

**HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**Friday, 3rd September, 2010**

**9.30 am**

**Darent Room, Sessions House, County Hall,  
Maidstone**







## AGENDA

### HEALTH OVERVIEW AND SCRUTINY COMMITTEE

**Friday, 3rd September, 2010, at 9.30 am**  
**Darent Room, Sessions House, County**  
**Hall, Maidstone**

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

*Tea/Coffee will be available from 9:15 am*

#### **Membership**

- Conservative (10): Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mr K A Ferrin, MBE, Mrs J A Rook, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A T Willicombe
- Labour (1): Mrs E Green
- Liberal Democrat (1): Mr D S Daley
- District/Borough Representatives (4): Councillor J Cunningham, Councillor C Kirby, Councillor M Lyons and Councillor Mrs M Peters
- LINK Representatives (2): Mr M J Fittock and Mr R Kendall

#### **Webcasting Notice**

Please note: this meeting may be filmed for live or subsequent broadcast via the Council's internet site – at the start of the meeting the Chairman will confirm if all or part of the meeting is being filmed.

By entering the meeting room you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If you do not wish to have your image captured then you should make the Clerk of the meeting aware.

#### **UNRESTRICTED ITEMS**

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

- | Item   | Timings |
|--|---------|
| 1. Substitutes   |         |
| 2. Declarations of Interests by Members in items on the Agenda for this meeting. |         |
| 3. Minutes (Pages 1 - 8)   |         |

- |    |  |                  |
|----|--|------------------|
| 4. | Update on SECAmb's Make Ready Programme (Pages 9 - 38)                                 | 9:30 –<br>10:10  |
| 5. | The Future of PCT Provider Services and the Use of Community Hospitals (Pages 39 - 86) | 10:10 –<br>12:40 |

This item will be examined in two sections as follows:-

- |    |                                     |               |
|----|-------------------------------------|---------------|
| a) | The Future of PCT Provider Services | 10:10 – 11:20 |
|----|-------------------------------------|---------------|

BREAK

- |    |                                |               |
|----|--------------------------------|---------------|
| b) | The Use of Community Hospitals | 11:30 – 12:40 |
|----|--------------------------------|---------------|

- |    |  |                  |
|----|--|------------------|
| 6. | Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update (To Follow) | 12:40 –<br>13:20 |
| 7. | Forward Work Programme (Pages 87 - 88)   | 13:20 –<br>13:25 |
| 8. | Committee Topic Discussion (Pages 89 - 90)   | 13:25 –<br>13:45 |
| 9. | Date of next programmed meeting – Friday 8 October 2010 @ 10:00am                              |                  |

### **EXEMPT ITEMS**

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

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

**25 August 2010**

*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 in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 23 July 2010.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mrs E Green, Mr S J G Koowaree (Substitute for Mr D S Daley), Mr R L H Long, TD, Mr C P Smith, Mrs P A V Stockell (Substitute for Mr K A Ferrin, MBE), Mr R Tolputt, Mrs J Whittle, Mr A T Willicombe, Cllr R Davison (Substitute for Cllr J Cunningham), Cllr M Lyons, Mr M J Fittock and Mr R Kendall

ALSO PRESENT: Mr M Cayzer, Mr N Dack, Mrs C Davis, Dennis Fowle, Mr R Kenworthy, Mr J Larcombe, Mr R A Marsh, Miss N Miller, Mr M Willis and Ms T Gailey

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

#### UNRESTRICTED ITEMS

##### 1. Meeting Dates for 2011 (Item 4)

Members noted the meeting dates for the Committee in 2011.

##### 2. Minutes (Item 3)

RESOLVED that the Minutes of the meeting held on 11 June 2010 are correctly recorded and that they be signed by the Chairman.

##### 3. Diagnostics - Waiting Times (Item 5)

*Dr Robert Blundell (Vice Chair, Kent Local Medical Committee), Dr Stephen Meech (Kent Local Medical Committee), Di Tyas (Deputy Clerk, Kent Local Medical Committee), Jochen Worsley (Locality Practice-Based Commissioning Manager, NHS West Kent), Sheila Pitt (Head of Cancer, Long Term Conditions and Therapies, NHS Eastern and Coastal Kent), Patricia Davies (Director of Performance Improvement, NHS West Kent), and Andrew Scott-Clark (Deputy Director of Public Health, NHS Eastern and Coastal Kent) were present for this item.*

(1) Representatives from NHS Eastern and Coastal Kent began this item with an overview explaining that the health needs in the two halves of the county differed due to the levels of deprivation in the coastal areas. However, the situation regarding diagnostics had improved over the last two years and out of 115 GPs, many now undertook diagnostic phlebotomy and cardiology work. However, more work needed to be done to ensure equality of access.

(2) NHS West Kent echoes the sentiments about progress having been made about waiting times. The point was made that the majority of referrals for diagnostics were made by consultants and not GPs and that projects were underway to move more services for people closer to home.

(3) Representatives from the Local Medical Committee (LMC), representing GPs, made the point that better access to diagnostics, and more responsibilities for GPs was welcome, but carrying out the tests and interpreting the results increased workload and had resource implications. In some instances results could be returned from suppliers the same day and some results could be sent on the computer, such as blood work. Many tests were carried out directly by GPs with a Special Interest (GPwSI).

(4) A straw poll carried out by the showed GPs had a high level of satisfaction with the situation regarding diagnostics in Kent. One of the main themes was that GPs often had to refer patients to a consultant in order to access some diagnostics, and there was a call for more direct access. Out of all the diagnostic tests, satisfaction with the provision of x-rays rated the lowest.

(5) Most x-ray results were made available in 1-2 weeks, but it could be longer. This was a generalised problem, and often one of administration in the sense that the tests had been carried out but the results took time to type up. The increasing use of electronic communication of results was improving the process.

(6) The important point was made that time was not necessarily a problem, clinically, but medical professionals had a role in reassuring patients until the results were known.

(7) Many tests were carried out directly by GPs with a Special Interest and the services available did differ by practice. It was explained that Primary Care Trusts had responsibility to ensure services were safe and accessible and that where GPs did not offer an enhanced service, they looked at what alternatives could be provided. The example was given that all anti-coagulation services had been moved out of Acute settings in East Kent.

(8) The apparent higher rate of diagnostics in East Kent compared to West Kent was discussed and the question posed as to whether this was due to poorer health or the culture of General Practice. It was not possible to give a direct explanation as there were many factors involved, but through questioning members posited the possibility that patients accessing private diagnostics directly in West Kent may be a contributing factor.

(9) Connected to this point, representatives from the Local Medical Committee made the observation that the 18-week target in place until recently was clinically insensitive but that in cases where it was necessary, ways could be found around the standard system. However, this would not affect the waiting times overall as patients would not be replaced in the queue, just moved back one place.

(10) The broader point was made that access to diagnostics had an impact on other resources. For example, accessing a private diagnostic service could cost £50, but this would be cheaper than a patient going to Accident and Emergency and getting a test there, costing £100.

(11) Two specific points were made about audiology. One related to the time it took to make repairs to digital hearing aids, and it was explained that digital hearing aids needed to be custom made to match the individual patients' hearing aid frequency, and this could be a cause for apparent delay.

(12) One Member suggested that extra capacity for delivering audiology appointments could be provided at the Royal Victoria Hospital in Folkestone. NHS Eastern and Coastal Kent promised to contact East Kent Hospitals NHS University Trust to examine the feasibility.

#### **4. Update on Health and Transport**

*(Item 6)*

*Mark Fittock (LINK Governor), David Hall (Head of Transport and Development, Kent County Council), Martyn Ayre (Senior Policy Manager, Kent County Council), Karen Thompson (Urgent Care Locality Development Manager, NHS Eastern and Coastal Kent), Martine McCahon (Locality Practice-Based Commissioning Manager, NHS West Kent), Kenneth Cobb, Transport Integration Manager, Kent County Council), Andrew Cole (Head of Urgent and Continuing Care, NHS Eastern and Coastal Kent), Patricia Davies, Director of Performance Improvement, NHS West Kent, and Neville Dack, LINK Project Worker.*

(1) Councillor Richard Davison declared an interest in this item as a member of a volunteer transport group.

(2) Members had before them a progress report of work being undertaken by KCC and the NHS in examining the issue of health and transport and a draft version of the *Access (Transport) to Health Services Report* by the Kent LINK.

(3) On behalf of LINK, Mark Fittock gave an overview of their report, the final version of which is now available on the Kent LINK website, being formally published the day of the meeting. He explained that transport links into all health areas and that overall Kent had good access going East-West, but was less well served North-South; some villages were more isolated than in the 1930s. The report had no costings as this was not the function of the report. It had been submitted to relevant NHS organisations for a formal response.

(4) On behalf of the KCC and NHS work stream, Martyn Ayre explained that the work began two years previously. David Hall made the overall point that the work had identified that the issue was not so much a lack of public transport, but a lack of coordination and information, and pointed to the good work coming out of a dial-a-ride pilot in Dover.

(5) There was a vigorous debate on the topic of car parking charges at hospitals. Views ranged from those Members who wanted to see free car parking at hospitals, as could be seen in Scotland, and those who pointed to potential unintended consequences of not having fees with people parking there who were not attending the hospital.

(6) The observation was made that transparency in charging was important if Trusts wished to mitigate criticism and in order to prevent unnecessary delay when

arriving at hospital for an appointment, charges upon leaving would be a good first step where this was not already in place.

(7) Members expressed their concern at the withdrawal of Kickstart funding for improved public transport links between Maidstone and Tunbridge Wells, which would facilitate access to the new Pembury Hospital. However, Mr Hall was able to report that a version of the scheme was being examined in consultation with Arriva and that there may be a need for some initial funding, but with Arriva taking on the full costs of providing the service after three years.

(8) The role of volunteer drivers was praised, but some Members felt that the process was often bureaucratic and off-putting for potential volunteers. However, this seemed to vary between organisations. Returning to the earlier point and information and coordination, it was generally felt that clarity around the eligibility for patient transport services was needed.

(9) As practical proposals, the notion of running shuttle buses to hospitals from park and ride areas was mooted. The Thanet Loop, which took patients to the Queen Elizabeth the Queen Mother Hospital in Margate was praised as an example of good practice.

## **5. Pharmaceutical Needs Assessment - NHS Eastern and Coastal Kent** *(Item 7)*

*Dr Robert Blundell (Vice Chair, Kent Local Medical Committee), Dr Stephen Meech (Kent Local Medical Committee), Di Tyas (Deputy Clerk, Kent Local Medical Committee), and Andrew Scott-Clark (Deputy Director of Public Health, NHS Eastern and Coastal Kent) were present for this item.*

(1) Mr Scott-Clark explained that the paper the Committee had before them was part of the pre-consultation phase leading to his Primary Care Trust carrying out a Pharmaceutical Needs Assessment (PNA). He clarified that the PNA would only cover NHS contract work and not items that pharmacies may sell over the counter. Work on the PNA would continue between now and February 2011 and the PCT was looking closely at boundary issues with other Primary Care Trusts. The work was now being carried out against the backdrop of plans contained within the recent NHS White Paper to move pharmacy commissioning to a new NHS Commissioning Board. Separate work was also going on at the national level around drug costs.

(2) Representatives from the Kent Local Medical Committee explained that the 2008 White Paper on pharmacy set out a vision for pharmacies to become health living centres. From the General Practice perspective, this has the potential to lead to fragmentation in patient care and record keeping.

(3) There was a discussion about the need to maintain a high street presence for pharmacies before focussing in on the role of pharmacies in GP practices. It was noted that an important distinction needed to be made between GP practices which happened to have a pharmacy on the premises but which was in effect a separate concern and those where the GP was also the dispenser. The latter performed a valuable service in small villages, and the income from providing this service could form an important part of the overall income of the practice, but that this service would cease if a pharmacy opened in the area.

(4) Members thanked the attendees for their useful information on this topic.

## **6. Update on Dover Healthcare**

*(Item 8)*

(1) Members had before them a letter from Stuart Bain, Chief Executive of East Kent Hospitals University NHS Foundation Trust, providing an update on progress with the Dover Hospital project.

(2) The Overview, Scrutiny and Localism read out some correspondence on the issue which had just been received from Mr Reg Hansell and Mr Doug Tutton.

(3) Members expressed their disappointment that the letter was not as unequivocal about the future of the project as should have been expected given the amount of time and effort the Committee, and many others, had already devoted to this subject.

(4) The Committee requested that this sentiment be conveyed to East Kent Hospitals University NHS Foundation Trust and further clarification as to the future of the project be requested.

## **7. Forward Work Programme**

*(Item 9)*

(1) The Committee noted the proposed business for the meeting on 3 September 2010 and the start time of 9.30am.

(2) The Chairman reported that there was limited space available for the visit to the Disablement Services Centre on 22 October 2010

(3) RESOLVED – That the report be noted

## **8. Update on Referral to the Secretary of State for Health**

*(Item 10)*

(1) The Committee had before them a letter from Andrew Lansley CBE, Secretary of State for Health dated 1 July 2010 which had appended to it the advice of the Independent Reconfiguration Panel to whom the Committee's referral had been sent by the former Secretary of State for Health.

(2) The Chairman invited Mr Wickenden to read to the Committee a letter he had received via e-mail from the South East Coast Strategic Health Authority (as the meeting had progressed) to Helen Grant the Member of Parliament for Maidstone and the Weald from the Secretary of State for Health dated 23 July 2010.

(3) In summary and for the purposes of the debate which followed Mr Lansley had clarified that implementation of the reconfiguration of Women's and Children's Services was to be implemented. However, he had asked for one report back by the end of September from the South East Coast Strategic Health Authority (SHA) following the further discussions which would be led by the SHA with all stakeholders

on the revised criteria for reconfigurations and the ten points of referral made by this Committee which could be resolved locally.

(4) During the discussion which followed the Committee's attention was drawn to an article which had been published in the Maidstone edition of the Kent Messenger that morning of a local mother who had given birth to her child on route to the Medway Maritime Hospital having been diverted from Tunbridge Wells when it was indicated to her that Maidstone could not accommodate the mother for the birth of her child. Mr Wickenden informed the Committee that he had been notified the previous evening by the press officer to the Maidstone and Tunbridge Wells NHS Trust that this article was to be published. He had indicated to Mr Wickenden that the local health economy was carrying out a thorough investigation into this case.

(5) Members discussed and expressed a range of views including:-

- the need for an urgent meeting in the Maidstone area to enable the public to attend and express their views;
- Maidstone Members of the Committee were clear that they wanted a full consultant led maternity service at Maidstone Hospital; and
- The decision by the Secretary of State had been made, the role of the HOSC in making the referral had been exercised and the role of the HOSC now was as a stakeholder to influence the SHA to ameliorate the concerns of Maidstone residents and the surrounding area.

(6) The Chairman indicated that he was very disappointed at the response of the Independent Reconfiguration Panel which was commissioned by the former Secretary of State for Health. He added that one of the prime functions of the Health Overview and Scrutiny Committee is to champion the patient voice and reduce health inequalities across the County.

(7) He suggested to the Committee that the Committee should indicate that it is not satisfied that the ten points of referral have been adequately dealt with and the Committee would be working with its partners to press the new Secretary of State for Health to address these points in greater detail.

(8) The Health Overview and Scrutiny will now need to work within the process laid down by the Secretary of State for Health to influence the SHA report to ameliorate the concerns of Maidstone residents and its surrounding hinterland.

(9) **RESOLVED:** - That the Chairman, in consultation with the Vice Chairman, Liberal Democrat and Labour Group spokesmen shall prepare a letter on behalf of the Committee to send to the Secretary of State setting out the views expressed by the Committee and that this letter should be circulated to Members of the Committee before being sent to the Secretary of State for Health.

## **9. Committee Topic Discussion**

*(Item 11)*

Members expressed the opinion that the outcomes of each item on the Agenda had been sufficiently considered during the relevant discussions.

**10. Date of next programmed meeting – Friday 3 September 2010 @ 9.30am**  
*(Item 12)*

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager  
To: Health Overview and Scrutiny Committee – 3 September 2010  
Subject: Item 4. Intended Outcomes: the Future of PCT Provider Services  
and the use of Community Hospitals

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## **1. Background**

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.

(2) This paper is intended to be a way to progress towards achieving these twin aims. The following questions are the ones submitted to South East Coast NHS Ambulance Trust in advance of the meeting.

## **2. Hierarchy of Questions**

(1). Overarching Questions

1. What progress has been in your Make Ready Depot programme?
2. How will this programme progress in the future?
3. How will this affect the way services are delivered?

## **3. Recommendations**

(a) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

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# Make Ready Kent HOSC Briefing 3 September 2010



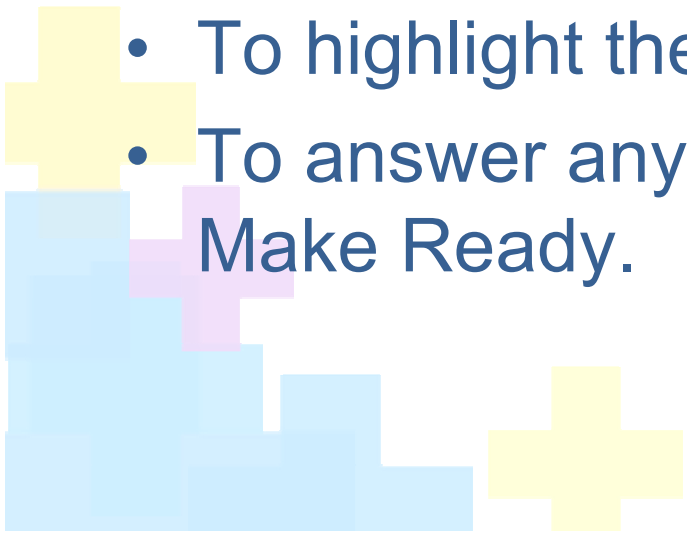
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# Aim

- To provide you with an overview of Make Ready and how it will be rolled out throughout SECAmb.
- To up-date you on our plans to introduce Make Ready in Kent and what it means for staff and patients.
- To highlight the benefits Make Ready brings
- To answer any questions you may have on Make Ready.

