HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 30th November, 2012

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 30th November, 2012, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Tristan Godfrey**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr K A Ferrin, MBE, Mr L B Ridings, MBE, Mr K Smith, Mr R Tolputt and Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor A Allen, Councillor A Blackmore, Councillor G Lymer and Councillor Mr M Lyons
LINk Representatives (2):	Dr M Eddy and Mr M J Fittock

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.

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

Item	Timings
1. Introduction/Webcasting	
2. Substitutes	

3. Declarations of Interests by Members in items on the Agenda for this meeting.

4. Minutes (Pages 1 - 18)

5.	Forward Work Programme (Pages 19 - 20)	10:00 – 10:05
6.	Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Relationship (Pages 21 - 60)	10:05 – 10:45
7.	Patient Transport Services: Written Update (Pages 61 - 66)	10:45 – 10:50
8.	HOSC Report, "Not the Default Option": Responses. (Pages 67 - 98)	10:50 – 11:30
9.	Tonbridge Cottage Hospital: Change of Use (Pages 99 - 104)	11:30 – 12:00

10. Date of next programmed meeting – Friday 4 January 2013 @ 10:00 am

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
(01622) 694002

22 November 2012

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 12 October 2012.

PRESENT: Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr B R Cope (Substitute for Mr N J Collor), Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr L B Ridings, MBE, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Ann Allen, Cllr Mrs A Blackmore, Cllr J Cunningham (Substitute for Cllr M Lyons) and Mr M J Fittock

ALSO PRESENT: Mr N J D Chard, Mr L Christie and Mr P W A Lake

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

Vice-Chairman in the Chair.

2. Minutes
(Item 4)

(1) A question was asked about the vascular services item from the previous meeting and the Committee was informed that Medway's Health and Adult Social Care Overview and Scrutiny Committee had also determined that the proposed review constituted a substantial variation of service. This topic would therefore be considered at the appropriate time by the Joint Health Overview and Scrutiny Committee established with Medway Council.

(2) RESOLVED that the Minutes of the meeting held on 7 September 2012 are correctly recorded and that they be signed by the Chairman.

3. Kent and Medway NHS and Social Care Partnership Trust: FT Application
(Item 5)

Angela McNab (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust), and Pippa Barber (Executive Director of Nursing and Governance, Kent and Medway NHS and Social Care Partnership Trust) were in attendance for this item.

(1) The Chairman introduced the item and welcomed the Committee's guests. Angela McNab was asked to provide an overview of the Foundation Trust (FT) application. Referring to the copy of the presentation Members had before them included in their Agenda pack, attention was drawn to the overarching

vision of the Trust and how achieving FT status would enable the Trust to realise this fully.

(2) It was explained that the Trust's clinical strategy underpinned all that Kent and Medway NHS and Social Care Partnership Trust (KMPT) undertook and this in turn has been clinician led with heavy user involvement. Four key strands could be identified in the vision. Firstly, stronger community services would enable a more localised service. Secondly, the services would be oriented to recovery. Thirdly, services should deliver quality patient experience. Fourthly, there was the goal to develop flagship specialist services. Forensic services run by the Trust were in the top 3 or 4 in the country. Expanding and enhancing specialist services would enable patients who would have needed to travel outside of Kent for treatment to be treated at facilities within Kent in the future. Along with this repatriation repatriated to Kent, length of stay would be reduced.

(3) In terms of the point of the FT process, a number of comments from Members were made about whether it made any difference to the quality of services and whether it was a distraction. It was explained that being granted FT status was a form of accreditation that the Trust was able to achieve high standards in governance and quality of service so that the connection between the two was close. The three key risks to achieving FT status were currently being examined by external assessors. Firstly, there was the need to achieve financial balance and demonstrate financial sustainability. Secondly, the safety of patients was essential. Thirdly, the need to engage staff and develop the organisation was necessary. When asked about the alternative, it was explained that the Trust could not remain as a NHS Trust in the way it was currently. If the FT application was not successful, it was possible that organisations based outside of Kent would take over the running of the services.

(4) Another difference between FT status and KMPT's current status as an NHS Trust was highlighted following a question on the Trust's estate. It was conceded that the Trust had a large number of older properties which were not fit for purpose. These properties could currently only be sold if no other NHS organisation wished to use them. KMPT would be freer to sell properties and reinvest the proceeds with FT status.

(5) In addition, being an FT meant it was a Membership organisation. This meant that staff, service users, the public, local authorities and others would be able to directly influence the work of the Trust. There would be 20 public governors, including 4 selected by staff and 2 appointed by Kent County Council. There would also be 2 carer representatives.

(6) On the subject of carers, there were carers' fora in East and West Kent and these fed into the patient experience groups. The needs of carers were an important part of the work of the Trust on a day-to-day basis and the assessment of carers needs was carried out in conjunction with social services.

(7) Mr Peter Lake asked to make a comment to the debate. He explained that he chaired a joint meeting between Kent County Council and KMPT on a regular

basis and looked forward to continuing successful partnership working and supported the FT application.

(8) Members asked a number of questions about the capacity of the organisation to improve. It was explained that on the key indicator for measuring patient satisfaction, the Trust had improved 8% over a year. However, the representatives of KMPT did not have to hand a record of what this was an increase from, though they would be able to provide it. External assessors had recently given a low score on quality and this was a good thing as the lower the score the better. The threshold for achieving FT status had been met on this but the Trust was looking to achieve a 0, which was the highest. On a range of issues raised by Monitor and the Care Quality Commission most had been dealt with and the general direction was improving, though the Trust explained that they were not complacent.

(9) Clarification was sought over some figures in the presentation and it was clarified that all 8 emerging Clinical Commissioning Groups (CCGs) in Kent and Medway supported the Trust, formal letters having been received from most of them already. There was consensus with the CCGs on the strategic goals, and the local variations sought by them as they commissioned services in the future would become clear. A number of specialist services would be commissioned directly by the NHS Commissioning Board. The Trust did also provide some services beyond Kent, and it was explained that this was additional capacity and was not provided at the expense of any Kent resident. The comment was made that it was unclear who would have the final say over issues and services in the future.

(10) It was explained that the next step was a board to board meeting with the Strategic Health Authority in early November.

(11) The Chairman proposed the following recommendation:

- That this Committee supports the FT bid and looks forward to a further update in 12 months time.

(12) In response to a question, the Trust undertook to return earlier if there were any issues with the application to discuss.

(13) RESOLVED that this Committee supports the FT bid and looks forward to a further update in 12 months time.

4. Joint Health and Wellbeing Strategy
(Item 6)

Roger Gough (Cabinet Member for Business Strategy, Performance and Health Reform, Kent County Council), Andrew Scott-Clark (Director of Health Improvement, Kent County Council), and Julie Van Ruyckevelt (Interim Head of Citizen Engagement for Health, Kent County Council) were in attendance for this item.

(1) After being welcomed by the Chairman and invited to address the Committee, Mr Gough proceeded to explain that the Joint Health and Wellbeing Strategy (JHWS) was a core part of the work of the Health and Wellbeing Board and

was mandated as such by the Health and Social Care Act 2012. The Joint Strategic Needs Assessment had existed for a few years, but the JHWS was a new kind of document. It was meant to inform the commissioning plans of the commissioners represented on the HWB. It was not an Operating Plan, and it was later explained that for this reason there were no financial costings in the JHWS. While it needed to be strategic, it could not be too high level to be essentially meaningless.

(2) Members' attention was drawn to the graphical representation of the structure of the JHWS on page 40 of the Agenda. Priorities for the JHWS came from a series of connected sets of information. Firstly, there was an examination of the areas of health where Kent performed worse than the national average. A closer look at the data would reveal the local priorities by showing where, for example, the areas of highest and lowest life expectancy would be found. These were given as King's Hill and Margate respectively. Gaps in provision would also be considered. A lot of public health goals looked to the longer term, but quick wins could be achieved by looking at gaps in provision. All this contributed to identifying which services needed to be improved or transformed as a priority.

(3) At the national level there were Outcomes Frameworks for the NHS, Public Health and Social Care with a possible one for children's services in development. The JHWS was intended to form a single Outcomes Framework for Kent.

(4) It was explained that the timeline set out in the papers had slipped slightly to enable the Strategy and associated engagement to be as robust as possible Phase 1 of the engagement process concentrated on key stakeholders but as some emerging CCGs were not fully able to comment at that time, there was a second opportunity. Mr Gough also made the offer that along with the current meeting he would welcome the opportunity to discuss the strategy further with any Member.

(5) One specific example of an issue where comments and suggestions were welcomed arose in response to a comment from a Member that the JHWS lacked a certain 'person centred' feel. This thought was taken positively, but given that health and social care cover such a variety of patient and personal experiences it was a challenge to capture the diversity.

(6) In response to a specific question it was explained that hard to reach groups such as gypsies and travellers were included in the health inequalities plan. It was also accepted that the wording on p.52 need to be looked at again.

(7) A particular criticism was made of the priority given to safeguarding issues in the JHWS as the wording on p.42 of the Agenda suggested it was not as high as it needed to be. This was explained to be a placeholder target until a better one could be developed and not an indication of its status as it was important to get it right.

(8) Similarly, the priority given to mental health services was questioned and anecdotal evidence provided that mental health charities were facing cuts in funding. In response it was explained that mental health was very important

and its place in the JHWS would act as a counter-weight to the considerable pressures on limited resources to be spent elsewhere.

(9) A broader argument was presented that the JHWS could give too high a priority to resources being used on such public health activities as breastfeeding rather than cancer and heart disease, given as the kind of things which affect most people most of the time. In response it was explained that in terms of breastfeeding uptake Kent was an outlier and that breastfeeding was one of the most important factors in ensuring longer term health, including reducing obesity and thus reducing the risk of cancer. It was accepted that it was difficult to input resources further upstream but that there were benefits of so doing. One Member commented that the JHWS was full of good intentions, but doubts remained about how possible it was to change people's lifestyles; however, as the attempt needed to be made, support needed to be given to the JHWS.

(10) One of the positive aspects of the HWB bringing all the commissioners together was that it would allow whole systems solutions to be tried. The South Kent CCG was working with the local HWB on integrated care and this way of developing plans was a model for the future to introduce across Kent.

(11) The place of providers was another issue to consider. Kent was similar to around ¾ of HWBs across England in not including providers on the HWB. However, there were existing ways of bringing commissioners and providers together which would be built on.

(12) The Chairman proposed the following recommendation:

- That this Committee thanks its guests for attending and welcomes the opportunity to feed into the development of the Joint Health and Wellbeing Strategy and looks forward to continuing in a constructive and productive relationship with the Health and Wellbeing Board.

(13) RESOLVED that this Committee thanks its guests for attending and welcomes the opportunity to feed into the development of the Joint Health and Wellbeing Strategy and looks forward to continuing in a constructive and productive relationship with the Health and Wellbeing Board.

5. East Kent Hospitals University NHS Foundation Trust Clinical Strategy
(Item 7)

The Chairman explained that due to the close connection between Items 7 and 8 on the Agenda, they would be discussed together. The Minutes of this discussion are below.

6. Trauma Services: Update
(Item 8)

Stuart Bain (Chief Executive, East Kent Hospitals University NHS Foundation Trust), Rachel Jones (Divisional Director for the Surgical Division, East Kent Hospitals University NHS Foundation Trust), Peter Gilmour (Director of Communications, East Kent Hospitals University NHS Foundation Trust), Paul Sutton (Chief Executive,

South East Coast Ambulance Service NHS Foundation Trust), Matthew England (Clinical Quality Manager, South East Coast Ambulance Service NHS Foundation Trust), Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), and Victoria Osborne-Smith (Senior Project Manager Trauma and Critical Care, NHS Kent and Medway) were in attendance for this item.

(1) Following the Chairman's welcoming of the guests, representatives of the NHS were asked to introduce the items. It was explained that the East Kent Hospitals University NHS Foundation Trust (EKHUFT) clinical strategy and the development of the trauma network were both broad and distinct strategies but that there were clear overlaps between the two.

(2) As regards major trauma, it was explained that Kent and Medway saw around 700 cases each year, or 2-3 each week. In East Kent the annual number was around 300. The clinical evidence supported the practice of taking patients directly to a major trauma centre which for Kent and Medway primarily meant King's College Hospital in London. There were three elements to the strategy. Firstly, the elements needed organising in a network and there was now a South East London Kent and Medway Major Trauma Network. Secondly, the systems needed to have in place the appropriate protocols. Thirdly, rehabilitation and recovery had to be considered. Shadow rehabilitation prescriptions were currently being used to identify gaps in service.

(3) It was being recommended that Medway Hospital and Tunbridge Wells Hospital be designated as a Trauma Unit. The original intention was also to recommend designation of William Harvey Hospital. Work was ongoing with EKHUFT as this formed part of their clinical strategy.

(4) Responding to a specific question, it was explained that Birmingham did have a major trauma centre, but that the adult's and children's centres were separate.

(5) Representatives from EKHUFT explained that they were currently in the engagement stage of developing their clinical strategy but that public consultation would follow should any major changes arise from it. It was accepted that in the past the NHS was legitimately criticised for presenting 'take it or leave it' choices and looked to improve on this. For example, the Royal College of Surgeons was coming into the Trust to provide some objective analysis.

(6) It was explained that along with the trauma system, there was a need to improve out of hours emergency surgery. Nationally, the mortality rate is 11-15% higher than regular hours surgery. At EKHUFT the rate was 9% higher. In response to a question about measuring outcomes in surgery, it was explained that it was more than a black and white question around mortality as longer term complications from surgery and co-morbidities needed to be factored in as well. The clinical strategy was broader than both trauma services and emergency surgery. EKHUFT was looking to stop inappropriate admissions to hospital, introduce one stop shops, establish leading edge day surgery centres, reduce length of stay, and aimed at things like rehabilitation.

(7) By way of context, it was explained that EKHUFT was a Trust composed of 3 district general hospitals and 2 community hospitals which operated from around 20 different sites. The Trust dealt with 600,000 outpatients each year. However, the services were often fragmented so that the same patient might need to travel to different places across the area to complete one episode of care. The idea of one stop shops was to reduce the number of sites where services were offered to 6 but to offer a more comprehensive service at each. While acknowledging issues around public transport, the Trust was looking to have a one stop shop within a 20 minute car drive of everyone in East Kent. This was considered appropriate for the often rural nature of the geography.

(8) In response to a specific question about the impact of the European Working Time Directive, the answer was given that there was an impact, particularly on shift patterns, but it was more broadly a problem with the medical training regime in England. More trust grade doctors had been appointed to ensure patient safety as there were more complex handovers.

(9) EKHUFT had a Hospital Standardised Mortality Ratio of 80 against the national average/benchmark of 100, which was good, and the clinical strategy was an attempt to stay ahead of the curve so that the latest advances in medicine could be adopted, such as da Vinci robots for complex surgery.

(10) Responding to a question about staffing levels in the Trust's accident and emergency departments (A&E), the response given was that while there were disagreements over nursing shift patterns, staffing was not being reduced. The chief Executive was not aware of any requests from the Royal College of Nursing for a meeting on this. 3 new locum consultants for A&E had been hired. 1 was a replacement, but the other 2 were new posts.

(11) The ambulance service was changing its service alongside these changes in other Trusts and services. Ways of working were altering so that there was a need on the one hand to stabilise patients in order to take them to centres of excellence, such as a Major Trauma Centre, rather than necessarily to the local A&E, and on the other hand to treat patients on the scene to avoid the need to admit them anywhere. With regards the questions raised about the air ambulance, the response given was that the Ambulance Trust did not need to own its air ambulance as it had very good working practices with the existing ones and handled the calls to its service. The Committee were informed that the air ambulance service was working towards 24/7 capability.

(12) A strand of comment and criticism from Members throughout these discussions was the cumulative effect of what seemed like good decisions individually. Adding them all together could change the landscape of health services completely and possibly in unintended ways. The logic could be, it was suggested, to centralise all services in London. Representatives from the NHS responded that the health landscape was changing but not all in one direction. There was repatriation and decentralisation as well as centralisation in health services. Primary angioplasty, for example, was now available in Kent. The fitting of multiple stents used to require several trips to London but could now be undertaken at local district general hospitals in Kent.

(13) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their valuable contributions and looks forward to further updates taking into account the comments made today.

(14) RESOLVED that the Committee thanks its guests for their valuable contributions and looks forward to further updates taking into account the comments made today.

7. The Tunbridge Wells Hospital: One Year On
(Item 9)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), and Dr Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust) were in attendance for this item.

(1) For this item, Members also had before them a copy of a presentation to which Trust representatives made reference during the discussion (see Appendix to Minutes).

(2) The Chairman welcomed the Committee's guests and invited the Chief Executive of Maidstone and Tunbridge Wells NHS Trust (MTW) to introduce the item. Mr Douglas reminded the Committee of the context five years previously when he took up the position of Chief Executive at MTW. The Trust was dealing with the impact of the report into Clostridium difficile. Without a new hospital, it would have been a possibility that the Kent and Sussex and Pembury Hospitals would have closed anyway but events at the Trust meant ambivalence at the Treasury and Department of Health towards building a new hospital became active support. As a result the new hospital, Tunbridge Wells at Pembury, is fit for purpose. Pictures were included in the presentation as a reminder of how much the quality of the estate has changed and improved. At the time, no alternative to the Private Finance Initiative (PFI) was available.

(3) The 7% increase in NHS spending at the time meant the prospects for the PFI were looked at optimistically and the costs were considered worth paying. Looking at the financial figures closely, it was reported, the costs of the PFI are not the whole of the story. The PFI costs around £20 million in 'rent'. The Pembury and Kent and Sussex Hospitals cost £7 million a year, so the new hospital adds £13 million. However, new building specifications have meant that even with the same number of beds, the hospital is 60% bigger. This in turn has meant the rates have risen from £350 thousand to £1.6 million. Running costs are also more in a bigger hospital. The Trust needs to deliver a 5% cost improvement programme each year just to stand still. The deflation of the tariff accounts for 4.5%, meaning 0.5% comes from other costs.

(4) The Trust was one of seven where the Department of Health was looking to provide support for the PFI costs and the future success of the Trust in applying for FT status was dependent on the financial sustainability of the Trust, which was linked to the costs of the PFI.

(5) Mr Douglas pointed to the successful move to the new hospital and claimed that moving hospitals without closing A&E availability was one of his personal career highlights. However, the move was in some ways only the start. As the first all single roomed NHS hospital, new ways of working are needed. More nurses are needed to staff single rooms. An all single room environment is not a panacea for infection control issues. It is very effective for preventing the spread of norovirus, less so for Clostridium difficile. Being in a single room is also detrimental to some groups of patients, such as those with dementia and the possibility of establishing a tailored ward at Maidstone was being considered. Public perception was also interesting as 20% of patients still considered they were on a mixed-sex ward despite the single rooms. There were open visiting hours, although mealtimes were protected – unless relatives wished to help patients eat. A real time feedback system of patient satisfaction was used, and rates were very high at 90%.

(6) Early problems with waiting times at accident and emergency were acknowledged, although these had been dealt with successfully. It was also acknowledged that more needed to be done to improve the appointments booking system and the way the Planned Care Office worked.

(7) On the subject of transport it was reported that no complaints were received at Tunbridge Wells Hospital about the availability of car parking. Public transport was more of an issue. The Trust believed a recent compromise reached putting more resources into volunteer car services was an improvement on the original section 106 agreement which was reliant on finding a bus company willing to provide the service when it cost around £300 for each person travelling from Borough Green. It was also reported that the bus company, Country Lines, had just gone bankrupt. Transport to the new hospital was always prefaced on the improvements to the A21 being completed by this point in time. Work on it now could potentially be disruptive to access.

(8) The Committee was informed that the Trust's clinical strategy maintained the focus on developing centres of excellence at both sites. The nature of medical training meant doctors specialised earlier, but there was a valuable role still for generalists at the hospital 'front door'. Emergency surgery was able to be carried out very quickly. In a number of areas it had been possible to repatriate services to Kent. The Trust employed the only specialised pelvic surgeon in the area. Building on the earlier debate, the Committee was informed that the Tunbridge Wells Hospital had received designation as a Trauma Unit.

(9) In response to a specific question, it was explained that while some services had diverted patients to Maidstone from Tunbridge Wells due to capacity issues, no wards had been closed.

