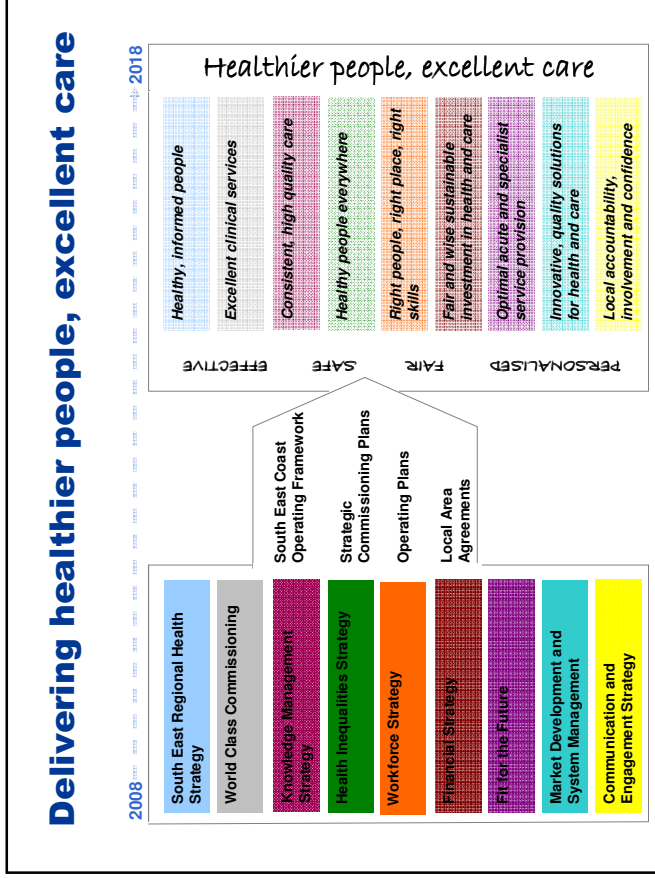


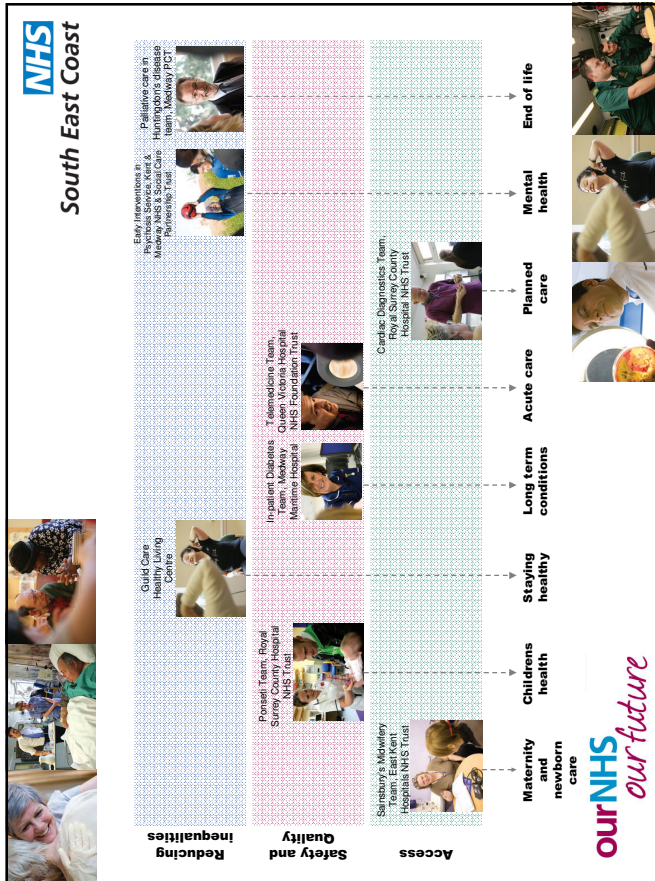
## A shared vision for healthier people, excellent care

It's 2018, NHS South East Coast has transformed health services so they are focused on maintaining health and providing optimal care at every life stage.

For the Smith family of Gravesend this means:

- Mother-to-be Anna is discussing birth choices with her midwife, who will support her one to one during her second child's birth.
- Her son, Alex, is overweight and benefits from a holistic package of care including access to leisure activities, health advice and help with maintaining a healthy diet.
- His weight problem has made him depressed, so Alex's GP has arranged a package of cognitive behavioural therapy to help as well.
- Four years ago, Anna's father-in-law, Jack, had a heart attack and received primary angioplasty straightaway and has recovered well.
- Her grandmother, Violet, suffers from dementia and has been well cared for at home by health and social carers working closely.
- Violet's condition is deteriorating and her family are preparing for her death with the support of her health and social care team.





**South East Coast**

**Our innovative approach**

**Fair**

**Hastings Station Plaza Primary Care Centre, Hastings & Rother PCT**

The PCT is planning an integrated primary care centre accessible to commuters, the town centre, and the student population. This is a deprived area with too few GPs. This will deliver a fit for purpose facility in the right place for patients, and offer accommodation for five of the existing GPs, currently in single handed practices, with capacity for an additional five.

**Safe**

**Wound Swab Policy Team Darent Valley Hospital**

At Darent Valley Hospital the Wound Swab Policy Group has pioneered an innovative patient safety approach - working to overcome the dangers of giving patients inappropriate antibiotics and subsequent antibiotic resistance through challenging established practices.

This is now Trust policy.

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## Our innovative approach

**Personal**



**Forum of Carers and People who Use Services (FoCUS) Surrey and Borders Partnership NHS Trust**

FoCUS places people at the heart of the way that services are provided. Patients and carers suggest ideas about how services can be improved. As a result, the trust has a new policy to improve safeguarding and access to personal possessions on the ward and they are installing soundproofing to ensure patient confidentiality.

**Effective**



**Stroke Pathway South East Coast Ambulance NHS Trust**

South East Coast Ambulance Service has developed and implemented a FASTrack system allowing them to bypass local district general hospitals and take stroke patients directly to specialist facilities.



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# Engaging and listening



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## Next Steps

**Pre-launch**

- Ongoing frontline staff engagement
- County-wide events for key stakeholders
- 15 May - South East Coast NHS summit to finalise the vision
- 22 May - SHA Board sign off

**Launch – 2 June**

Webcast event in Brighton - 300 representatives from patients, public, frontline staff, stakeholders, media, exhibition space, evening dinner with local leaders.

**Post-launch**

*Summer* – 13 week informal consultation, town centre road shows, meetings with key staff and key stakeholders and third sector providers, planned media campaign.

*Autumn* – implementation plan refined.








**South East Coast**

## What patients told us

- 'Listen to us' – incorporate patient views into staff training.
- Give us joined up support – across the NHS, social services and community based/voluntary organisations.
- 'Involve us – be in partnership with us – and talk to us, our families and support the carer'.
- 'Don't change everything, a lot of it works very well'.






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### What staff told us

- **Workforce issues (51%)**
  - more frontline staff, improve pay, improve morale.
- **Service developments (31%)**
  - Keep existing services local, improve access, more investment in preventative and community services.
- **Managerial / policy changes (21%)**
  - Reduce service changes that aren't evidence based, too much reliance on targets.
- **Improve infrastructure (21%)**
  - Improve hygiene in hospitals and bring back matron, improve data sharing and record keeping.





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### What the public told us

- The NHS delivers good services.
- Improve access to care.
- Make the public part of the team through awareness raising and education.
- Treat the patient as an individual and within the context of the family.
  - involve carers
- How will the NHS pay for the proposed changes?




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## What clinicians told us

- **Services should be personalised**
  - Patients want to make informed choices about all aspects of their care.
- **Better information about services**
  - Signpost services clearly.
- **Services should be integrated**
  - Clinical information should be easy to share between organisations.
  - Care should be planned and delivered in a holistic way.
- **A better skilled workforce**
  - Workforce skills should be up-to-date so that patients get the best care possible.
- **Services should be easily accessible**
  - Better home care will improve patients' experience of care and avoid unnecessary hospital referrals.
  - Primary care should be more accessible.