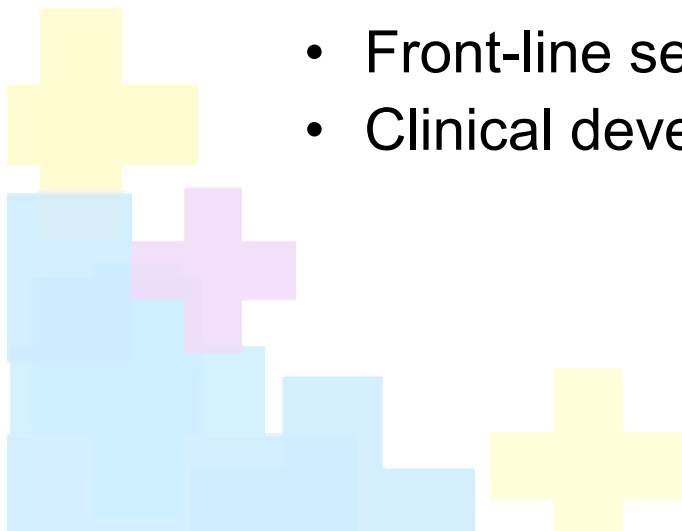




# Drivers For Change

## Why are we doing it?

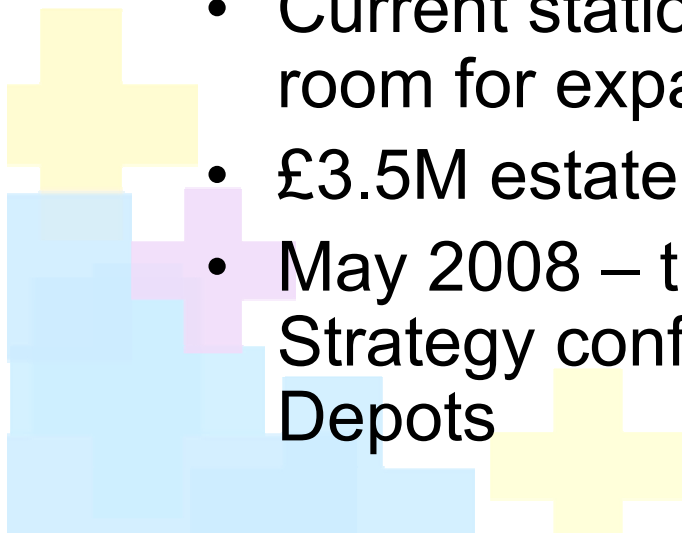
- A key part of our vision & our commitment to providing the best possible services to patients
- Helps to tackle the challenge of Infection Control
- Reduces risk – to staff, vehicles and equipment
- Release efficiencies to permit investment in:
  - Front-line services and staff
  - Clinical developments and innovation





# Context for Change

- Old estate (68% built pre 1974)
- Often mal-located, which impedes response.
- Speed of response is key to clinical outcomes
- Patient demand/location changes – static stations cannot and do not reflect these changes
- Current stations are often “bulked out”, with no room for expansion
- £3.5M estate backlog maintenance
- May 2008 – the approval of the Trust’s Estate Strategy confirmed the move to Make Ready Depots



# So, what is the definition of Make Ready?

***“A crew friendly quality assurance vehicle and equipment preparation programme designed to minimise cross infection and maximise patient safety.”***



# Award Winning

**best of  
health  
awards**  
2009

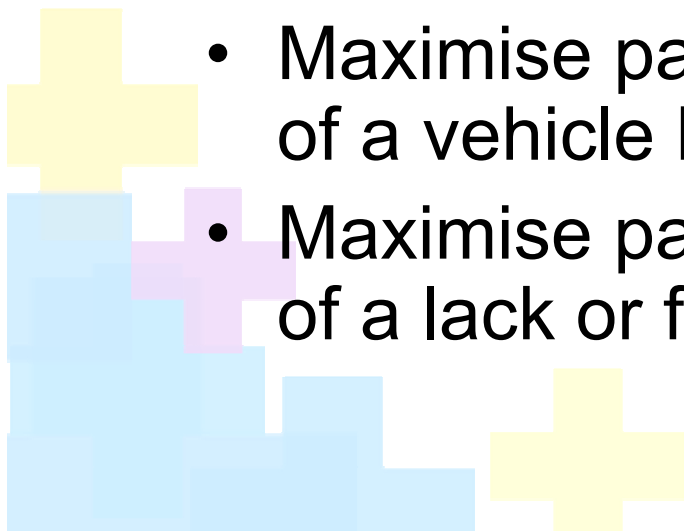
- 2009 Regional Winner Best of Health Awards for Patient Safety.
- 2009 – commended by CQC and recommended for roll out across the English ambulance services.
- 2009 – visits by, NPSA, UK ambulance services, BF Cyprus.

The South East Coast regional heat of the  
**Health and Social Care Awards 2009**  
Passionate People Innovative Ideas Transforming Care



# Benefits - maximise patient safety

- Maximise patient safety through a rigorous vehicle and equipment cleaning and infection control regime
- Maximise patient safety by maximising the hours clinicians can see patients
- Maximise patient safety by minimising the risk of a vehicle breaking down en route
- Maximise patient safety by minimising the risk of a lack or failure of key clinical equipment





# Concept

- All resources start and ends their shift at large central depots
- Depots are supported by a network of Ambulance Community Response Posts (ACRP)
- ACRPs are aligned with patient demand and provide locations from where crews will respond during their shifts
- The move to Make Ready will see staff responding from more, not less, locations (more ACRPs than stations)
- Some ACRPs will be former stations, if in the right, patient-led location.
- All ACRPs have an agreed set of crew facilities
- ACRPs can be moved in response to changes in demand



# Planning Assumptions – Depot Locations May 10





# Depot Locations

- Chertsey (Open)
- Hastings (Open)
- Thanet (Open)
- Paddock Wood (Summer 11)
- Ashford (Autumn 11)
- Polegate
- Medway
- Brighton
- Redhill
- Crawley
- Guildford
- Arundel





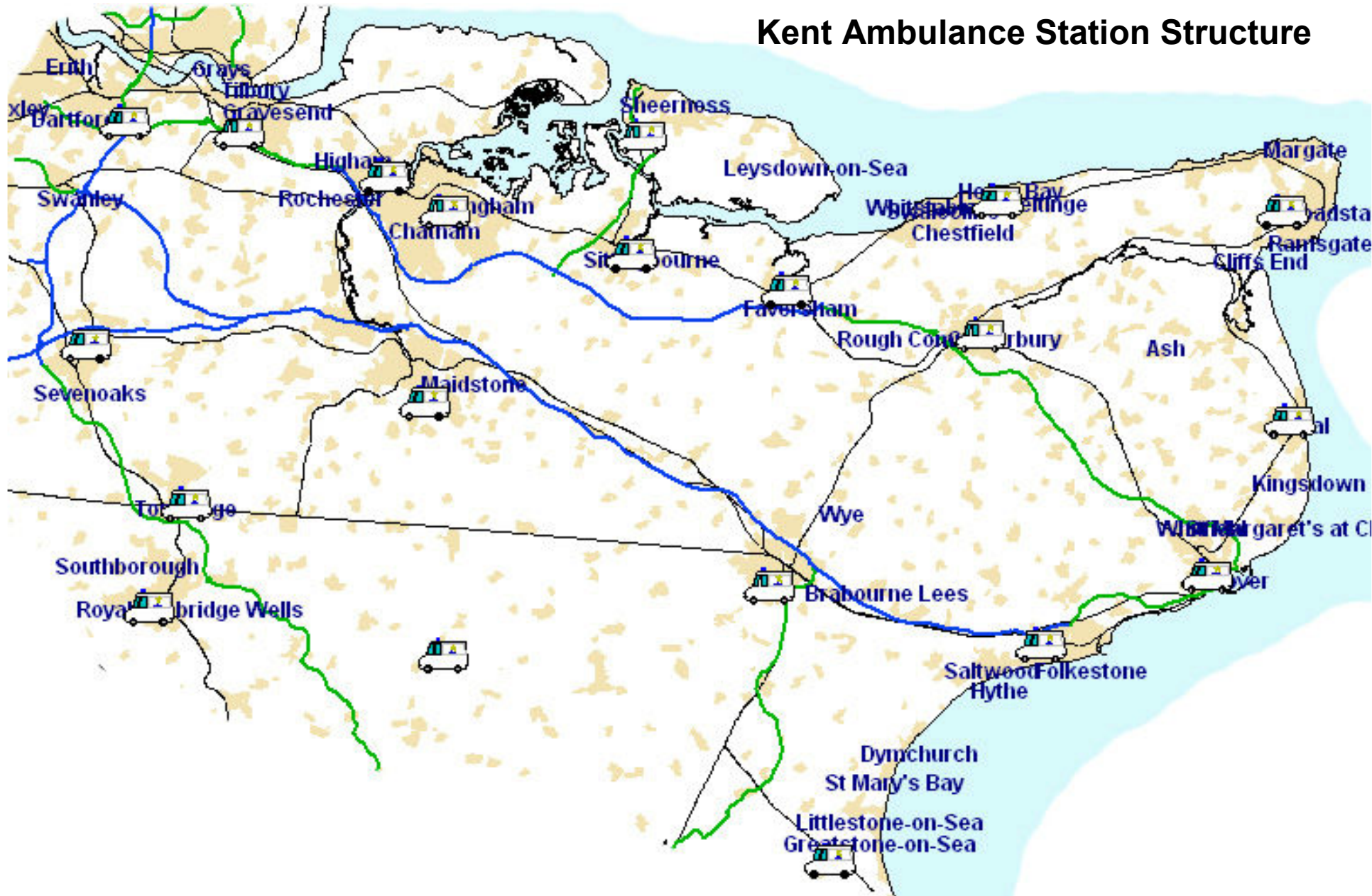
# How are depot locations chosen?

- Central to the operational dispatch areas geographically
- Located close to main hospitals
- Enabling good access for all staff in the area
- Availability of suitable sites