(10) The Trust was also developing other services, such as the diabetes service in the centre of Tunbridge Wells and stroke rehabilitation beds at Tonbridge Cottage Hospital. The midwife-led birthing unit at Maidstone was proving more popular than expected, with 400 deliveries carried out this year. Satisfaction levels were also high there, including for those patients requiring transfer to Tunbridge Wells. The Tunbridge Wells Hospital provided some private rooms, as the Kent and Sussex had beforehand and this was used to help earn income for the Trust.

(11) It was explained that it needed to be borne in mind that the move towards more services in the community was laudable, but did mean a reduction in income for the Trust.

(12) The question was raised about the balance between managers from Tunbridge Wells and Maidstone in the new hospital. The answer was given that ward managers were fairly evenly divided. However, there were more Tunbridge Wells managers in the leadership of the maternity service, but the midwives managing the Maidstone birthing unit were from Maidstone.

(13) One Member made the useful comment that Trusts made statements about the ratio of staff and performance for example, but it was difficult for an overview and scrutiny committee to fully judge whether these statements were valid and requested more context in the future where possible. In response, the East Midlands dashboard was given as a good example of capturing useful data.

(14) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their informative contributions, looks forward to further updates and wishes the Trust well with the challenges ahead.

(15) RESOLVED that the Committee thanks its guests for their informative contributions, looks forward to further updates and wishes the Trust well with the challenges ahead.

8. Date of next programmed meeting – Friday 30 November 2012 @ 10:00 am
(Item 10)

Maidstone and Tunbridge Wells NHS Trust

Tunbridge Wells Hospital

One Year on - 50 Years in the Making

Background

- **1856** - Calls begin for a hospital in Tunbridge Wells
- **1934** - Kent & Sussex (K&S) Hospital opens
- **1957** - Calls start for a new hospital to replace K&S and Pembury hospitals - **eight** bids follow over four decades
- **1997** - Health Minister John Denham says case for new Tunbridge Wells Hospital is "inescapable"
- **1998** - Courier newspaper postcard appeal generates **59,000** responses from residents. Local MPs take case to Parliament
- **2001** - Health Secretary Alan Milburn includes Tunbridge Wells in fourth wave of PFI hospital schemes
- **2003** - Outline planning permission received
- **2004** - Trust receives 70 expressions of interest from developers
- **2005** - Three developers invited to submit bids to build PFI hospital
- **2006** - PFI scheme undergoes further DH and Treasury business case reviews
- **2006** - Equion chosen as Trust's first choice developer
- **2007** - Government approve Tunbridge Wells Hospital as one of seven PFI hospital developments
- **2008** - Construction work commences
- **2011** - New Tunbridge Wells Hospital opens
- **2012** - Tunbridge Wells Hospital one of seven PFI hospitals identified to receive financial support from the Department of Health

The "inescapable" need for change

Kent & Sussex and Pembury Hospitals

- Hospital estate up to 100 years old
- Patients treated in Victorian Nightingale Wards
- Hospitals unfit for delivery of modern day healthcare
- Among highest levels of mixed sex breaches nationally
- Poor privacy & dignity – typically 4 toilets/showers for 30/40 patients
- Open wards and bed space identified in Clostridium difficile outbreaks
- Difficult to provide optimal patient care with services across 3 sites

Inspection comments

"The ward entrance is gloomy and depressing"

"Mattresses stored in the day room made it impossible to clean"

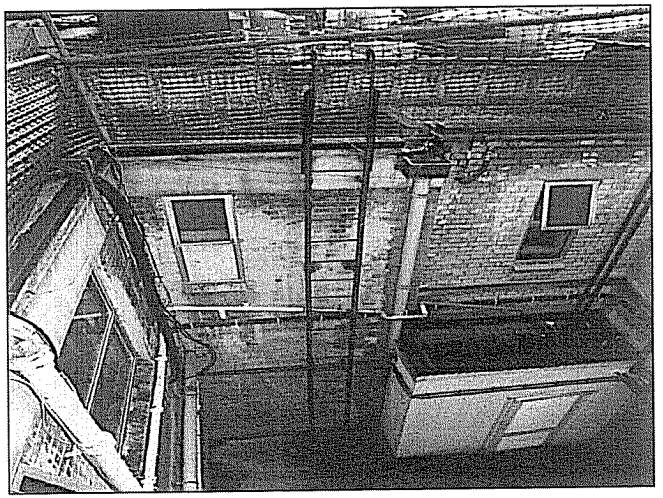
"Toilets are few in number and small for patients in need of assistance"

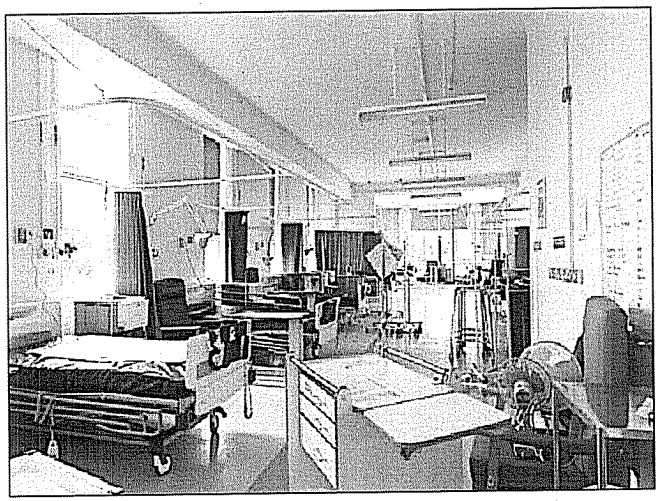
"One shower was doubling as an equipment park"

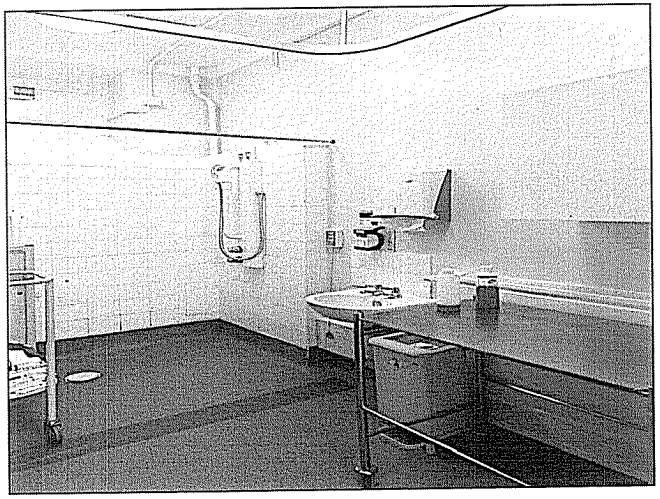
"One must question adequacy of bathing facilities for a ward of 28 patients"

"Storerooms, in keeping with other parts of the hospital, were very full, cluttered and inadequate to contain modern equipment"

"The light fittings in the high ceilings were rather dirty and obviously inaccessible."





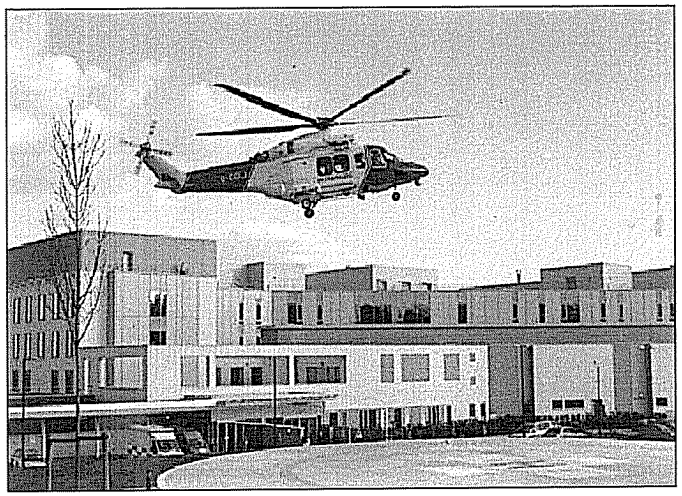


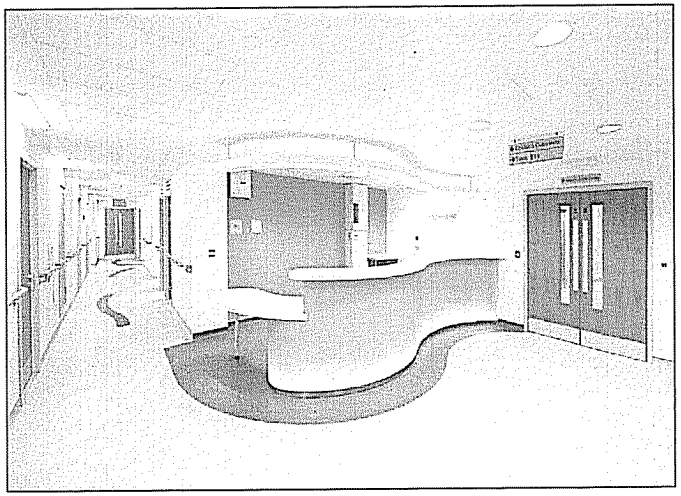

Kent & Sussex
DO NOT THROW
WET WIPES INTO
THE MASERATOR!!
WARNING

The new Tunbridge Wells Hospital

Some of our early achievements

- First NHS hospital to offer every inpatient a single en-suite room
- No mixed sex breaches
- High levels of patient privacy and dignity
- Groundbreaking `hospital within hospital' design
- Commended by the National Patient Safety Agency
- Template for future hospital design worldwide
- Centres of expertise able to provide higher standards of care
- Unrivalled facilities for families
- Two hospitals working together with shared centres of expertise
  - Consultants available for longer each day
  - Increased opportunities for subspecialisation
- Generating Private Patient income to support NHS care
- Recommended for Trauma Unit status



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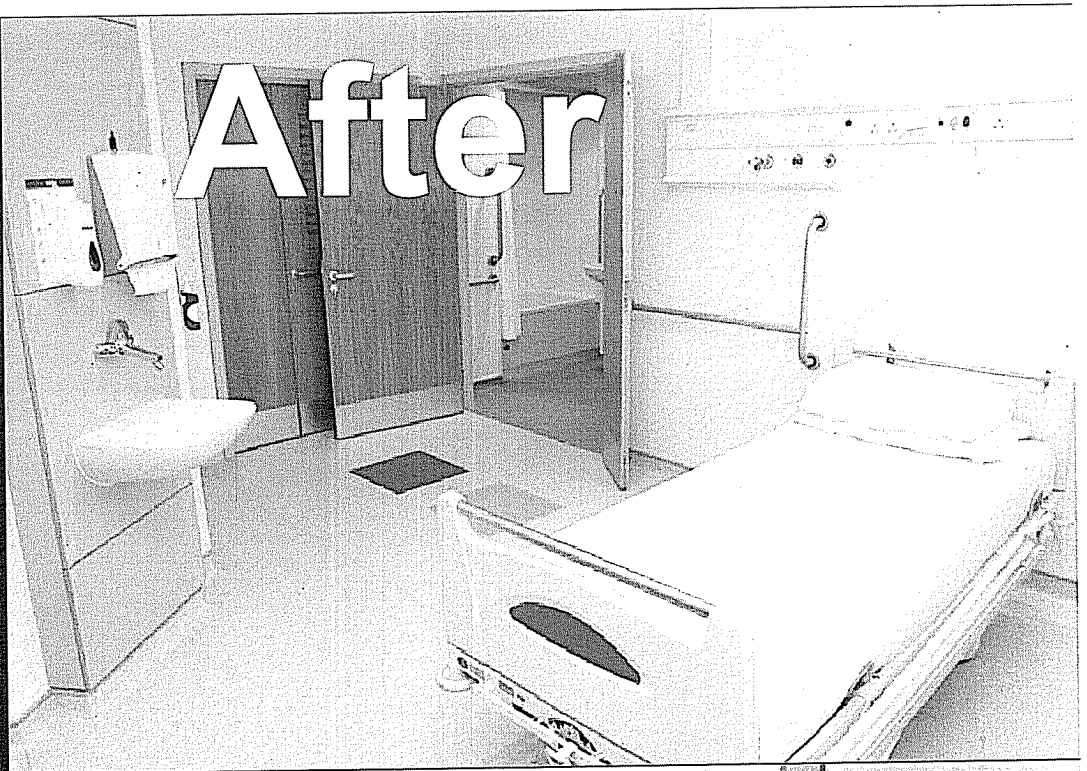
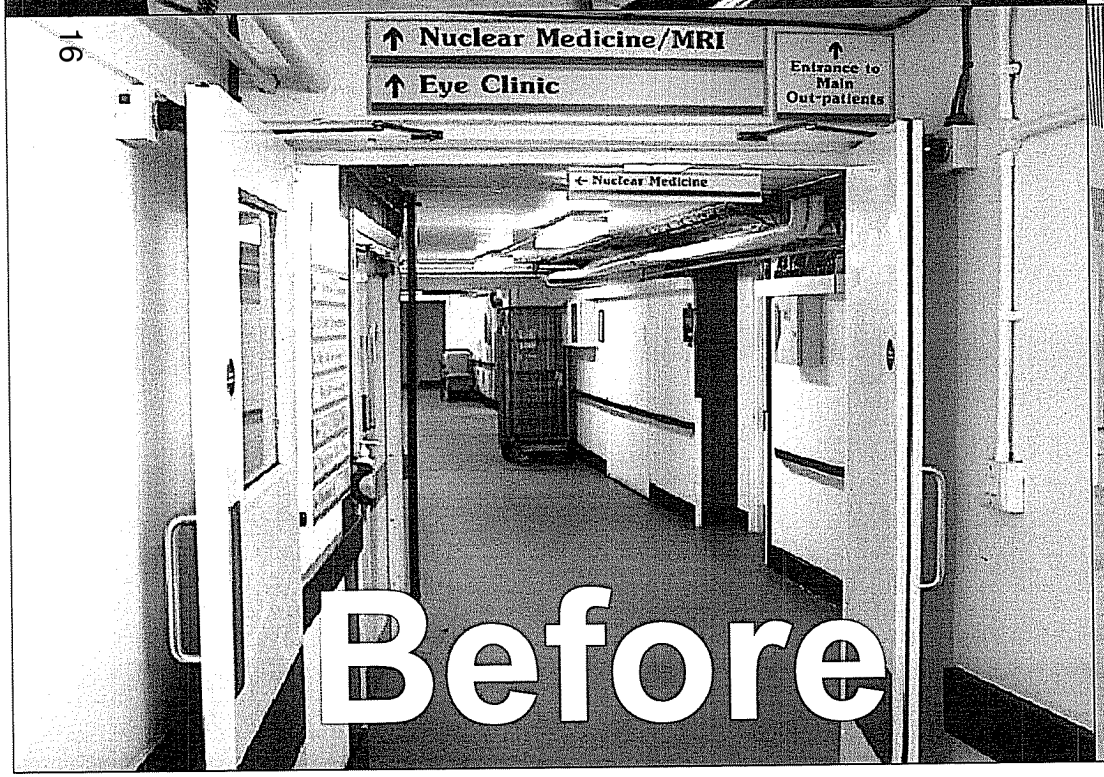
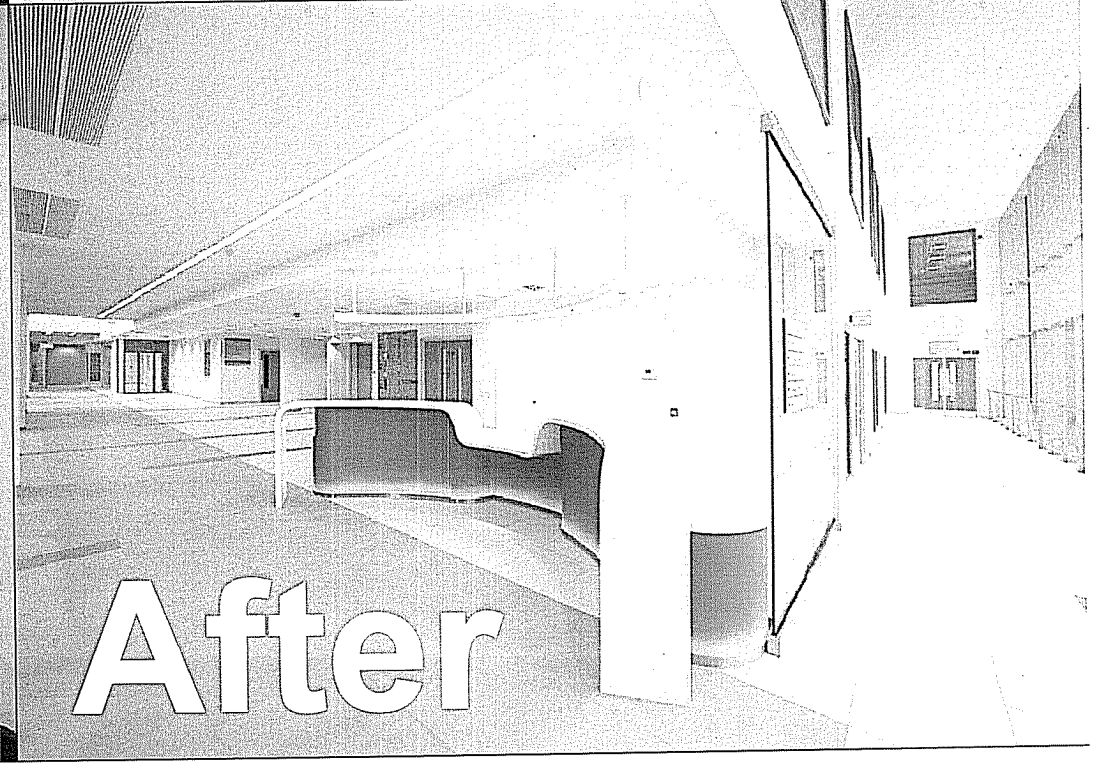

After


Nuclear Medicine/MRI
Eye Clinic
Entrance to Main Out-patients
Nuclear Medicine
Before


After

Challenges

- Moving patients into the new hospital from K&S
- Maintaining momentum and staff morale
- Car parking and public transport
- Embedding new systems and working practices

Performance

- Steady improvement in 4 hour A&E waiting times
- Low infection rates
- Fall in cancelled operations
- Patients having emergency surgery sooner
- Birth Centre exceeded all expectations
- No drop-off in patients to other areas
- Maintaining key performance standards

Service Integration

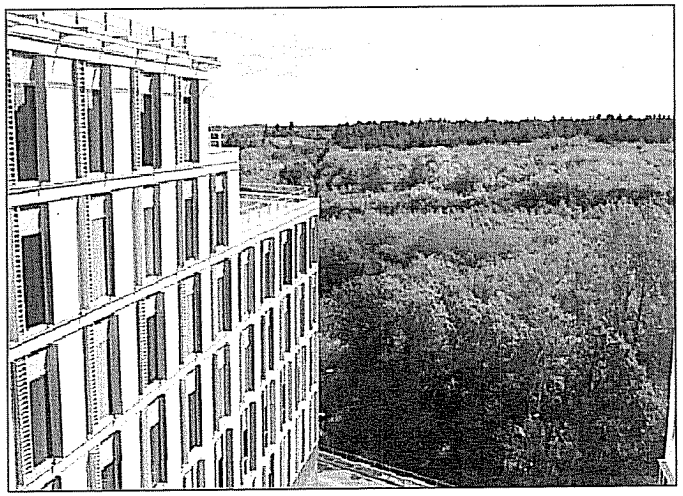
- Diabetes Care in Tunbridge Wells town centre
- Stroke rehabilitation in Cottage Hospital

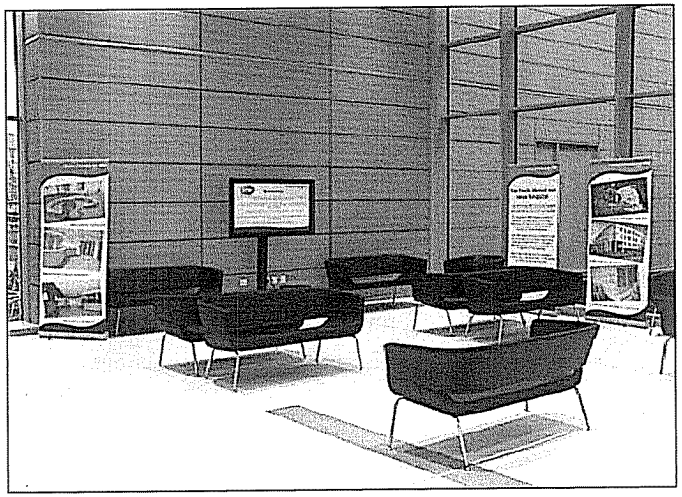
Financial sustainability

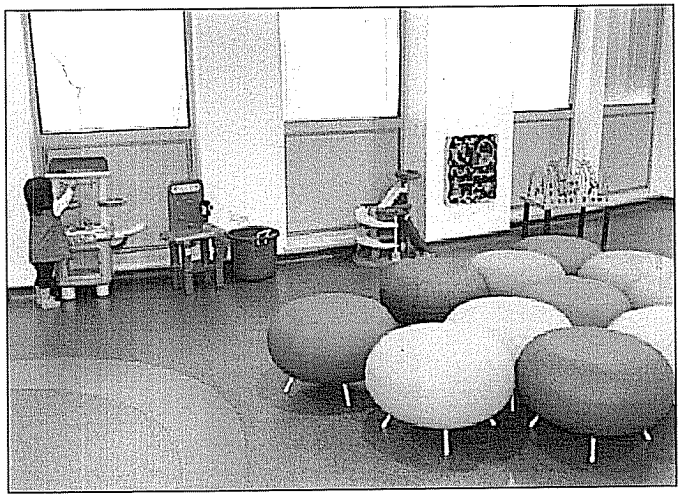
- PFI was only funding on offer – Department of Health financial support

Foundation Trust status

- Achieve FT Status by April 2014







Patient Feedback

Real-time feedback through…..