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# Our recommendations

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These are a flavour of the rich work undertaken to date. All recommendations are subject to review and sign off by the South East Coast Chief Executive Forum.

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## Acute care

- By 2011 there will be:
  - No cases of hospital acquired MRSA
  - less than 2000 cases of *C. Diff*
- Single point of access for all conditions.
- By 2009 there will be an agreed protocol that all patients will go to the most appropriate centre of excellence, irrespective of location.
- All appropriate patients to receive primary angioplasty by 2010 (through 8 local centres).
- All appropriate patients to have access to 24/7 specialist stroke service by 2010 (through local centres and/ or networks).



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## Mental health

- Emergency referrals for schizophrenia and bipolar disorders should be seen within 2 weeks by 2011.
- Choice in mental health services including an increase in psychological therapies available by 2011 including specific programmes of support for:
  - Offenders especially young offenders
  - Those with depression and anxiety disorders
  - Children and adolescents
- Referral to treatment in 6 - 8 weeks by 2010.



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These are a flavour of the rich work undertaken to date. All recommendations are subject to review and sign off by the South East Coast Chief Executive Forum.

## Maternity and newborn care

- All pregnant women will see a midwife for health and social assessment of needs, risks, and choices by 12 weeks by 2009.
- Minimum 60 hours of consultant cover on all labour wards will be provided by 2009.
- A specialist perinatal mental health mother and baby unit will be available by 2018.
- All women will receive 1:1 midwife care in labour by 2010.
- Reduced maternal and neonatal morbidity and mortality.



These are a flavour of the rich work undertaken to date. All recommendations are subject to review and sign off by the South East Coast Chief Executive Forum.

## End of life care

- By 2012 all providers will use the:
  - Gold Standards Framework
  - Liverpool Care Pathway
  - Preferred priorities of care in providing end of life care.
- By 2015 a palliative care visiting service will be available everywhere, every day.
- All NHS organisations will have workforce education and training strategies in place for end of life care by 2010.



These are a flavour of the rich work undertaken to date. All recommendations are subject to review and sign off by the South East Coast Chief Executive Forum.

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## Children's health

- Reduction of teenage conception rates to 1.15% by 2010.
- An integrated multi disciplinary "team around the child" available in all areas by 2011.
- Transition teams in all areas for vulnerable young people by 2011.
- Increase in all aspects of children's care in community and non NHS settings.



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These are a flavour of the rich work undertaken to date. All recommendations are subject to review and sign off by the South East Coast Chief Executive Forum.

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## Staying healthy

- By 2010 a holistic package of care will be available for obese people or those at risk of becoming obese including:
  - Increased access to leisure facilities
  - One to one health advice
  - Dietary support
- PCTs will develop comprehensive alcohol support services targeting young people by 2011.
- Increased access to GUM clinics:
  - Within 48 hours
  - Evenings and weekends



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## Long term conditions

- Joint commissioning of services with social care by condition pathway by 2010.
- All patients will receive ongoing support, education and training to manage their condition by 2012 e.g. DESMOND.
- Creation of clinical networks for all long terms conditions.



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## Planned care

By 2011:

- 93% of patients will see a GP within 48 hours.
- 83% will be able to book an appointment more than 3 days in advance.
- All patients with breast symptoms who are referred will see a specialist within 2 weeks.
- All women will receive their cervical screening test results within 2 weeks.
- Shorter hospital stays and more day surgery supported by improved primary and community care.
- Full implementation of primary care diagnosis facilities.



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**South East Coast enablers**

- Increased flexibility and opportunity for joint budgets.
- Individual personal budgets.
- Greater links with social care, and the third sector as providers.



**National enablers**

- Stronger legislation with respect to:
  - Alcohol advertising and sales,
  - Food labelling,
  - Provision of sex and relationships teaching in schools
- The Tariff
- Informatics

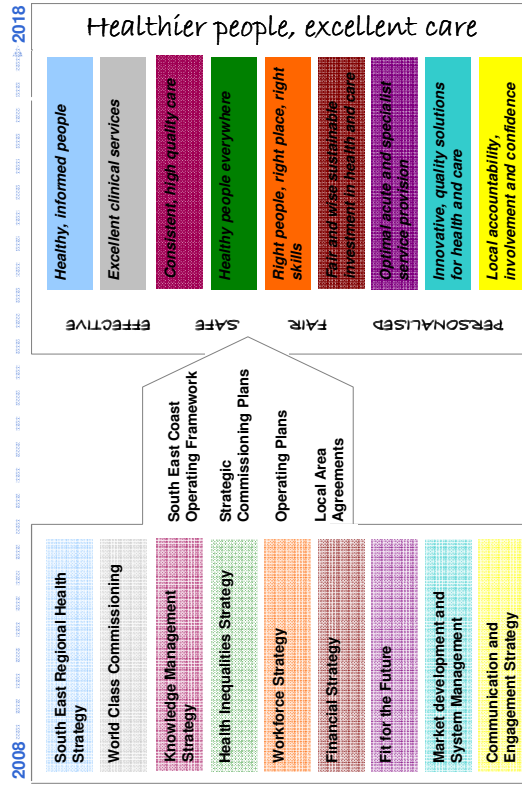





**Making it happen**

# How we will deliver our vision



## Leadership and development

- Principles**
  - Partner with staff
  - Engage with external stakeholders
  - Listen to needs of patients and the public
- Talent Management**
  - SHA to lead by example – senior leaders, focused on managing the talent pipeline with 100% PDPs and appraisal tools to spot talent
- South East Coast Academy – leadership community**
  - Local improvement networks
  - Web-based good practice advice, virtual improvement faculty
  - Innovation in partnership with universities and post-grad education centres
- Clinical champions**
  - Healthier People, Excellent Care clinical leadership programme
  - Use of expanded CPGs to review and refresh aspirations
  - Create formal links between CPGs and national/international centres of excellence






## Holding the NHS to account, delivering our vision

- Performance agreements for PCTs and Trusts focussed on delivery of the Vital Signs.
- Re-focussing ground breaking SEC commissioning rules on levers and incentives for highest quality services.
- SEC Operating Framework bringing together PCTs, Trusts, LAs, independent providers.
- Local market management framework.
- Strong partnership working based on real engagement including integrated working with LINKS, HOSCs and key stakeholders to deliver robust and ambitious LAAs.






## What difference will patients and the public see in South East Coast by 2018

- No hospital acquired infections.
- Stroke, heart attacks and trauma will always be treated in specialist units.
- Perinatal mental health service for new mothers.
- Access to diagnostic services on the high street.
- Reversal of the rising trend in obesity.
- Expansion of the expert patient programme for key long term conditions.
- Majority dying outside of hospital out of choice.
- Closure of the 18year life expectancy gap.




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By: Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – Friday 13 June 2008

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

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1. Attached is a revised version of the Rolling Action Sheet that was considered by the Committee at its meeting on 9 May – amended in accordance with comments made by Members at that meeting.

**Recommendations**

2. The Committee is asked to note the report and comment on it as appropriate.

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**Kent County Council**

**Health Overview and Scrutiny Committee**

**ROLLING ACTION SHEET**

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

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
23 March 2007 – 17	Cancer Services	All acute Trusts	<i>RESOLVED:- that the Committee should continue to monitor the development of cancer services across Kent and Medway.</i>	Ongoing	
23 March 2007 – 18	Proposed Whitstable Polyclinic	- Eastern and Coastal Kent PCT - East Kent Hospitals NHS Trust	<i>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.</i>	Ongoing	Proposal scrutinised by Canterbury City Council Health Scrutiny Panel on 26 July 2007
7 September 2007 – 49	Restructuring and refocusing the HOSC	HOSC	<b>RESOLVED:-</b>  a) <i>That the suggestions [regarding meeting dates and style of working] set out in paragraph 9 of the report be endorsed and that it be acknowledged a large amount of work needed to be done to achieve these.</i>	Ongoing	Agreed meeting dates and style of working have been adopted