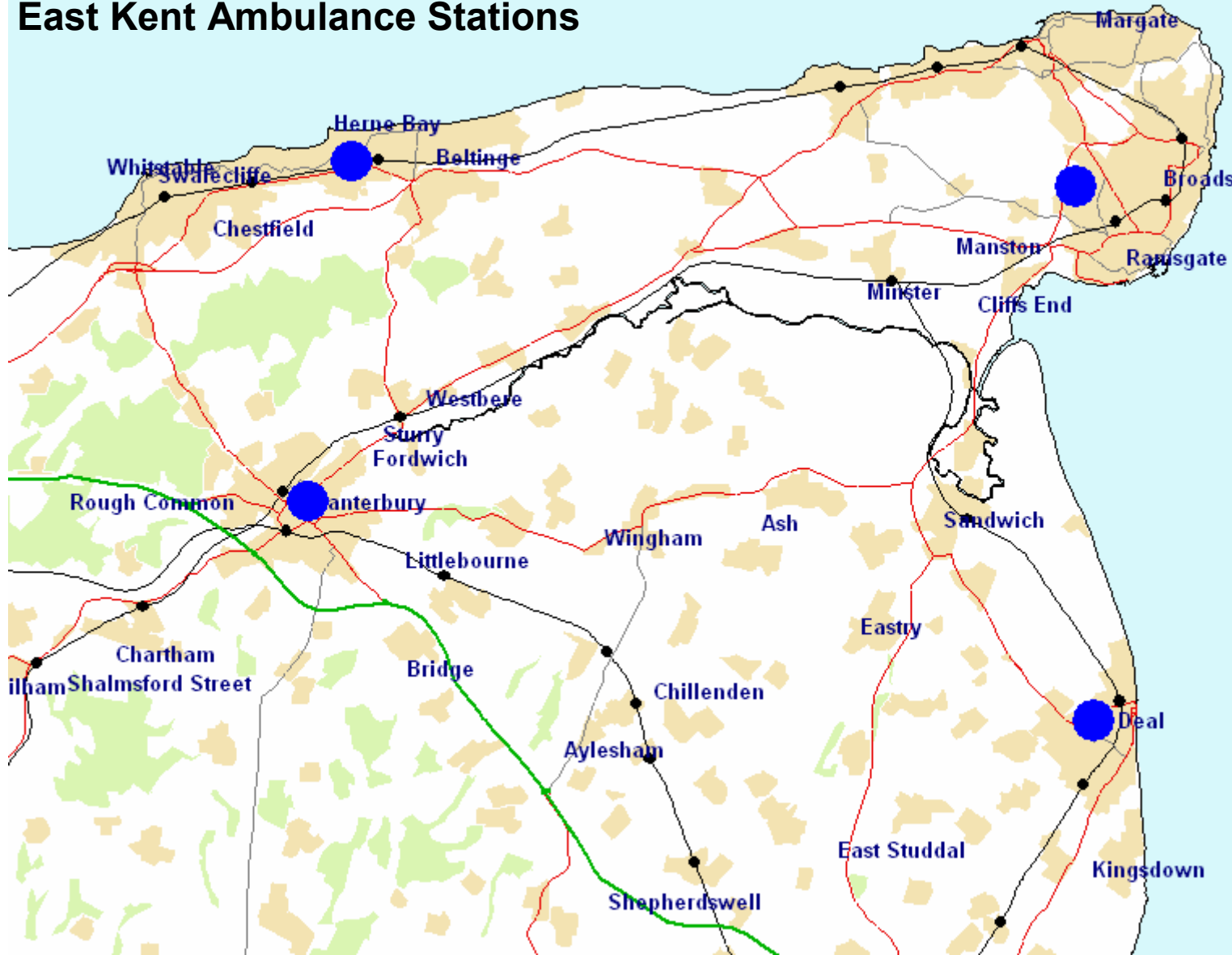




# Kent Ambulance Station Structure

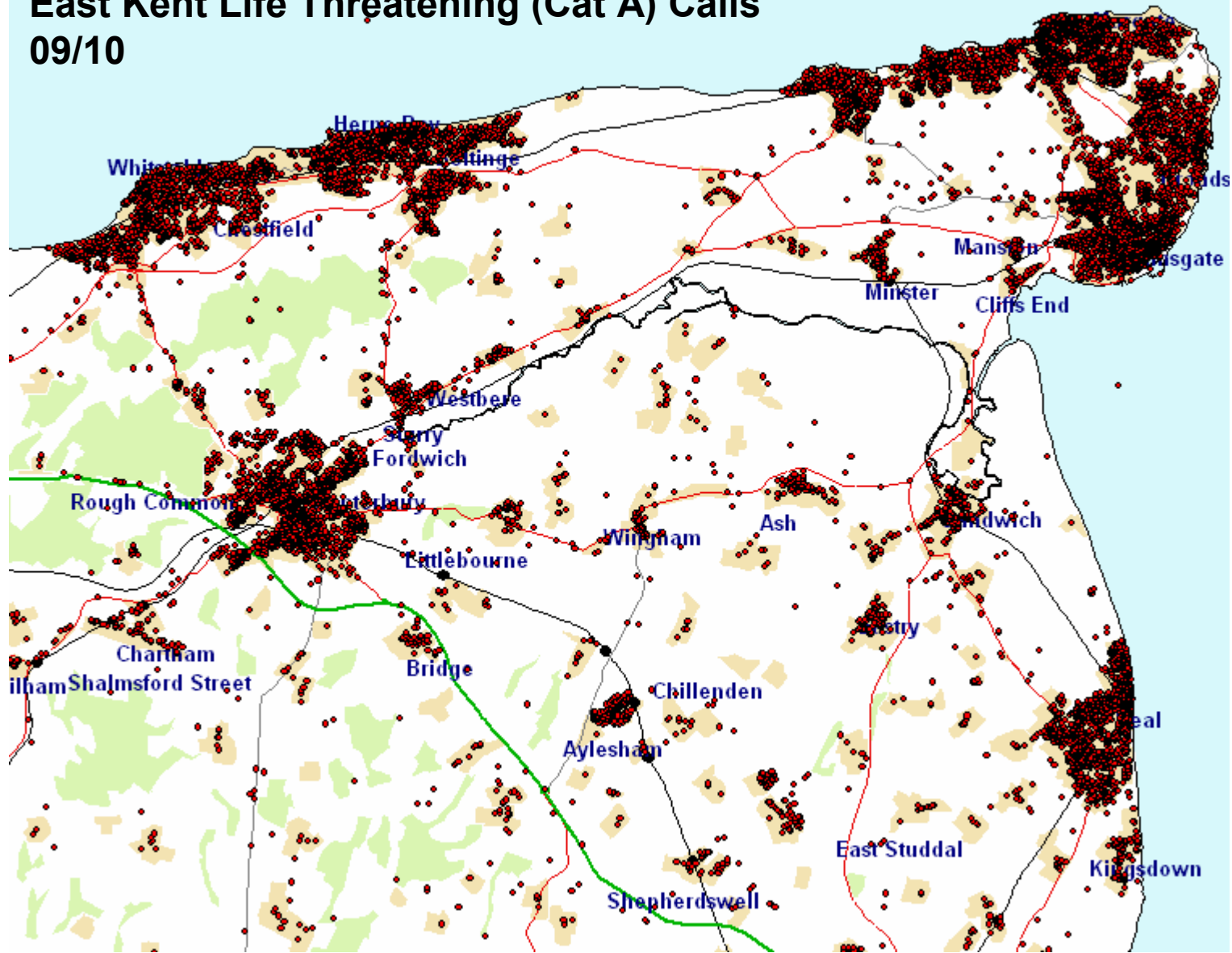


# East Kent Ambulance Stations



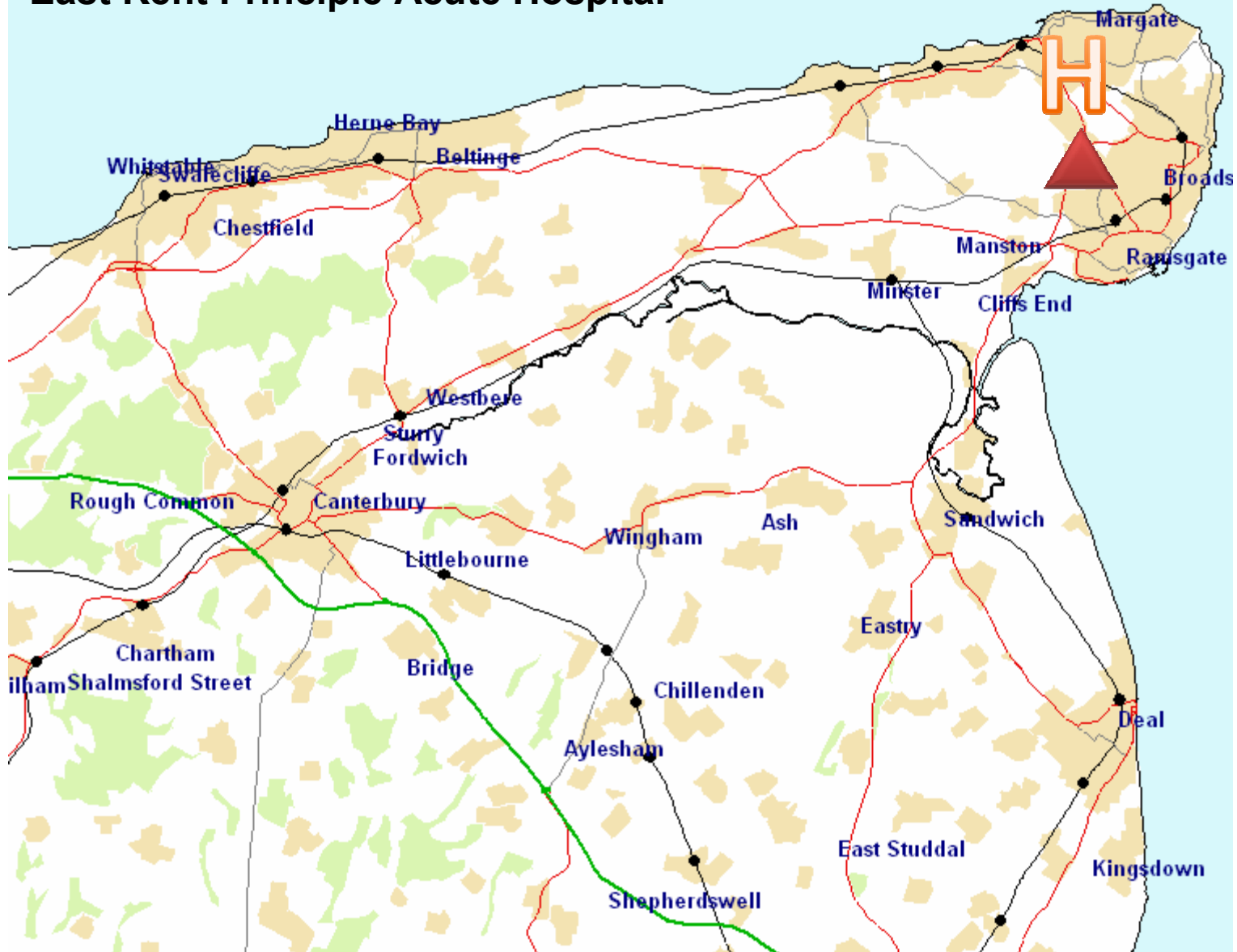
# East Kent Life Threatening (Cat A) Calls

09/10

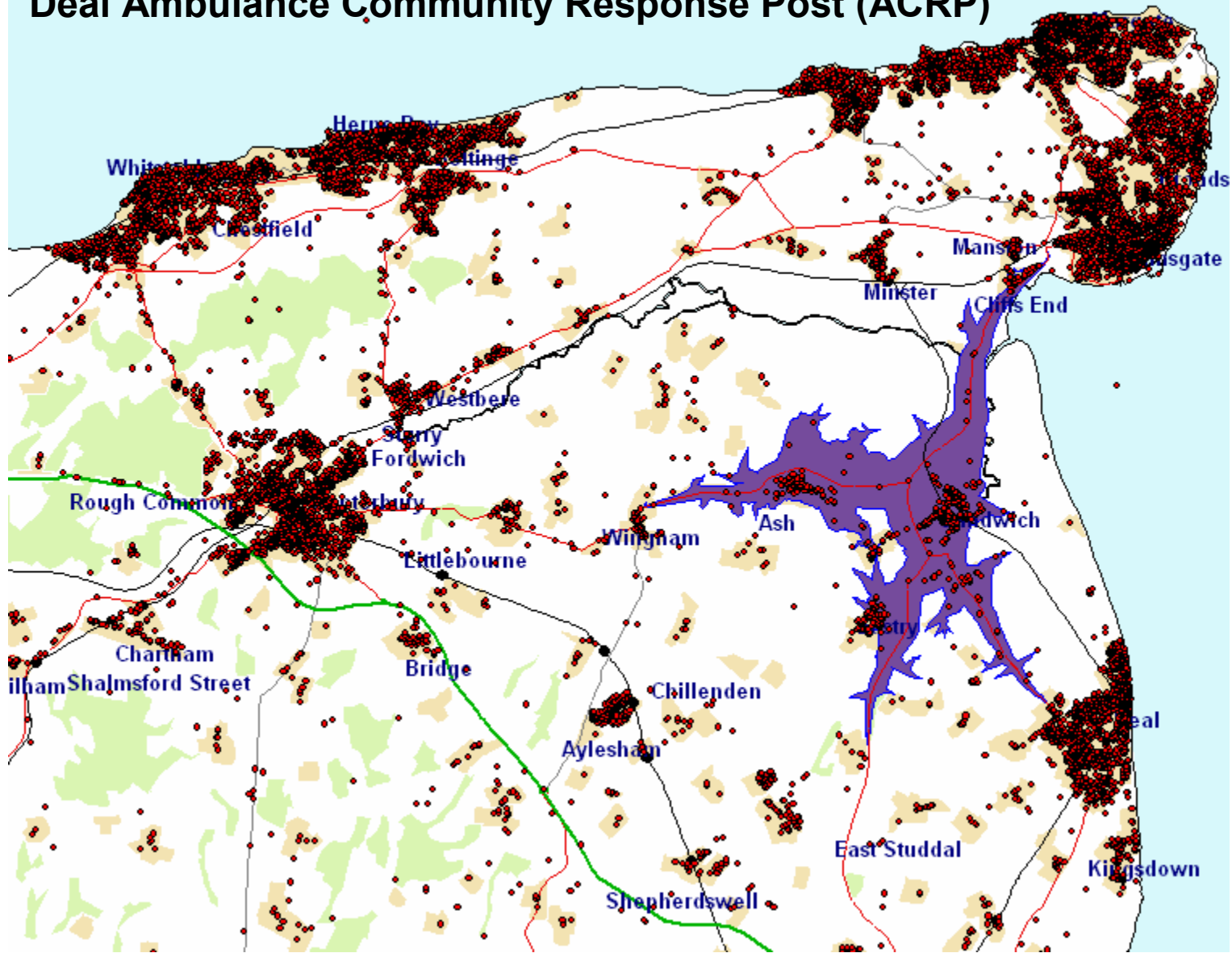




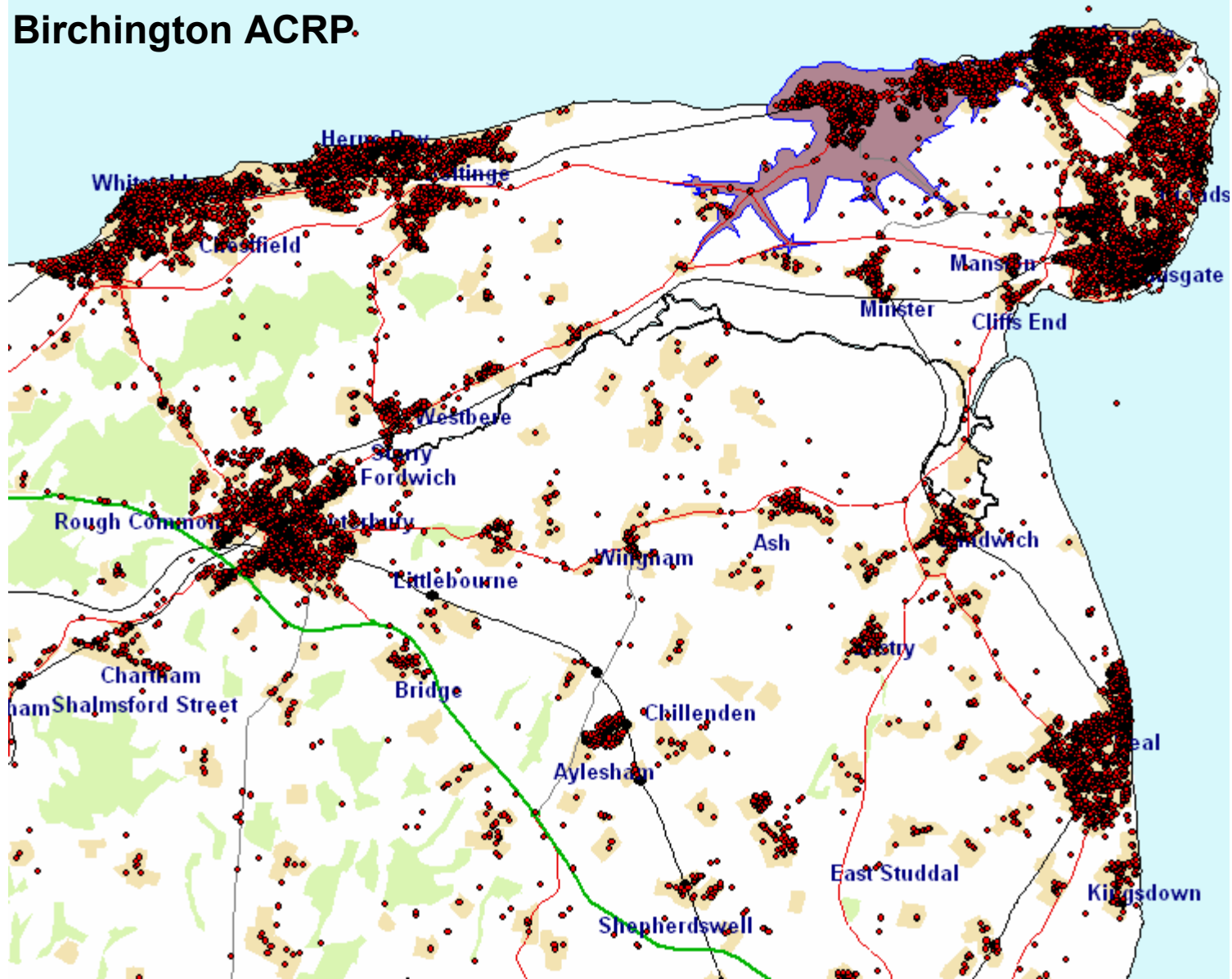
# East Kent Principle Acute Hospital



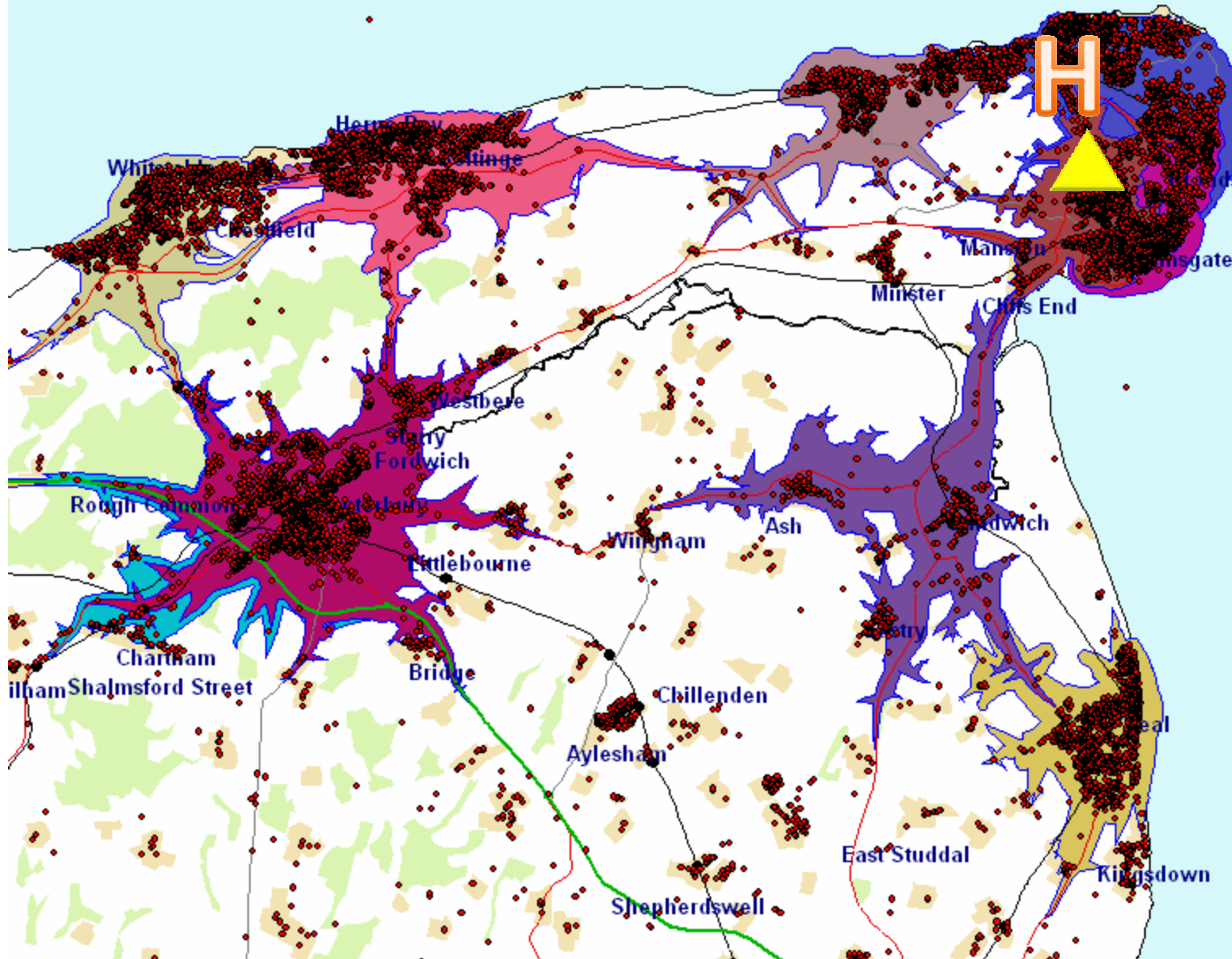
# Deal Ambulance Community Response Post (ACRP)



# Birchington ACRP



## 10 ACRPs Located In Line With Patient Demand








# Improved infection control through deep cleaning programme

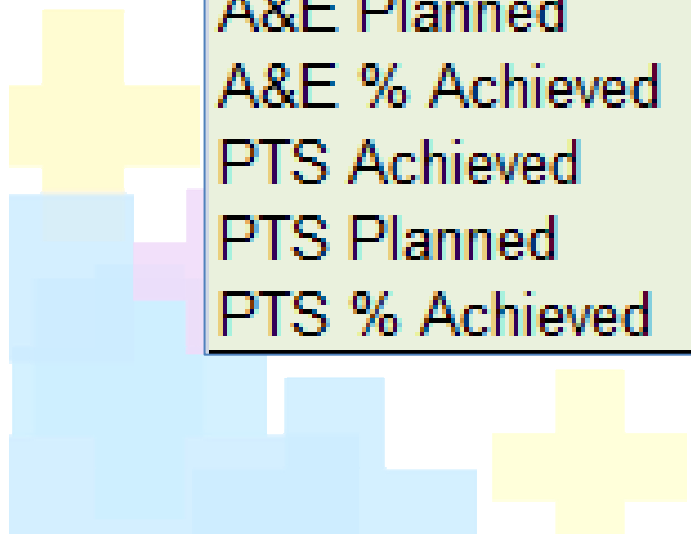
- Undertaken every six weeks
- Linked to vehicle servicing schedule
- All equipment removed
- Vehicle serviced
- Vehicle deep cleaned
- Vehicle restocked