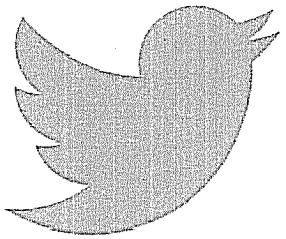
Twitter - Facebook - Friends and Family test early adopters

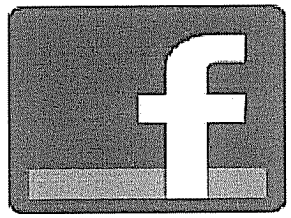
Philkenmore Sep 18, 2:23am via Twitter for iPhone
… Yesterday at new #Pembury hospital –part of #MTW Trust – all single bedded. Amazing place, shows real innovation & change NHS can achieve

PhillipRTW: Does anyone know the opening times for radiology at Pembury Hospital? Can't find it anywhere online! #NHS #asktwitter6.22am, Sep 14 from Twitter

MTWnhs: @philiprtw Pls visit http://t.co/hPM2YRzY and call the Relevant number to find out the most up-to-date opening hours as times vary 11:45am, Sep 14

PhilipRTW: @MTWnhs Many thanks for that! I went in this afternoon after phoning and was in and out in half an hour! Many thanks, love the new hospital. 10:29pm, Sep 14





Maidstone and Tunbridge Wells NHS Trust carries out real-time inpatient surveys. Over **3,000** inpatients have been surveyed in the new hospital since September 2011. To date, **90%** of inpatients say they are happy with their care and overall experience.

The Trust is an early adopter of the Friends and Family test. Since August 2012 it has asked **1,230** patients if they would be happy for friends and relatives to be treated at Tunbridge Wells Hospital.

98% of patients surveyed said they would be happy to recommend us.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 November 2013

Subject: Forward Work Programme: 2013.

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1. HOSC Meeting Dates 2013.

(a) The following are the scheduled dates for the formal meetings of the Health Overview and Scrutiny Committee in 2013:

- 4 January.
- 1 February.
- 8 March.
- 7 June.
- 19 July.
- 6 September.
- 11 October.
- 29 November.

2. Forward Work Programme

(a) The proposed Forward Work Programme for early 2013 is set out below:

- 4 January

1. East Kent Maternity Services Review: Implementation.

2. Cancer Services: Overview.

- 1 February

1. Patient Transport Services.

2. Audiology.

3. Maidstone Hospital: Current and Future Developments.

- 8 March

1. Services Overview: a) Diabetes Services; and b) Ophthalmology. *(Due to the close overlap between these two areas, it is anticipated they will be considered together).*

(c) As was discussed at the HOSC meeting of 13 April 2012, there is a need to retain as much flexibility as possible in the forward work programme in order to deal appropriately with issues which may arise

within the health economy. The exact scheduling of some of the items listed above may vary.

(d) If any Member has any specific question on any of the items on the forward work programme which they would like asked of the relevant Trust(s) in advance of the item being discussed, please pass them to the Research Officer to the Committee for inclusion in the list of questions submitted to the NHS in advance.

2. Kent and Medway NHS Joint Overview and Scrutiny Committee.

(a) This Joint Committee with Medway Council was established at the meeting of the County Council of 25 March 2004. The arrangements were updated at County Council on 14 September 2006.[1]

(b) The Joint Committee consists of 12 Members: 8 from Kent County Council and 4 from Medway Council.

(c) The first meeting of this Committee took place on 3 July 2012. This considered the review into adult inpatient mental health services. The date of a second meeting on this topic is to be confirmed.

(d) Following the decision of this Committee that the proposed review of vascular services constituted a substantial variation of service and the same decision made by Medway Council's Health and Adult Social Care Overview and Scrutiny Committee, this topic will therefore be considered at the appropriate time by the Kent and Medway NHS Joint Overview and Scrutiny Committee.

3. Recommendation

That the Committee note the meeting dates for 2013 and approve the Forward Work Programme.

[1] http://democracy.kent.gov.uk/Data/County%20Council/20060914/Agenda/sep06-item7.pdf

Item 6: Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Relationship.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 November 2012

Subject: Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Relationship.

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1. Background

(a) The Committee last discussed this item at its meeting of 9 March 2012 and received a written update at its meeting of 7 September 2012.

2. Recommendation

That the Committee consider and note the report.

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

To: Health Overview and Scrutiny Committee, 30 November 2012

Subject: A) NHS Foundation Trust Status and Monitor
B) Financial Support for NHS Trusts
C) South London Healthcare NHS Trust

Part A - NHS Foundation Trust Status, Monitor and the Co-Operation and Competition Panel

1. Foundation Trusts (FTs)

(a) Foundation Trusts are independent public benefit organisations but remain part of the NHS. They are accountable to Parliament as well as the local community. They have a duty to engage with their local community and encourage local residents, staff and service users to become members. Members can stand for election to the board/council of governors.

(b) The council of governors is drawn from various constituencies, with members either elected or appointed by that constituency. It works with the board of directors, which has the responsibility for day-to-day running of the FT.[1]

(c) As things currently stand, there are a number of differences between NHS Trust and NHS Foundation Trust status. One of the areas of difference is around financial duties:

1. NHS Trusts have a duty to break even, meaning that their expenditure must not exceed their income, taking one financial year with another. Spending on capital and cash held must be within certain limits.

2. FTs are not statutorily required to break even, but must achieve the financial position set out in their financial plan. One main measure of an FT's financial performance is EBITDA (earnings before interest, tax, depreciation and amortisation).[2]

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[1] Monitor, *Current practice in NHS foundation trust member recruitment and engagement,* 2011, http://www.monitor-nhsft.gov.uk/sites/default/files/Current%20practice%20in%20foundatio...ecruitment%20and%20engagement.pdf

[2] Academy of Medical Royal Colleges and Audit Commission, *A Guide to Finance for Hospital Doctors*, July 2009, p.23, http://www.audit-commission.gov.uk/health/audit/financialmgmt/hospitaldoctors/Pages/hospitaldoctors9jul2009.aspx

2. The Foundation Trust Pipeline

(a) There are currently 144 FTs across England.[3] The NHS Operating Framework for 2012/13 provides the following summary of the FT Pipeline:

- *"Progress on the NHS Foundation Trust (FT) pipeline is not an end in itself but a critical means for creating clinically and financially sustainable organisations across the provider sector. NHS trusts are expected to achieve NHS FT status on their own, as part of an existing NHS FT or in another organisational form by April 2014, with a few concluding beyond this date by exceptional agreement. Plans for all NHS trusts have been agreed under Tripartite Formal Agreements (TFAs), which codify the locally owned issues, actions and processes and set out the journey each organisation must take going forward."*[4]

(b) Since October 2010, the Department of Health has been developing new processes to assist aspirant Trusts towards authorisation. The completions of a 'tripartite formal agreement' (TFA) for each Trust has been a core element of this with the TFA summarising the main challenges faced by each organisation along with the actions to be taken by the Trust, SHA and Department of Health.[5] Any issues were put into four categories:[6]

- Financial;
- Quality and Performance;
- Governance and leadership; and
- Strategic issues.

(c) In Kent and Medway, the Foundation Trusts are currently:

- East Kent Hospitals NHS University Foundation Trust;
- Medway NHS Foundation Trust; and
- South East Coast Ambulance Service NHS Foundation Trust

(d) The ***NHS Trust Development Authority (NTDA)*** was established as a Special Health Authority in June 2012 to be able to take on the

[3] Monitor, http://www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/nhs-foundation-trust-directory
[4] Department of Health, *The Operating Framework for the NHS in England 2012/13*, 24 November 2011, p.29, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf
[5] National Audit Office, *Achievement of foundation trust status by NHS hospital trusts*, Full report p.6, 13 October 2011, http://www.nao.org.uk/publications/1012/foundation_trusts.aspx
[6] All TFAs can be accessed here: http://healthandcare.dh.gov.uk/foundation-trusts-tripartite-formal-agreements/

responsibility for overseeing NHS Trusts (i.e. those which are not FTs) from April 2013 when SHAs will have been abolished.[7]

4. Monitor

(a) Monitor is the independent regulator of NHS Foundation Trusts and is directly accountable to Parliament.

(b) The three main strands to its work are currently:

1. Assessing the readiness of Trusts to become FTs;

2. Ensuring FTs comply with their terms of authorisation and that they are well governed and financial robust; and

3. Supporting FT development.[8]

(c) When assessing an NHS Trust applying for Foundation Trust status, the focus is on three key questions:

1. Is the trust well governed with the leadership in place to drive future strategy and improve patient care?

2. Is the trust financially viable with a sound business plan?

3. Is the trust legally constituted, with a membership that is representative of its local community?[9]

(d) Once an FT has been authorised, Monitor looks to ensure it is compliant with its terms of authorisation which are a set of detailed requirements around how the FT must operate. Some of the areas covered in the terms of authorisation are:

- the general requirement to operate effectively, efficiently and economically;

- requirements to meet healthcare targets and national standards; and

- the requirement to cooperate with other NHS organisations. [10]

(e) Each FT is assigned an annual and quarterly risk rating which indicate the risk of failure to comply with the terms of authorisation. Two risk ratings are published:

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[7] http://www.ntda.nhs.uk/about/
[8] http://www.monitor-nhsft.gov.uk/home/about-monitor/what-we-do
[9] http://www.monitor-nhsft.gov.uk/about-monitor/what-we-do-0#1
[10] http://www.monitor-nhsft.gov.uk/about-monitor/how-we-do-it/how-monitor-regulates-nhs-foundation-trusts

1. governance (rated red, amber-red, amber-green or green); and

2. finance (rated 1-5, where 1 represents the highest risk and 5 the lowest).[11]

(f) Where an FT is at risk of breaching its terms of authorisation, Monitor can require an action plan from the organisation but has a range of formal intervention powers where improvement has not been demonstrated.

(g) FT development is supported through such programmes as service-line management which involves identifying specialist clinical areas and managing them as distinct operational units.[12]

(h) A number of changes to the role of Monitor are being introduced as a result of the Health and Social Care Act 2012. It will become the sector regulator for health and carry out functions in the following areas:

1. Licensing providers of NHS care

2. Regulating prices;

3. Enabling integration;

4. Safeguarding choice and competition

5. Assessing NHS providers for FT status;

6. Supporting service continuity.[13]

5. The Co-operation and Competition Panel

(a) Monitor and the Department of Health jointly sponsor ***The Co-operation and Competition Panel*** (CCP). The CCP was formally established on 29 January 2009.[14] It provides advice on the application of the Department of Health's *Principles and Rules of Co-operation and Competition*.[15] Cases are undertaken by the CCP in the following four categories:

- Merger cases;
- Conduct cases;
- Procurement dispute appeals; and

[11] Ibid.
[12] http://www.monitor-nhsft.gov.uk/SLM
[13] Monitor, *Introduction to Monitor's future role*, 20 June 2012, http://www.monitor-nhsft.gov.uk/monitors-new-role/-introduction-monitors-new-role
[14] Co-operation and Competition Panel, *Guide to the Co-operation and Competition Panel*, http://www.ccpanel.org.uk/content/Guide-to-the-CCP.pdf
[15] Co-operation and Competition Panel, *Principles and Rules of Co-operation and Competition*, http://www.ccpanel.org.uk/content/Principles_and_Rules_REVISED5.pdf

- Advertising and misleading information dispute appeals.[16]

(b) On 15 February 2012 the CCP accepted the merger of Dartford and Gravesham NHS Trust and Medway Foundation Trust for review. The scope was to see whether the proposed merger was consistent with Principle 10 of the *Principles and Rules of Co-operation and Competition.*[17]

(c) Principle 10 is:

- *"Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interests, for example because they will deliver significant improvements in the quality of care."*[18]

(d) Phase 1 of the review was completed on 11 April 2012. Phase 2 was completed on 10 October 2012 and a report published. The report's conclusion was:

- *"On the basis that the safeguards are in place, the CCP recommendation to the Department of Health and Monitor is that the proposed merger is consistent with Principle 10 of the Principles and Rules."*[19]

(e) The Executive Summary of the CCP report is attached as an Appendix.[20]

Part B - Financial Support for NHS Trusts[21]

(a) On 3 February 2012, the Department of Health announced that 7 Trusts may receive additional funding support from the DH. The Trusts are:

1. Barking, Havering and Redbridge NHS Trust;

[16] Co-operation and Competition Panel, *About the CCP*, http://www.ccpanel.org.uk/about-the-ccp/index.html

[17] Co-operation and Competition Panel, *Merger of Dartford and Gravesham NHS Trust with Medway NHS Foundation Trust*, http://www.ccpanel.org.uk/content/cases/Dartford_and_Gravesham_NHS_Trust_with_Medway_NHS_Foundation_Trust/121009_Dartford_Medway_Merger_Report_Excisions_Final_2.pdf

[18] Co-operation and Competition Panel, *Principles and Rules of Co-operation and Competition*, p.4, http://www.ccpanel.org.uk/content/Principles_and_Rules_REVISED5.pdf

[19] Co-operation and Competition Panel, *Merger of Dartford and Gravesham NHS Trust with Medway NHS Foundation Trust*, p.4, http://www.ccpanel.org.uk/content/cases/Dartford_and_Gravesham_NHS_Trust_with_Medway_NHS_Foundation_Trust/121009_Dartford_Medway_Merger_Report_Excisions_Final_2.pdf

[20] Sourced from: Ibid., pp. 1, 3-4.

[21] This section sourced from: Department of Health, *NHS trusts to receive funding support*, 3 February 2012, http://mediacentre.dh.gov.uk/2012/02/03/nhs-trusts-to-receive-funding-support/

2. Dartford and Gravesham NHS Trust;

3. Maidstone and Tunbridge Wells NHS Trust;

4. North Cumbria NHS Trust;

5. Peterborough and Stamford Hospitals NHS Foundation Trust;

6. South London Healthcare NHS Trust; and

7. St Helens and Knowsley NHS Trust.

(b) These Trusts had demonstrated they face "serious structural financial issues" and have historic PFI arrangements. Subject to 4 tests, these Trusts will be able to access financial support up to £1.5 billion over 25 years. A local plan to achieve long term, financial balance must also be in place.

(c) The 4 tests are:

1. The problems they face should be exceptional and beyond those faced by other organisations;

2. They must be able to show that the problems they face are historic and that they have a clear plan to manage their resources in the future;

3. They must show that they are delivering high levels of annual productivity savings;

4. They must deliver clinically viable, high quality services, including delivering low waiting times and other performance measures.

Part C – South London Healthcare NHS Trust

(a) On 16 July 2012, the Regime for Unsustainable NHS Providers was implemented for the first time and applied to South London Healthcare NHS Trust (SLHT). The regime is a way for the Government to deal with NHS Trusts that "are either unsustainable in their current configuration or at serious risk of failing to deliver sustainable services, and of failing to comply with the plans to move towards achieving Foundation Trust status."[22] The Trust Board was suspended and a

[22] Office of the Trust Special Administrator, *Draft Report. Securing sustainable NHS services. Consultation on the Trust Special Administrator's draft report for South London Healthcare NHS Trust and the NHS in south east London*, 29 October 2012, p.83,http://www.tsa.nhs.uk/sites/default/files/TSA-DRAFT-REPORT-WEB3.pdf

Trust Special Administrator (TSA), Matthew Kershaw, appointed to be accountable officer for the Trust and develop recommendations for the Secretary of State with the aim of ensuring high quality sustainable services.

(b) A draft report with draft recommendations was published on 29 October 2012 and a consultation on them will run from 2 November to 13 December 2012. A final report will go to the Secretary of State for Health on 7 January 2013. The Secretary of State then has 20 working days to determine what action to take, and so this will take place by 1 February 2013. The Secretary of State's decision is final; there is no right of appeal.

(c) The summary of the recommendations is appended to this Background Note.[23]

(d) Further information on Draft recommendation VI, organisational solutions, provides the following further information on Queen Mary's Hospital Sidcup:

- *"Draft recommendation II sets out the proposals for the future of Queen Mary's Hospital in the context of the development of a Bexley Health Campus. The site should be owned and run by Oxleas NHS Foundation Trust. Under Oxleas' leadership the hospital will have a sustainable future, providing the services that commissioners have identified are required for the local population and a centre of excellence for inpatient mental health services across Bexley and Bromley."*

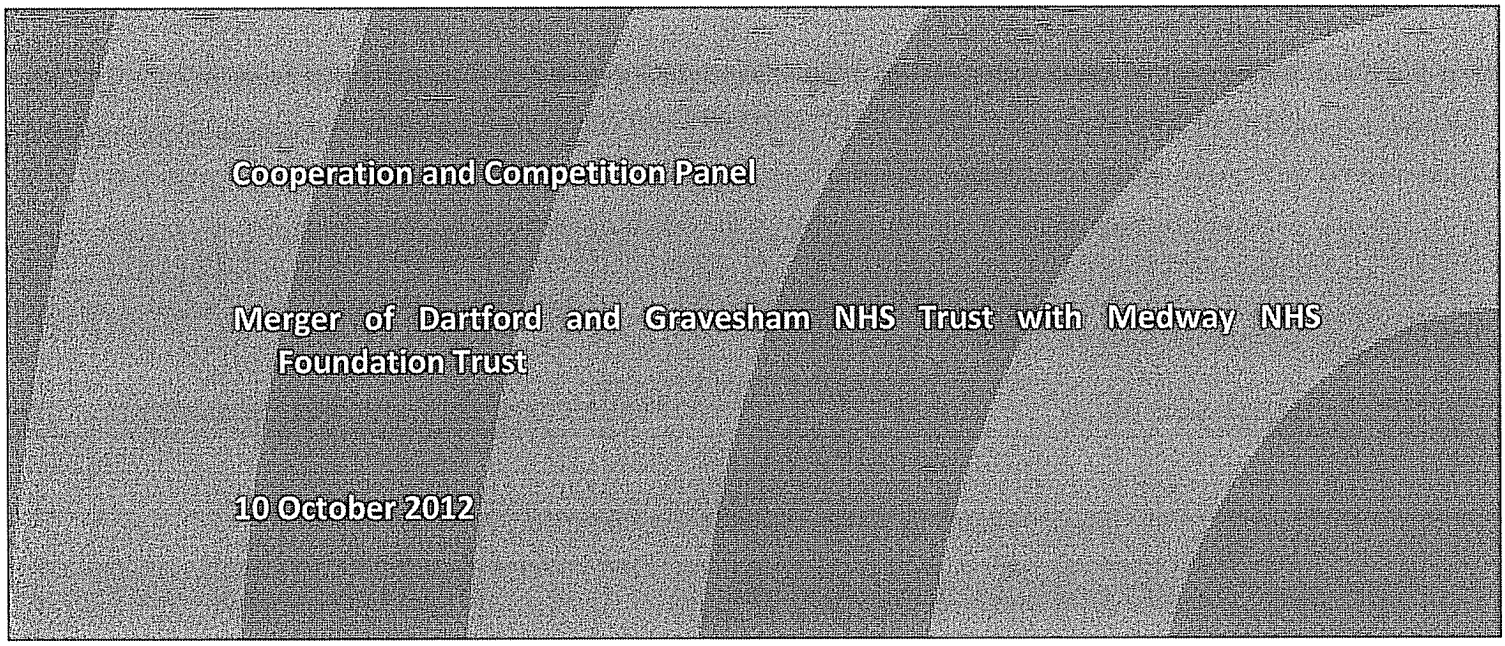
- *"The majority of services currently provided from the site will continue to be provided there, with some new services being added – specifically a satellite radiotherapy unit to be provided by Guy's and St Thomas' NHS Foundation Trust. As per draft recommendation V, day case elective surgery and endoscopies, both currently delivered at Queen Mary's Hospital by South London Healthcare NHS Trust will continue to be provided there. However, as the Trust will no longer exist, Bexley CCG should initiate a procurement exercise to secure the right provider of care for the future. In the interim, the draft recommendation is for Dartford and Gravesham NHS Trust to be the provider of these services. The small number of inpatient elective procedures that currently take place at Queen Mary's Hospital (around 2,000 per year) should be consolidated with the elective surgical work for south east London in the proposed elective centre at University Lewisham Hospital. As outlined in draft recommendation V, further work will be undertaken to explore a partnership model for the delivery of services that would see services being provided by a range of organisations on*

[23] Take from: Office of the Trust Special Administrator, *Draft Recommendations*, http://www.tsa.nhs.uk/sites/default/files/Summary%20of%20TSA%20recommendations.pdf

> *the University Lewisham Hospital site, for which the outpatient services would be available on the Bexley Health Campus."*[24]

[24] Office of the Trust Special Administrator, *Draft Report. Securing sustainable NHS services. Consultation on the Trust Special Administrator's draft report for South London Healthcare NHS Trust and the NHS in south east London*, 29 October 2012, pp.71-2, http://www.tsa.nhs.uk/sites/default/files/TSA-DRAFT-REPORT-WEB3.pdf

CO·OPERATION & COMPETITION PANEL
FOR NHS-FUNDED SERVICES



EXECUTIVE SUMMARY

1. The Cooperation and Competition Panel (CCP) has reviewed the proposed merger of Dartford and Gravesham NHS Trust (Dartford and Gravesham Trust) with Medway NHS Foundation Trust (Medway Trust) (the Merger Parties). Our advice to the Department of Health and Monitor is that the proposed merger is consistent with Principle 10 of the Principles and Rules for Cooperation and Competition (Principles and Rules), as long as the behavioural safeguards that the CCP has agreed with the Merger Parties and NHS Kent and Medway (Commissioners) are put in place.[1]

2. In reaching our findings we considered the effect of the merger on patient choice and competition in elective, non-elective, community, outpatient and specialist services in the north Kent area.