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>b) That the Committee welcome the work being carried out to revise the protocols, including discussions with NHS and District Council colleagues, regarding the delegation of some issues to District Councils and the establishment as part of this of a clear reporting-back process to the Committee ...</p>		
			<p>c) That the proposal for an induction/briefing day for Members be welcomed.</p>		
27 November 2007 – 71	Infection prevention and control	All acute Trusts and PCTs	<p>The Committee concluded as follows from the meetings held on 9 and 27 November:-</p> <p>a) To note that part of the Director of Public Health's role is to proactively monitor infection prevention and control across the Kent and Medway Health economy;</p>		
			<p>b) To ensure that the Strategic Health Authority and Primary Care Trusts share best practice by individual Trusts, so that there is a consistent approach across the Kent and Medway health economy;</p>		
			<p>c) To seek clarity on the respective roles of Primary Care Trusts, the acute hospital Trusts and the Strategic Health Authority;</p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>d) To seek clarity about how the Primary Care Trusts are dealing with the issue of antibiotic prescribing;</p>		
			<p>e) To consider what methods are being used by health organisations to inform patients and the public about how they can help avoid infection risks;</p>		
			<p>f) To welcome the opportunity to receive an action plan from the Maidstone and Tunbridge Wells NHS Trust on how they are responding to the Healthcare Commission report, having heard that bed occupancy within the Maidstone and Tunbridge Wells NHS Trust was currently at 95% instead of the recommended level of 85%;</p>		
			<p>g) At a future meeting, to understand how adult social care, health and other stakeholders are responding to the issue of step-down facilities and delayed discharge;</p>		
			<p>h) To understand from the Strategic Health Authority how the money recently allocated by the Government for deep cleaning is to be allocated to Trusts across the Kent and Medway Health Economy;</p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>i) To welcome the offer of the Healthcare Commission to provide some training for Members of the Committee on what makes a good third-party dialogue contribution to the Annual Health Check;</p>		
			<p>j) To welcome the Healthcare Commission's offer for Members to accompany them on some visits to health organisations, so that Members may see at first hand how the Committee can contribute to the Healthcare Commission's Annual Health Check;</p>		
			<p>k) To state that the cleaning of health establishments should include the non-clinical areas, especially above head height;</p>		
			<p>l) To state that deaths that might be related to adverse effects of medical treatment or to poor standards of care, or where there has been any complaint about healthcare services, should be referred to the relevant Coroner as a matter of routine;</p>		
			<p>m) To write to the Government responding to the draft regulations for Local Involvement Networks;</p>	21 December 2007 (Department of Health deadline)	Response agreed by HOSC spokesmen and submitted

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>n) To ensure that relevant information is sent to the Healthcare Commission and, if appropriate, the minutes of each Health Overview and Scrutiny Committee meeting;</p>		
			<p>o) To encourage Members of the Health Overview and Scrutiny Committee to attend meeting[s] of local health organisations' Boards;</p>		
			<p>p) To build into the Committee's work programme as core business the matter of compliance with the Healthcare Commission's Core Standards;</p>		
			<p>q) To have a dialogue with the existing Patient and Public Involvement Fora, the Local Involvement Network (when established), Patient Advice and Liaison Services, Independent Complaints Advocacy Services, local Members of Parliament and local councillors; to listen to patients' concerns; and to utilise more effectively information that is provided and act on concerns that are expressed;</p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>r) To ensure that the good work going on in various local level Patient and Public Involvement Fora feeds into the Health Overview and Scrutiny Committee to enable it to provide an evidence-based strategic view across the county;</p>		
			<p>s) To analyse whether, if the Committee had operated in the style that it does now when it asked colleagues from Kent and Medway health economy to address the Committee on infection control in October 2004, July 2006 and June 2007, the public would have been better served;</p>		
			<p>t) To consider whether it has helped for the Committee to seek written evidence in advance of each meeting, agree a work programme (up to two years ahead) and link this to the training of Members for service on the Committee;</p>		
			<p>u) To consider the role of senior clinicians in changing the leadership and culture of NHS organisations;</p>		
			<p>v) To support measures to ensure that a correct balance of food is eaten by patients in hospitals, having due regard to the patients' clinical needs;</p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>w) <i>To consider whether spot checks of hospital food suppliers should be undertaken by Environmental Health and Trading Standards;</i></p>		
			<p>x) <i>To investigate what training adult social care and health providers undertake to ensure that infections in the community are not brought into hospitals;</i></p>		
			<p>y) <i>To consider how the County Council can help with a campaign to advise the public on taking steps to help avoid infection in hospitals and elsewhere.</i></p>		
			<p>z) <i>To seek the views of microbiologists on the effectiveness of different cleaning products against Clostridium difficile;</i></p>		
			<p>aa) <i>To examine the role of non-executive directors on the Boards of NHS bodies;</i></p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>bb) <i>To look at possible inequalities in the funding of health services and the impact of this on ratios of nurses and healthcare assistants;</i></p>		
			<p>cc) <i>To understand how Trusts spend their budgets;</i></p>		
			<p>dd) <i>To undertake a review of arrangements regarding hospital visitors.</i></p>		
			<p><i>The Vice Chairman, and the Conservative and Liberal Democrat spokesmen would like to suggest the following recommendations to the Committee, having heard and considered the conclusions of the evidence taken by the Committee at its meetings on 9 and 27 November:</i></p> <p>a) <i>At the heart of the Health Overview and Scrutiny Committee's work programme should be the Healthcare Commission Core Standards.</i></p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>b) Evidence should be recorded from the Health Overview and Scrutiny Committee's work programme electronically, so that when the Health Overview and Scrutiny Committee is asked to make third-party submissions for the Annual Health Check the evidence for this is already available.</p>		
			<p>c) There should be greater collaboration between the Patient Advice and Liaison Services, the Independent Complaints Advocacy Services, the Patient and Public Involvement Fora / the Local Involvement Network, Members of Parliament and local authority councillors, in order to listen to patient concerns and utilise more effectively the information they provide to assist in formulating the Health Overview and Scrutiny Committee's work programme.</p>		
			<p>d) The Overview and Scrutiny Manager should, together with colleagues from health organisations, explore and arrange an ongoing programme of training and activities to address the knowledge deficit for all stakeholders involved in scrutinising the health economy.</p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
14 December 2007 – 72	Audiology	<ul style="list-style-type: none"> <li>- Eastern and Coastal Kent PCT</li> <li>- East Kent Hospitals NHS Trust</li> <li>- Kent Adult Social Services</li> <li>- Maidstone and Tunbridge Wells NHS Trust</li> <li>- Medway NHS Foundation Trust</li> <li>- West Kent</li> </ul>	<p>e) <i>Recognising that the patient and public view is paramount, the Health Overview and Scrutiny Committee and the County Council should respond to the draft regulations for Local Involvement Networks to ensure that there is an adequate right to inspect premises where healthcare is provided. This will make for robust scrutiny, helping to bring about health improvements and reduce health inequalities – which are the fundamental principles of Health Overview and Scrutiny.</i></p>	21 December 2007 (Department of Health deadline)	Response agreed by HOOSC spokesmen and submitted
			<p><i>The Committee concluded that:-</i></p> <p><i>(a) further work needed to be done to inform the public of the new services being provided by Clinicienta;</i></p> <p><i>(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);</i></p> <p><i>(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;</i></p>	April 2008	

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
		PCT	<p><i>(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;</i></p> <p><i>(e) data collection and collation for audiology services must be improved, to enable commissioners to commission services effectively;</i></p> <p><i>(f) it needed to be recognised that dealing with a patient with audiology needs was about more than just fitting a hearing aid;</i></p> <p><i>(g) patients were entitled to copies of their audiograms;</i></p> <p><i>(h) audiology should be recognised as an important service in the strategic plans of the Primary Care Trusts;</i></p> <p><i>(i) Hi-Kent Kent provided a valuable and well-respected service;</i></p> <p><i>(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);</i></p> <p><i>(k) the Healthcare Commission Annual Health Check should take account of RTT waiting times for audiology services;</i></p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>(l) a written report on audiology services should be received by the Health Overview and Scrutiny Committee every four months;</p> <p>(m) audiology patients should be subject to an automatic recall;</p> <p>(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;</p> <p>(o) patients should be encouraged to return hearing aids where they were no longer required or are not being used;</p> <p>(p) PCTs and others needed to consider carefully the mental health needs of people with hearing impairment.</p> <p><b>RESOLVED that:-</b>            (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.</p>		<p>Topic provisionally scheduled for HOSC meeting, 18 July 2008</p>