# Key Performance Indicators

Year	09/10	
Month	(All)	
Sum of HASTINGS		
<b>Vehicle Deep Cleaned</b>		<b>Total</b>
A&E Achieved		152
A&E Planned		158
A&E % Achieved		96.2%
PTS Achieved		431
PTS Planned		454
PTS % Achieved		94.9%





# Monthly Swab Testing

Eclipse Scientific Group, Medcalf Way  
Bridge Street, Chatteris  
Cambridgeshire, PE16 6QZ  
Telephone: 01354 695858  
Fax: 01354 692215  
E-Mail: enquiries@esglabs.co.uk  
Web Site: www.eclipsescientific.co.uk



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## TEST CERTIFICATE

Mr Roland Conn  
Lightbridge Support Services  
1 Stangate House  
Stanwell Road  
Penarth  
CF64 2AA  
Fax: 0208 7560845

Certificate Number: TOHT296774-1 Final

Order Number: Secamb-Kent

Date Analysis Started: 04/09/2008

Date Reported: 08/09/2008

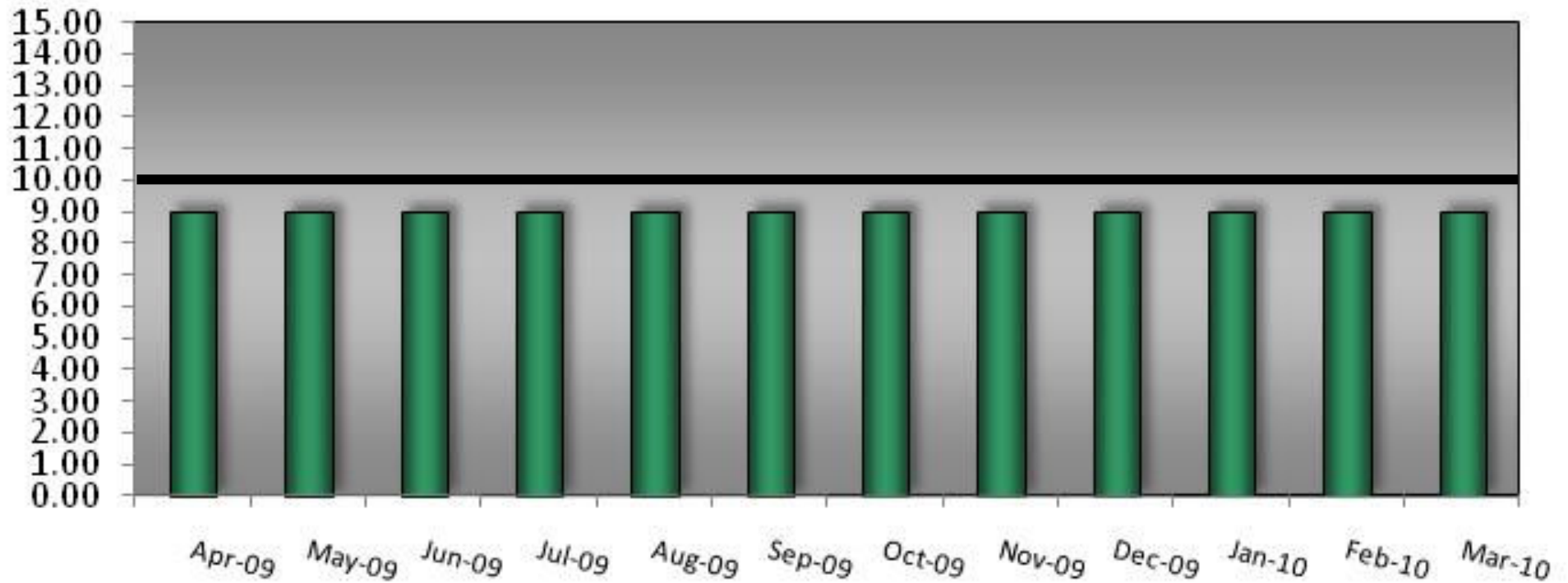
Lab Ref.	Sample Details	Method Number	Test	Result	Units	Flag
OHT1184370	Desc: Medway 394 - Trolley Mattress. Sampled on 03/09/08 @ 02:10. Received Date: 04/09/2008 Order No: secamb-kent ARF No: 151015 Suffit: tvc, ent,staph Contact: Roland Conn	ESGM-M300	Total Viable Count, 3 days 30°C	10	cfu / Area Swabbed	
		ESGM/303	Enterobacteriaceae (presumptive)	<10	cfu / Area Swabbed	
		ESGM-M307	Staphylococcus aureus	<1	cfu / Area Swabbed	
OHT1184371	Desc: Medway 394 - Front Patient Seat. Sampled on 03/09/08 @ 02:12. Received Date: 04/09/2008 Order No: secamb-kent ARF No: 151015 Suffit: tvc, ent,staph Contact: Roland Conn	ESGM-M300	Total Viable Count, 3 days 30°C	<10	cfu / Area Swabbed	
		ESGM/303	Enterobacteriaceae (presumptive)	<10	cfu / Area Swabbed	
		ESGM-M307	Staphylococcus aureus	<1	cfu / Area Swabbed	



# Trust Vehicles – CDiff Profile

## Clostridium Difficile

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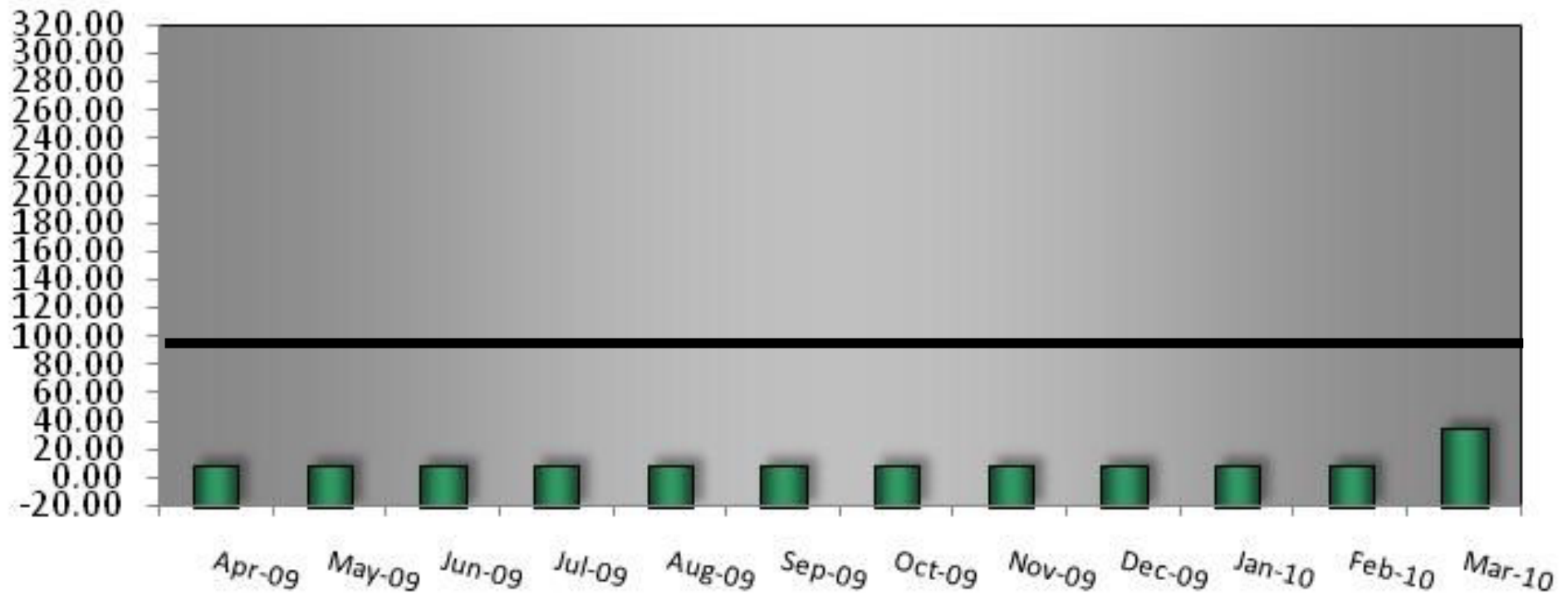




# Trust Vehicles - Enterobacteracea Profile

## Enterobacteracea

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# Benefit Analysis – in summary

- Improvements to patient & staff safety
- “Liberate” clinician time lost currently at start, during and end of shifts
- Reduce stock through improved management and reduced wastage
- Standardise equipment on every vehicle
- Reduce overall fleet size, through better use
- Improve infection control rates
- Reduce vehicle break downs
- Improved management of staff and issues through on site management presence
- Benefits through economies of scale
- Meet environmental standards
- Modernise the estate
- Reduce estates running costs.
- Improve work/life balance for staff through introducing a variety of shift patterns



# Q&A Session



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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 3 September 2010

Subject: Item 5. Intended Outcomes: the Future of PCT Provider Services and the use of Community Hospitals

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## 1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.

(2) This paper is intended to be a way to progress towards achieving these twin aims. Two sets of questions are set out below, both of which the meeting will look to having answered by the end of the meeting: the strategic, overarching questions, and the more detailed questions. The detailed questions were those submitted to both Primary Care Trusts in advance of the meeting on 14 May, which representatives from the NHS were unable to attend, and to which updated answers have been requested.

## 2. Hierarchy of Questions

### (1). Overarching Questions

- a) What are the main challenges in the way of delivering first class community health services for the people of Kent?
- b) How can the Health Overview and Scrutiny Committee help to achieve this goal?

### (2). Detailed Questions

- a) What decisions have been made about the future direction of community services in Kent?
- b) What is the timeline of key organisational and service changes?
- c) What are the plans for the use and development of community hospitals in the future?
- d) Do you have plans for any public consultations as a result of changes to community services community hospitals?
- e) Can you outline the differences between the commissioner and the provider functions of your organisation?
- f) What services does your PCT Provider Service (PCTPS) provide?
- g) How many staff are employed by your PCTPS, and what staff groups does this include?

- h) Specifically, what role do health visitors play within community services, how many are currently employed, and how many have been employed in each of the last five years?
- i) How many properties, including the community hospitals, does your PCTPS own or manage?
- j) What are the governance arrangements of your PCTPS and how does this connect with the commissioning side of the PCT?
- k) How much is spent on community services each year?
- l) How are community services commissioned and funded?
- m) What may be the impact of the current financial situation?
- n) What role have other organisations played in the development of your proposals – for example the Kent LINK, other PCTs, other provider Trusts in Kent and Medway, NHS South East Coast?
- o) What is the definition of a ‘community hospital’?
- p) What is the difference between the community hospitals you are responsible for and hospitals like the Royal Victoria Hospital in Folkestone run by an Acute Trust?
- q) Can you provide a list of what services you currently provide at each community hospital?
- r) Are there any plans to add to or remove any of these services in the future?
- s) Where are Minor Injury Units (MIUs) provided and how do the services delivered here differ from those provided in acute settings such as Accident and Emergency Departments and Emergency Care Centres?
- t) Have you any plans to develop/change MIU provision?
- u) Are there any inpatient beds at your community hospitals?
- v) If there are, how many are there and what is the average length of stay?
- w) How do community hospitals work with other Trusts and Social Services (such as receiving patients discharged from Acute Trusts)?

### **3. Recommendations**

- (a) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

Background Note.

By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 3 September 2010

Subject: Item 5. The Future of PCT Provider Services and the Use of Community Hospitals.

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## 1. The Future of PCT Provider Services

- (a) Community health services cover a range of services provided by a variety of organisations and staff groups including community nurses, health visitors, community dentistry, physiotherapy, and community rehabilitation. Since their establishment, the vast majority of Primary Care Trusts both *commissioned* and *provided* these services.
- (b) The policy direction over the last few years has been towards the increasing separation of the commissioner and provider functions of PCTs<sup>1</sup>. The development of the options for the provider arms is often referred to as Transforming Community Services (TCS).
- (c) A deadline of 31 March 2010 was set for PCTs to have “agreed with SHAs proposals for the future organisational structure of all current PCT-provided community services.”<sup>2</sup> A further deadline of 31 March 2011 was set for the “Implementation of any new provider form ... or very substantial progress to have been made towards the new organisational form, meeting the milestones agreed on approval with the SHA towards final implementation.”<sup>3</sup>
- (d) Following the General Election, information as to the policy of the new administration towards community services was contained in the *Revision to the NHS Operating Framework*<sup>4</sup> and the NHS White Paper, *Equity and Excellence: Liberating the NHS*. The following is an extract from the White Paper:

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<sup>1</sup> Department of Health, *NHS Next Stage Review: Our Vision for Primary and Community Care*, 3 July 2008, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalassets/dh\\_085947.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalassets/dh_085947.pdf)

<sup>2</sup> Department of Health, 16 December 2009, *The NHS Operating Framework for England for 2010/11*, p.42, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh\\_110159.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_110159.pdf)

<sup>3</sup> Department of Health, 5 February 2010, *Transforming Community Services: The assurance and approvals process for PCT-provided community services*, p.3, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_112146.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112146.pdf)

<sup>4</sup> Department of Health, 21 June 2010, *Revision to the NHS Operating Framework in England 2010/11*, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_116860.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116860.pdf)

“The Government will apply a consistent approach across all types of NHS services. We will end the uncertainty and delay about the future of community health services currently provided within PCTs. We will complete the separation of commissioning from provision by April 2011 and move as soon as possible to an ‘any willing provider’ approach for community services, reducing barriers to entry by new suppliers. In future, all community services will be provided by foundation trusts or other types of provider.”<sup>5</sup>

- (e) The NHS White Paper also discussed the abolition of Primary Care Trusts “from April 2013.”<sup>6</sup> For reference, a timeline of the key proposals within the White Paper is contained in the Appendix.
- (f) The recent NHS White Paper contained within it the aim to “accelerate the development of currencies and tariffs for community services.”<sup>7</sup> One of the White Paper supporting documents stated, “Monitor and the NHS Commissioning Board will need to work closely together in deciding which services should be subject to national tariffs, and in developing appropriate currencies for pricing and payment purposes. Currencies will identify units of services for payment purposes and may have a direct impact upon incentives.”<sup>8</sup>
- (g) The NHS White Paper contained the following section on the future of Foundation Trusts:

“Our ambition is to create the largest and most vibrant social enterprise sector in the world. The Government’s intention is to free foundation trusts from constraints they are under, in line with their original conception, so they can innovate to improve care for patients. In future, they will be regulated in the same way as any other providers, whether from the private or voluntary sector. Patients will be able to choose care from the provider they think to be the best. As all NHS trusts become foundation trusts, staff will have an opportunity to transform their organisations into employee-led social enterprises that they themselves control, freeing them to use their front-line experience to structure services around what works best for patients. For many foundation trusts, a governance model involving staff, the public and patients works well but we recognise that this may not be the best model for all types of foundation trust, particularly smaller organisations such as those providing community services. We will consult on future requirements: we envisage that some foundation trusts will be led only

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<sup>5</sup> Department of Health, 12 July 2010, *Equity and Excellence: Liberating the NHS*, p.37, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117352.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf)

<sup>6</sup> Ibid., p.53.

<sup>7</sup> Department of Health, 12 July 2010, *Equity and Excellence: Liberating the NHS*, p.25, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117352.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf)

<sup>8</sup> Department of Health, 26 July, 2010, *Liberating the NHS: Regulating healthcare providers. A consultation on proposals*, p.16, [http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_117782](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117782)

by employees; others will have wider memberships. The benefits of this approach will be seen in high productivity, greater innovation, better care and greater job satisfaction. Foundation trusts will not be privatised.”<sup>9</sup>

## 2. Community Hospitals

- (a) The Department of Health have provided the following definition of a community hospital:

(1) “A modern community hospital service aims to provide an integrated health and social care resource for the local population to which it belongs. These local facilities develop as a result of agreements between local people, service providers and the NHS. Community hospitals are an effective extension to primary care with medical support provided largely by GPs. The health and social care provided may include medical care, rehabilitation, palliative care, intermediate care, mental health care, maternity care, surgical care and emergency care. Community hospital care is characterised by care pathways that make the most of local sources of support. The community hospital provides a focus for local community networks.”<sup>10</sup>

- (b) Eastern and Coastal Kent Community Services are responsible for the services at Faversham Cottage Hospital, Queen Victoria Memorial Hospital (Herne Bay), Sheppey Community Hospital (Minster), Sittingbourne Memorial Hospital, Victoria Hospital (Deal) and Whitstable and Tankerton Hospital.
- (c) West Kent Community Health is responsible for the services at Edenbridge and District Memorial Hospital, Gravesham Community Hospital (Gravesend), Hawkhurst Community Hospital, Livingstone Hospital (Dartford), Sevenoaks Hospital, and Tonbridge Cottage Hospital.
- (d) In most areas, community hospitals are part of the PCT estate and will remain with the commissioner. The following is the relevant extract from *Transforming Community Services*:-

“Therefore, In order to maintain the maximum freedom of choice, commissioners should plan on the basis that they will retain direction over estate and that providers should be tenants, not owner-occupiers.”<sup>11</sup>

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<sup>9</sup> Department of Health, 12 July 2010, *Equity and Excellence: Liberating the NHS*, p.36, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117352.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf)

<sup>10</sup> E-mail from Department of Health Customer Service Centre, 18 November 2008, DH Ref: DE00000363761.