3. For non-elective, community, outpatient and specialist services we concluded that it is likely that there will be sufficient choice and competition following the merger. We also concluded that adverse effects from the merger arising from the referral relationship between the Merger Parties and others are unlikely to arise.

4. We concluded that the merger is likely to give rise to material costs to patients and taxpayers as a result of a loss in patient choice and competition for two elective services provided at Medway Maritime Hospital: Urinary Tract and Male Reproductive System Procedures and Disorders, excluding the West Kent Cancer Centre (Urology Services); and Endocrine System Disorders (Endocrinology Services). In respect of all other elective services we concluded that there is unlikely to be a reduction in patient choice and competition following the merger.

5. The CCP carefully considered a number of benefits the Merger Parties submitted would be achieved through the merger. We concluded the benefits submitted by the Merger Parties either did not constitute benefits to patients or taxpayers, or were not specific to the merger under review. The CCP therefore concluded these did not offset the identified costs. However, although a number of the submitted benefits could be achieved without the merger, we concluded that the Merger Parties should nevertheless be held to achieve those benefits if the merger went ahead.

6. With no benefits to offset the costs to patients and taxpayers arising from the merger, the CCP concluded that it was necessary to address the loss of patient choice and competition in the two service lines with appropriate behavioural safeguards. In the interests of timeliness, we sought to agree these safeguards with the Merger Parties and Commissioners prior to finalising our Phase II report, rather than undertake a full remedies consultation process after publication of the CCP's report.

[1] The Principles and Rules are available at:. www.ccpanel.org.uk. NHS Kent and Medway represents the following primary care trusts: NHS West Kent, NHS Eastern and Coastal Kent and NHS Medway and successor Clinical Commissioning Groups.

7. The Merger Parties and Commissioners have made commitments that have provided sufficient comfort to the CCP that appropriate behavioural safeguards can be put in place to address the material costs identified in our analysis. These safeguards cover the following:
    - Promotion of patient choice by Commissioners through the regular dissemination of key performance information on service quality at Medway Maritime Hospital to GPs and patients;
    - Service quality indicators for elective Urology Services and Endocrinology Services at the Medway Maritime Hospital to be measured by the Merger Parties and monitored by Commissioners. Where quality declines against agreed benchmarks, Commissioners are empowered to take timely action to address the decline, that could include re-tendering the service if necessary; and
    - Timely delivery of benefits by the Merger Parties, to be monitored by Commissioners.

8. The safeguards related to service quality indicators and the timely delivery of benefits will be codified in the Standard Acute Contract agreed between the merged trust and Commissioners post-merger. The safeguards will operate for as long as it is necessary to address the loss in patient choice and competition following the merger. Commissioners will review the appropriateness and effectiveness of the service quality indicators two years from the date of the merger. Should Commissioners form the view that the measures are no longer required, they may apply to Monitor for approval to revoke them.

9. The safeguards relating to merger benefits will expire three years following the merger, on Commissioner acceptance of the final report on the benefits realisation plan. The safeguards relating to patient choice will be reviewed within four years of the merger. Should Commissioners form the view that the measures are no longer required, they may apply to Monitor for approval to revoke them.

10. In the CCP's view these safeguards would have the benefit of timely resolution of an important issue combining a clear set of obligations on the Merger Parties to deliver benefits to patients, commitments by Commissioners to monitor the obligations, and arrangements to ensure that if quality declined the interests of patients will be protected.

11. On the basis that the safeguards are in place, the CCP recommendation to the Department of Health and Monitor is that the proposed merger is consistent with Principle 10 of the Principles and Rules.

Draft recommendations

Summary

The draft recommendations put forward in the TSA's report propose a response to the long-standing issues at South London Healthcare NHS Trust (and its predecessor Trusts) and the sustainability challenges that are forecast to be facing the wider south east London system in the future. The recommendations are set in the context of the need to move towards a model of healthcare that ensures continued improvement in life expectancy and quality of life while addressing the challenges of an ageing population, the growth in the number of people with long term conditions and constrained levels of funding to the NHS. Only through a response to all of these dimensions can safe, high quality, affordable health services be secured for the population of south east London in a sustainable way.

The scale of change required both in the Trust and across the wider health economy is significant and cannot be delivered instantly. A three-year transformation programme is recommended. Through this, the NHS in south east London will be able to deliver services within the resources available by the end of the financial year 2015/16. At this point of the UPR process, it is proposed that the transformation programme has six elements to it:

1. The operational efficiency of the hospitals that make up South London Healthcare NHS Trust needs to improve so that the Trust's costs are in line with strong performing NHS organisations.

2. Queen Mary's Hospital Sidcup should be developed into a Bexley Health Campus providing a range of services to the local population, including day case elective surgery, endoscopy and radiotherapy. The facility should be owned by Oxleas NHS Foundation Trust and services should be provided by a range of organisations.

3. Vacant and poorly utilised premises should be exited (leases) or sold (freeholds). The NHS should engage with the local authorities in Bromley and Bexley in the

process of selling surplus estate to ensure its future use maximises regeneration opportunities.

4. On an annual basis until the relevant contracts end, the Department of Health should provide additional funds to the local NHS to cover the excess costs of the PFI buildings at Queen Elizabeth Hospital and Princess Royal University Hospital.

5. In line with commissioner intentions to improve the quality of care for the local population, there should be a transformation in the way services are provided in south east London. Specifically, changes are recommended in relation to community-based care and emergency, maternity and elective services:

    - Community Based Care – The Community Based Care strategy for south east London should be implemented to deliver improved primary care and community services in line with the aspirations in the strategy. This will enable patients to receive care in the most appropriate location, much of which will be closer to, or in, their home.

    - Emergency care – Emergency care for the most critically unwell patients should be provided from four sites - King's College Hospital, St Thomas' Hospital, Queen Elizabeth Hospital and Princess Royal University Hospital. Alongside this, services at University Hospital Lewisham, Guy's Hospital and Queen Mary's Hospital Sidcup will provide urgent care for those that do not need to be admitted to hospital. Emergency care for those patients suffering from a major trauma (provided at King's College Hospital), stroke (provided at King's College Hospital and Princess Royal University Hospital), heart attack (provided at St Thomas' Hospital and King's College Hospital) and vascular problems (provided at St Thomas' Hospital) will not change from the current arrangements.

    - Maternity care – There are two options under consideration to ensure that a high quality of care is provided for women needing to be in hospital during pregnancy and for women when giving birth. Obstetric-led deliveries could be centralised in line with critical emergency care across King's College Hospital, St Thomas's Hospital, Queen Elizabeth Hospital and Princess Royal University Hospital; alternatively, there could also be a 'stand-alone' obstetric-led delivery unit at University Hospital Lewisham. All other maternity care will continue to be provided in a range of locations across south east London.

    - Elective care – An elective centre for non-complex inpatient procedures (such as hip and knee replacements) should be developed at University Hospital Lewisham to serve the whole population of south east London. Alongside this

elective day cases procedures should continue to be provided at all seven main hospitals in south east London; complex procedures should continue to be delivered at Kings' College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas' Hospital, and specialist procedures at Guy's Hospital, King's College Hospital and St Thomas' Hospital. Outpatient services should be delivered from a range of local locations.

6. In order to deliver this transformation programme, South London Healthcare NHS Trust should be dissolved and other organisations should take over the management and delivery of the NHS services it currently provides. In addition to the proposals for Queen Mary's Hospital Sidcup outlined above:

   - The Queen Elizabeth Hospital site should come together with Lewisham Healthcare NHS Trust to create a new organisation focused on the provision of care for the communities of Greenwich and Lewisham.

   - There are two options for Princess Royal University Hospital. The first is an acquisition by King's College Hospital NHS Foundation Trust, which would enable the delivery of service change, enhance the services offered at the site and strengthen the capacity of the site to deliver the necessary operational improvements. This is the preferred option at this stage. However, an alternative option is to run a procurement process that would allow any provider from the NHS or independent sector to bid to run services on the site.

   - It is important that these new organisations are not saddled with the issues of the past. To this end, it is recommended that the Department of Health writes off the debt associated with the accumulation of deficits at South London Healthcare NHS Trust. By 31 March 2013, this is estimated to be £207m.

Taken together, this proposed set of actions should improve outcomes for patients, resolve the financial issues within South London Healthcare NHS Trust and, more broadly, secure financial sustainability across the wider health economy.

However, delivering this is a considerable task that will require strong leadership and implementation capacity. Further analysis will be undertaken to define the transition and implementation requirements before completion of the final report in January 2013 and in conjunction with the consultation process. However, it is already clear that transitional support will be required to allow time to implement change.

The TSA's draft report that outlines the recommendations in full can be downloaded from:

www.tsa.nhs.uk/document-downloads

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Dartford and Gravesham NHS
NHS Trust

Medway NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S OFFICE
Direct Line 01634 833944
Fax No: 01634 825290

Cllr Christopher Smith
Vice Chairman in the Chair
Members Suite
Sessions House
County Hall
Maidstone
KENT
ME141XQ

Ref: HOSCNovember2012.doc

21 November 2012

Dear Councillor Smith,

Re: Health Overview and Scrutiny Committee Meeting – 30th November 2012

First of all, we would like to convey our sympathies at the sudden passing of Councillor Snelling, on behalf of both our organisations. He will be greatly missed by many colleagues in organisations throughout the county.

Further to the letter we received from the committee, please find our written update on the integration between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust below.

Over the past few months we have finalised a comprehensive plan for integration and submitted it to the relevant official bodies, in anticipation of becoming one trust in spring 2013. Our organisations are currently mobilising and preparing for integration.

1. Cooperation and Competition Panel (CCP) update

In October, the CCP concluded their consideration of the impact integration could have on patient choice and competition. They recommended that the integration should be allowed to proceed to the next stage.

They found that there will continue to be sufficient patient choice and competition for the vast majority of services, following integration. We worked very closely with the CCP throughout the process, along with local GP commissioners, to ensure that patient choice, competition between providers and the quality of services are protected.

Two specific services (elective non-cancer urology and endocrine surgery) were identified by the CCP as requiring additional measures to ensure choice is maintained after integration. We have therefore agreed a number of measures to protect the high quality of those specific services, with the CCP and local commissioners.

This recommendation, that the integration be allowed to proceed, will be taken into account by Monitor, the regulator of NHS Foundation Trusts, and the Department of Health alongside our detailed plans as they consider whether to approve the integration.

2. Finalisation of detailed plans

We have finalised our detailed plans for integration, developed from the Outline Business Case. The plans outline our vision for the integrated trust – Better Care Together: high quality core services and enhanced specialised services for our patients and local communities. They also explore our rationale for integration, the benefits and the plans in place to realise those benefits.

Our Better Care Together vision is about putting patients at the heart of what we do and ensuring that we can deliver high quality services for our local communities now and into the future. There are eight core benefits to realising our vision:

- Patients at the heart of everything we do – excellent quality and personalised care
- Clinical sustainability
- Safeguarded local and core services
- Improved and expanded range of specialised services
- Improved partnership working and integrated care
- Financial sustainability
- An attractive organisation for talented people, creating a sustainable workforce
- A top performing organisation

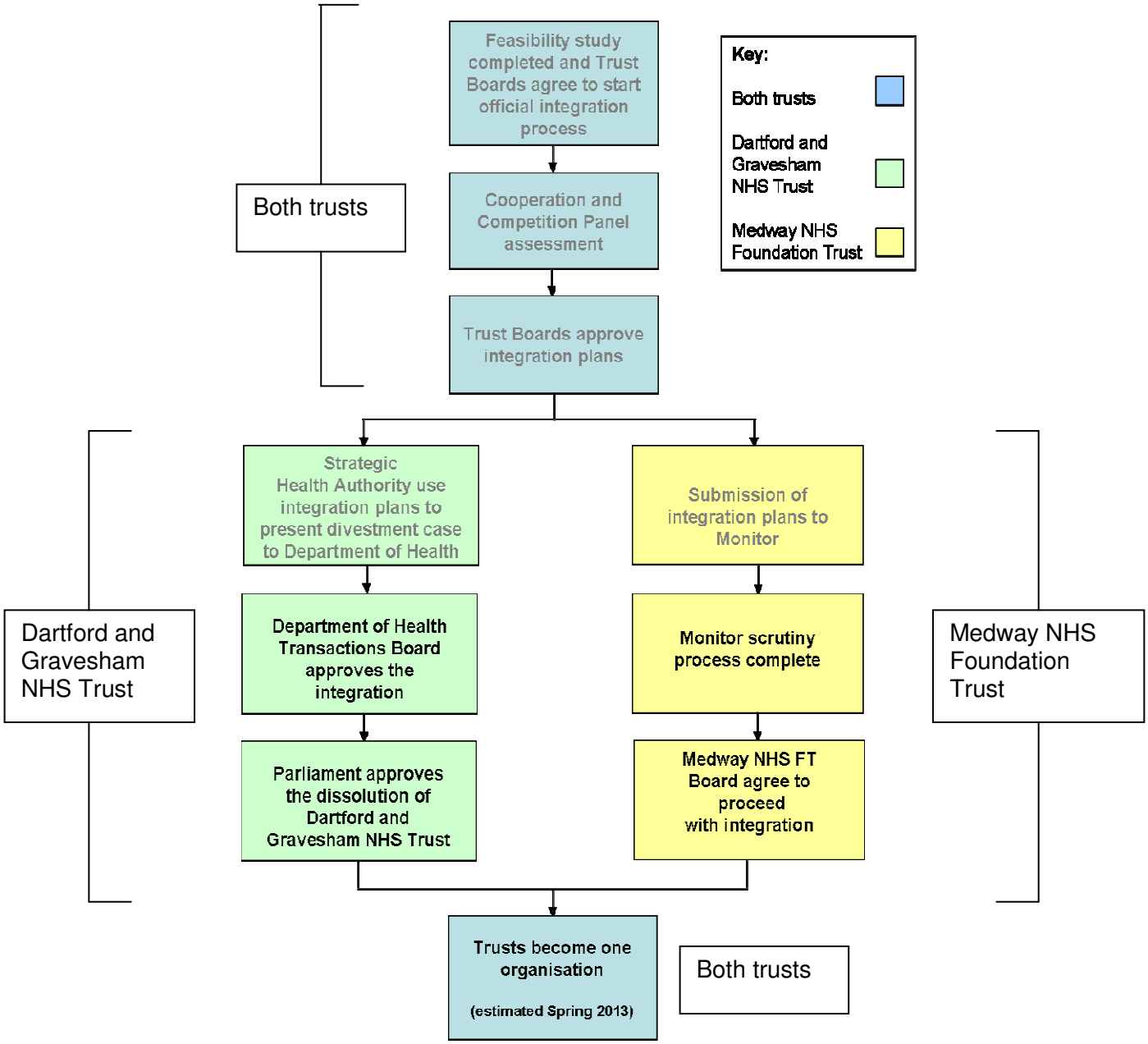
To make this vision a reality, we have developed a number of strategic aims, organisational values and principles. Further details can be found within the executive summary of our business plans, at Annex A, and within the business plans, which can be downloaded from the trusts' websites: www.medway.nhs.uk and www.dvh.nhs.uk

3. Submission

These detailed integration plans were submitted to Monitor, the regulator of NHS Foundation Trusts, and the Department of Health in early November. They will now scrutinise the plans to ensure that the integrated trust will be clinically and financially sustainable for the future, as well as delivering benefits for patients.

This scrutiny process can take some time, but we expect to receive the outcomes of their deliberations in spring 2013. The diagram below shows the process and progress made to date:

Figure 1: Integration Progress Flowchart



4. Dartford and Gravesham NHS Trust's PFI

Further to our update in September, structural support for Dartford and Gravesham NHS Trust's PFI has been included within the Heads of Terms for the integration transaction. This amounts to £6m per annum for the duration of the PFI contract (19 years from 2013/14).

This has been agreed on the basis of four tests being passed, as laid out by ministers when structural support for 7 PFI hospital trusts was announced in February 2012:

1. The problems faced must be exceptional and beyond those faced by other organisations.
2. The Trust must show that the problems are historic and that there is a clear plan to manage resources in the future.
3. The Trust must show that they are delivering high levels of annual productivity savings.
4. The trust must deliver clinically viable, high quality services – including delivering low waiting times and other performance measures.

The Department of Health is currently assessing submissions to confirm that Dartford and Gravesham NHS Trust has passed these tests.

A meeting has been arranged to gain assurance on this matter with Lord Earl Howe (Parliamentary Under-Secretary of State for Quality in the Department of Health) ourselves and local MPs in December.

5. Appointment of Designate Trust Board

Following submission, we have appointed a Designate Trust Board to oversee and lead this period of transition:

- Denise Harker, Chair
- Mark Devlin, Chief Executive
- Susan Acott, Chief Executive of Dartford and Gravesham NHS Trust / Integration Director
- David Meikle, Director of Finance
- Jacqueline McKenna, Director of Nursing
- Dr Gray Smith-Laing, Medical Director
- Miss Annette Schreiner, Associate Medical Director
- Patrick Johnson, Director of Operations (Medway NHS Foundation Trust)
- Julie Hunt, Director of Operations (Dartford and Gravesham NHS Trust)
- Lois Howell, Director of Governance
- Andy Brown, Interim Director of Human Resources

Medway NHS Foundation Trust's non-executive directors and three of Dartford and Gravesham NHS Trust's non-executive directors will complete the Designate Trust Board.

On an operational level, we have developed in-depth systems integration plans for the next five years and it is the implementation and further development of these plans that these designate executives have responsibility for. These plans include all systems and processes that need to be in place in advance of and for day 1, right through to service developments planned for years 3 to 5.