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
14 December 2007 – 73	Dentistry	<ul style="list-style-type: none"> <li>- Eastern and Coastal Kent PCT</li> <li>- West Kent PCT</li> </ul>	<p>Having heard and received responses to its questions, the Committee reached the following conclusions:</p> <p>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 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.</p> <p>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.</p> <p>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.</p>	April 2008	

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
11 January 2008 – 79	Mental health	- Kent Adult Social Services - Kent and Medway NHS and Social Care Partnership Trust - Medway PCT	<p><b>RESOLVED:-</b>  (a) <i>That the conclusions of the Committee be drawn to the attention of health colleagues; and</i></p> <p>(b) <i>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.</i></p> <p>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:</p> <p>a) <i>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;</i></p> <p>b) <i>that the Committee must keep up-to-date with implementation of KCC's Young Carers Strategy "Invisible People";</i></p> <p>c) <i>that the Committee must decide whether it wished to respond to the consultation on the Partnership Trust's application for Foundation Trust status;</i></p>		Topic scheduled for HOSC meeting, 18 July 2008
				March 2008 (end of consultation period)	Topic scheduled for HOSC meeting, 13 June 2008

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>d) <i>that submitting third-party commentaries for the Healthcare Commission's Annual Health Check was core business for the Committee;</i></p>	<p>30 April 2008 (Healthcare Commission deadline for receipt of Core Standards declarations and third-party commentaries)</p>	<p>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</p>
			<p>e) <i>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;</i></p>		
			<p>f) <i>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;</i></p>		
			<p>g) <i>that the Committee should consider the feasibility of a "one-stop shop" approach to hospital admission, which had been mentioned in evidence;</i></p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p><i>h) to welcome NHS colleagues' undertaking to provide the Committee with a full beds schedule for all 46 of the Partnership Trust's wards;</i></p>		<p>Information received from Kent and Medway NHS and Social Care Partnership Trust, 21 April 2008</p>
			<p><i>i) to investigate arrangements in A&amp;E departments regarding service users who present with mental health issues, and whether a more consistent approach, based on best practice, was needed;</i></p>		<p>Information received from Kent and Medway NHS and Social Care Partnership Trust, 21 April 2008</p>
			<p><i>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;</i></p>		
			<p><i>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;</i></p>		
			<p><i>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;</i></p>		
			<p><i>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;</i></p>		

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
			<p>n) to acknowledge the valuable role of the voluntary sector in the mental health field;</p>		
			<p>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.</p>		
28 March 2008 – 13	Healthcare Commission Annual Health Check	All trusts	<p>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 Commission 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.</p>	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; Working Group meeting held on 25 April 2008, to discuss with other trusts their declarations

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
28 March 2008 – 13	Reconfiguration of services	Maidstone and Tunbridge Wells NHS Trust	<p><i>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.</i></p>	May 2008	<p>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 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</p>

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
9 May 2008 – 16	HOSC action points	HOSC	<i>RESOLVED: that an updated version of the rolling action sheet should be considered at each meeting of the Committee as a standing item.</i>	Ongoing	presentation of the outcome of their views, as will be made to the PCT Board, is also made to the HOSC, at the appropriate time.” Action sheet updated
9 May 2008 – 17	Working Group on Healthcare Commission Core Standards	- All Trusts - HOSC	<i>RESOLVED:</i>  a) <i>retrospectively to agree to the setting up of the Working Group that considered the self-declarations of the six remaining Trusts on 25 April 2008 – with similar arrangements to be made regarding the gathering information for third-party commentaries in respect of 2008–9; and</i>  b) <i>to note the information set out in the summaries of the Working Group meeting on 25 April 2008 and the Committee meeting on 28 March 2008.</i>		
9 May 2008 – 19	Healthcare services in	- Dover DC - Eastern and	<i>RESOLVED unanimously, on the motion of Dr</i>	August 2008	All stakeholders written to, 29 May

Minutes reference	Topic	NHS (or other) body concerned	Recommendation / action point	Deadline / bring-forward date	Action taken to date
	Dover	Coastal Kent PCT - East Kent Hospitals Trust	<p>Robinson, seconded by Mr Marsh, that:</p> <p><i>The Health Overview &amp; Scrutiny Committee of KCC strongly recommend &amp; support E K Hospitals Trust working closely with the ECK PCT &amp; Dover District Council to locate a central site in Dover for the Community Hospital Services for the population of Dover &amp; the surrounding areas.</i></p> <p><i>This proposal to be delivered to the EKHT by the end of August 2008. This third option to be considered &amp; evaluated alongside options 1 &amp; 2 concerning the Buckland Hospital Site.</i></p>		2008

Foundation Trust status  
Background Briefing

### **Characteristics of Foundation Trusts**

Foundation Trusts (FTs) were established under the Health and Social Care (Community Health and Standards) Act 2003 (now consolidated into the National Health Service Act 2006) as “independent public benefit corporations”.

These are a new type of organisation, existing within the public sector to provide public services on a non-profit basis – but with unprecedented commercial and managerial freedoms. The government states that the model for these corporations is the “mutualism” and “social ownership” of co-operatives, “social enterprises” and the voluntary sector.

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

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

### **Foundation Trust accountability and governance**

Unlike ordinary NHS Trusts, FTs are not accountable to the Secretary of State for Health – and hence are also not subject to performance-management by their local Strategic Health Authority (SHA).

FTs are instead accountable to a regulatory body, the Office of the Independent Regulator (known as “Monitor”), which has the status of an independent corporate body. Monitor is accountable to Parliament and must by statute “exercise its functions in a manner consistent with the performance by the Secretary of State of his duties ...”

Each FT is run by a Board of Directors, which works with an elected Council of Governors, representing “key stakeholders”.

Some Governors are elected by Trust “Members”, who are drawn from among local residents, patients and staff (residents and patients must opt in; staff membership can be on an opt-in or opt-out basis, depending on the

constitution of the FT concerned). There must be a “staff constituency” and a “public constituency” for elections; there may also be a “patients’ constituency”.

Other Governors are appointed to represent local partner organisations (Primary Care Trusts, local authorities and others). Governors play an advisory, guardianship and strategic role; they are not involved in the day-to-day running of the FT and so do not deal with matters such as budget-setting and performance-management.

Governors directly appoint the non-executive directors of FTs, including the Chair, but cannot mandate or recall them. The DoH states that “The executive directors are appointed by a committee consisting of the Chair, the other non-executive directors and the chief executive”. The Chief Executive is appointed by the non-executive directors, subject to approval by the Governors.

### **Transition to Foundation Trust status**

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

In order to become a FT, a Trust must go through the following stages:

#### *Preliminary Stage*

A Trust wishing to apply for FT status must first prepare:

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

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

#### *Preparatory Stage*

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

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

authorisation lays down a number of limits and obligations on it (this is further explained below).

The government is committed to seeing all acute hospital Trusts, and mental health Trusts, in a position to apply for Foundation status by the end of 2008 (although this appears in practice to have slipped into 2009). All SHAs must seek to fulfil this target.

Trusts that are still not in a position to become FTs by the government's deadline face the prospect of merger, acquisition and rationalisation at the hands of one of the FTs.

There are now precedents for takeovers by FTs. Good Hope Hospital NHS Trust in Birmingham has been taken over by Heart of England NHS Foundation Trust. And South Staffordshire Healthcare FT has taken over the mental health services provider arm of Shropshire County PCT. Ashford and St Peter's Hospitals Trust, in Surrey and Middlesex, considered a merger with Frimley Park Hospital Foundation Trust – but has now decided not to proceed with this and to pursue FT status in its own right.

It appears to be the government's intention that ambulance Trusts and the provider arms of PCTs will also become FTs in due course (the latter as "Community Foundation Trusts"), and possibly the commissioning arms of PCTs too.