<sup>11</sup> Department of Health, 13 January 2009, *Transforming Community Services: Enabling new patterns of provision*, p.72, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_093196.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093196.pdf)

- (e) NHS Medway (the provider arm of NHS Medway) is responsible for St. Bart's Hospital in Rochester, Wisdom Hospice in Rochester and three Healthy Living Centres across Medway.
- (f) The Royal Victoria Hospital at Folkestone and Buckland Hospital at Dover are part of East Kent Hospitals University NHS Foundation Trust.

## Appendix – White Paper Timetable

- (a) The timetable below that contained in the NHS White Paper and outlines the Government’s proposed timetable (subject to Parliamentary approval for legislation) for the commitments contained within the paper<sup>12</sup>.

Commitment	Date
Further publications on: <ul style="list-style-type: none"> <li>• framework for transition</li> <li>• NHS outcomes framework</li> <li>• commissioning for patients</li> <li>• local democratic legitimacy in health</li> <li>• freeing providers and economic regulation</li> </ul>	July 2010
Report of the arm’s length bodies review published	Summer 2010
Health Bill introduced in Parliament	Autumn 2010
Further publications on: <ul style="list-style-type: none"> <li>• vision for adult social care</li> <li>• information strategy</li> <li>• patient choice</li> <li>• a provider-led education and training</li> <li>• review of data returns</li> </ul>	By end 2010
Separation of SHAs’ commissioning and provider oversight functions	
Public Health White Paper	Late 2010
Introduction of choice for: <ul style="list-style-type: none"> <li>• care for long-term conditions</li> <li>• diagnostic testing, and post-diagnosis</li> </ul>	From 2011
White Paper on social care reform	2011
Choice of consultant-led team	By April 2011
Shadow NHS Commissioning Board established as a special health authority	April 2011

<sup>12</sup> Department of Health, 12 July 2010, *Equity and Excellence: Liberating the NHS*, p.51-53, [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117352.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf)

Arrangements to support shadow health and wellbeing partnerships begin to be put in place	April 2011
Quality accounts expanded to all providers of NHS care	
Cancer Drug Fund established	
Choice of treatment and provider in some mental health services	From April 2011
Improved outcomes from NHS Outcomes Framework	
Expand validity, collection and use of PROMs	
Develop pathway tariffs for use by commissioners	
Quality accounts: nationally comparable information published	June 2011
Report on the funding of long-term care and support	By July 2011
Hospitals required to be open about mistakes	Summer 2011
GP consortia established in shadow form	2011/12
Tariffs: <ul style="list-style-type: none"> <li>• Adult mental health currencies developed</li> <li>• National currencies introduced for critical care</li> <li>• Further incentives to reduce avoidable readmissions</li> <li>• Best-practice tariffs introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs, and some orthopaedic surgery</li> </ul>	2011/12
NHS Outcomes Framework fully implemented	By April 2012
Majority of reforms come into effect: <ul style="list-style-type: none"> <li>• NHS Commissioning Board fully established</li> <li>• New local authority health and wellbeing boards in place</li> <li>• Limits on the ability of the Secretary of State to micromanage and intervene</li> <li>• Public record of all meetings between the Board and the Secretary of State</li> <li>• Public Health Service in place, with ring-fenced budget and local health improvement led by Directors of Public Health in local authorities</li> <li>• NICE put on a firmer statutory footing</li> <li>• HealthWatch established</li> <li>• Monitor established as economic regulator</li> </ul>	April 2012
International Classification of Disease (ICD) 10 clinical diagnosis coding system introduced	From 2012/13
NHS Commissioning Board makes allocations for 2013/14	Autumn

direct to GP consortia	2012
Free choice of GP practice	2012
Formal establishment of all GP consortia	
SHAs are abolished	2012/13
GP consortia hold contracts with providers	April 2013
PCTs are abolished	From April 2013
All NHS trusts become, or are part of, foundation trusts	2013/14
All providers subject to Monitor regulation	
Choice of treatment and provider for patients in the vast majority of NHS-funded services	By 2013/14
Introduction of value-based approach to the way that drug companies are paid for NHS medicines	
NHS management costs reduced by over 45%	By end 2014
NICE expected to produce 150 quality standards	By July 2015

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## KENT ADULT SOCIAL SERVICES

Written Submission to the Health Overview and Scrutiny Committee  
Meeting 3 September 2010

### THE FUTURE OF PCT PROVIDER SERVICES AND THE USE OF COMMUNITY HOSPITALS

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Summary:

- Opportunity for joint cost reductions
  - Personalisation and Choice
  - Early Intervention and Prevention
  - Provision of Care Closer to Home
  - Integrated working
  - System of incentives
- 

#### INTRODUCTION

1. Kent Adult Social Services (KASS) welcomes the opportunity to submit this evidence to the Health Overview and Scrutiny Committee (HOSC) in its consideration of aspects of the *Transforming Community Services*.
2. The views of KASS expressed in this submission are against the background of long standing partnership arrangements with NHS organisations in Kent that cover older people, mental health and learning disabilities services, from the strategic multi-agency team and the case management levels.
3. The need to work together to improve the lives of the people of Kent, at a time when we face the twin challenges of rising demand (due to the impact of demographical changes) and reducing public funding is compelling.
4. Equally compelling, is the need to ensure improved user experience brought about through locally integrated services that deliver better health outcomes which is derived from flexible and responsive approaches whilst enabling people to exercise more choice and control. This will result in people being able to stay at home for as long as possible and with fewer unplanned admissions to hospital and long term residential care and is in line with the policy set out in the Government's recent White Paper :” Equity and Excellence, Liberating the NHS “.

#### EVIDENCE

##### Opportunity for joint cost reductions

5. The *Total Place* national reports provide evidence of the benefits that may be realised by public services which are prepared to seize the opportunity to redesign how facilities and other assets are used. These could be combined to deliver improved services and thereby secure financial and non-financial efficiencies.

KASS is of the view that is an area that HOSC may wish to pursue and test the extent to which the NHS community service organisations in Kent are willing to explore the potential opportunities.

6. At one end of the spectrum, it is possible to envisage arrangements where shared systems and approaches can lead to cost reductions. Although this will be challenging, partly as a result of the need to overcome organisational, cultural and professional barriers, we are confident there is collective will to put strategy in place to overcome them.

### **Personalisation and Choice**

7. KASS observes that the transformation changes taking place across adult social care has its equivalent programme in the NHS. The foundation of this is captured in the Next Stage Review by Lord Darzi (*Department of Health, 2008*) and more recently in the Government's White Paper: " *Equity and Excellence, Liberating the NHS* " .
8. KASS supports any move that leads to people being offered choice and control over how they are supported. This position underlies why KASS is supporting NHS Eastern and Coastal Kent's Personal Health Budget pilot. We believe that we can work together by influencing the market and encourage improved choice for people through commissioning personalised service, which individuals can choose through their personal budgets.

### **Early Intervention and Prevention**

9. KASS is aware of the growing evidence base of the efficacy of early intervention and preventative services that we know can prevent or delay older people from needing more expensive support services. The headline report shows that the reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every extra £1 spent on the *Partnerships for Older People Projects* (POPPs) services, there had been approximately a £1.20 additional benefit in savings on emergency bed days.
10. Furthermore, through the implementation of pro-active case coordination services visits to A+E departments fell by 60%, hospital overnight stays were reduced by 48%, phone calls to GP's fell by 28%, visits to practice nurses reduced by 25% and GP appointments reduced by 10% (*National Evaluation of the Partnerships for Older People Projects: final report, January 2010*).
11. The place of preventative services should therefore form part of the consideration of changes to community services. This should not be limited to services delivered that are delivered from fixed locations. In addition, we place a high value on the NHS making use of 'out-reach' models of care as part of these changes.

## Provision of Care Closer to Home

12. We strongly believe that this is the chance for making 'Care Closer to Home' a reality. The changes under consideration must include investment in different forms of NHS rehabilitation services for the most vulnerable people in the community whose need for non-acute care may be as a result of stroke, dementia, falls or end-of-life.
13. We believe that the provision of 'assessment/step down beds' which allow patients to be assessed away from the acute site is essential. Not only would this help improve the quality of assessment but also lead to better patient experience. Moreover, it would free-up acute beds at a quicker rate, and reduce the number of delayed transfers of care.
14. We would advocate that the provision of 'emergency nursing respite' should be in place so that those eligible for nursing care can be looked after if their carers become ill, or if their carers require respite. The contribution of carers is estimated at between £67bn and 87bn (*Carers UK, 2007*). It is essential that the proposed changes should be taken forward in a way that positively address better support for carers
15. The KASS position in regards to the use of community hospitals is that their role within the health care system should be reviewed and re-defined, to incorporate a mixture of the above services.

## Integrated working

16. KASS and the Primary Care Trusts have maintained an effective joint working approach within the new commissioning systems and structure despite the inherent challenges. In addition to addressing the modernisation of existing services and working within a tight resource position, a number of joint funded initiatives and partnership projects have been implemented. Examples are:
  - Dementia Collaborative Pilot (incorporating DementiaWeb and Dementia Helpline)
  - POPPS (INVOKE)
  - Whole System Demonstrator Project (WSD)
  - Westview, Westbrook House and Broadmeadow (rehab and recuperation)
  - C4 Project (Canterbury)
17. While these projects have provided an insight into future commissioning practices and services which benefit the public, they have also presented some challenges in terms of joint-working. Provider services, community hospitals and KASS are, in essence, part of one system and aligning the strategies of each so that planning and performance is measured similarly is crucial.

18. A key part of planning and performance management is the evaluation of services and projects. The review of services is not always possible in a joint-working structure because of the difficulties inherent when combining different systems and agendas. A consistent approach to evaluation and performance management would be welcomed.

### **System of incentives**

19. The implications of the separation of commissioning function and from those of a provider of community services in the NHS need to be further analysed in order to identify the full range of opportunity, both in joint commission and joint provision. This would include understanding the implications of the 'tariff system' in so far as it affects the operations of primary and secondary care services. The HOSC may wish to explore this area to better understand how it may affect future operations.

### **Conclusion**

20. KASS would wish to maintain its collaboration with as set out in the NHS Eastern and Coastal Kent's *Community Services Commissioning Strategy 2009-2013* and the *NHS West Kent's Best Possible Strategic Commissioning Plan 2010-2015*
21. We are in no doubt that HOSC would wish to explore what each PCT is planning to put together under the proposed arrangement. In particular, to assess what this means in terms of opportunities and benefits in terms of improved outcomes for patients.
22. In conclusion, there are opportunities for the NHS to work with KASS and other partners, focused on bringing together service arrangements that can truly deliver improvements for the people of Kent. Health and social care services in the community can be redesigned in order to provide a more integrated service in the community that lead to better outcomes and long term efficiencies. This would be greatly advanced if assistive and mobile technology use is given a central role.

**Oliver Mills**  
**Managing Director**  
**Kent Adult Social Services**  
**20 August 2010**

#### Officer contact details:

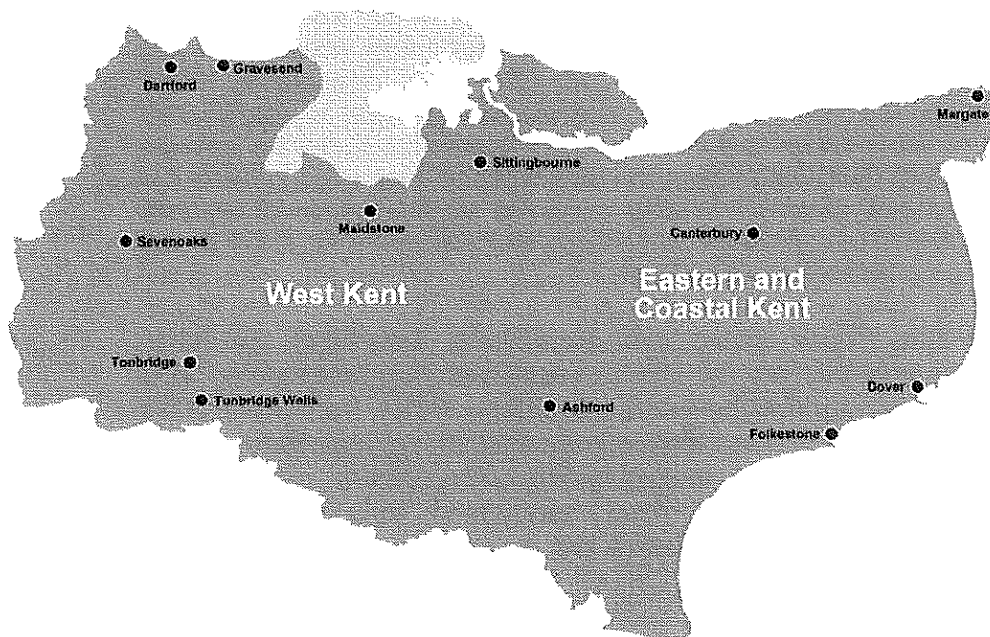
Anne Tidmarsh  
Director of Commissioning and Provision (East)  
[anne.tidmarsh@kent.gov.uk](mailto:anne.tidmarsh@kent.gov.uk)  
Tel: 01227 598840

## The Future of PCT Provider Services

Overview of NHS Eastern and Coastal Kent and NHS West Kent  
Health Overview and Scrutiny Committee – 3 September 2010

### Context

The map below shows the geography covered by NHS Eastern and Coastal Kent (ECK) and NHS West Kent (WK) and their respective community services. They collectively cover a population of 1,366,208, (ECK – 710,483 and WK – 655,725) delivering services predominately in people's homes, in community hospitals, health centres and clinics.



### Introduction

This paper by NHS Eastern and Coastal Kent (ECK) and NHS West Kent (WK) provides members of the committee with an overview of the current position regarding the future of PCT Provider Services and responds to the questions posed in Mr Wickenden's letter of 16 July 2010

This paper provides a summary of the current community services proposals for Kent and responds to the two overarching questions posed by the committee:

- What are the main challenges in the way of delivering first class community health services for the people of Kent?
- How can the Health Overview and Scrutiny Committee help to achieve this goal?

Section 2 (as Appendix A) provides answers to any specific questions that are not answered in Section 1.

## **SECTION 1: The Future of PCT Provider Services**

*This section will answer questions one, two, ten, thirteen and fourteen posed by the committee.*

### **1.0 National Context**

1.1 The *Transforming Community Services* national programme has been in place for over two years, accelerated during the last six months of the previous government. The programme required that by 31 March 2010 PCTs would have agreed proposals for the future organisational structure for all current PCT-provided community services with implementation of the new organisational form, or very substantial progress made, by March 2011. This was accelerated further by the Coalition Government reflected in the NHS Operating Framework for 2010/11 "*Separating PCT commissioning from the provision of services remains a priority. This must be achieved by April 2011, even if this means transferring services to other organisations while sustainable medium-term arrangements are identified and secured...Existing approved applicants for Community Foundation Trusts, however, should continue to prepare for the first step of being established as NHS Trusts.*"

1.2 The White Paper '*Equity and excellence: Liberating the NHS*' supports the delivery of this by separating commissioning and provision throughout the NHS, abolishing PCTs from April 2013 and Strategic Health Authorities in April 2012. An associated paper '*Liberating the NHS: regulating healthcare providers*' sets out how providers will be freed from centralised through the NHS Foundation Trust process. and will fall under a new system of regulation.

### **2.0 Local Context**

2.1 For many months work has been underway developing first class community services across Kent. Some of the challenges faced included:

- Ensuring strong alignment and integration with Kent County Council and social care.
- Allowing integration of clinical services with other sectors and agencies at a patient, rather than organisational level.
- Meeting the broad spectrum of health needs associated with the demographics and health inequalities of Kent.
- Ensuring best practice across the whole county which supports efficient ways of working.
- Providing choice to patients in a geographical area that hinders competition in the eastern and southern parts of

Kent.

- Ensuring care traditionally delivered in hospital can be safely and appropriately delivered in the community especially in the care of children, treatment of long term conditions, rehabilitation and end of life care.
- Harnessing strong community engagement and involvement in community services.
- Delivering the PCTs' Strategic Commissioning Plans in the current economic climate.
- Ensuring effective economies of scale in a tough economic climate with a reduction in overheads and an increasing level of productivity and efficiencies.
- Maintaining good staff engagement and satisfaction and ensuring NHS staff terms and conditions are retained during organisational change.
- Ensuring GP commissioning, as it evolves, is strongly linked to community care, whilst maintaining governance and safety.

2.2 In order to meet these challenges both ECK and WK have made recommendations on future function and form for their provider services to their Boards.

2.3 In September 2009 ECK confirmed its intention to move its provider services towards a Community NHS Foundation Trust model. This builds on the track record of joint working and integration between its provider services and other agencies and sectors such as KCC social services and primary care. It provides real opportunity for further integration through a proposed clinical operating model between the community service, social care and GP commissioning. It also builds on the commitment to initiatives such as Total Place and Gateways.

2.4 In January 2010 ECK submitted a business case to NHS South East Coast (SECSEA) and the Department of Health (DH) to become an NHS Trust in its own right (a separate legal entity), which would then seek NHS Foundation Trust status. At the end of February 2010 ECK were informed that their provider services had been successful in their bid to become a separate NHS Trust, subject to ratification by the DH Transactions Board. ECK is one of eight PCT provider services in England to be on this path. This will result in ECK provider services being a separate NHS Trust from 1 October 2010.

2.5 WK's Board agreed to an integration of its community services with those of ECK in March 2010, with core community services focused around GP commissioning clusters. This integration supports the resolution of challenges set out above whilst providing both clinical and management integration to meet the financial demands of the current economic climate.