6. South London Healthcare NHS Trust recommendations update

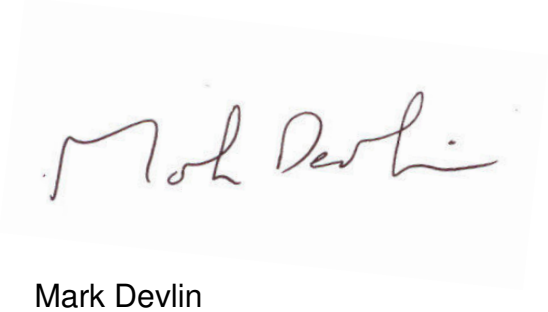
Both trusts welcome the recommendations made by Matthew Kershaw, the Trust Special Administrator, in his draft report to the Secretary of State. Dartford and Gravesham NHS Trust has a long standing, good relationship with the people of Bexley and already provide its residents with a range of elective, emergency and maternity services.

We are pleased to see that it is currently recommended that Dartford and Gravesham NHS Trust should now provide day case elective surgery and endoscopies at Queen Mary's Hospital on an interim basis. However, it is too soon to speculate on the outcome of these recommendations as they are subject to a 30 working day consultation period that commenced on Friday 2 November. The Secretary of State's will announce his decision in February 2013.

The trusts' plans for integration will be carefully updated with any changes in service provision, following the consultation on the Special Administrator's recommendations. Our plans already reflect the desire to offer more services to Bexley patients. The proposal for services to be offered from Queen Mary's Hospital would better enable the integrated trust to deliver high quality services closer to home to the Bexley population, along with the wider North Kent area.

Thank you for this opportunity to provide an update to members and we look forward to attending the HOSC meeting on 30 November. Should members have any questions in the meantime, please do not hesitate to contact us.

Yours sincerely,



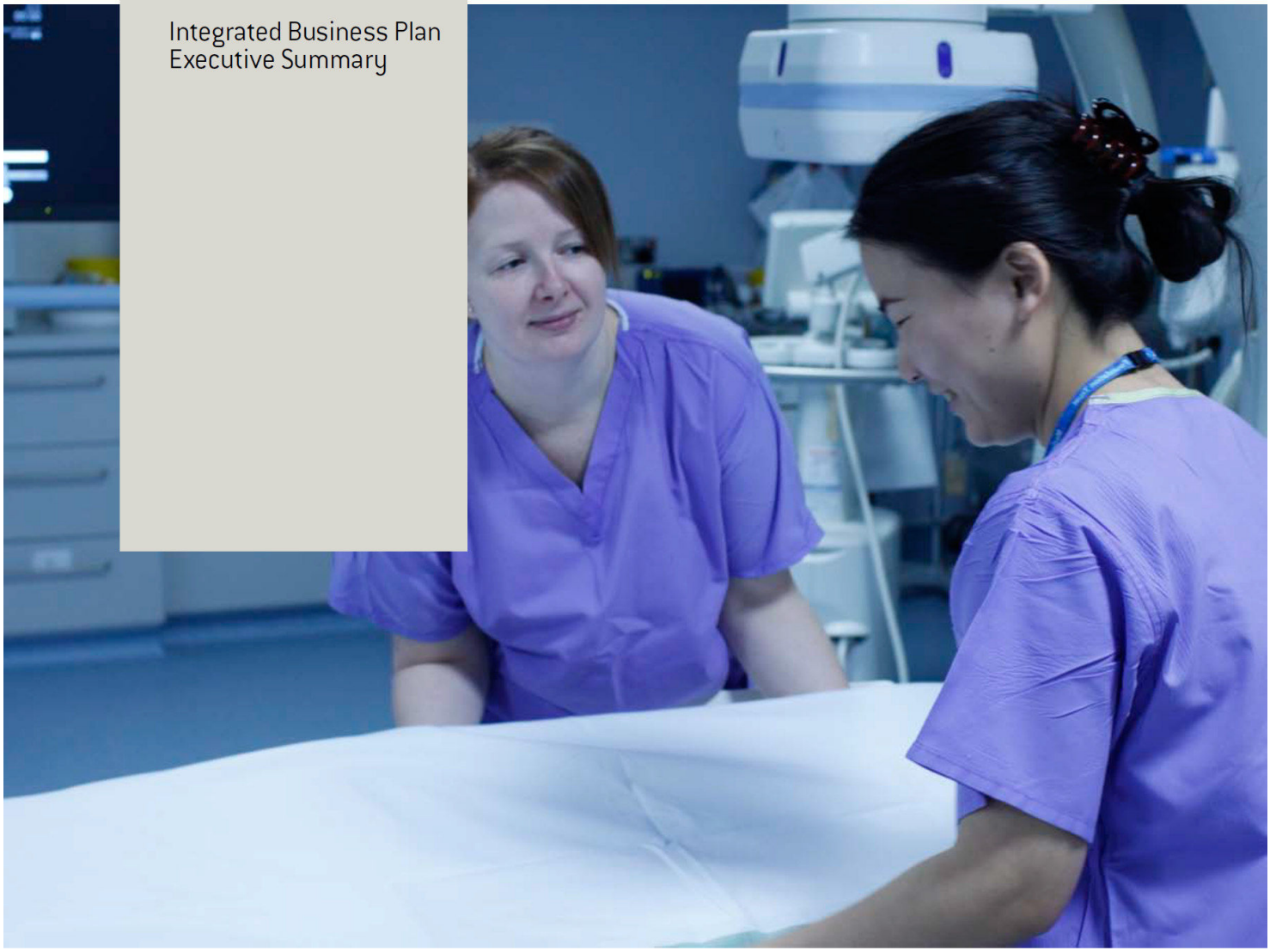
Mark Devlin
Chief Executive
Medway NHS Foundation Trust

Susan Acott
Chief Executive
Dartford and Gravesham NHS Trust

Annex A: Integrated Business Plan Executive Summary

Better Care Together

Integrated Business Plan Executive Summary



Darent Valley Hospital
Medway Maritime Hospital

Foreword

Since 2010, Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust have been exploring partnership and in 2011 began working towards becoming one trust, with the support of our key stakeholders, including GPs. As a culmination of the work that has taken place over the last 18 months, this document clearly sets out why our trusts have chosen integration, the benefits we plan to realise and why we believe that our vision of Better Care Together will benefit our patients, staff and growing communities.

Both trusts have always strived to provide sustainable, high quality core services and have a joint ambition to develop enhanced specialist services. In the context of our communities' growing needs, but recognising the financial restraint facing NHS organisations nationwide, we will best be able to achieve this by coming together as one organisation.

Over the past 18 months, our senior clinicians have taken the lead in developing plans for services at Medway Maritime Hospital and Darent Valley Hospital and are eager to turn them into reality. We have already celebrated some early successes, including developing paediatric surgery, so that many sick children and their families no longer have to travel into London for treatment.

Our doctors and nurses are also focusing on working with local universities to expand research, development and education at both hospitals. This will make sure that leading edge medicine and new medical trials are available to our patients, at the same time as providing new opportunities for our staff.

Throughout the integration process we have focused on listening to and working with our communities and their representatives. We have heard how important keeping services local is to our patients. As one organisation, we are committed to safeguarding the range of services our hospitals currently provide, maintaining local access to core services.

We will also be able to develop enhanced specialist services, offering our patients a local choice in addition to London hospitals. This investment is only possible with the financial savings that integration allows us to realise; resulting from the pooling of our resources, reduced management costs and sharing of best practice. Furthermore, we will work collaboratively with community healthcare providers, commissioners and other health and social care providers to develop integrated care pathways, ensuring that our patients receive care in the right place, at the right time.

Integration offers us a range of opportunities: to compare with the very best hospitals in the NHS, to continually improve patient care and to achieve excellent service quality. The key to delivering our Better Care Together vision will be putting our patients at the heart of everything we do.

We would now like to invite you to read this Integrated Business Plan to discover more about our plans, and how we plan to deliver Better Care Together for the communities of North Kent now and in the future.

Mark Devlin
Chief Executive
Medway NHS Foundation Trust

Denise Harker
Chair
Medway NHS Foundation Trust

Improved local services for patients

This document outlines the proposed integration of Medway NHS Foundation Trust (MFT) and Dartford and Gravesham NHS Trust (DGT) to form the new North Kent Hospitals NHS Foundation Trust (NKHFT), consisting of Darent Valley Hospital in Dartford and Medway Maritime Hospital in Gillingham.

Integration represents an important opportunity to safeguard, improve and enhance the range of healthcare services for our local communities, at a time of challenge and increased pressure on resources in the NHS. An independent report shows that spending in our local health economy will reduce by £60m over the next five years, so we need to change the way we provide healthcare.

Our vision is to provide high quality core services and enhanced specialist services for our patients.

People will continue to have access to high quality, safe services at both hospitals, as well as having the choice of some new services closer to home. We already provide many services of which we are very proud and aim to build on the strengths of each hospital, taking opportunities to improve and enhance services.

Coming together provides the long term sustainability that cannot be achieved by each trust alone. Integration benefits over the first three years alone total £16m and a financial surplus is projected for 2013/14 onwards. This financial sustainability will allow us to protect, and safely deliver, existing services at both hospitals, as well as invest in the development of new specialist services locally.

This is our vision for Better Care Together.

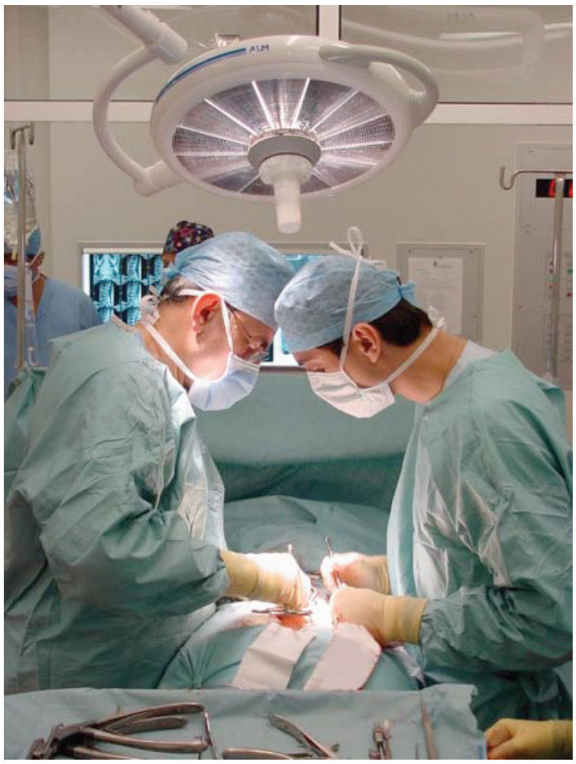
Better Care Together means putting patients at the centre of everything we do.

What does Better Care Together mean?

At the heart of our integration plan is our aim to deliver Better Care Together. This means putting patients at the centre of everything we do. We recognise that each of our patients has their own unique needs, whether they are elderly, have a young family or live with a long term condition. Integration will help us to meet the needs of both individuals and communities, now and in the future.

Our vision is Better Care Together: To provide high quality core services and enhanced specialist services for our patients.

Our strategic aims are shown in the diagram below:



Our vision is:
To provide high quality core services and enhanced specialist services for our patients.

The principles underpinning our vision:

We will exceed your expectations: We will care for you and treat you with compassion and respect.

- We recognise that being a patient can be daunting. We will do everything we can to make it a positive experience. This includes involving you in decisions every step of the way.
- We will care for you as a whole person, not just your health needs, by listening and respecting your views and wishes.

We will innovate and improve: We will make sure that our care and treatment compares with the very best.

- We will learn from each other and top performing hospitals to continually improve our services.
- We will expand our involvement in research and development, so that we are at the cutting-edge of medical advances, providing our patients with greater access to new treatments and trials.

We will be an organisation to be proud of: We will attract the best and brightest to join us so that we can continually provide excellent care.

- With more specialised services and involvement in cutting-edge research, we will be able to offer the best and brightest new opportunities and experiences.

Better Care Together: High Quality Core Patient Services & Enhanced Specialist Services

We will provide high quality core services at both of our hospitals and develop enhanced specialist services. By core services, we mean both Darent Valley Hospital and Medway Maritime Hospital will offer:

- Accident and Emergency departments, led by consultants
- Outpatient services
- Children's services
- Comprehensive maternity services

Not all hospitals provide specialist services and our patients frequently have to travel to London to access them. We will work with commissioners, staff, patients and our local communities to develop and enhance specialist services based on the needs of the communities we serve. This means that our patients will be able to access high quality specialist services at a hospital more local to them.

"As one trust we will see over 10,000 births a year across the two hospitals, making us one of the largest maternity units in the country. This number of births means that we will be able to develop more subspecialist services, such as foetal medicine and maternal mental health services. This not only means a better range of services for our patients, but also helps us to recruit high quality doctors and nurses. As one organisation, we will be working towards becoming a centre of excellence for maternity services."

Miss Annette Schreiner, Medical Director, Dartford and Gravesham NHS Trust

"Integration will enable us to provide high quality and cost effective services in a wider catchment area, and make it a better experience for both the children and their families. This will also lead to more widely skilled, flexible staff working across both hospitals.

"We have already started some services, such as children's surgery, including tongue tie clinics, surgery for pyloric stenosis (a narrowing of the opening from the stomach into the small intestine causing projectile vomiting in babies), neuro-developmental clinics for high risk preterm infants and sickle cell disorders clinics."

Dr Selwyn D'Costa and Dr Aung Soe, Clinical Directors for Children's Services at Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust

Better Care Together: Patient Centred and Personalised Care

Putting our patients at the centre of everything we do will be at the heart of our new organisation. We will continue to improve the quality of care that our patients experience. We will:

- Care for our patients with compassion and empathy
- Focus on understanding their individual needs
- Make our patients feel comfortable and provide emotional support
- Ensure our patients and their families are at the centre of decisions about their care and treatment

Our values reflect the care our nurses will provide, consistently performing at the level of the top performing trusts in the country. We will continue to work in partnership with universities and other healthcare providers, so that nursing and midwifery practice reflects modern standards. Our practice will reflect what is important to our patients:

- Being informed
- Being treated as an individual
- Having a choice
- Being safe

We will build on the improvements already made in both trusts to ensure that our patients have the best possible experience. We will encourage patients to give feedback on their experiences and use that feedback to continually improve our services.

"Partnership means strength and to our patients we hope this will mean unity and consistency. We have a joint duty to provide equality across both areas whilst appreciating the individual needs of our patients. We feel that joint populations will benefit from our shared professional knowledge to give an enhanced patient experience. Specialist skills across our combined area mean that our patients have greater access to quality treatments locally. Our nurses and midwives are passionate about ensuring that local care is responsive to patient need."

Deborah McAllion, Head of Midwifery, Dartford and Gravesham NHS Trust

"We have a very strong ethos of care and compassion within the Medway nursing team. We have worked hard over the years to ensure that all our patients receive top quality nursing care. We recruit nurses for their compassion, attitude and their clinical knowledge. This leads to an excellent experience for our patients with patient centred, personalised care. This will continue to the integrated trust with both sites working in unison to ensure an excellent patient experience."

Jayne Gray, Head of Nursing, Emergency Department, Medway NHS Foundation Trust

Better Care Together: Sustainable Services

In order to realise our Better Care Together vision, we must be both clinically and financially sustainable.

Integration will help us to protect our core services. Together we will serve the critical population mass required to deliver safe and clinically sustainable services, meeting clinical guidelines. This will enable us to safeguard existing services at both hospitals and work with commissioners to develop enhanced specialist services locally. This will maintain local access to core services and improve access to specialist services for our local communities.

Financial sustainability is becoming increasingly difficult in today's economic climate. With commissioners needing to save approximately £60m within the local health economy, this is a threat to core services. As one organisation, economies of scale, such as reduced management costs, will ensure greater financial sustainability than each trust standing alone. Together we will be able to maximise efficiencies and improve productivity. This, combined with the ability to reinvest surpluses as a Foundation Trust, will allow us to reinvest in frontline clinical services.

"Last year, our hospitals treated many patients with gastrointestinal bleeds. It is difficult for either hospital to operate a gastrointestinal bleed rota that meets official guidance, but together it will be much easier and more sustainable. With a greater number and range of staff, we will have a joint gastrointestinal bleed rota, staffed exclusively by gastroenterologists, providing round the clock care. This means that our patients with gastrointestinal bleeds will see doctors with the right expertise, whatever time of day it is."

Dr Gray Smith-Laing,
Medical Director,
Medway NHS
Foundation Trust

Better Care Together: Innovative Partnerships

NKHFT will work with a broad range of partners to not only identify how best to provide for the health needs of our communities, but also to drive greater collaboration and alignment of services. These partners include:

- Clinical commissioning groups
- Health and wellbeing boards
- Clinical networks
- Other health and social care providers, including community healthcare providers, mental health providers and tertiary care providers
- Governors
- Members
- Patient groups
- Local charities
- Local universities

These partnerships will help NKHFT to develop specialist services, offering our patients an alternative, local, choice to London providers. These developments, in turn, provide greater opportunities for our staff, making it easier to recruit high quality staff and appoint to nationally hard-to-fill positions, such as middle grade A&E doctors.

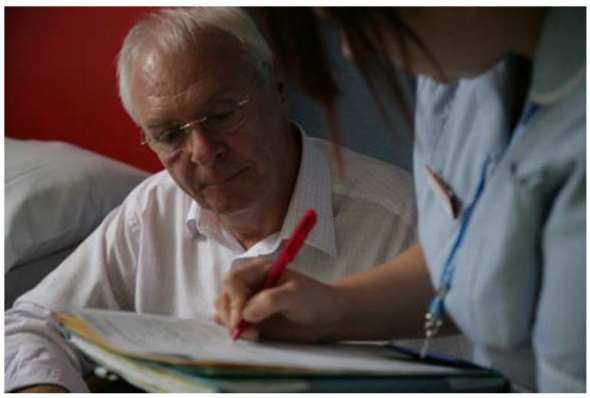
"The CCGs support an integration that offers the opportunity to improve both the quality of services and clinical outcomes for patients in North Kent."

Medway Clinical Commissioning Group, Dartford, Gravesham and Swanley Clinical Commissioning Group, Swale Clinical Commissioning Group

Better Care Together: Engaged Local Communities

Engaging and involving our patients and communities will allow us to shape and focus future clinical services around local needs.

We have worked closely with our local communities in development of our plans for integration and NKHFT will continue to build on these relationships. NKHFT will collaborate with and actively listen to stakeholders, including its strong membership base, using feedback to make improvements to patient care.



"I would like to endorse what others have said: it has been a very comprehensive public consultation that has been taking place...The LINks have arranged some of our own events which have been very well attended by members of the public as well as members of both health authorities, not only from the administrators, but from the clinicians as well."

Mark Fittock, Kent LINk Governor, speaking at Kent Health Overview and Scrutiny Committee (March 2012)

"The Council of Governors looks forward to representing our constituencies and ensuring our members have a say in shaping the future of the integrated organisation."

Ruth Jenner, Senior Governor Medway NHS Foundation Trust

Better Care Together: Top Performing

Drawing on all of the other strategic aims, NKHFT aims to become one of the top 15 performing organisations in its field in quality, safety, productivity and efficiency.

NKHFT will use research and evidence to improve and deliver high quality services with excellent health outcomes. We will work to modernise services, drive innovation and improve effectiveness, through:

- Developing integrated models of care to meet the needs of our local communities
- Sharing best practice across the entire organisation to ensure consistency in the quality of care and services provided
- Developing innovative partnerships across health and social care boundaries to provide care closer to home

Central to this will be evolving services in line with patient and GP feedback to become an organisation of which our communities are proud.

"Research and innovation are the key to excellent patient care. Research-active institutions increase patient confidence. With the integration of Medway and Dartford research into one, we complement each other immensely. This will undoubtedly make our integrated trust the research hub for Kent."

Mr Seshadri Sriprasad, Chairman of the Research and Development Committee, Dartford and Gravesham NHS Trust

Professor Jonathan Duckett, Head of Research and Development, Medway NHS Foundation Trust

"Research and innovation are the way forward in delivering high quality medical care. Research and development reflects on a host organisation in a positive manner, allowing higher staffing levels and high quality medical care. Integration with Darent Valley Hospital will allow us to share the strengths of both teams and grow research and development activity."

The need for change

Both DGT and MFT are performing well against many of their indicators and each have the support of their local communities and staff. However, we need to continually improve and look for new ways to deliver sustainable, high quality healthcare. In particular, there are significant benefits of scale and opportunity arising from integration.

The drivers of change are:

- An opportunity to improve both the quality and range of specialist services for local people.
- Improving clinical outcome requirements to deliver care in line with Royal College recommendations and national guidance, as well as implementing safe and effective clinical rotas.
- The policy context, specifically the Health and Social Care Act's aim to provide more integrated care, closer to home and for all NHS trusts to become Foundation Trusts.
- Financial viability linked to the economic downturn and the impact of the NHS Operating Framework.