### **Overview and Scrutiny**

FTs are subject to the duties and powers set out in the regulations governing Health Overview and Scrutiny Committees (HOSCs). The duty to consult HOSCs about any "substantial development" or "substantial variation" in local services applies to a FT where it seeks from Monitor permission to vary the terms of its authorisation in a way that would affect its "protected services". "Protected services" are all the clinical services that an FT is obliged to offer to NHS patients.

In the case of FTs, HOSCs do not have the power to refer changes in services to the Secretary of State for Health – but there is instead an equivalent power of referral to Monitor.

### **Political Controversy**

FTs are a major plank of the government's NHS reforms and have proved to be politically controversial. The passage through Parliament of the Bill that established them saw a substantial backbench revolt on the government side in the Commons. A number of changes were made to the legislation, in order to assuage concerns raised by MPs. The FT policy continues to be opposed by a number of stakeholders, including several major trade unions within the NHS.

Some of the key arguments for and against FTs can be summarised as follows:

<b>For</b>	<b>Against</b>
<p>FTs help to fulfil the government's aim of decentralising public services; and they aid the creation of a "patient-led" NHS.</p> <p>The devolution of decision-making to local level makes Trusts more responsive and accountable to their patients and communities.</p>	<p>The existence of FTs risks the fragmentation of the NHS, as government policy turns it into a market, made up of competing (public and private) providers, driven by commercial imperatives.</p> <p>Where FTs and other Trusts exist together, there could be a "two-tier" NHS, with FTs having unfair financial advantages over other Trusts. The resultant "uneven playing field" would be even more damaging in the context of Patient Choice and Payment by Results.</p>
<p>FTs support the government's Patient Choice agenda by increasing the plurality and diversity of providers within the NHS.</p> <p>At the same time, they are still subject to national NHS standards, performance ratings and systems of inspection, enforced by the Healthcare Commission and other regulatory bodies.</p>	<p>The emergence of a market in the NHS chiefly benefits those who are best able to exercise choice – who tend to be those who are better off and less ill (those that have always been best able to get what they need from the NHS).</p> <p>And it will encourage commercially oriented providers to "cherry pick" those patients, areas, conditions and treatments that are most profitable – to the detriment of other services.</p>
<p>Local ownership and control are guaranteed through Members and Councils of Governors, representing patients, staff and other stakeholders in the community.</p> <p>This provides much more democracy and accountability than exists in ordinary Trusts, where the only patient and public voice is through Local Involvement Networks, and HOSCs.</p>	<p>FTs are not genuinely accountable to their local communities. Governors have only limited powers. Not all Governors are elected and those that are elected, are elected by Members, who are a small group of self-selecting individuals and are not accountable to the wider community.</p> <p>Only a small minority of Members may actually be involved in elections (in some cases, e.g. University College London Hospitals NHS Foundation Trust, Governors have been elected with votes in single figures).</p>
<p>By becoming more autonomous, flexible and locally accountable, FTs</p>	<p>Fragmentation and marketisation of the NHS will risk widening health</p>

<b>For</b>	<b>Against</b>
<p>are better able to tackle health inequalities through addressing local circumstances.</p>	<p>inequalities and geographical disparities in healthcare provision.</p>
<p>FTs are able to offer additional financial incentives to staff, so as to address the problem of recruitment and retention in areas that have a high cost of living or are unattractive to work in.</p> <p>At the same time, staff remain protected by nationally negotiated agreements on terms and conditions of employment.</p>	<p>FTs are able to poach staff from other Trusts, by “topping up” national terms and conditions of employment, exacerbating the trend towards a two-tier NHS.</p>
<p>FTs’ greater financial freedoms incentivise innovation and entrepreneurialism, leading to the improvement of services.</p> <p>At the same time, FTs are bound by rules that prevent them becoming primarily businesses rather than providers of NHS services.</p> <p>They are legally incorporated as non-profit “independent public benefit corporations”, with Members – rather than shareholders who draw dividends.</p> <p>Any surplus made by an FT is the result of prudence and initiative, and will be ploughed back into providing healthcare.</p> <p>FTs’ “principal purpose” is the provision of free NHS care. “Protected services” are set down in FTs’ terms of authorisation, which are upheld by Monitor. Any changes to these will be subject to scrutiny by an FT’s own governance structures, as well as the local HOSC, which can make a referral to Monitor.</p> <p>Monitor must by law “exercise its functions in a manner consistent with</p>	<p>FTs are primarily “market actors”, operating in an increasingly commercial environment and competing with for-profit providers within the NHS.</p> <p>FTs cannot make profits, but they are expected to make a surplus (which they are allowed to keep) – and they are doing this on a significant scale. It has been estimated that the combined cumulative surplus of all FTs currently stands at around £2 billion.</p> <p>FTs can choose, on the basis of commercial considerations, which services they will provide.</p> <p>Monitor is essentially a market regulator, concerned primarily about FTs’ financial viability, rather than the adequate provision of NHS services. It is not explicitly bound to ensure the continuation of a comprehensive, free and universal NHS, in the way that the Secretary of State is.</p>

For	Against
the performance by the Secretary of State of his duties ...”	
<p>FTs are prohibited from charging NHS patients for care under primary NHS legislation.</p> <p>Care provided by FTs for NHS patients will remain free at the point of use, as it has always been.</p>	<p>FTs have a commercial incentive to charge patients for an enhanced NHS service. The possibility of such charging within the NHS is shown by the “Jentle Midwifery” premium NHS service (offering continuity of care from a designated midwife), now being provided for a £4,000 fee by Queen Charlotte’s and Chelsea Hospital (which is actually not a FT hospital).</p> <p>There is also an incentive to charge privately for procedures that can be re-classified as “cosmetic” and thereby removed from the scope of NHS provision. This is illustrated by the case of the Foundation Skin Clinic, set up by the Harrogate and District NHS Foundation Trust, which charges for services previously available as free NHS care.</p> <p>FTs further have an incentive to maximise revenue from charging NHS patients for facilities such as parking and telephone services.</p>
<p>There is a “lock” on NHS assets within FTs – designated “protected property” may not be sold to generate a surplus, preventing any “asset-stripping”.</p>	<p>The lock on NHS assets is not absolute. If a service is contracted to an outside provider, the NHS estate thereby freed up can be “unlocked” and disposed of, with the proceeds staying entirely within the FT.</p>
<p>Monitor sets a private income cap for each FT in the FT’s authorisation, in accordance with a statutory rule. Under that rule, the cap in each case is effectively set at the proportion of total income derived from private patients in the financial year 2002–3, or in the first full year in which the FT was a (non-Foundation) Trust (if later than 2002–3).</p>	<p>The private income cap still allows for private work to grow in line with overall growth in income.</p> <p>The cap does not cover all commercial income. Most importantly, it does not cover income generated in joint ventures with commercial partners or through subsidiaries and spin-off companies. Several FTs have exploited this loophole – which</p>

<b>For</b>	<b>Against</b>
<p>This ensures that FTs cannot fundamentally shift the balance of their activities away from their “principal purpose” of providing NHS care.</p> <p>FTs are actually more restricted in this regard than ordinary Trusts, whose income from treating private patients is not subject to any limit.</p>	<p>Monitor believes to be entirely lawful. Moorfields Eye Hospital NHS Foundation Trust has used its ability to borrow more freely in order to set up a clinic in Dubai, in the United Arab Emirates, providing paid-for services under, as the Chief Executive has put it, “the widely recognised Moorfields brand name”.</p> <p>The trade union UNISON argues that such activities are against the spirit of the legislation governing FTs and is currently seeking a judicial review on the matter. In response to UNISON’s action, Monitor is undertaking a three-month consultation on its interpretation of the private income cap rules.</p> <p>Meanwhile, the Foundation Trust Network, which represents FTs, has been lobbying for the abolition of the private-income cap.</p>

David Turner  
 (Research Officer, Health Overview and Scrutiny Committee)  
 5 June 2008

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GP-led health centresBackground Briefing**Equitable Access to Primary Medical Care**

Lord Darzi is an eminent surgeon who is currently serving as a junior health minister. In June 2007 the Secretary of State for Health, Alan Johnson, asked Lord Darzi to undertake a review of the NHS in England, with a view to producing a strategy for the next decade.