2.6 SECSHA agrees with the PCTs that such an integration across Kent could provide considerable efficiency gains and reduction in management costs with the following benefits:

- Sharing clinical expertise and best practice across the county.
- Wider access and greater choice for patients especially at the current PCT borders.
- Reduced service inequalities.
- Greater integration between health, KCC and social care to realise the benefits of single assessment processes, personal health budgets for health and social care and a single point of access for referrals, carers and clients/patients .
- A stronger community focus with locality working across the 12 districts of Kent within a community ownership framework possible through the NHS Foundation Trust model.
- Strengthened opportunities for innovation, clinical careers, audit and research.
- Improved interface with the acute sector with standardised approaches, for example in hospital discharges.
- A strong community employer working with the voluntary sector, volunteers and local communities.
- The opportunity for Kent to become a strong, national voice and centre for community service innovation and delivery.
- Reduced duplication of back office functions.

### **3.0 Engagement and Timescales**

3.1 In light of the nationally accelerated timescales the local timeline to deliver this integration includes the following milestones:

*August - September 2010*

Engagement with key stakeholders including Health Overview and Scrutiny Committee, GPs, LINKs and staff on the proposed arrangement.

*September 2010*

PCT Boards agree proposed business case for pan-Kent organisation.

*1 October 2010*

ECK Community Services become Eastern and Coastal Kent Community Health NHS Trust.

*October - December 2010*

Cooperation and Competition Panel assess business case for impact on competition and choice.

*January 2011*

Cooperation and Competition Panel recommendation published.

*1 April 2011*

Integration of WK Community Services with Eastern and Coastal Kent Community Health NHS Trust to form Kent Community Health NHS Trust.

*April 2011 - December 2012 (indicative dates)*

Journey to NHS Foundation Trust status including full public consultation..

- 3.2 Both ECK and WK have undertaken staff and partner engagement through 2009/10, including direct engagement with HOSC in October 2009 and a paper to the HOSC in May 2010. WK also held a workshop with stakeholders including other NHS Trusts in Kent, in March 2010 to inform their Board decision.
- 3.3 The move of ECK Community Services to separate NHS Trust status is expected to positively impact on the delivery of services as the benefits set out above highlight.
- 3.4 The move to a pan-Kent organisation does not require public consultation under the Local Government and Public Involvement in Health Act 2007. However the establishment of a new NHS Foundation Trust status does require a full 12-week public consultation which will be undertaken in accordance with legislative requirements. ECK and WK and the new community NHS Trust would also undertake separate formal public consultations if any significant clinical service changes were to be proposed, in line with the Act.
- 3.5 Although formal public consultation is not required ECK and WK remain committed to clear communication and engagement throughout the transition. There has already been fruitful engagement with stakeholders including other NHS organisations, Kent LINK and CASE Kent (Community Action South and East Kent). Both Kent LINK and CASE Kent have written letters of support to ECK Community Services becoming an NHS Trust.

- 4.0 How can the Health Overview and Scrutiny Committee help achieve first class community services?**
- 4.1 The PCTs welcome the interest of the Health Overview and Scrutiny Committee as a key stakeholder in helping them in the development of first class community services.
- 4.2 By April next year Kent will be one of only eight community services organisations in the country. This means that the county will benefit from a strong organisation focused on the delivery of high quality community services, not diverted from this by competing priorities of acute and mental health trusts or establishing social enterprises. HOSC members' support for the proposal to build this strong Kent organisation owned by the community (through the NHS Foundation Trust model), with clinicians dedicated to community services would demonstrate their interest in developing high quality services. The organisation will have the capability and capacity to deliver local services in local communities to meet local health needs as identified through the joint needs assessments undertaken with Council colleagues, working alongside GPs and social care.
- 4.3 It is anticipated that the opportunity that this change provides for the communities of Kent will be welcomed by all stakeholders. It provides a more stable and welcome solution for the clinical and support staff providing community services than other options, and facilitates further integration of health and social care to the benefit patients/clients as well as significantly reducing management costs.
- 4.4 We welcome the opportunity to discuss this and gain support from HOSC on 3 September 2010.

**APPENDIX A:**

**SECTION 2: Outstanding Questions and Answers**

*This section will answer specifically questions five, six, seven, eight, nine, eleven and twelve posed by the committee.*

- 1.0 *Can you outline the differences between the commissioner and the provider functions of your organisation? (Question 5)*

The commissioner role is to identify the health needs of the population, in conjunction with other agencies particularly KCC, specify the services required to meet those needs and commission these services, performance managing the NHS and independent sector providers who deliver them.

The provider function is to manage and provide the community services it has been commissioned to deliver to the highest possible standard and to agreed quality and performance measures.

- 2.0 *What services does your PCT Provider Service (PCTPS) provide? (Question 6)*

Both ECK and WK provider services have a portfolio of services to meet local need for both adults and children. Both portfolios also include some specialist services. Although the specifications are different in ECK and WK they broadly cover the same types of services including:

- Community Nursing
- Community Hospital Inpatient and Outpatient Services
- Intermediate Care
- Specialist Nursing and Community Matrons
- Dietetics
- Health Visiting and School Nursing
- Adult Speech and Language
- Outpatient Physiotherapy
- Equipment and Wheelchair Services
- Podiatry
- Sexual Health
- Childrens Community Nursing
- Walk in Centre and Minor Injury Units

As well as others that are specific to each local area.

3.0 *How many staff are employed by your PCTPS, and what staff groups does that include? (as at April 2010) (Question 7)*

Eastern and Coastal Kent		West Kent	
Headcount		Headcount	
<b>Staff Group</b>	<b>Total</b>	<b>Staff Group</b>	<b>Total</b>
Add Prof Scientific and Technical	16	Add Prof Scientific and Technical	3
Additional Clinical Services	731	Additional Clinical Services	393
Administrative and Clerical	845	Administrative and Clerical	387
Allied Health Professionals	463	Allied Health Professionals	210
Estates and Ancillary	190	Estates and Ancillary	116
Healthcare Scientists	4	Healthcare Scientists	4
Medical and Dental	88	Medical and Dental	125
Nursing and Midwifery Registered	1156	Nursing and Midwifery Registered	631
<b>Grand Total</b>	<b>3493</b>	<b>Grand Total</b>	<b>1869</b>
Full Time Equivalent		Full Time Equivalent	
<b>Staff Group</b>	<b>Total</b>	<b>Staff Group</b>	<b>Total</b>
Add Prof Scientific and Technical	11.99	Add Prof Scientific and Technical	2.09
Additional Clinical Services	567.86	Additional Clinical Services	291.85
Administrative and Clerical	665.77	Administrative and Clerical	271.30
Allied Health Professionals	396.59	Allied Health Professionals	157.76
Estates and Ancillary	113.94	Estates and Ancillary	75.95
Healthcare Scientists	2.05	Healthcare Scientists	3.65
Medical and Dental	52.12	Medical and Dental	19.16
Nursing and Midwifery Registered	955.30	Nursing and Midwifery Registered	468.98
<b>Grand Total</b>	<b>2765.62</b>	<b>Grand Total</b>	<b>1290.74</b>

4.0 *Specifically, what role do health visitors play within community services, how many are currently employed, and how many have been employed in each of the last five years?(Question 8)*

Health Visiting teams play a key and fundamental role in the delivery of the Healthy Child Programme 0-5 years. The Healthy Child Programme is a national screening and support programme for children and constitutes a number of assessments to be undertaken at key points in the child's development. This includes delivering a range of services to all families (Universal Service) with additional support offered to families and children who through our Family Health assessment model have been identified as requiring additional support (Progressive Universalism).

All families have a comprehensive assessment, taking into account both Health and Social needs, whilst also considering resilience and protective factors such as additional family support and access to available services. This assessment is undertaken by a qualified Health Visitor.

The key purpose of the service is to ensure that all families have access to a range of assessment and support at key stages in their baby and child's life, and also includes promotion of healthy lifestyle choices to all families. This aims to engage in and promote key health priorities such as raising breast feeding rates, early identification of Postnatal Depression, increase immunisation uptake, reduce obesity, smoking and substance misuse, reduce teenage conception rates, promote positive parenting with a particular emphasis on supporting young parents. Additionally we work closely with our School Nurse colleagues identifying those families who will require support on transition into school.

Through early detection of vulnerability we identify and support high level complex families requiring additional support such as those suffering domestic abuse, mental health issues, substance misuse or poor socio economic factors. These supportive services seek to reduce inequalities and deprivation, prevent social exclusion, and reduce criminal behaviour in the long term. We support the Child In Need process through working in partnership with our Social Work colleagues and when required produce professional reports and attendance in addition at Case Conferences, Core groups and Court. Health Visiting also directly supports families in the CP process.

A large proportion of Health Visiting service time is undertaken to support this Safeguarding Children agenda

We are developing close working relationships with colleagues in Childrens Centres. We continue to work closely in partnership with our colleagues in Midwifery, G.P practices, therapies such as Speech and Language and Early Support, voluntary sector, early year's education and Social Services.

There has been a remodelling of the workforce over recent years ensuring that the highly specialised skills of qualified Health Visitors are used appropriately. This has created skill mix teams and also enabled a career pathway both into the profession and within it.

The last two years have also seen particular difficulties in recruitment of Health Visitors and we have an aging demographic within the workforce. This has also resulted in skill mix in order to maintain safe effective services. Both of these issues are reflected in the establishment figures overleaf.

The staffing numbers of qualified Health Visiting staff for both organisations are shown below. In reviewing the statistics it should be recognised that the figures do not reflect the rest of the health visiting clinical workforce in bands lower than qualified health visitors.

Eastern and Coastal Kent			West Kent		
Health Visitors Employed	FTE	Head Count	Health Visitors Employed	FTE	Head Count
Apr-06	90.06*	Unknown	Apr-06**	40.67	52
Apr-07	104.32	Unknown	Apr-07**	43.78	55
Apr-08	99.35	125	Apr-08**	37.06	46
Apr-09	91.02	117	Apr-09	64.32	86
Apr-10	98.42	117	Apr-10	64.08	85

\* April 06 – Does not include Swale figures.

\*\* Data prior to 2009 may not be accurate.

5.0 *How many properties, including the community hospitals, do your PCTPS own or manage? (Question 9)*

Initially, the freehold of the buildings owned by the PCT and used by community services, including the community hospitals, will remain with the PCTs. The new Trust will retain a small number of existing leases with private landlords for office buildings solely occupied by PCT Provider Services staff and leases with other agencies such as KCC and GPs where provider staff occupy space in their premises. Given the changes to the NHS structure signalled in the White Paper this position is likely to be reviewed in the coming months.

6.0 *How much is spent on community services each year? (Question 11)*

	Provider	2008/09 Budget	2009/10 Budget	2010/11 Budget	% of total PCT budget (09/10)
NHS ECK	NHS ECK Community Services	£116.071m	£119.473m	£121.633m	9.85%
	Other Providers	£2.261m	£1,774m	£1,624m	0.15%
NHS WK	NHS West Kent Community Health	£58.725m	£59.921m	£57.408m*	6.16%
	Other Providers in Kent	£99,515	£170,288	£175,000 estimated	0.017%

\*For 2010/11, the reduction in spend is attributable to a change in providers for certain services, ie £2m from Urgent Care, £165k from Rainbow Lodge, £261k from Primary Care Counselling, £779k from the GP Out of Hours

7.0 *How are community services commissioned and funded? (Question 12)*

The commissioning and funding of community services is managed in the same way as the commissioning of any other healthcare service, including those provided by acute hospitals or in primary care. Decisions about healthcare services are informed by local priorities developed by considering current and future health needs of the population; developing clinical practice and existing services. ECK and WK engage public and clinicians in ongoing development of services to deliver these local priorities. Each organisation has a 5-year Strategic Commissioning Plan (SCP) which sets out the priorities and actions to be taken to deliver improvements in health outcomes.

Service specifications are developed to ensure delivery of clinical care pathways tested against national and local best practice. Commissioners use these service specifications to ensure providers deliver services in line with contracts. Funding for community services is allocated from the overall PCT budget, in the same way as any other service areas, and again in line with their SCP.

The delivery of the PCTs' SCPs including community services, are set within the challenging economic climate facing NHS and other public services. Both ECK and WK have undertaken financial forecasting to identify the scale of quality improvements and productivity and efficiency gains needed in the coming years to meet the needs of the population and ensure financial stability in the local health economies. There is a strong emphasis in both organisations for the delivery of more efficient community services, enabling a significant shift of care from acute hospitals to community settings. The development of the community services organisations is an important step in ensuring a provider environment capable of delivering a wide range of high quality services in a number of settings with an improved patient experience.



**Community Hospital Services  
Overview of NHS Eastern and Coastal Kent Health Overview and Scrutiny  
Committee - 14<sup>th</sup> May 2010**

**1. Introduction**

- 1.1 This paper aims to provide Members of the Committee with an overview of the current position of community hospitals in NHS Eastern and Coastal Kent (NHS ECK).
- 1.2 The questions answered in each section of this paper are referenced on the right hand side of the paper.
- 1.3 Appendix one shows a map of where community hospitals are located within NHS ECK
- 1.4 Appendix two provides details of the admission criteria from community hospitals

**2 What are community hospitals?**

**Q15**

A community hospital is a venue/ site outside of the main acute hospitals which provides a variety of services to local people. These typically include inpatient-beds, out-patient clinics, diagnostic facilities, daycare, minor injuries service and other extended primary and intermediate care services although services will vary between hospitals depending on other services available in the local area. Medical care is predominately provided by GPs working with consultant medical colleagues. Staff work in multi-disciplinary and multi-agency teams to provide services including rehabilitation, acute medical care, palliative and terminal care, step- down care and respite care that are integrated with the full range of services provided by ECK CS.

**3 Community Hospitals in NHS ECK**

**Q17**

There are six community hospitals within NHS ECK along with two small hospitals the Royal Victoria Hospital and Buckland Hospital managed and run by East Kent Hospitals Foundation Trust all other community hospitals are run and managed by ECK CS. listed below is summary of the services that are provided on each of the hospital sites;

**3.1 VICTORIA HOSPITAL DEAL**

General opening hours: 8.15 – 6pm Monday - Friday

**Minor Injury Unit**

- Minor Injuries Unit is open from 8.00 a.m. – 6.00 p.m.  
7-days per week

**Outpatients Department**

- Range of out patient departments facilities for acute and community clinics:

Include ECG (Heart tracings) Phlebotomy Service for GP's (blood tests) X-Ray facilities Orthopaedic	General Medicine General Surgery Gynaecology Paediatric (children) Gastroenterology	Rheumatology Care of the Elderly Ear, nose, throat Ophthalmology
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**Inpatients – two wards comprising:**

- 26 beds of which 4 are continuing healthcare

**3.2 QUEEN VICTORIA MEMORIAL HOSPITAL HERNE BAY**

General opening hours: 8.30 - 6pm Monday - Friday

**Day Centre**

- Multi -disciplinary support for older people
- Blood Transfusions
- I.V. Therapies (drugs administered into a vein, through a cannula)

**Outpatients Department**

- Wide range of acute and community clinics:

Phlebotomy (blood tests) General Surgery Gynaecology Paediatric	Gastroenterology Orthopaedic X-Ray Dermatology	Rheumatology Care of the older person (HCOOP) Hearing Tests
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**Inpatients – 23 Beds**

- For intermediate care including palliative care beds

**3.3 WHITSTABLE and TANKERTON HOSPITAL**

General opening hours: 8.30 - 6pm Monday - Friday

**Outpatients Department**

- Small Outpatients department providing facilities for acute and community clinics;

General Surgery Gynaecology	General Medicine Ophthalmology	Rheumatology
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**Inpatients** - 2 Wards comprising:

- 1 ward with 9 beds
- 1 ward with 24 beds for intermediate and continuing care

**3.4 FAVERSHAM COTTAGE HOSPITAL**

General opening hours: 8.30 - 6pm Monday - Friday

**Treatment Centre**

- Minor Injury Unit – 8.00 a.m. – 8.00 p.m. 7-days per week
- Outpatients – Multi-agency provided in adjoining Health Centre – OPD facilities for acute and community clinics supported by:

Gynaecology Paediatric Care of the older person	Vascular Nurse Hand Clinic East Grinstead	Rheumatology Physiotherapy
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**Inpatients** – two wards comprising:

- 1 ward of 14 continuing care beds
- 1 ward of 15 Intermediate care

**3.5 SITTINGBOURNE MEMORIAL HOSPITAL**

General opening hours: 8.30 - 6pm Monday - Friday

**Minor Injury**

- Services for Minor Injury/Illness from 9.00 a.m. – 9.00 p.m. 7-days per week

**Outpatients Department**

- range of outpatient services for acute and community clinics supported by:

General Surgery Obstetrics/Gynae (women's health ) Children's Clinics Medical Urology (bladder) Obesity Clinics Lymphoedema Clinic Dietician	Orthopaedic (bones) Ophthalmology (eyes) Dermatology (skin) Speech Therapy Podiatry (feet) Physiotherapy Psychiatry ECG (heart tracings) Rheumatology Nurse	Elderly Medicine Ear, nose throat Sexual Health Public Health Clinics Continence Service District Nurse Clinics Phlebotomy Weight Management Team
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Audiology (hearing)		
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**Inpatients**

- 24 bedded ward – primary/intermediate care including palliative care

**3.6 SHEPPEY COMMUNITY HOSPITAL**

General opening hours: 8.30 - 8pm Monday - Friday

**Minor Injury**

- Currently open from 9.00 a.m. – 9.00 p.m. for minor injury/illness 7-days per week

**Outpatients Department**

- Wide range of Out patient services for acute and community clinics support by:

General Surgery Obstetrics/Gynae Children's Clinics Medical Urology Obesity Clinics Lymphoedema Clinic Dietician	Orthopaedic Ophthalmology Dermatology Speech Therapy Podiatry Physiotherapy Psychiatry ECG	Rheumatology Nurse Elderly Medicine ENT Sexual Health Public Health Clinics Continence Service District Nurse Clinics Audiology
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- Open access centre provided by Dulwich Medical Centre – walk-in primary care services

**Inpatients –**

- 20 beds – primary/intermediate care including 8 x stroke beds
- 20 beds – primary/intermediate care - including palliative care

**3.7 Buckland Hospital Dover**

Buckland Hospital in Dover provides a range of outpatient services, a minor injuries service, a renal dialysis unit and an endoscopy unit. There are two wards – the maternity ward that has 20 beds and the Carousel Ward (Paediatrics) which has 4 beds.