These represent a combination of factors pulling us towards our vision of Better Care Together – creating an opportunity to improve health outcomes for more people and provide a more exciting place to work for our staff – along with external factors that are pushing us to make changes. Financial viability is fundamental to us providing the care we want to provide and our communities need. As things stand, the long-term financial viability of each trust is at risk.

Why this partnership?

DGT and MFT already share many synergies and have a long-standing history of working in partnership. This will be the integration of two trusts already closely aligned:

- The trusts serve neighbouring communities, with similar demographic, health and deprivation profiles, including some of the poorest wards in Kent and the South East region. This provides opportunities to build services specific to our local health economies.
- The trusts have a common core clinical business, as neighbouring medium sized district general hospitals.
- The trusts have strong and long standing clinical relationships at a number of levels including shared patient pathways, junior doctor rotations and services provided on each other's sites.
- The trusts will consolidate clinical support services and corporate functions to become more efficient.
- The combined trust estate and equipment will present opportunities to enable clinical developments and scope to make the most of DGT's Private Finance Initiative (PFI) facilities and close some unsuitable estate at MFT.
- The trusts serve different secondary markets, located at either end of their local population base. This gives further growth opportunities at both ends of the local health economy, in Bexley, to the west of DGT, and Swale, to the east of MFT.

The Benefits

Patients at the centre of everything we do – excellent quality and personalised care

Integration will allow NKHFT to build on the improvements already made in both trusts, to ensure that patients have the best possible experience. The Trust will focus on using patient feedback, improving quality, meeting clinical guidelines, reducing health inequalities and increasing research and development activity, to become the hospital of choice for our patients.

Clinical sustainability

NKHFT will serve the necessary critical mass of population to maintain existing services and develop specialist services. Integration will also enable NKHFT to meet rota requirements, such as the gastrointestinal bleed rota, so that clinical services can be provided safely.

Safeguarded and improved core services

There will be the opportunity to improve and expand services, given the similar demographic and health profiles of the communities served by the hospitals.

Improved and expanded range of specialist services

NKHFT will work with commissioners and other partners to develop existing and new specialist services, for which local patients currently have to travel to London. These will be developed in line with community needs.

Improved partnership working

We recognise that a system-wide approach is needed to improve health outcomes for our communities. NKHFT will work in partnership with health and social care providers, other community based organisations and clinical networks to improve quality of care and establish integrated care pathways. NKHFT will also enhance patient involvement in healthcare services, by having a clear focus on capturing, listening and using patient feedback to develop services and monitor the quality of patient experience.

Financial sustainability

Integration will result in a more financially sustainable organisation, due to:

- clinical and estates synergies
- changes to ensure best use of both estates
- economies of scale
- increased income from specialist services
- reduced management costs
- removal of duplication in corporate functions
- opportunities to expand the Trust's market share in secondary markets

An attractive organisation for talented people – creating a sustainable workforce

With two workforces coming together as one, NKHFT will have an appropriately trained and responsive workforce, with substantial expertise, skills and experience. With a greater range of services being developed, NKHFT will be able to offer staff more varied and rewarding work, making it a more attractive place to work and train. This will also help the Trust to better recruit and retain staff, resulting in improved standards and continuity of care.

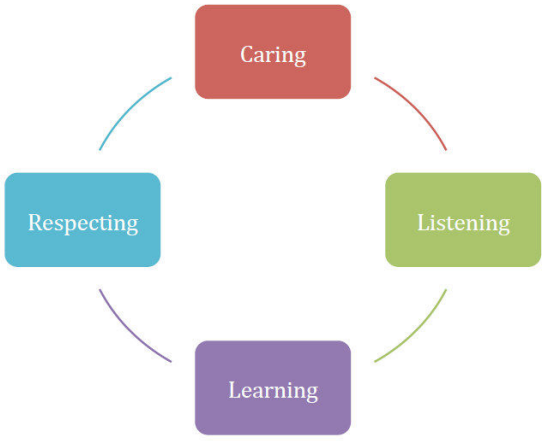
A top performing organisation

Integration provides us with the opportunity to create the culture required to become top performing district general hospitals, achieve efficiency and productivity improvements and share, learn and adopt best practice from both each other and other organisations.

Making it happen:
Culture and organisational development

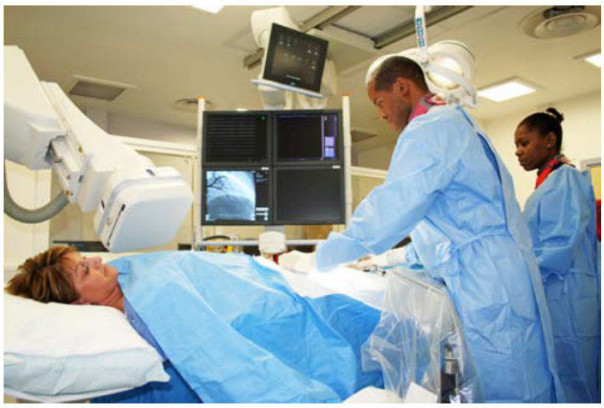
A positive and open culture is a fundamental component of high performing organisations. This is true for us and is particularly important for integration. We recognise that Better Care Together can only be fully realised and delivered with a supportive and cohesive organisational culture.

The following values describe our desired culture:



We recognise how important strong leadership is going to be during the process of integration. We have agreed a shared set of leadership behaviours and staff and patients can expect our leaders to:

- Take responsibility
- Ensure high standards
- Develop services
- Respect others
- Demonstrate integrity
- Lead staff



Making it happen: Implementation plans

Plans have been produced in all areas to ensure the delivery of Better Care Together following integration:

- Clinical – safeguarding our existing services, as well as improving the range and quality of local services, to deliver improved health outcomes
- Financial – delivering a sustainable, viable trust for our local communities by maximising efficiencies
- Organisational development and workforce – making sure we have the right people with the right skills at the right time for NKHFT
- Engagement and communications – supporting all staff to understand the changes and start living Better Care Together, to benefit patients of the new trust as rapidly as possible
- Stakeholder and community involvement – consulting and involving people before, during and after integration
- Estates – optimising the efficiency of our estate by reducing the footprint of the Medway Maritime Hospital site and increasing clinical space at Darent Valley Hospital
- Corporate services – reducing management costs and removing duplication in back office functions
- Information management and technology – realising the digital vision to support the delivery of our plans

Joint working across many levels has been the key to the development of these plans and will be the key to implementing them. Clinical directors have worked together to develop their service visions, whilst directors have come together to plan and implement systems integration, ensuring that NKHFT will be safe and operational from day 1. Our governors have scrutinised our plans and helped us to further shape and develop them.

What NKHFT will look like

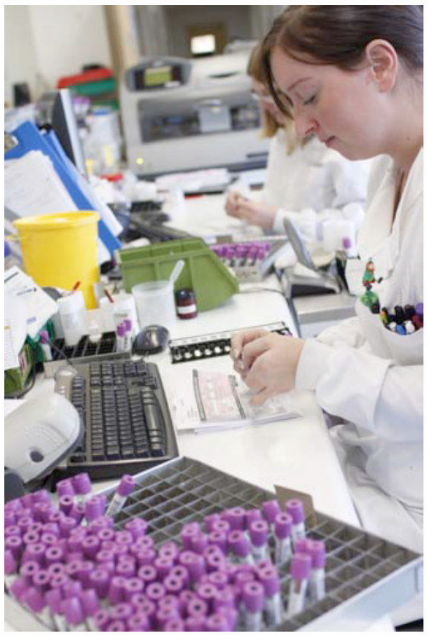
NKHFT will consist of two hospitals: Darent Valley Hospital in Dartford and Medway Maritime Hospital in Gillingham, and a range of community services. Both hospitals are consistently recognised by CHKS as two of the top 40 hospitals in England. We will serve a population of over 660,000 from Dartford, Gravesham, Swanley, the Medway towns, Swale and Bexley.

Both of our hospitals will offer core services, including A&E, maternity, children's and outpatients' services. We will be developing new and enhanced services, for which patients currently have to travel to London, and they will be based on one site or the other. However, we will offer outpatient appointments for those services on both sites, to keep services as local to our patients as possible. For example, we will increase the range of children's surgery carried out locally: children's surgery will take place at Medway Maritime Hospital, where we have specialist equipment, but patients and their families will have the choice of either hospital for their outpatient appointments.

The Trust will be both clinically and financially sustainable, for now and the future. Our population base exceeds the recommended minimum for safe provision of services, as laid out by the Royal Colleges, and we expect to achieve a financial surplus from 2013/14 onwards.

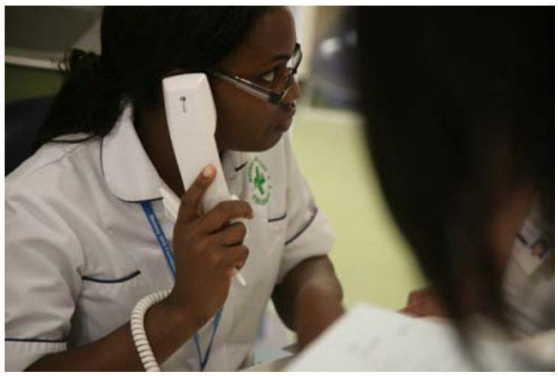
In 2014/15, we expect NKHFT to look like this:

- A total combined income of over £400m
- 588,752 outpatient appointments
- 174,791 people cared for in A&Es and walk-in centres
- 58,215 inpatients and day case patients
- 60,671 emergency admissions
- 10,800 babies delivered



Conclusion

The integration of Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust to form North Kent Hospitals NHS Foundation Trust is an exciting opportunity to create a sustainable healthcare provider for our local communities. It is also a compelling response and sustainable strategic solution to a range of complex clinical, financial and political drivers that have to be addressed.



The newly created organisation will be shaped through the delivery of our healthcare vision: Better Care Together. This vision and strategy have been designed around a number of key principles that involve exceeding expectations, relentlessly innovating and improving and becoming an organisation that staff, patients and stakeholders are proud of and want to recommend.

Our Better Care Together vision is designed to take the best from both organisations and drive up overall quality across all services, delivering a step change in healthcare for our local communities.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 November 2012

Subject: Patient Transport Services: Written Update.

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1. Background

(a) The Committee last discussed this item at its meeting of 9 March 2012. It is next on the Forward Work Programme for the meeting of 1 February 2013.

2. Recommendation

That the Committee note the report.

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NHS

Kent and Medway

Introduction

As members of the HOSC are aware, following a comprehensive report on transport undertaken by the Kent and Medway LINKS in 2010, NHS Kent and Medway agreed to undertake a procurement project to deliver an improved service. This paper reports on the current status of the procurement for the Non-Emergency Patient Transport Service (also known as PTS), and responds to the specific questions raised.

Current position

The current PTS service provision is delivered in a variety and combination of PTS contracts, sub-contracts and ad-hoc arrangements across Kent and Medway, either directly or through subcontracts. There are currently 23 separate contracts for PTS throughout Kent and Medway.

Each service uses a managed assessment and booking service for the services they provide that enables both advanced booking of journeys and urgent booking on the day of travel.

The current legacy contracts are performance managed as part of other contracts and lack the key features needed for cost-effective operation which are principally; a clear service specification based on outcomes, visibility of levels of activity and associated costs, performance measures and incentive schemes.

The new service was initially to begin 1 April 2013. The contracts with current providers were scheduled to end on 31 March 2013.

However, it was felt that a short extension was necessary to fully evaluate the extensive bids, resolve any outstanding contractual arrangements with stakeholders and agree responsibility for activity, provide some clarity around some of the journeys and further define some outstanding specification issues. As a result, all current providers have agreed to extend their existing service for 3 months to allow the new service to begin 1July, 2013.

Service improvements

It is the aim of the new service to improve quality of service for patients, by providing equality of service across the patch, improved levels of quality and customer service, consistent application of the eligibility criteria and improved contract reporting requirements. The aim of this procurement is to also streamline the booking service and make it easier for eligible residents of Kent and Medway to access the service. Additionally, alongside the procurement, it is expected that we will work to

improve the booking systems with trusts to reduce the number of aborted and cancelled journeys.

Lastly, it is intended that the new PTS service provide a reduction in costs and the ability to provide a greener, more effective service overall.

Outcome of plans for developing the service in future

The commissioners of PTS across Kent and Medway were clear that re-tendering PTS across Kent and Medway could improve several areas such as:

a. Equity of access - the population need to be able to access services which meets its needs. One example can be through consistent application of eligibility criteria by PTS Providers.

b. Quality of services – high quality services may lead to better patient outcomes and enhance the reputation of the NHS. One example is to ensure that service provision is aligned and there is a single point of access to improve the experience for service users.

c. Patient experience - the ability to drive up quality and improve patient experience as a result of more efficient or effective use of resources.

Engagement

The project engaged with Clinical Commissioning Groups (CCGs) throughout the project's entirety, including during the definition of service requirements and during the procurement process.

CCGs were invited to review the draft service specifications and to contribute to their development. Many of the comments received were incorporated into the final draft.

CCGs were invited to review the draft tender documents and to contribute to their development. GPs also helped evaluate bids and have contributed to the service specifications, sit on the Project Board and assist with specific requests related to the procurement of the service.

There has also been extensive engagement with patients and provider staff throughout the procurement process. In the initial stages, the commissioners engaged service user representatives in reviewing the then current service and defining the details of the service specifications. Patient representatives will continue to participate during mobilisation and as part of the requirements of the contract; the provider of the new service is required to maintain a patient engagement group that holds regular meetings and implements feedback from those meetings.

In the later stages of the procurement, the Project Team involved service users in preparing for evaluating bids and conducting bid evaluation. Service users scored the bids independently from each other and without influence from Project Team members, although support was provided merely to guide them through the process.

Staff employed by providers to deliver the current service were invited to engagement events to contribute to developing the specification. The current service managers have been involved as stakeholders where it was established that they were not bidding for the service. Staff will be eligible for Transfer of Undertakings (Protection of Employment) Regulations (TUPE) and will be managed according to those regulations. The TUPE regulations require the current employers to consult with their staff prior to the transfer, and the new employer to transfer staff on the same terms and conditions of employment.

There will be on-going engagement with;

- acute hospitals - including outlying acute hospitals such as Queen Victoria, Greenwich & Bexley,
- commissioners who are users of the service, and
- the mental health trust and community hospitals on contract management.

This is to jointly ensure that there are no operational problems and should one arise, it can be addressed and corrected. During mobilisation, meetings will continue to be held with these providers to address any other issues.

Who will be commissioning PTS in the future

The new service will be commissioned by the CCG organisations, with one to take the lead on the contract. The service will be managed by Kent and Medway Commissioning Services (KMCS) once the organisation is formally in place. Both the Project Manager and the Associate Director in charge of the project are expected to continue to manage PTS through mobilisation and implementation during the early phases. Once the service has been established, contract management will be performed by a KMCS contract manager and CCG lead.

Connection between PTS, emergency services and volunteer transport

Patients managed as emergencies are defined differently by the NHS. However, we have ensured that the service specifications for both PTS and emergency services are complementary and address the current gaps in contract provision. Currently, there are occasions which require ad hoc provision to be arranged which is both inconvenient for patients and costly. The new contract will ensure a comprehensive service.

We will require the provider of the new service to refer patients who do not qualify for PTS to volunteer organisations as well as providing information on alternative transport options.

Current and future commissioning of mental health PTS

The procurement for this project includes mental health transport and therefore, it is expected that this will continue to be commissioned this way. Representatives from the mental health service have been involved in the specification and on-going patient engagement arrangements will need to reflect the different needs of a wide range of patient groups.

Conclusion

It is believed that the new PTS service will provide a more equitable service for all residents, a reduction in costs and the ability to provide a more effective service overall.

The Project Team will provide regular updates to HOSC during the mobilisation stages of this project and requests that HOSC continue to support this project.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 November 2012

Subject: HOSC Report into Reducing A&E Attendances

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1. Background

(a) On 9 March 2012, the Health Overview and Scrutiny Committee approved the report of its review into reducing A&E attendances: *Not the Default Option.* This report is attached. This was then sent to all NHS Trusts in Kent and Medway requesting a response once full consideration had been undertaken of the key findings and recommendations.

(b) Responses from East Kent Hospitals University NHS Foundation Trust and Kent Community Health NHS Trust were received and included in the Agenda pack for the 20 July meeting. These are again included in the current Agenda pack for reference.

(c) At the 20 July meeting, Helen Buckingham, Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway, undertook to coordinate a collective response before the winter and the Chairman asked for discussion of this response to be added to the Forward Work Programme.[1] This report is included in the current Agenda.

2. Recommendation

That the Committee consider and note the report.

[1] Minutes, Health Overview and Scrutiny Committee, 20 July 2012 meeting, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3981&Ver=4

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“Not the Default Option.”

Health Overview and Scrutiny Committee,
Kent County Council
March 2012

A Review into Levels of Attendance at Accident and Emergency Departments.

Accident and Emergency: Not the Default Option

1. Key Issues

(a) As many as 1 in 5 people who attend accident and emergency departments in Kent and Medway could be treated more effectively elsewhere.[1] This runs counter to the health service's aim of making sure everyone is seen in the right place at the right time by the right person.

(b) The impact goes beyond that of the individual turning up at A&E. The forecast spend for 2011/12 on accident and emergency attendances by Kent and Medway residents is just under £45 million. An additional £342 million is likely to be spent on emergency hospital admissions.[2] In the current financial climate, with the NHS as a whole asked to find £20 billion in efficiency savings by the end of 2014/15 as part of QIPP (Quality, Innovation, Productivity and Prevention), it was not surprising to find that all the NHS organisations we spoke to agreed that reducing accident and emergency attendances and admissions was a local priority. Nationally, the QIPP workstream looks to achieve a 10% reduction in A&E attendances.[3]

(c) With limited resources, each A&E attendance costs £52 to £183 and where this is spent on people who could be treated elsewhere, it is unable to be spent on other services.[4] There is also a negative impact on the organisations providing the services. Those available outside acute hospitals may be under utilised, and there is a knock on effect to the whole range of services provided by the Hospital Trusts and the Ambulance Service as staff and resources are diverted to deal with emergency attendances and subsequent admissions.[5]

(d) Yet for all the discussion about the cost of A&E, the alternatives are not without cost. The Committee was provided with information on the overall costs of different elements of urgent and emergency care[6] and we will be following this issue up to see what the costs are of individual episodes of care at Minor Injuries Units and elsewhere.

(e) However, if we concentrate too much on the details of the costs of care we risk being diverted from the bigger picture. Most important is the impact on the patient concerned. The care provided by the skilled professionals in accident and emergency departments is generally very

[1] HOSC Minutes, 25 November 2011.
[2] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.14.
[3] Department of health, October 2011, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115468
[4] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.30.
[5] Evidence from South East Coast Ambulance Service NHS Foundation Trust, HOSC Agenda 14 October 2011, p.45. Evidence from Maidstone and Tunbridge Wells NHS Trust, HOSC Agenda 25 November 2011, p.4.
[6] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.35.

good, and a necessary service for thousands of people each week across Kent and Medway. For many people though, they may be missing the convenience of care closer to home as well as avoiding an unnecessary visit to hospital.

(f) The majority of people attending A&E go there directly, without having being referred or conveyed by an ambulance.[7] The Committee was made aware of research which had been conducted around the reasons why people choose to go to accident and emergency departments over the alternatives. The reasons are no doubt very complex and depend on the individuals concerned and the situation, but, tellingly, research in Maidstone in 2008 showed **that 42% chose A&E because they did not know where else to go.**[8]

(g) More generally, the Committee senses that both where there is a lack of knowledge or confusion about the alternatives, and where accessing the alternatives has been a negative experience, attending A&E has in effect become the default option for too many people. A 24/7 accident and emergency department is a great asset to a community and there will always be a need for the life saving skills delivered by the health professionals working in them, particularly where there is a good chance of being seen within 4 hours. However, there is an urgent need to address this idea of default.

(h) The Committee has identified four interconnected factors it believes have contributed to this idea of default which will set the context for the recommendations it is making.

(i) These factors are:

- the changing nature of urgent and emergency care;
- lack of consistency;
- lack of joined up services; and
- lack of effective communication.

2. The Changing Nature of Urgent and Emergency Care

(a) The Department of Health defines urgent and emergency care as "the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly."[9] This is a helpful definition, but it is very broad and covers everything from advice received online or on the phone from NHS Direct to being transferred to a Major Trauma Centre in a London Hospital.