In October 2007 Lord Darzi published *Our NHS, Our Future – NHS Next Stage Review, Interim Report* (the final report will be published in July 2008). In the interim report, poor access to primary care was highlighted as a key issue in the NHS and Lord Darzi recommended that the government should invest in new resources to ensure equitable access to Primary Medical Services.

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 new GP practices in the 25% of Primary Care Trusts (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).

This was confirmed in the NHS Operating Framework for 2008–9, which stated that "all PCTs will complete procurements ... for new GP-led health centres" during the year.

The health centres (which are also 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 Department of Health (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 seem bound to use the Alternative Provider Medical Services (APMS) contracting route for this procurement. This raises the possibility that contracts could be awarded to corporate, for-profit providers – although the DoH says that GP practices 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:

- 1) SHAs to sign off PCT project specifications by 29 February 2008;
- 2) PCTs to place adverts and have a Memorandum of Information for bidders by 16 May 2008;
- 3) PCTs to evaluate pre-qualifying questionnaire responses and select bidders by 29 August 2008;
- 4) SHAs to sign off Invitation to Tenders and PCTs to issue to selected bidders by 31 October 2008;
- 5) Contracts to be awarded and signed by 31 December 2008.

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

Jill Norton, Assistant Director of Primary Care Provider Services at Medway PCT, has reportedly stated that it will be:

“extremely difficult for some PCTs to meet the targets” due to the daunting timescale and “absolutely intense” workload.<sup>1</sup>

## Scrutiny and consultation

There is a clear expectation that, as part of this timetable, PCTs will (between May and August 2008) undertake consultations around this procurement exercise with:

- local authority Health Overview and Scrutiny Committees under s.244 of the National Health Service Act 2006 and Regulation 4 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002;
- local Patient and Public Involvement Forums / Local Involvement Networks and the local community, under s.242 of the National Health Service Act 2006.

Scrutiny and consultation should cover:

- service specification;
- selection of preferred bidder;
- proposed contractual mechanism.

The following issues are likely to arise in the course of scrutiny and consultation:

- *the intended locations of the proposed new services*

Are the PCTs targeting them at the right areas and populations (those that are the most under-doctored and in the greatest need)?

- *how the new services are to be funded*

Some PCTs are reported to be intending to use money from their core budgets, in addition to the allocation that is being provided specifically for this procurement. Eastern and Coastal Kent PCT has reportedly confirmed that “the main funding will come from the PCT’s own budget”.<sup>2</sup>

- *the proposed service model*

Exactly what mix of services will be provided? What elements, if any, will there be of integration and co-location with other community-based services, including social care?

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<sup>1</sup> "How the APMS drive is gaining speed", [www.pulsetoday.co.uk](http://www.pulsetoday.co.uk), 20 February 2008

<sup>2</sup> "Exclusive: PCTs raid own funds to build 'unnecessary' polyclinics", [www.healthcarerepublic.com](http://www.healthcarerepublic.com), 27 February 2008

- *the possibility of adverse knock-on effects for other services*

Some GP practices have raised concerns about this – for instance in Chatham, where four new services under Equitable Access to Primary Medical Care are said to be planned close to the King’s Family Practice. Dr Christine Huxham, senior partner at the practice, has reportedly said that “Undoubtedly we’re going to fall dramatically. I don’t know whether we will be viable ... We’ve just been told it’s happening ... We’ve had no say in it at all”.<sup>3</sup>

- *how the procurement process is to be handled*

What are the PCTs doing to ensure a genuine "level playing field", to allow GP practices to compete with corporate providers in bidding for the APMS contracts to run services under Equitable Access to Primary Medical Care? There is a widespread perception amongst GPs that the APMS contracting mechanism is biased in favour of the corporate sector – although APMS contracts have been won by GP practices, including some in Kent and Medway.

### **Political controversy**

The plan for GP-led health centres has been politically controversial. It has been interpreted by the British Medical Association (BMA) as part of a government drive to replace traditional GP surgeries, provided by independent practitioners, with polyclinics containing many doctors and serving large populations, run by large for-profit corporate providers.

Another report by Lord Darzi, *Healthcare for London: A Framework for Action*, published in July 2007, clearly advocates a polyclinic-based model for primary medical care in the capital (although the report does not state how this service is to be commissioned). London PCTs have been told that if they undertake a polyclinic pilot this will be regarded as meeting their obligation to set up GP-led health centres under Equitable Access to Primary Medical Care. The BMA fears that this model is to be applied across the country.

The Association is currently running a “Support Your Surgery” campaign on this issue, targeted at patients and the general public.<sup>4</sup>

HM Opposition has also raised concerns about Lord Darzi’s plans for primary medical services. The Leader of the Opposition, David Cameron MP, has stated 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 “imposing them on local communities without public support and against the wishes of GPs themselves”.<sup>5</sup>

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<sup>3</sup> “GPs cry foul over polyclinic threat”, [www.pulsetoday.co.uk](http://www.pulsetoday.co.uk), 8 April 2008

<sup>4</sup> [www.supportyoursurgery.org.uk](http://www.supportyoursurgery.org.uk)

<sup>5</sup> Speech to King’s Fund, 21 April 2008, [www.conservatives.com](http://www.conservatives.com)

The Secretary of State, however, has told Parliament 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 further argued that the investment of £250 million in additional primary care for underserved areas should be welcomed. And he stated that Lord Darzi’s polyclinic plan for London was specific to the capital and “not a blueprint for the rest of the country”.<sup>6</sup>

David Turner  
(Research Officer, Health Overview and Scrutiny Committee)  
5 June 2008

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<sup>6</sup> Hansard, House of Commons Debates, 23 April 2008

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**Commissioning Business Unit comments for inclusion in submission to June HOSC**

1. The proposed locations for the centres and why they have been chosen

The reasons for the proposed locations (yet to be finalised) are described in the March 2008 PCT Board paper – and was based on Public Health led needs analysis

2. Funding of the centres, including whether any part of the money for them is to come from PCTs' own budgets, as distinct from the special allocation for the centres

Funding for the GP led Health Centres will be included in PCT baseline budgets in future years. Any expenditure incurred in 2008/09 will be met from PCT contingency funds.

3. The proposed service model in each case, including how this has been arrived at and whether there is likely to be any adverse impact on existing local GP practices

The proposed service model is based on Department of Health core requirements. The GP-led Health Centre must meet the following criteria:-

- Core GP services
- Maximising opportunities to integrate and co-locate with other community based services, including social care
- Easily accessible locations
- 7 day a week service
- 8am – 8pm
- Open to registered and non-registered patients
- Bookable GP appointments and walk-in services
- APMS contract

Additional requirements are currently being determined based on:

- PCT objectives
- PBC commissioning intentions
- PPE events
- Additional needs assessment

The provision of additional services may have an impact on patient flows within the local health economy. In the case of Swale it is anticipated the provision of additional GP led services will enable a large proportion of the currently un-registered population to access GP services

4. The procurement process, including any measures being taken to ensure a "level playing field" between GP practices and other potential providers

Direct public involvement in the procurement evaluation process has to be balanced with the need to accommodate both confidentiality issues and

commercial sensitivities. These issues apply not only to the PCT's own data but also to that provided by the bidders.

However as the procurement is for a public service it is very necessary to capture the views of those for whom it is intended.

During earlier public engagement meetings on the required services and preferred locations in Swale and Thanet, volunteers were sought for a public reference group and a number of individuals expressed a willingness to be involved. This group is being canvassed for their views on what would be seen locally as the critical aspects of the service provision and location. The information gathered, including views from the wider public, is being included in the "Invitation to Participate in Dialogue (ITPD)" and will also be reflected in the evaluation criteria against which individual supplier responses will be matched and scored.

#### "Level playing field"

Within the procurement process it is necessary to maintain a level playing field for all bidders and on this basis GPs will be treated no differently to other bidders. The requirement will specify a range of required services that all bidders must provide either directly or through other contractual arrangements. While any major company may be able to offer all of the services from directly employed staff they may equally require to sub-contract certain specialist services. Smaller companies, including GP groups, may need to sub-contract or form consortia with others to offer the required range.