**3.8 Royal Victoria Hospital Folkestone**

**Q16**

Royal Victoria Hospital, Folkestone, provides a range of outpatient services, Other Services available include Chemotherapy in the Community, a Day Hospital, Dermatology Minor Procedures. It is also home to the Folkestone Walk-

In Centre, which treats minor injuries and illnesses. There is one ward - The Derry Unit (Urology) which has 10 beds.

3.9 Minor Injuries Units treat minor injuries and Walk in Centres can treat minor injuries and minor illnesses. No appointment is needed. They are staffed by Nurse Practitioners. These services have variable opening times but are usually open 365 days a year. Examples of illness and injuries where a Walk in Center would provide treatment include;

- Minor cuts and bruises.
- Minor burns.
- Strains and sprains.
- Stomach upsets.
- Coughs and colds.
- Minor infections.
- Minor bites and stings.
- Emergency contraception.

3.10 An emergency care centre is provided at Kent and Canterbury Hospital to treat emergency medical cases for example stroke, whilst serious road traffic accidents would be seen at Accident and Emergency (A&E) departments at either William Harvey or Queen Elizabeth Queen Mother Hospitals. People who have a serious injury or illness should call 999 or go to an A&E department. These units are staffed by specialist doctors and nurses and are open 24 hrs a day and 365 days a year. The emergency care centre would treat patients with a number of more serious conditions including:

- Loss of consciousness.
- Pain not relieved by simple analgesia.
- Acute confused state.
- Chest pain.
- Breathing difficulties.
- Serious accidents.
- Severe bleeding.
- Deep wounds.
- Suspected broken bones.

**Q19**

3.11 There are 175 inpatient beds across all six community hospitals. These beds are primarily used to provide intermediate care for patients who either do not require admission to an acute hospital, but require treatment that cannot be delivered in their own home or patients who are able to be discharged from an acute hospital, but are not yet ready to return home. Examples of this would include Stroke patients who need further support to mobilise. Non weight bearing orthopaedic patients needing 6/8 weeks bed rest before starting rehabilitation. Amputees needing help mobilising from bed to chair. Intermediate care is also provided in a number of other venues including nursing homes where community nurses provide in-reach services to support patient care and in facilities such as

Westview and Westbrook through joint working with KCC.

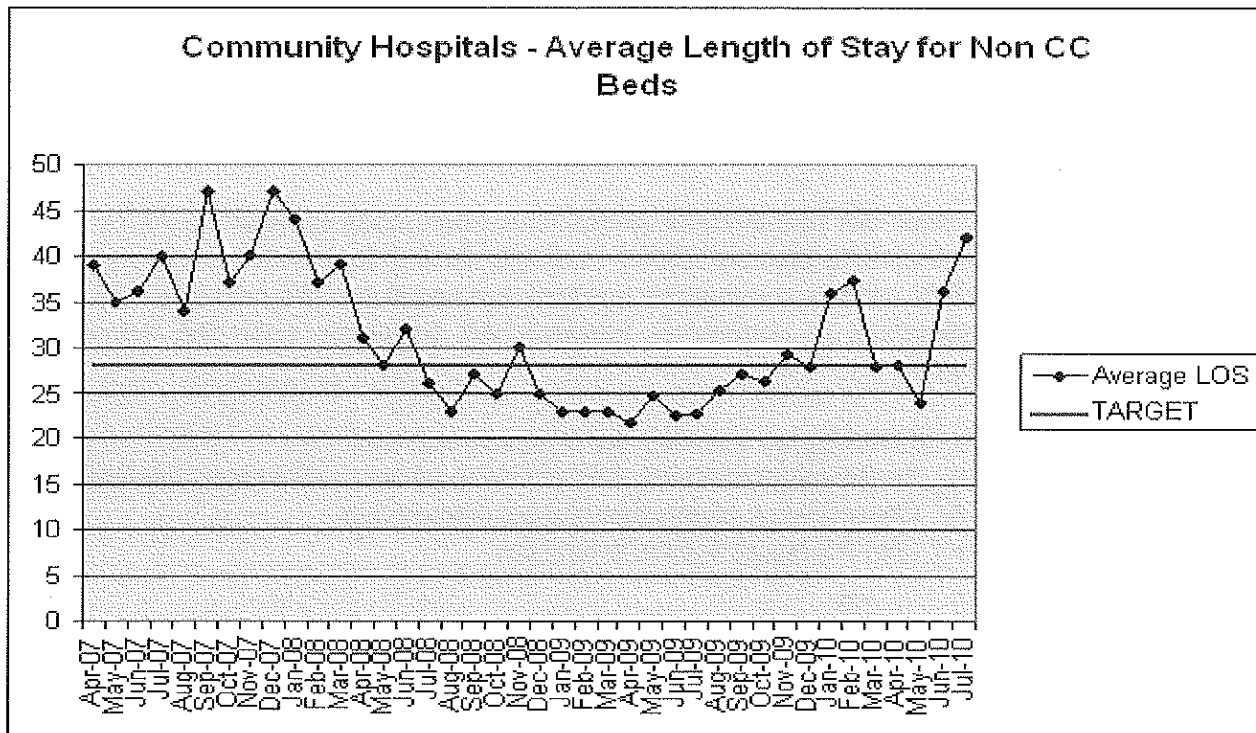
In addition to intermediate care there is also provision for palliative care patients focusing on system management.

- 3.12 Intermediate care provision in Shepway is provided at Broadmeadow, a Kent County Council facility in Folkestone which has 20 intermediate care beds. Intermediate care beds are also available at West View in Tenderden, (30 beds), Westbrook House, Margate (30 beds) and Cornfields in Dover (14 beds). West View and Westbrook House are both integrated care centres and are subject to Section 75 funding arrangements between KCC and NHS Eastern and Coastal Kent. The beds are staffed by KCC care staff and nursing staff who have been seconded to KCC from NHS Eastern and Coastal Community Services. Cornfields is a KCC provided unit.

Intermediate care is provided to all four units by the community intermediate care teams who in-reach into the facilities to provide the rehabilitative support required. This model of intermediate care has been achieved by good joint working between the local authority and NHS Eastern and Coastal Kent.

- 3.13 The table below illustrates average length of stay in the in-patient beds in ECK-CS run community hospitals with a current average length of stay of 28 days for rehabilitation patients. This is in line with other facilities (Social Services and Independent Sector) intermediate care beds. There are still, on occasion, difficulties caused by lack of care home beds or long waiting lists in care homes of choice which can impact on length of stay figures in some areas. A proactive approach is applied in supporting families in seeking alternative long term placements in these situations.

**Q21, Q22**



Community Hospitals support patients who require on-going rehabilitation and a higher level of medical and nursing input than could be safely be provided in a home setting thus preventing patients from being admitted to or staying in an acute hospitals when the nature of their illness means this is not clinically necessary.

ECK CS work closely with the acute hospitals and KASS to identify suitable patients for community hospitals. Intermediate care reaches into the acute hospital wards as part of the discharge process. They provide support and easy access to the ward staff to facilitate quicker discharge. Care mangers from social services are a part of this process.

Patient's progress is managed proactively in partnership with KASS in weekly multidisciplinary team meetings that include nursing team therapists and Social Services review all patients' progress to ensure clear treatment and discharge plans are made in a timely manner.

**Q23**

**4. The future of community hospitals?**

4.1 Community hospitals play a critical role in supporting the implementation of the PCTs community services commissioning strategy. One of the goals of the strategy is to commission more and better services closer to or within people's homes and to make it easier for them to access health services so that as a consequence there is a reduction in referrals into acute hospitals. In order to

deliver this the PCT needs to ensure community hospitals are able to:

- Increase the range of services available
- Increase the accessibility of services
- Ensure services are responsive to the public's needs

It is clear that considerable strides have been made to meet the PCTs strategic commissioning plan but further work is underway to ensure community hospitals are fully utilised and that the buildings are updated and modernised. The further development of community hospitals will be based upon the following key principals.

- Ensuring the safe delivery of clinical services
- Increasing productivity and achieving optimum utilisation of estate
- Consolidation of services and accommodation.
- Improved local access to services

**Q3**

- 4.2 The provision of minor injury services in East Kent is subject to regular reviews, both as part of the NHS Eastern and Coastal Kent's Urgent Care Strategy and through periodic performance management of the providers with the emphasis on delivering better patient care whilst ensuring enhanced value. In addition to provision in minor injuries units and walk in centres minor injury services are provided by ten GP practices in areas where patients do not have easy access to minor injury units or walk in services.

**Q18**

## **5. Consultation**

NHS ECK has ensured there has been strong engagement involving all services users at each of the community hospitals. As an example in March 2009, the NHS Eastern and Coastal Kent Patient and Public Engagement team commissioned a market research project from Opinion Leader to inform the development of a revised service specification for Faversham Minor injuries unit. By using street surveys, service user surveys and public meetings the market researchers were able to test the local community awareness of the service and to identify people's experience of using the Minor Injury Unit.

More than 500 people from Faversham gave their views during this market research. The results showed that 11 per cent of people did not know there was a Minor Injuries Unit based at Faversham Cottage Hospital. Further engagement activities from April to June 2009 concluded that the community of Faversham was in favour of the Minor Injury Unit continuing and for it to be developed further.

The results of the market research were shared at a public meeting. The meeting was also an opportunity for NHS Eastern and Coastal Kent to confirm the following:

- (a) The commitment that local people should have access to minor injury services and that a pilot (from 1 July 2009 to 31 March 2010) would be run to test an enhanced service with dedicated specialist nurses;
- (b) During the pilot the service would be promoted and communicated in an attempt to increase usage and reduce the number of Faversham residents attending other urgent care services including Accident and Emergency Departments.

There has also been good engagement with other stakeholders about plans to redevelop a hospital in Dover. NHS ECK is committed to ensuring service users continue to be involved in the development of services at all of the hospital sites.

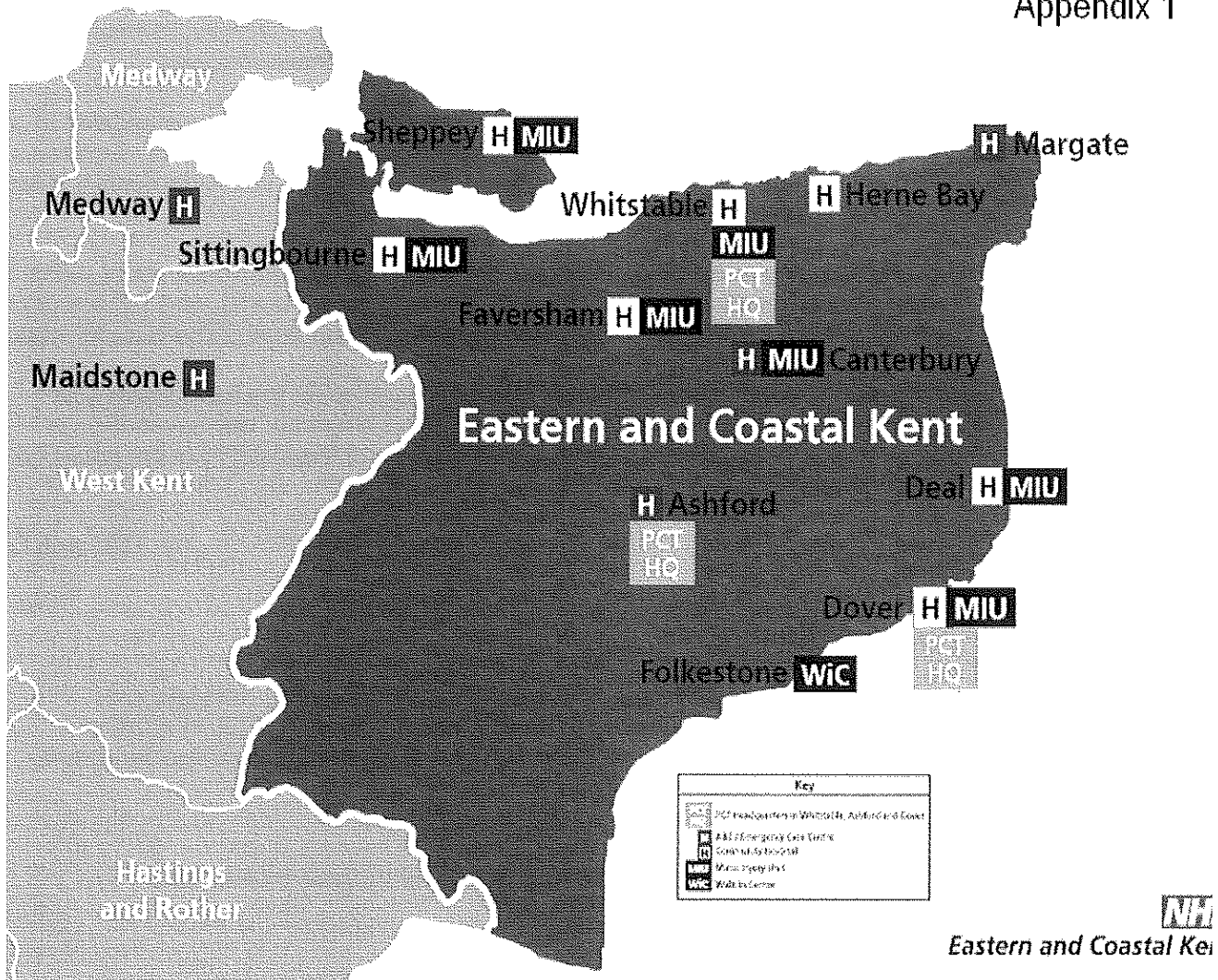
A revised service specification has now been drafted for the Faversham MIU which has extended the opening hours to twelve hours per day seven days a week from 1<sup>st</sup> July 2010 and reflects comments and feedback from the public co-design events.

**Q20 and Q4**

## **6. Appendices**

Appendix 1 Shows a map of the locations of community hospitals with services managed by ECK CS within NHS ECK. In addition Buckland Hospital in Dover is managed by East Kent Hospitals University Foundation Trust.

Appendix 2 Shows the admission criteria for community hospitals.