[7] Evidence from Acute Trusts, HOSC Agenda 25 November 2011.
[8] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.25.
[9] Department of Health, October 2011, http://www.dh.gov.uk/en/healthcare/urgentandemergencycare/index.htm

(b) The Committee heard about a wide range of services available across the whole care pathway, with more in development. Accident and emergency departments themselves are also changing and this is mirrored by changes in each part of the pathway. Many of these changes are positive and contribute to delivering improved healthcare and saving lives. However, where they are not communicated successfully to the public or coordinated well with each other, there is a danger that they are having the **unintended consequence of increasing public confusion.** This could exacerbate the tendency to regard the nearest A&E department as an element of certainty and continuity and hence the default option.

(c) Primary care, and GPs in particular, are key to ensuring people receive the right care at the right time. They provide continuity of care and are in a better position to treat the whole person than staff in an A&E. While concerns were raised during our evidence gathering around the difficulties sometimes experienced by people wishing to make an appointment with a GP, this was balanced by the acknowledged need to ensure that GPs could access the appropriate services provided by others efficiently and directly for their patients.

(d) There are six Type 1 accident and emergency departments within Kent and Medway providing a full range of services for minor and major emergencies. Work is already underway to address accident and emergency attendances. All the Acute Trusts we spoke to were looking at ways to allow patients to bypass A&E, such as being directly admitted to an assessment unit by a GP, or signposting people who turned up but could be seen elsewhere to a more appropriate place. Many sites had pharmacies, GP services and other non-emergency care co-located with the A&E department. We heard that such work had enabled East Kent Hospitals NHS University Foundation Trust to reduce A&E attendances by 2%. Good work in other areas had been impacted by changes outside of Kent, such as the closure of A&E at Queen Mary's in Sidcup.

(e) A&E itself is also changing, with the establishment of certain specialist centres. Patients requiring primary angioplasty, for example, will often be taken direct to William Harvey hospital at Ashford. Three hospitals are aiming to be Level 2 Trauma Units, and this will also impact where people are taken in certain clinical circumstances. The intention is for these units to be at the William Harvey in Ashford, Medway and Pembury.

(f) Parallel to these changes, the ambulance service itself is also changing, with the training and introduction of Paramedic Practitioners able to treat people at home or closer to home, and Critical Care Paramedics able to care for patients over longer distances to enable them to access specialist treatment.

(g) There are mental health services provided along the entire urgent and emergency care pathway. This includes the Crisis Resolution and Home Treatment Teams who take referrals from a range of sources, and provide treatment at home as well as facilitating admissions to acute inpatient beds. It was admitted that finite resources may mean the Teams are unable to prioritise someone in A&E.[10] However, the good work in developing liaison psychiatry services embedded in A&E departments across the County was recognised.[11] The well regarded RAID (Rapid Assessment Interface and Discharge) 24/7 service in Birmingham had looked to the service in East Kent for inspiration.[12] The liaison psychiatry services in Medway and West Kent are also great successes, but are not currently provided 24/7.[13]

(h) On 1 April 2011, Kent Community Health NHS Trust was formed as a new organisation, bringing together the two community service provider arms of the Primary Care Trusts in West Kent and Eastern and Coastal Kent. One of the major health policy drivers in recent years has been towards a broader shift of activity out of the acute sector and into the community and there is a lot of interesting activity in this sector, including telehealth and the use of community hospitals to provide step up beds from the community to avoid acute hospital admission. The Trust made the point that the levels of people attending A&E do not directly impact community health services; however, there was the potential for more effective use of the sector to avoid admission to hospital.[14]

(i) One area of community services activity which is directly geared to providing an alternative to A&E attendance are the **10 minor injuries units and 3 walk in centres across Kent and Medway.**[15] The levels of use vary across the sites, with the Folkestone walk in centre seeing 1000 patients each month, and the minor injuries unit in Faversham seeing 100.[16] The evidence tends to suggest that while people living near one of these sites will often turn to them before A&E, increasing their use is restricted by at least two things. Firstly, the geographical spread means that access to them is unequal; **Maidstone, for example, does not have a minor injuries unit**, meaning the A&E at the acute hospital is the more accessible option. Secondly, there is variation across minor injuries units and walk in centres with regards the services offered and the opening hours. At the six minor injury units and one walk in centre run by Kent Community Health NHS Trust, for example, the opening hours vary. Where people are unclear about

[10] Evidence from Kent and Medway NHS and Social Care Partnership Trust and NHS Kent and Medway, HOSC Agenda 3 February 2012, p.20.
[11] Ibid, p.21
[12] Minutes, HOSC, 3 February 2012.
[13] Evidence from Kent and Medway NHS and Social Care Partnership Trust and NHS Kent and Medway, HOSC Agenda 3 February 2012, p.21.
[14] Information from Kent Community Health NHS Trust, HOSC Agenda 14 October 2011, p.52.
[15] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.23.
[16] Ibid.

what services are available and when, the easier choice is to go straight to A&E. **The very phrase 'minor injury' means different things to medical professionals and the public.**

(j) All of these developments taken together mean an increase in the complexity of the problems presented by those patients who do attend A&E departments.

(k) It would be highly misleading to suggest that the different healthcare providers never acted in an integrated way or worked together to improve the quality of services. For example, Dartford and Gravesham NHS Trust had worked with local nursing homes and GPs on the assessment of elderly patients before being sent to hospital. This had resulted in a 30% reduction in admissions from nursing homes.

(l) The Committee feel strongly that any patient requiring urgent care shouldn't notice any difference when moving from one organisation to another, such as from a minor injuries unit to an A&E department, and different providers need to share information efficiently and effectively. Anecdotal evidence suggests that this is not always the case.[17] If the patient experience is disjointed, such as being referred to A&E from a minor injuries unit with tests being carried out twice in the same day, then this will impact future decisions negatively. However, we also acknowledge that there is sharing of information across Trusts and as not all minor injuries units are able to carry out all tests, the tests may be different, but the perception of the patient remain. We feel this is an area where further work needs to be undertaken to fully assess the extent of this problem.

(m) The situation is analogous with regards GP out-of-hours services, where the first experience (or the reported experience of others) is likely to determine future choices, even where the provider may have changed, or the service improved. This is one area where we hope the development of Clinical Commissioning Groups and thus the increased involvement of GPs in commissioning decisions will be able to make a positive impact.

(n) One message that came out from all the meetings the Committee held on this topic was the belief within the NHS that the coming together of three changes across Kent and Medway would address a lot of these issues. These are:

- NHS 111.
- NHS Pathways.
- Directory of Services.

(o) NHS 111 is to be a single point of access for patients unable to contact their GP, but who do not need to call 999 or attend A&E. It has been

[17] Minutes, HOSC, 6 January 2012.

trialled in the North East of England and results suggest it has led to a decrease in A&E attendances.[18] The intention is that it becomes an England-wide non-emergency healthcare service on a three-digit telephone number.[19] When rolled out nationally by April 2013, it will replace the NHS Direct number, though NHS Direct is expected to continue, alongside other providers.[20] It will be commissioned locally.[21] The procurement for the whole south east coast region is currently underway with a view to it becoming operational by 1 April 2013. NHS Pathways is triage software currently used for 999 calls and some GP out of hours calls. The Directory of Services refers to the development of a live database of what services are available when and where. The intention is that the three of them in conjunction will ensure that anyone using the service will be directed to the right service in the right place to suit each individual person.

(p) If successful, this could be the biggest means to changing the default to A&E which we currently have. **The importance of getting the communication of the change right cannot be underestimated. A person's first experience of 111 may determine whether there is a second.**

3. Conclusion

(a) This short report has focused on the challenges faced by the local health economy in finding another way of responding to the needs of people who attend A&E in a more effective and efficient manner. However, there is the much bigger issue of why people need to access urgent and emergency care services in the first place. While accidents will always happen, there are large numbers of A&E attendances which could be prevented in the first place, and not simply be dealt with elsewhere.

(b) Overall, it has been estimated that around 35% of A&E attendances are alcohol related (including violent assaults, road traffic accidents, mental health emergencies and deliberate self-harm).[22] Locally, self-

[18] Evidence from South East Coast Ambulance Service NHS Foundation Trust, HOSC Agenda 14 October 2011, p.47.
[19] Ofcom, *New 111 non-emergency healthcare phone number confirmed*, December 2009, http://media.ofcom.org.uk/2009/12/18/new-111-non-emergency-healthcare-phone-number-confirmed/
[20] Department of Health, *NHS 111*, November 2010, http://www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/DH_115054
[21] Department of Health, *Dear Colleague Letter. Rolling out the NHS 111 Service,* August 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129104.pdf
[22] Department of Health, *Checklist Improving the management of patients with mental ill health in emergency care* settings, September 2004, p.3 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4089197.pdf

harm is the third highest reason for attending A&E in West Kent and Medway, and sixth highest reason in East Kent.[23]

(c) The evidence for saying that a higher priority needs to be given to public health and preventive work speaks for itself. The establishment of the Health and Wellbeing Board in Kent and the transfer of public health responsibilities to local government give grounds for optimism. While we can admit that problems exist and that all sectors of the health service agree that reducing A&E attendances is a priority, we believe that not only can those one in five people referred to at the beginning of this report be treated more appropriately and at a lower cost to the whole health economy, but that more can and will be done to reduce the need for any kind of urgent and emergency care.

4. Recommendations

1. **The patient journey should be seamless, with no duplication of diagnostic tests, or better communication with patients of why tests are being carried out. We ask the commissioners and providers to report back to the Committee with details of what work is being undertaken to assess the scale of the problem and achieve this.**

2. **Lack of awareness or confusion around the alternatives to accident and emergency mean turning to A&E is often the simplest and most rational choice, even where it is not the most appropriate one. Commissioners and providers should produce a joint communication plan to simplify the choice of GP out-of-hours services, minor injuries units, walk-in-centres and other alternatives and improve public understanding.**

3. Following from the above recommendation, the Committee asks that commissioners and providers explore the appropriateness and viability of introducing **standardised opening hours** around a clearly understood set of services across all the minor injury units in Kent.

4. We ask the commissioners to provide further information on the costs per case for those patients seen at a walk in centre or minor injuries unit compared to those seen at A&E departments.

5. The Committee congratulates the work done so far in developing Liaison Psychiatry services and asks that commissioners and providers work together to ensure the successes are consolidated and the service fully rolled out across the county.

[23] Evidence from Kent and Medway NHS and Social Care Partnership Trust and NHS kent and Medway, HOSC Agenda 3 February 2012, p.20-21

6. The role of GPs in ensuring the goal of each person receiving the most appropriate treatment at the right time is achieved cannot be underestimated. We ask NHS Kent and Medway to provide assurances that all of the emerging Clinical Commissioning Groups are leading on the work to develop the urgent and emergency care pathway.

7. The rollout of 111 is a great opportunity accompanied by great risks. There is only one chance to introduce it properly. The Committee requests that the commissioners of the service and relevant providers involve the HOSC and other key stakeholders early on in the development of the communication and implementation strategies.

8. The creation of the Health and Wellbeing Board and transfer of substantial public health responsibilities to local government provides a golden opportunity to develop integrated preventive health plans and we ask the Health and Wellbeing to prioritise work which will reduce the number of people entering the urgent and emergency care pathway in the first place.

9. The HOSC requests that NHS Kent and Medway produce a written report for the Committee by the end of the year detailing what success has been achieved in reducing attendance at A&E and what plans have been agreed with the NHS provider Trusts in order to further meet the challenge.

Appendix – Committee Meeting Information

(a) In the first part of 2011, the Health Overview and Scrutiny Committee of Kent County Council held a series of meetings into *NHS Financial Sustainability.* In the resulting report, the Committee undertook to carry out a series of further whole systems reviews focussing on some of the key areas impacting financial sustainability across the Kent health economy.

(b) To provide a focus to the discussions, the Committee looked to answering the following two strategic questions:

- What is the impact of the current levels of attendance at accident and emergency departments on the sustainability of health services across Kent and Medway?

- How can levels of attendance best be reduced?

(c) The HOSC held three meeting on the first of these reviews, *Reducing Accident and Emergency Admissions.* The dates of these meetings, along with names of organisations attending are below along with links to the Agendas. The evidence provided to the Committee from NHS organisations in Kent and Medway can be found in the respective Agendas.

- 14 October 2011

    - NHS Kent and Medway
    - South East Coast Ambulance Service NHS Foundation Trust
    - Kent Community Health NHS Trust
    - Kent Local Medical Committee

        - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3502&Ver=4

- 25 November 2011

    - East Kent Hospitals NHS University Foundation Trust
    - Medway NHS Foundation Trust
    - Dartford and Gravesham NHS Trust
    - Maidstone and Tunbridge Wells NHS Trust

        - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3503&Ver=4

- 3 February 2012

    - NHS Kent and Medway

- Kent and Medway NHS and Social Care Partnership Trust
- Kent Local Medical Committee

    - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3977&Ver=4

(d) Preliminary findings were published and discussed at the meeting of 6 January 2012.

    - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3976&Ver=4

(e) The Committee would like to thank everyone involved in the inquiry for their openness and informative engagement with the process. The HOSC has always aimed at a constructive engagement with the local NHS and believes that scrutiny should lead to positive outcomes. The following findings and recommendations are offered in this spirit.

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Kent and Medway

NHS Kent and Medway - update report to Kent HOSC on their recommendations in the review of A&E attendance in March 2012: 'Not the default option'

Work to develop the urgent care system in Kent and Medway is led by the CCGs through the Urgent Care boards (or equivalent) in each area. This update is therefore a summary of progress from their plans, for each of the recommendations:

1. The patient journey should be seamless, with no duplication of diagnostic tests, or better communication with patients of why tests are being carried out. We ask the commissioners and providers to report back to the Committee with details of what work is being undertaken to assess the scale of the problem and achieve this.

The majority of diagnostic tests are undertaken by the local acute provider and therefore it is highly unlikely for the same test to be repeated. The order system for tests will normally flag the recent requests and the results that the patient has had, to minimise duplication. Patients going via either A&E or the assessment unit will have their results available.

Diagnostics are considered as pathways are developed. For example, in Ashford a new community geriatrician role is being developed to provide specialist support for management of the pathway. This will include diagnostics at initial assessment within primary care.

2. Lack of awareness or confusion around the alternatives to accident and emergency mean turning to A&E is often the simplest and most rational choice, even where it is not the most appropriate one. Commissioners and providers should produce a joint communication plan to simplify the choice of GP out-of-hours services, minor injuries units, walk-in-centres and other alternatives and improve public understanding.

Integrated communications plans in each area have been developed. These have a level of consistency across Kent, but include locally appropriate messages and targeting of specific groups of people. They build on information gathered through the urgent care needs assessment as well as through local surveys (e.g. surveys carried out in Medway by the LINk and in Darent Valley Hospital by commissioners), regional questionnaires and focus groups.

This public engagement identified, for instance, that many people, particularly teenagers and young adults, and also the working population, are not aware of the range of services provided by pharmacies, out of hours GPs or even their own GP practice.

The communications plans aim to help these people find out what their options are. Some people have heard of the alternatives to A&E but do not think of them when they are worried - the campaign therefore aims to bring them to mind for this group.

The plans set out a framework for a wider and deeper level of communication than in previous years, to enable local people to find out about local services, through communications targeted at specific groups, wider communications, news releases, innovative use of social media and the creation of a web and smartphone app. We are grateful for the support offered by Kent County Council with this communication.

An example of the poster tailored to Ashford is attached. Ashford CCG is developing magnets and leaflets documenting which services patients can use as an alternative. The team has met with local groups such as children's centres to discuss service provision. In addition the magnets and posters were distributed within supermarkets, libraries, schools and other local public areas, as well as to GP practices and health service locations. The poster for Ashford has also been translated into Nepalese and Ashford CCG has also established a forum with volunteers and care homes.

Once NHS 111 is available in the area from March 2013, this will allow a 'phone before you go' message which will help patients to access the best service for their needs, and will be sensitive to actual opening hours and availability of the right skills for the condition. Marketing of the NHS 111 service will be linked to the national campaign as well as having a local flavour.

3. Following from the above recommendation, the Committee asks that commissioners and providers explore the appropriateness and viability of introducing standardised opening hours around a clearly understood set of services across all the minor injury units in Kent.

Each urgent care system is considering the future arrangements for the tapestry of urgent care services that are currently available. The HOSC has rightly identified that the current picture of minor injuries units, walk in centres, urgent care centres is confusing for patients. Other urgent services are also available – including the GP out of hours services (in Kent, the contract is due for review from April 2014) and urgent access community nursing (especially when the integrated teams and single points of access have been implemented).

A review of MIU/WIC services in the eastern and coastal Kent area (now the area covered by the East Kent Federation of CCGs and Swale CCG) is currently on-going. This review is currently in draft form and with MIU/WIC providers to comment. The review examines the disparate nature of MIU/WIC services including the different services offered and opening hours. Standardisation in these areas will be

considered as part of the review recommendations phase. The outcome of review will then inform the broader redesign of urgent care which includes the GP out of hours service.

In west Kent, the CCG is looking at the issues facing the whole of the urgent care system. The Emergency Care Intensive Support Team has recently visited and a plan to review the system is being developed.

In Dartford, Gravesham and Swanley, community services and out of hours services are both due to be reviewed. In Swale the review is underway and the CCG is working on some quick wins as well as the longer term strategy to ensure care delivered in the community is meeting the needs of our population in an integrated way.

In each area, the reviews are at an early stage and partners will be involved in the design.

The other route to tackling this complexity is by using NHS 111 to help patients access the most appropriate service. NHS 111 service will provide detailed information on the type of services required by patients and will not only support patients to reach the best service in the current arrangements but will also help to inform the future requirements.

4. We ask the commissioners to provide further information on the costs per case for those patients seen at a walk in centre or minor injuries unit compared to those seen at A&E departments.

The current pricing for MIU and walk in centres is complex and for most, is not separately priced on a cost per case basis. The review work in east Kent will help to identify the amount paid to each unit, but within a broader service contract. Where the national 'Payment by Results' pricing applies to Minor Injury Units, the national tariff of £54 applies, whatever investigations are provided. In the Emergency Departments, the tariff is also £54 if no investigations are carried out, but ranges from £81 to £235 dependant on the category of treatment and investigation.

5. The Committee congratulates the work done so far in developing Liaison Psychiatry services and asks that commissioners and providers work together to ensure the successes are consolidated and the service fully rolled out across the county.

Implementation of the psychiatric liaison services across Kent and Medway is underway with Kent and Medway NHS and Social Care Partnership Trust (KMPT) collaborating with both West Kent Acute trusts, Dartford and Gravesham NHS Trust and Maidstone and Tunbridge Wells NHS Trust, as part of the QIPP Programme. The aim is to integrate the delivery of mental and physical health services in the acute setting and improve performance.

Progress to date has included increasing the mental health staff establishment at each hospital.

- At Darent Valley Hospital the mental health clinical staff numbers have increased from 2.8 whole time equivalent (wte) band 6 mental health clinicians to 3.8 wte and the appointment of 0.5 wte consultant psychiatrist.
- At Maidstone and Tunbridge Wells Hospitals mental health clinical staff have increased from 4.8 wte band 6 mental health clinicians to 6.8 wte and the appointment of 1.0 wte consultant psychiatrist.

At Medway NHS Foundation Trust the dedicated Liaison Psychiatry Team has been operational since November 2011 and was nurse led with 4.6 wte mental health clinicians. At the beginning of September a 0.5wte Consultant Psychiatrist was appointed. A single point of access has been in place for almost one year as has a self-harm and Mental Health Act Pathway. The team is available 7 days a week from 9am to midnight and provides mental health assessment, advice and awareness training to the Emergency Department. Standards have been negotiated with the crisis team and psychiatric on call Doctors so that there is consistency across the 24 hour period including timely and safe transfer to the mental health unit when psychiatric admission is required. An average of 150 people each month (including both Medway and Swale populations) are assessed with the majority seen in the Emergency Department. Medway Foundation NHS Trust has noticed that an increased number of patients are being seen sooner in the Emergency Department with fewer admissions.

In addition new processes have been put in place including:

- a single point of access which is open 24 hours a day, 7 days a week which has been introduced at all hospitals,
- a new pathway covering self-harm,
- a new Mental Health Act pathway

A training programme has been prepared and delivery initiated to key acute trust staff.