Bidders will not be judged on the basis of organisation size only their ability to deliver the service without risk to their organisation, the service delivery or the PCT. This means that a small organisation, adequately funded and with a sound delivery plan has the same opportunity as major national company.

**4 June 2008**  
**Paul O'Brien**

## **Improving access to local medical services – background briefing notes**

The NHS “Next Stage Review” Interim Report (October 2007) carried out by Lord Darzi (the Report), reported that, despite sustained investment and improvement in the NHS over the past ten years, access to primary medical care services - that is those health services which are local to where people live, and the quality of those services, continues to vary significantly in different localities across the country including some areas of Eastern and Coastal Kent.

Recent research shows that the gap in life expectancy has widened between different areas despite service improvements right across Eastern and Coastal Kent. Specifically, disadvantage (which encompasses financial circumstances and social class, lifestyle, levels of illness and death rates) is considered one of the more important indicators of poor health.

Lord Darzi pledged to provide more local services reflecting local needs and with easy access for everyone. This “Equitable Access in Primary Medical Care Programme” will play a significant role in achieving this vision.

Ministers have announced that PCTs will establish new local health services reflecting local need.

Eastern and Coastal Kent PCT Board has agreed not one but two new developments, one in Swale and one in Thanet.

The decision to locate new local health services in these areas has been calculated using various indicators and evidence. This has been agreed by all the relevant stakeholders including the Local Medical Committee and the public health teams. An assessment of local health needs influenced the decision as well as levels of disadvantage, life style, life expectancy and quality of life. Local GP activity was also taken into account when making final decisions.

In line with Department of Health requirements the PCT will be delivering a service which will be:

- Open 8am to 8pm, 7 days a week
- GP led
- For registered and non registered patients
- For booked appointments and a walk in service
- Up and running by April 09

The time scales for planning and delivery are very tight. (see summary document)

We are engaging with local people to ascertain what the local population is looking for from the new service in relation to:

- the range of services to be provided
- location of the service

For further information contact:

Jenny Knight Head of Patient and Public Engagement- 01304-216845

Lynne Selman Director of Citizens Engagement and Communications

- 01227- 79504

Perpetua Egan PPE Manager for Canterbury and Swale - 01304-216854

## **Distribution list**

PCT Practice Based Commissioning leads and General Practitioners in Thanet and Swale

Parish councilors for Thanet and Swale

Local Authority Health Overview and Scrutiny Committees

PCT Health and Wellbeing sub groups for Thanet and Swale

PCT Non – executive directors for Thanet and Swale

PCT Patient and Public Reference Group

Local Medical Committee

Local Dental Committee

Local Pharmacy Committee

Local Optician Committee

Eastern and Coastal Kent Public Health Directorate

Local Authority regeneration leads

Children's Trusts

Head of Community Hospitals

Social services district managers

Local voluntary groups

General public via local press

Representation from seldom heard groups

Eastern and Coastal Kent NHS community services

Eastern and Coastal Kent Virtual panel

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## Chief Executive's Office

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### Outline Brief on the new GP Health Centre

This paper outlines a summary of the proposed primary care procurement of West Kent PCT (WKPCT) as part of the national Equitable Access to Primary Medical Care Services programme.

We propose to develop a 3 GP health centre which will be open from 08.00 to 20.00, seven days a week. It will provide a range of services that will be similar to most GP surgeries for patients who register with the practice, and it will also offer a range of walk-in services for non-registered patients.

The PCT has not yet determined the specific site but we propose to locate the new centre in the north of West Kent where it will serve new residents moving into the Kent Thameside development and the Dartford area.

This location has been decided on by the Evaluation Group overseeing the procurement, after taking into account the PCT's public health needs assessment which clearly identifies this area of population growth as the part of West Kent most in need of the services that the new health centre will provide.

Members of the Evaluation Group have discussed this with the Local Medical Committee and local GPs in Dartford, Gravesham & Swanley who are supportive of the location and objectives of the new health centre.

The Evaluation Group includes representatives from the Local Medical Committee, local GPs, local borough councils, social services, and the Health Network, West Kent PCT's panel of members of the public who are helping the PCT to improve and develop services. It will be involved throughout the procurement process, and will carry out the evaluation of the final bids, making a recommendation to the PCT's Board.

This new health centre will not replace any of the existing GP practices and we do not anticipate any adverse impact on existing GP services. We have received expressions of interest from a number of local practices interested in providing this new facility. Some groups of local GPs have teamed up with private sector developers to bid jointly, which means there is not always a clear distinction between public and private sector bids.

Additional funding for this project has been included in the PCT annual allocation, as it has for all PCTs, as this is a national initiative. At this stage it is not possible to determine whether this will cover the whole cost, but as the population increases, the PCT budget will be increased, over time, to cover the costs of the new residents.

The objectives of the new health centre are to increase the capacity of primary care facilities, increase the choice for patients and encourage innovation in service provision. This initiative is also an important stage in the way that WKPCT will reduce health inequalities and put much greater emphasis on health promotion.

The Public Health Strategy Priorities for WKPCT are to:

- Reduce inequalities
- Improve mental health and well being of children
- Reduce teenage pregnancies and improve sexual health of young people
- Improve lifestyles of the adult population
- Increase the number of older people supported to live at home and in the community
- Reduce drug and alcohol misuse.

It is possible that the new health centre will be located at a site in the Thames Gateway development area, near Ebbsfleet, that has been designated for a health facility. A final decision on the site for the health centre will only be made when we have been out to tender and agreed a preferred partner for this development.

WKPCT has produced a Project Specifications summary that will be developed in discussion with potential bidders, the local population and other interested bodies as the procurement process progresses. WKPCT sees this specification as a minimum standard and is keen to discuss innovation, in terms of service delivery and scope of services.

The procurement process has been developed by the Department of Health to ensure that there is a level playing field.

As well as involving a range of key stakeholders in the development of the project, the PCT has specified that public representation is part of the criteria that will be used in evaluating and scoring the bids.

This is not a national requirement but reflects the importance placed on patient experience and involvement by West Kent PCT.

Bidders will have to demonstrate how they intend to engage patients and develop their plans in liaison with patient representatives. As a minimum, the PCT has specified:

- the establishment of a patient group within the first year of the contract and regular meetings thereafter
- the production of relevant patient information which includes but is not limited to a leaflet written within the first six months of the contract and which will be regularly updated, at least annually.

By: Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – Friday 13 June 2008

**ACCESSING HEALTHCARE – ESTABLISHMENT OF SELECT COMMITTEE**

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1. It is proposed to establish a Select Committee to look at the role of transport issues in affecting access to healthcare services in Kent.
2. Attached is a paper setting out the background to the issue and proposed terms of reference for the Select Committee.

**Recommendations**

3. The Committee is asked to note the attached paper and approve the establishment of the Select Committee.

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## Select Committee on Transport and Access to Healthcare

### **Background**

The availability of transport is a key factor in people's ability to use healthcare services.

A 2003 report by the government's Social Exclusion Unit, found that there were five main transport-related barriers to accessing public services:

- 1) availability and physical accessibility of transport;
- 2) cost of transport;
- 3) services and activities located in inaccessible places;
- 4) safety and security;
- 5) lack of information / limited "travel horizons".

According to the report:

- 1.4 million people a year in England go without medical help because of transport problems;
- a third of people without a car have difficulty travelling to their local hospital;
- in one market town, half of those without a car never go to the dentist;
- in London, the majority of older people travelling to hospitals and dentists experience difficulty getting there;
- a quarter of mental health service users have restricted access to services for financial reasons – mostly to do with transport.

Issues around transport to health services are a factor in health inequalities. According to Tudor Hart's "Inverse Care Law" those who most need healthcare, who tend to be the poorest and most socially excluded, also have the greatest difficulty in obtaining it. Lack of access to transport among more disadvantaged social groups is a significant limitation on their ability to access healthcare.

Inadequate access to appropriate transport can also curtail access to healthcare for minority groups with special needs, such as people with learning, physical or other disabilities, frail older people and people with mental health problems.