## Appendix 2

### CRITERIA FOR REFERRAL TO COMMUNITY HOSPITAL

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

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

#### 2. Patient Categories

<b>Category 1</b>	Requiring Rehabilitation / Recuperation will go home	Following an acute episode provided either at home or step down into an Intermediate care bed if still requiring 24 hour supervision for assessment & rehabilitation with home as the definite discharge destination <b>NB: Home must always be considered before step-down bed</b>
<b>Category 2</b>	Requiring 24 hour care (residential) or a high level social care package to get home due to functional ability	Following an acute episode step-down into a community hospital bed or Intermediate care bed in a care home for assessment and rehabilitation to improve functional ability to go home rather than Residential care or home with a reduced care package or Residential Care rather than Nursing Care
<b>Category 3</b>	Requiring 24 hour nursing care (nursing or residential) as a result of an acute episode	For step down into a community hospital bed/care home at the point of medical fitness & MDT decision for progress to INP for nursing home care or fully funded NHS continuing care
<b>Category 4</b>	Palliative / terminal care. Requiring 24 hour care and	Step down into hospice / community hospital bed for

	symptom control	symptom control or straight home with community services Plan for on going care either at home or in care home
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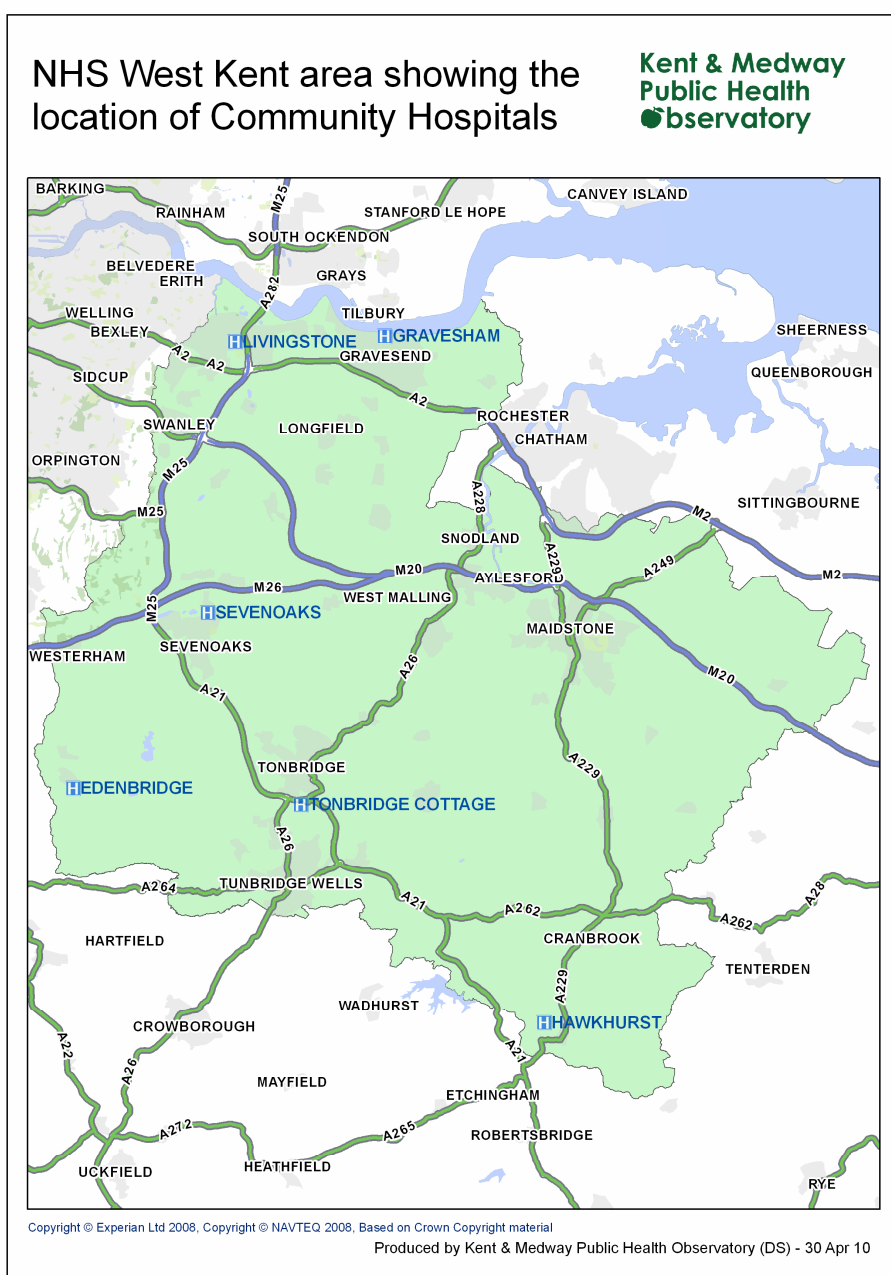
**Community Hospitals in West Kent**  
**Health and Overview Scrutiny Committee, 14<sup>th</sup> May**  
**2010**

**Introduction**

West Kent Community Health (WKCH) currently manages six community hospitals across West Kent. These are based in Gravesend, Dartford (Livingstone Hospital), Edenbridge, Hawkhurst, Tonbridge and Sevenoaks (see map 1).

The community hospital sites are owned by NHS West Kent and managed by WKCH.

Map 1



There are two commonly used definitions of a community hospital: one focusing on primary care and the other on acute care. Modern community hospitals are likely to be a meeting point bridging acute and primary care.

Acknowledging the bridge between primary and acute care, Professor Lewis Ritchie defines a community hospital in the following way: "A local hospital, unit or centre providing an appropriate range and format of accessible health care facilities and resources designed to meet the needs of local people. These will typically include inpatient beds, out-patient clinics, diagnostic facilities, day care, minor injuries service and other extended primary care and intermediate care services. Medical care is predominantly provided by GPs working with consultant medical colleagues. Staff work in multi-disciplinary and multi-agency teams to provide services including rehabilitation, acute medical care, palliative and terminal care, step-down care and respite care."

Professor Geoff Meads has focused on the primary care elements of community hospitals in his definition: "The community hospital is a service that offers integrated health and social care and is supported by community-based professionals" (Meads, G. Participate. University of Warwick, 2004).  
**(Q15)**

**The Department of Health also provides guidance on the function of a community hospital within the healthcare system.**

- A modern community hospital service aims to provide an integrated health and social care resource for the local population to which it belongs.
- These local facilities develop as a result of agreements between local people, service providers and the NHS.
- Community hospitals are an effective extension to primary care with medical support provided largely by GPs.
- The health and social care provided may include medical care, rehabilitation, palliative care, intermediate care, mental health, maternity, surgical care and emergency care.
- Community hospital care is characterised by care pathways that make the most of local sources of support.
- The community hospital provides a focus for local community networks.

**Services provided at our community hospitals. (Q17, Q18)**

**1/ Livingstone Hospital**

The unit is divided into three sections consisting of an acute assessment and intervention area, where patients are located on admission in order to observe and monitor their health care needs; a progression area, for those patients that have been identified as requiring moderate to high nursing support for their rehabilitation; and an independent area for those patients that are

progressing well and are achieving their mutually agreed goals. The hospital offers 29 inpatient beds.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a care manager, a pharmacist, a visiting medical officer and medical consultants upon request.

The Impact (Rapid Response) and Community Liaison Teams, which support people in their own homes, are also based at the Livingstone Hospital.

## **2/ Hawkhurst Community Hospital**

The unit is divided into three, three bedded wards and single rooms. Following initial holistic assessment patients are placed in the area most appropriate to their needs. This will be based upon whether they have a high health care requirement; require a moderate level of nursing with support for their rehabilitation; or need support to gain maximum independence to assist with the progression towards their jointly agreed rehabilitative goals. The hospital offers 22 inpatient beds. Other services onsite include outpatient physiotherapy and speech and language therapy, and consultant outpatient clinics.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a speech and language therapist, a care manager, visiting consultants, GPs, and a pharmacist.

## **3/ Edenbridge and District War Memorial Hospital**

The unit has a variety of small bays (of up to 3 patients) and single rooms and offers 17 inpatient beds.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a care manager, a pharmacist, a visiting medical officer and medical consultants upon request.

In addition there is a day hospital facility where patients can be referred for individualised programmes of rehabilitation that are time limited and goal focussed.

Edenbridge and District War Memorial Hospital also provides a Minor Injuries Unit which is open 8.30pm – 4.30pm

#### **4/ Sevenoaks Hospital**

The unit has a variety of small bays and single rooms and offers 24 inpatient beds.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a care manager, a pharmacist and medical consultants.

In addition there is a day hospital facility where patients can be referred for individualised programmes of rehabilitation that are time limited and goal focussed. There are also specialist services within the day hospital for long term maintenance, Parkinson's sufferers and falls prevention.

Sevenoaks Hospital also offers outpatient clinics such as fracture and dressings clinics, X-ray facilities, daily phlebotomy (blood testing) clinic. There is also a Minor Injuries Unit which is open from 8am – 8pm.

#### **5/ Tonbridge Cottage Hospital**

The unit has a variety of small bays and single rooms and offers 24 inpatient beds.

The team consists of a modern matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a care manager, a pharmacist, and a community medical officer.

In addition there is a day hospital facility where patients can be referred for individualised programmes of rehabilitation that are time limited and goal focussed. There is also a specialist service for falls prevention and rehabilitation.

Tonbridge Cottage Hospital also offers a range of outpatient clinics and is a base for the on call GP service.

#### **6/ Gravesham Community Hospital**

Gravesham Community Hospital offers a variety of services the outpatient clinics listed below:

- Child behaviour,
- BCG Clinic,
- ENT,
- retinal eye screening,
- school nurse hearing screening,
- psychiatric clinics,
- orthopaedic & rheumatology treatment clinic,
- fracture clinic,

- family planning,
- smoking cessation,
- young persons' clinic,
- ultrasound,
- vascular clinic,
- cardiac rehab,
- physiotherapy.
- Dressings clinic
- Phlebotomy (blood testing)
- Access point for needle exchange
- Chlamydia screening and the morning after pill.

In addition to the outpatient clinics, there is a day hospital provided which specialises in building up people's confidence and independence as they recover from illness or injury. It also offers specialist sessions for people with dementia.

The hospital also provides a Minor Injuries Unit which is open from 9am – 9pm.

**Gravesham Community Hospital also houses the Sapphire Unit which is a specialist neuro-rehabilitation unit providing 15 inpatient beds and the following services:**

- Specialist care of patients with a neurological condition such as multiple sclerosis, Parkinson's Disease, stroke, head injury.
- The highly skilled and experienced nurse-led team specialise in supporting patients' rehabilitation.

#### **Gravesham Place (located at Gravesham Community Hospital)**

Gravesham Place is a care home run by Kent Adult Social Services offering residential care and intermediate care, for people recovering from illness or injury.

***There are currently no plans to add or remove services from any of the community hospitals. However, there is service modernisation plans active throughout the community services provision in line with the Transforming Community Services agenda.***

#### **Inpatient Beds (Q21, Q22)**

All of our six community hospitals provide inpatient beds and in total there are 131 beds available. The average length of stay in one of these beds is currently 21.6 days.

## **Minor Injuries Units (Q19, Q20)**

There are three MIUs operating in West Kent at Edenbridge Hospital, Sevenoaks Hospital and Gravesend Community Hospital. These are open seven days a week, 365 days a year. The opening hours are dependent on the site:

**Edenbridge Hospital MIU: 8.30am – 4.30pm**

**Sevenoaks Hospital MIU: 8am – 8pm**

**Gravesend Community Hospital: 9am – 9pm**

The MIUs currently treat non-emergency injuries. These are walk-in centres (no appointment required) and are staffed by emergency nurse practitioners.

Emergency Nurse Practitioners at an MIU can clean and stitch cuts or grazes, remove foreign bodies from ears/noses etc, dress minor wounds, treat minor burns, treat minor eye injuries and more.

There are currently no plans in place to change the MIU services available. However, we will be reviewing how the MIU interfaces with other services in an effort to look at how MIU can further assist with the effective navigation and treatment of patients to reduce the impact on emergency care services.

In comparison, Accident and Emergency Centres and Emergency Care Centres are designed to assess and treat those patients with serious illness or injury which could present a threat to life. There is also an Urgent Care Centre in Dartford which is able to treat minor illness as well as injury.

All of these centres are open seven days a week, 365 days a year. The A&E and Emergency Care Centres are open 24 hours a day.

## **The difference between the acute hospitals and community hospitals. (Q16)**

Acute trusts provide services such as surgery, intensive care units, A&E departments, specialist medical intervention, interventions requiring medical technology, neonatal intensive care and other services which fall under the category of 'acute brief interventions.' Community hospitals provide services which are more designed to be an extension of the primary care service in an environment where health and social care are more integrated to provide services such as:

- Rehabilitation (eg physiotherapy)
- Palliative care
- Intermediate care
- Minor surgery (such as podiatrics)
- Public health and wellbeing services
- Dental Care
- Counselling
- District-nurse led clinics

- Health Visitor led clinics
- Chiropody and podiatry
- Health promotion
- Older people's services
- Children's services
- Maternity Services
- Mental Health
- Inpatient Beds
- Acute and community outpatient clinics
- Continuing care beds
- Diagnostic facilities
- Day Care
- Minor Injuries Care

### **Relationship with other trusts (Q23)**

The community hospitals provide a supportive role for the acute trusts in the area, specifically for those patient requiring intermediate care and rehabilitation which could not be achieved in the home. The community and acute teams work closely together to facilitate patient discharge and the relationship with social services allow therapists and nursing teams to effectively review patient progress and ensure that patients are discharged efficiently and into an appropriately managed home environment.

### **Properties owned or managed by PCTPS (Q9)**

Following the PCT – provider split, the PCT is following the principle of the commissioner retaining the assets and as such, West Kent Community Health do not own any of the PCT premises. The management of the premises in terms of hard FM/ estates management is outsourced to a shared services provider and the operational day to day reporting of the premises issues is the responsibility of West Kent Community Health.

### **Future Development of Community Hospitals. (Q3)**

There are no immediate plans to change the focus of our community hospitals which concentrate on the rehabilitation of patients in terms of step down from acute hospitals and assessment of patients needs in terms of step up from GPs. In line with Transforming Community Services, we have been a national pilot site for the “Productive Community Hospitals” toolkit and we will continue to look for opportunities to improve the quality of what we do and the productivity of our staff.

### **Conclusion**

This paper aims to provide a summary of community hospitals in NHS WK. NHS WK will welcome questions on this matter at the Health Overview and Scrutiny Committee on the 14<sup>th</sup> May.





# Kent Local Medical Committee

8 Roebuck Business Park, Ashford Road Harrietsham Kent ME17 1AB  
Tel: 01622 851197 Fax: 01622851198 Email [Info@kentlmc.org](mailto:Info@kentlmc.org)

A brief overview from Dr Robert Blundell on the five Community Hospitals across West Kent with a more detailed report on Hawkhurst Hospital, a Community Hospital close to his practice.

## **West Kent Community Hospitals**

There are Five Community Hospitals.

Currently they are run by West Kent Community Trust. This trust separated from West Kent PCT in December of 2009.

The hospitals have different backgrounds.

Some such as Sevenoaks resulted from the closure of District General Hospital. Others were donated to communities by wealthy benefactors prior to the NHS maintained by their communities and adopted by the NHS subsequent to its formation in 1948.

The Community Hospitals run by West Kent Community Trust are:

Dartford  
Edenbridge  
Sevenoaks  
Tonbridge  
Hawkhurst

These communities have different needs depending upon their geographical location and ease of access to District General Hospitals, nursing homes, specialised community nursing services and hospices etc.

They were generally staffed by local GPs who looked after their own registered NHS patients. 'Low tech' medical conditions requiring admission were admitted and step down care was provided which allowed patients to be rehabilitated closer to their homes thus facilitating friend and family visits.

The present Management of the Community Hospitals has sought to apply universal admission criteria to the Community Hospitals two years ago. Some GPs would argue that these criteria were not flexible enough as they did not adequately consider the geographical location or specific needs of the communities. The present managing trust has also sought to ensure full occupancy of the hospitals Patients from outside of the traditional catchment areas have been seen for re-cooperation in Community hospitals distant from their homes. Furthermore this policy has on occasions led to beds not being available in appropriate community hospitals at the requisite time. Thus patients from Hawkhurst have found themselves rehabilitated in Edenbridge or Crowborough and /or Tonbridge patients sent to Sevenoaks and vice-versa. This policy is at the very least 'not green' as it engenders long journeys for

friends and relatives when visiting and similarly it logistically makes pre discharge occupational home visits very difficult.

### Hawkhurst Hospital

This is the most isolated of the West Kent Community Hospitals. It is about three miles from the East Sussex border and located roughly at the intersection of the midway points of the MTW Hospitals with The Conquest in Hastings, and similarly between The William Harvey Hospital Ashford and East Bourne Hospital. Hawkhurst Hospital was extended at the end of the 1990s and now has 25 Beds.

There are no nursing homes within 8 miles of Hawkhurst and in the 1990's Hawkhurst Hospital had 'Lying In' postnatal beds and afforded respite and terminal care facilities to the community. The lying-in beds have gone and the role of the hospital in affording respite and terminal care has been disputed. This has led to patients from Hawkhurst being discharged from Hawkhurst Hospital to a Nursing Home nine miles away in Staplehurst for terminal care.

Hawkhurst Hospital has a Physiotherapy Department and an outpatient Consulting Room in what was the Matron's Bungalow. This facilitated consultations with visiting Consultant Specialists from both Hastings and the MTW Hospitals. Unfortunately inadequate facilities and arguably unsympathetic hospital management have caused many of these specialists to withdraw their services. Similarly in the past two years five of the seven GP Practices which had admitting rights have resigned from the Staff of the Hospital. One of the remaining Practices has a contract to supervise. At a recent open Board Meeting the Community Trust Board did express interest in redeveloping the Out-Patient Dept. in Hawkhurst and considering offering inpatient services to those living close to the Hospital in East Sussex.

Dr Robert Blundell  
Vice-Chair Kent Local Medical Committee  
24<sup>th</sup> August 2010

By: Paul Wickenden, Overview, Scrutiny and Localism Manager  
To: Health Overview and Scrutiny Committee – 3 September 2010  
Subject: Item 7. Forward Work Programme.

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## 1. Background

- (1) As discussed at the Meeting of the Committee on 23 July 2010, there was a need to reorganise the Forward Work programme in order to accommodate the rescheduled topic of The Future of PCT Provider Services and the Use of Community Hospitals.
- (2) The proposed new Forward Work Programme is outlined below:-
  - a) 8 October 2010 –
    - 1) Pain Management Services.
  - b) 26 November 2010 –
    - 1) Primary Angioplasty.
    - 2) Community Mental Health Services.
  - c) 7 January 2011 –
    - 1) Dentistry.
  - d) 4 February 2011 –
    - 1) Stroke Care Pathway.
  - e) 25 March 2011 –
    - 1) Cancer Care.
  - f) 29 April 2011 –
    - 1) Accessing Mental Health Services.
      - a. Crisis Resolution Home Treatment Teams.
      - b. Forensic Mental health Services.

## 2. Recommendations

- (1) The Committee is asked to approve the revised Forward Work Programme.

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 3 September 2010

Subject: Item 8. Committee Topic Discussion.

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## **1. Background**

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve.

(2) At the meeting on 26 March, Members of the Committee requested an opportunity at each meeting to discuss what they had heard and decide whether the outcomes for each main agenda item had been achieved, or whether there was a need for further information to be requested, and from whom.

## **2. Recommendations**

(a) The Committee is asked to assess whether the outcomes for this meeting have been achieved or if further information on any topic is required by the Committee.

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