Transport issues are not solely relevant to disadvantaged people and other minority groups. Where there are poor road connections to healthcare facilities, or inadequate (or prohibitively expensive) parking facilities, this can impact adversely on a very large proportion of patients (and visitors). The same is true where healthcare facilities are too distantly located.

Transport-related difficulties in accessing healthcare can represent significant costs for the NHS, individuals, communities and society as a whole:

- Missed appointments cost the NHS money, as well as wasting the time of clinicians and other staff.
- Providing outreach services (i.e. services that travel to the patient) can be costly and time-consuming for clinical staff, representing an uneconomic use of their time.
- If patients do not present at an earlier stage of their condition, they will present at a later stage (possibly as an emergency case), requiring a more costly medical intervention and with the likelihood of a worse clinical outcome.
- Rural communities can be made less sustainable by the difficulty of accessing healthcare and other vital services.

### **Proposed Terms of Reference**

To consider:

- transport issues affecting the ability of deprived communities in Kent to access healthcare;
- transport issues affecting the ability of rural communities in Kent to access healthcare;
- the scope and content of Kent's second Local Transport Plan (LTP2), covering the period 2006–7 to 2010–11, with reference to integrated accessibility planning with the NHS and how far issues relevant to health inequalities are being addressed by LTP2;
- what scope there is for more and better joint accessibility-planning involving KCC, the NHS, district councils, transport providers, the voluntary sector and other stakeholders, through means such as sharing data, developing site-specific travel plans, commissioning and providing transport services, and integrating services;
- the possible impact on accessibility of plans to provide some aspects of healthcare "closer to home" while providing others at specialist centres;
- how inequalities in access to transport affect the impact of Patient Choice on the NHS;
- the role of NHS Patient Transport Services and whether these might be used to a greater extent to help overcome transport-related problems in accessing healthcare services;
- whether current and planned healthcare facilities in Kent are in optimal locations from the point of view of transport;
- the role of volunteer drivers in facilitating access to healthcare services in Kent and whether the best use is being made of this resource;

- car-parking arrangements (including charges) for patients and visitors at NHS premises in Kent, particularly the planned new Pembury Hospital;
- what examples of good practice are present locally and elsewhere in the UK and Europe, and how these can be replicated around Kent.

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By: Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – Friday 13 June 2008

**“FIT FOR THE FUTURE” WORKSTREAMS – INCLUDING DECISION ON JOINT SCRUTINY OF UROLOGY PLANS WITH MEDWAY HOSC**

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1. As part of the “Fit for the Future” process, a commissioning review is being conducted regarding the provision of urology services in Kent and Medway. The review is being led by Medway Primary Care Trust, on behalf of the three PCTs in Kent and Medway.

2. Attached is a paper containing: a summary of a briefing note that has been received from Medway PCT – including four questions to which the PCT wishes the HOSC to respond; and an extract from the draft minutes of a recent meeting of Medway Council’s Health and Adult Social Care Overview and Scrutiny Committee, at which this issue was discussed.

**Recommendations**

3. The Committee is asked to note the attached paper and decide:

a) how it wishes to respond to the questions asked by Medway PCT regarding Stage 2 of the urology commissioning review; and

b) whether it wishes to undertake joint work on this matter with Medway Council’s Health and Adult Social Care Overview and Scrutiny Committee and, if so, in what form.

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## Kent and Medway Urology Commissioning Review

### **Summary of briefing note provided by Medway Primary Care Trust**

The services with which this review is concerned involve highly specialised urological surgery, representing just under two per cent of all urology operations. The underlying issue is the familiar one of the need for appropriately sized catchment populations in order to ensure the necessary "critical mass" for high surgical standards.

A review undertaken by Prof Tony Mundy in March 2007, as part of "Fit for the Future", noted lack of progress towards centralising urology services in Kent and Medway. Prof Mundy expressed support for providing services on a single site – while recognising that a staged development towards this might be required.

A Urology Commissioning Steering Group (UCSG) was set up on behalf of the three Kent and Medway Primary Care Trusts (PCTs) in October 2007, to develop a Commissioning Specification and facilitate a process leading to contracts / Service Level Agreements to provide services until 2012.

Once the UCSG had agreed the process to be undertaken and the detailed content of the Commissioning Specification, acute Trusts were asked to respond to the Specification. A separate Evaluation Panel considered the responses, evaluating them against the Specification, using predetermined scoring and weighting methodologies. This was Stage 1 of the commissioning process (concluding at the end of December 2007).

Three responses were received, from the four current providers:

- East Kent Hospitals Trust;
- Medway Trust / Dartford and Gravesham Trust; and
- Maidstone and Tunbridge Wells Trust.

In aggregate, these responses proposed three multi-disciplinary teams on three sites.

The Evaluation Panel agreed that there should be two multi-disciplinary teams, one in East Kent and one in West Kent. The external surgical members of the panel further stated that in West Kent there should be one surgical site for highly specialised urology, and indicated that additional work was required regarding: casemix; identification of the appropriate site; and impact on patient experience.

The procedures to be undertaken at the single West Kent specialist urological surgery centre were agreed by the consultant urologists in January 2008. These are fourteen selected radical urological procedures – all complex operations for urological cancer. It was agreed that patients would have their outpatient and diagnostic appointments, and treatments other than surgery

(including follow-up treatment, where appropriate), from their local Trust and only travel to the specialist surgical site for their pre-surgery assessment and surgery.

Stage 2 of the commissioning process, to determine the site from which the core casemix for specialist urology will be delivered in West Kent, has been in progress since February 2008, following the setting up of a new workstream, the West Kent Urology Site Feasibility Group.

It is intended in West Kent to: move to a single multi-disciplinary team by 1 July 2008; set out detailed plans on the implementation of a single surgical site for highly specialised Urology by the end of July 2008; and implement the single-site surgical solution by 1 April 2009.

Analysis of data regarding West Kent has shown that:

- total selected radical procedures for the three most recent years (2004-5 to 2006-7) were 477, of which 85 were at Dartford and Gravesham Trust, 218 at Medway Trust, and 174 at Maidstone and Tunbridge Wells Trust;
- the patients treated at Dartford and Gravesham Trust mainly came from Dartford, Gravesham or Sevenoaks;
- nearly two-thirds of the patients treated at Medway Trust came from the Medway area, with most of the remainder living in Swale;
- the patients treated at Maidstone and Tunbridge Wells Trust mainly came from Maidstone, Sevenoaks, Tunbridge Wells, and Tonbridge and Malling with a few from other areas.

Two prospective providers, representing three organisations, have completed a site feasibility questionnaire and been interviewed by the Evaluation Panel:

- Medway Trust / Dartford and Gravesham Trust (as "the Medway and Darent Unit"); and
- Maidstone and Tunbridge Wells Trust.

Before Stage 2 can be concluded (with a preferred option for the single West Kent site going to the UCSG and the PCT Boards), the views of the Kent and Medway HOSCs are required on the following questions:

*1) Do the HOSCs support the approach being taken within Stage 2 of this Review?*

*2) Do the HOSCs require any further information in relation to the process that we are following, or a presentation to the HOSCs at one of its meetings?*

*3) It is understood that the HOSCs will need to decide upon whether they consider any of the elements within Stage 2 to be of a nature that*

*may require further consultation, either with the HOSC or more formally with the public. We would be grateful for this advice if at all possible before the end of June to allow us to incorporate this into our paper to the three PCT Boards for their July meetings.*

*4) Would it be helpful for representatives from the Urology process to meet with a smaller group of members from both HOSCs to brief more fully to obtain a firm steer on process?*

**Extract from the draft minutes of Medway Council's Health and Adult Social Care Overview and Scrutiny Committee meeting, 22 May 2008**

*The Chief Executive of Medway PCT stated that if the Urology Review were not dealt with by the Committee until the next meeting on 10 July this would set back the process until September. She queried whether this could be dealt with in a different way by means of a task group. The Overview and Scrutiny Co-ordinator explained that this would need to be the joint Committee with Kent County Council's Health Overview and Scrutiny Committee and would need to ensure that the Committee were given delegated authority to respond to the Trust on behalf.*

David Turner  
(Research Officer, Health Overview and Scrutiny Committee)  
5 June 2008

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