The three NHS Trusts are currently collating data in order to monitor the impact of the additional resource and the impact on meeting the CQUIN targets. This includes looking at A&E response times, admission avoidance, reduced lengths of stay, increased awareness of nursing someone whose behaviour is impacting on their care and treatment (cognitive impairment, depression, psychosis), with informed care planning, effective risk management and reduced incidents.

6. The role of GPs in ensuring the goal of each person receiving the most appropriate treatment at the right time is achieved cannot be underestimated. We ask NHS Kent and Medway to provide assurances that all of the emerging Clinical Commissioning Groups are leading on the work to develop the urgent and emergency care pathway.

As described above, each Clinical Commissioning Group is working to redesign the model for urgent services, utilising the opportunity for NHS 111 to help guide the patient to the right service first time. Each area has an Urgent Care Board that is clinically led by the CCGs and is driving change.

Medway and Swale have a joint Whole System Urgent Care Programme Management Group that is committed to on-going implementation of system redesign through the delivery of actions in the Urgent Care Plan. The group membership includes representation from all key Providers across Medway and Swale. The main focus of the redesign is to ensure that many more patients are diverted away from the Emergency Department to a range of effective community treatment and prevention services that deliver the right care in the right place at the right time.

The whole systems group is led by GPs, and key projects on the delivery plan have GP leadership and engagement as appropriate. Similarly, an urgent care delivery group in Dartford, Gravesham and Swanley is in place and across the north area (Medway, Swale and DGS), a Transformation Board supports the integration and development of services across the whole area.

In west Kent, the Urgent Care Board is chaired by the Clinical Commissioner for urgent care and supported by clinicians and managers from all the main partners. There is an action plan to improve the capacity and work flow within Maidstone and Tunbridge Wells Hospitals, following the report from the Emergency Care Intensive Support team. It focuses on the flow through the hospitals; admissions management and length of stay and discharge management.

In east Kent, the four CCGs work together in a Federation, and have an Integrated Urgent Care Programme, supported by an operational delivery group. They recognise that in east Kent an effective integrated system will ultimately ensure that the local health economy works within a planned budget and to high standards of safety and quality. A successfully delivered integrated urgent care system will incorporate elements of acute care, community services, social care and out of hours provision. For example a neighbourhood care team that is actively striving to deliver the Long Term Conditions agenda but is not intimately aligned with the step down / step up / ambulatory care / hospital at home alternatives to acute admission will not deliver an integrated service.

Therefore the aim in east Kent is to integrate all of these services together, and take a huge step forward in developing and integrating the primary and secondary care interface.

As well as these structures to ensure commissioning is clinically led and co-ordinated, the key role of GPs is well recognised.

There are examples from across Kent and Medway including the Quality and Outcomes Framework for general practice which includes an element where GPs are asked to review A&E attendances and admissions for their population and consider what actions they can take locally. One example in Dartford, Gravesham and Swanley CCG involved a practice discussing urgent care services with their patient participation groups, gaining feedback on a number of issues and testing posters with patients to ensure the communications were appropriate.

All east Kent CCGs have signed up to the Professional Standards for urgent care. This has been about ensuring:

1. All practices will have a nominated GP Urgent Care lead and adopt a multidisciplinary approach to access that involves clinicians and reception staff.
2. For telephone appointment requests, practices should either offer an appointment (either phone, home or surgery) ***or*** ring patient back.
3. Practices should record all urgent care referrals, generated by the practice (e.g. 999, MIU, A&E), in the same way as elective referrals.
4. All patients requesting a home visit will be offered the next available visit ***or*** 'triage' slot by the reception team.

The intention of these "standards" is to begin the process of applying the "Best Practice" findings from the Primary Care Foundation report - "Urgent Care: A practical guide to transforming same-day care in general practice". This allowed practices to identify current performance against the PCF standards for urgent care, and more importantly the areas requiring improvement to allow future demand to be met. All practices have completed an action plan which outline the steps required to improve same day access to primary care services, and the practices overall response to patients who are high users of urgent care services.

They are currently working through how they can implement these standards and report back to the CCGs quarterly. They are also looking at providing a direct line for paramedics, and working with EKHUFT for better contact with consultants.

The second element of the scheme focuses on the validation of A&E attendance data. Practices have been asked to implement a system whereby A&E data is clinically validated, with further agreed steps then taken to manage patients who had a primary care need in the practice. All practices have implemented systems for monitoring patient use of A&E on at least a monthly basis, with action plans in place outlining the steps taken by the practice e.g. providing communication material for alternative services, calling patients into the practice for a clinical review, arranging appointment with other professionals best suited to meet patient needs.

Ashford CCG has also implemented a project to determine the impact of using a GP within the A/E department so that for patients who present themselves they are seen by a GP in the first instance.

A Medway GP project is raising further awareness of differences in A & E attendance ratios and working practices across GP practices. Sharing information and best practice is enabling and supporting practices to review their own patterns of A & E attendances and develop action plans to make improvements. This project has helped to identify that there are still a high numbers of patients that frequently attend A & E. Further work is planned as part of this project to review reasons for this and then address them.

All CCGs are working with GP practices to improve the identification of patients at risk of hospitalisation through the strategy for Long Term Conditions (LTC). A validated decision support tool identifies those who have had frequent admissions and other factors to enable GPs to predict patients at risk of admission and then provide more co-ordinated care to support them. The work on the strategy includes arrangements for sharing information, integrated health and social care teams and support for self-care and self-management.

Having the right information about a patient when they need urgent care is a crucial element, to enabling management of patients without requiring A&E. GP practices are working on this through a number of routes. Part of the LTC programme involves better arrangements for sharing information with patients consent, and Swale are piloting a system called 'Patients Know Best' which facilitates the sharing of information. GPs are already well advance in some parts of Kent in populating the Summary Care Record which contains information on allergies and medication. The 'Special Patient Notes' arrangements that are already in place from GPs with Out of Hours providers are being considered to ensure that appropriate clinical information can be available to clinicians within the NHS 111 service. The ambulance service are developing their 'IBIS' system to allow special notes to be flagged to the 999 service and help identify if for example, a patient has requested they follow a particular care plan.

7. The rollout of 111 is a great opportunity accompanied by great risks. There is only one chance to introduce it properly. The Committee requests that the commissioners of the service and relevant providers involve the HOSC and other key stakeholders early on in the development of the communication and implementation strategies.

The NHS 111 service will be provided by South East Coast Ambulance Service NHS Foundation Trust, in partnership with Harmoni (now Care UK). They were selected following a competitive procurement process which included evaluation by a wide selection of stakeholders.

The NHS 111 service will provide a service which helps to manage patients urgent care needs with advice, but also helps to navigate them through the urgent care pathway. It is supported by a Directory of Services (DoS) which is locally owned and populated by the CCGs with the services available for their population. The clinical

assessment tool that the NHS 111 service uses links directly to this DoS and is sensitive to the skills patients are identified as needing and the timescale for the response so that patients will only be referred to services which can meet their needs. Over time, the service will be able to book appointments directly into some services.

Now that mobilisation is underway, each cluster is establishing local governance arrangements involving stakeholders to ensure the service is developed in conjunction with the other partners in urgent care, including the voluntary sector.

The NHS 111 service will also provide valuable management information about the services required but unavailable, or potentially where services are available but little used, or are duplicated. This will support the redesign work referred to in section 5.

KCC colleagues are working with the commissioners in this development, and the Directory of Service will include details on social care as well as the newly forming health and social care integrated teams. The marketing and communication plan for NHS 111 is linked to the nationally planned campaign. The plan is being developed with stakeholders.

8. The creation of the Health and Wellbeing Board and transfer of substantial public health responsibilities to local government provides a golden opportunity to develop integrated preventive health plans and we ask the Health and Wellbeing to prioritise work which will reduce the number of people entering the urgent and emergency care pathway in the first place.

Many of the areas in the draft strategy presented to HOSC in October will support this. In particular, the section in outcome three has a particular focus:

> *We want people with long term conditions to experience well-co-ordinated services which prevent them from being admitted to hospital unnecessarily or experiencing a crisis.*
>
> *If we do this in Kent the following will happen; more patients and their carers will be supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improve access to patient information; reduce number of times patients have to repeat information to professionals (Tell us Once);* ***see a 15%reduction in A&E admissions****; a 20% reduction in emergency admissions and a 14% reduction in elective admissions. More importantly this will lead to a 45% reduction in the rates of people dying earlier than expected*.

There are a number of local initiatives designed to develop more proactive models of care which will impact on A&E attendance and unplanned admissions. For example, Swale's Health Inequalities project is designed to address health inequalities in

relation to cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD). This is being undertaken through direct action in primary care to reduce variation in care and treatment and identify people with currently undiagnosed need. In addition, a public facing campaign raises awareness of these diseases with a view to disease avoidance and/or improved management.

9. The HOSC requests that NHS Kent and Medway produce a written report for the Committee by the end of the year detailing what success has been achieved in reducing attendance at A&E and what plans have been agreed with the NHS provider trusts in order to further meet the challenge.

As described above, each urgent care board has agreed plans with their providers to meet the challenge. These are locally led and owned, and examples of some of the initiatives include:

- Integrated teams between health and social care, with single points of access are due to be in place in Dartford, Gravesham and Swanley in November 2012. West Kent CCG has a similar approach with social care with the benefits expected early in 2013.

- A clinical audit was completed this month to identify whether patients conveyed to A&E at Medway NHS Foundation Trust by South East Coast Ambulance Foundation Trust (SECAMB) in response to a 999 call could have been managed by using an alternative pathway. Where alternatives to A&E may have been possible, the audit will identify areas for development to enable these alternatives to be used if available or considered for commissioning if not.

- In Maidstone, Swale and Dartford, Gravesham and Swanley, significant work with care homes is being undertaken to support clinical management in the home, to minimise unnecessary transfer to hospital.

- In Maidstone and Tunbridge Wells, urgent appointments are now available for GPs to refer elderly patients for consultant assessment, to avoid the need to go via A&E.

- Darent Valley Hospital has implemented a geriatrician led assessment unit which, in addition to providing specialist urgent care for older people attending the hospital, will provide telephone support for healthcare professionals. Enabling the provision of specialist advice and guidance to ensure patients are treated in their home if clinically appropriate to do so.

- In Maidstone and Tunbridge Wells, GPs are working in A&E to reduce short stay admissions and support management of non-registered patients.

- A clinical audit of GP out of hours referrals to A&E has been undertaken in west Kent, to help inform improved management.

- A GP to work in SECAmb emergency operations centre has been agreed to support the use of alternative pathways across Kent and Medway and to identify where healthcare professional referrals could be managed differently.

- Work has been undertaken to strengthen further the Medway on Call Care (MedOCC) and South East Coast Ambulance (SECAmb) alterative treatment pathway to enable more patients, with specific conditions, to be treated by either MedOCC or SECAmb ambulance crews. This diverts more patients away from A & E. During November 2012 SECAmb crews are also attending training sessions with MedOCC to improve awareness and knowledge of the pathway which will is a key action to increasing referrals.

- Opening hours at the MedOCC@ Medway base have been extended this year to enable more patients with primary care treatable conditions arriving at A&E to be treated by MedOCC. The plan is for an additional 2500 Medway and Swale patients to be seen by MedOCC rather than A & E, and results to date show that projected numbers are approximately 2700.

- Disease specific pathways have been developed in most areas to improve care for patients with diabetes, heart failure, those at risk of falls, DVT, cellulitis and respiratory disease.

- Swale CCG as part of its intermediate care review is working towards putting in place community geriatrician service to support the work with care homes, to support the Multi-Disciplinary Teams (MDTs) in primary care in relation to our risk stratified patients with highest need, to support advice and guidance to GPs.

- Ashford CCG are implementing care systems for patients with long term care needs to ensure that they are supported to manage at home through education and development of support systems. They will be working with volunteers to establish care networks. Community matron hours have been extended to include on call so that they can assist both care homes and the out of hours teams to manage patients within their homes.

- South Kent Coast CCG has developed a Rural Minor Injury Service. They identified that poor transport links exist between certain areas and the nearest out of hours (OOH) base, minor injury service (MIU) or A&E, with patients travelling 30 minutes to an hour using public transport. There are also significant seasonal changes in populations which has had an impact on local services providing general medical services. The service commenced in August 2012, operating 8am-8pm, 7 days a week. There has been enormous local support for this pilot service and the service has been well used to date. The CCG will begin evaluating the pilot early 2013; the outcome will inform their commissioning intentions for 2013/14.

Current Accident and Emergency Department activity

Each urgent care board monitors activity at A&E, ambulance incidents and in emergency admissions. Further work is underway to enable routine monitoring of Minor Injury Unit and Walk in Centre data. Out of hours data has recently been significantly improved and will start to provide information about the outcome for patients. The minimum dataset for NHS 111 provides patient level data that will enable clinical audit across the patient journey, and reporting is being developed as part of the service mobilisation.

Activity so far this year shows a continued increase in A&E attendances, although the numbers of ambulance incidents shows a greater increase than the numbers taken to hospital or seen in A&E, suggesting that alternatives are beginning to be used.

A&E Attendances-2012-2013 April- August:

Kent and Medway commissioner activity

April - August	% change on 11-12
RN7-Dartford & Gravesham NHS Trust	3%
RPA-Medway Hospitals	1%
RVV-East Kent University Hospitals Trust	0%
RWF-Maidstone & Tunbridge Wells Hospital	2%

Ambulance activity, to Sept 2012

PCT	% increase on 11/12 total	% increase on 11/12 conveyed
West Kent	6%	2%
Medway	5%	0%
Eastern & Coastal Kent	6%	1%
Total	6%	1%

Provisional data published nationally by Hospital Episode Statistics Online for April to July 2012 show a 5% increase compared to the same period last year. The increases in Kent and Medway are therefore lower in comparison.

Summary

There has been progress on many areas to support appropriate A&E attendance; however this will continue to be a priority. CCG plans are being developed for 2013/14 and longer term strategies for urgent care are also being worked up in each area. Urgent care and management of long term conditions continues to be a very high priority on all their agendas.

Example of poster developed as part of the integrated communications plan for use in the Ashford area:

"Not the Default Option"
A review into levels of attendance at Accident and Emergency Departments

East Kent Hospitals University NHS Foundation Trust welcomes the above report, produced for Kent County Council's Health Overview and Scrutiny Committee.

The report summarises well, many of the key issues around attendances at Accident and Emergency Departments across Kent and Medway.

We welcome the recommendations described in the report and offer the following responses to HOSC members for the meeting in July 2012:

Recommendation 1

The patient journey should be seamless, with no duplication of diagnostic tests, or better communication with patients of why tests are being carried out. We ask the commissioners and providers to report back to the Committee with details of what work is being undertaken to assess the scale of the problem and achieve this.

We provide GPs with direct access to diagnostic examinations. This approach is consistent with ensuring that patients are given access to early diagnostics, ensuring faster treatment pathways and better health outcomes for patients in our community.

The ability to scan patients before being referred to the secondary provider enables GPs to discuss the outcome the scan with the patient and agree their on going treatment, which may be management via the GP surgery or onward referral to a specialist service in one of our hospitals.

This approach is also coherent with the government's white paper (and now bill) - Equity and Excellence: Liberating the NHS, as well as many other health initiatives including; 6 week diagnostic waits; the Cancer Reform Strategy and TIA & Stroke management.

We take pride in the early implementation of these initiatives for patients that require early use of diagnostics to support better outcomes. For example, the daily TIA service ensures that patients are seen at the clinic and have an MRI scan on the same day. Supporting early treatment of these patients and potentially avoiding a future stroke.

Our Pathology services provide a 24 hour turnaround time for blood results. GPs access the results electronically via an IT system, Dart OCM. Our pathology staff are available to discuss interpretation and offer support to the GP. This process ensures the patient is referred to a specific pathway of care, which may be provided in the primary or acute setting.

There is daily dialogue between the operational staff and key diagnostic services to ensure that internal standards for investigations are maintained with minimal duplication of requesting tests. As part of our drive to improve services, a number of patient pathways are being reviewed from 'end to end' to identify areas where requests for diagnostic tests have been duplicated. Where this is found to be the case, the required improvements will be put in place.

In relation to the need to improve communication with patients of the reason why diagnostic tests are being carried out, we recognise this as a definite need for all healthcare providers.

Our healthcare professionals are required to clearly explain to patients why diagnostic tests are required. The results of a recent CQ Audit demonstrate that communication to patients is not always optimal. The CQ Audit also highlighted issues with our outpatient clinics where we acknowledge that some physicians do not always explain to patients clearly enough why diagnostic tests are required. In response, we have developed an action plan which documents changes that need to take place to ensure communication between the clinician and patient is improved.

We intend to introduce a telephone helpline for patients who attend an outpatient appointment. If a patient is concerned or unsure about the information they have been given during their consultation with the doctor they can use the helpline to ask for further clarification, including help with understanding why diagnostics tests are required. The patient's query will be directed to the appropriate area to ensure the correct response is given.

We will continue to monitor its performance in this area through the use of patient surveys so that we can be assured of improving communication with our patients.

Recommendation 2

Lack of awareness or confusion around the alternatives to accident and emergency mean turning to A&E is often the simplest and most rational choice, even where it is not the most appropriate one. Commissioners and providers should produce a joint communication plan to simplify the choice of GP out-of-hours services, minor injuries units, walk-in-centres and other alternatives and improve public understanding.

We are working closely with partners and commissioners in exploring ways to reduce attendances at A&E departments through the Integrated Urgent Care Board (IUCB). We would support the IUCB in developing a joint communication plan to simplify the choice of alternative providers and to improve public understanding of service provision.

Recommendation 3

Following from the above recommendation, the Committee asks that commissioners and providers explore the appropriateness and viability of introducing standardised opening hours around a clearly understood set of services across all the minor injury units in Kent.

We provide 24 hour, 7 day A&E services from the William Harvey Hospital in Ashford and from Queen Elizabeth The Queen Mother Hospital in Margate. We also provide 24 hour, 7 day Emergency Care services from Kent and Canterbury Hospital, Canterbury. All three sites have co-located 24 hour Minor Injuries Units attached to them.

We also provide a Minor Injuries Unit service from Buckland Hospital in Dover. The MIU at Buckland Hospital, Dover is open from 0900hrs to 1900hrs Monday to Friday and 1000hrs to 1800hrs on weekends and bank holidays. We have profiled these opening hours to match patient needs based on a review of attendances.

Recommendation 4

We ask the commissioners to provide further information on the costs per case for those patients seen at a walk-in centre or minor injuries unit compared to those seen at A&E departments.

We believe that our Commissioners are best placed to respond to this recommendation.

We are of the view that patients should attend the most appropriate facility and that healthcare providers should respond effectively and efficiently to the patient's condition. We will continue to work with commissioners through the IUCB in reviewing the provision of walk-in centres, MIUs and A&E departments.

Recommendation 5

The Committee congratulates the work done so far in developing Liaison Psychiatry services and asks that commissioners and providers work together to ensure the successes are consolidated and the service fully rolled out across the county.

We are involved in discussions regarding the further development of Liaison Psychiatry services but recognise that this is a service area which the Kent and Medway NHS and Social Care Partnership Trust leads on behalf of Commissioners.

Recommendation 6

The role of GPs in ensuring the goal of each person receiving the most appropriate treatment at the right time is achieved cannot be underestimated. We ask NHS Kent and Medway to provide assurances that all of the emerging Clinical Commissioning Groups are leading on the work to develop the urgent and emergency care pathway.

We continue to work with GPs and CCGs in developing integrated healthcare services on behalf of our patients.

Recommendation 7

The rollout of 111 is a great opportunity accompanied by great risks. There is only one chance to introduce it properly. The Committee requests that the commissioners of the service and relevant providers involve the HOSC and other key stakeholders early on in the development of the communication and implementation strategies.

We value the involvement of the HOSC with this issue and undertake to work with our partners with the implementation of 111, including communicating plans as service change is indicated. We recognise that our commissioners are best placed to lead on this recommendation.

Recommendation 8

The creation of the Health and Wellbeing Board and transfer of substantial public health responsibilities to local government provides a golden opportunity to develop integrated preventive health plans and we ask the Health and Wellbeing to prioritise work which will reduce the number of people entering the urgent and emergency care pathway in the first place.

We are members of the Integrated Planned Care and Long Term Conditions Board which has been established in Kent and Medway. One of the aims of this Board is to examine how A&E attendances could be reduced for patients with long term conditions.

We are also keen to work with CCGs to explore further ways of reducing A&E attendances by providing increased levels of care closer to the patients' home through the increased use of telemedicine and tele-health and through the improved provision of ambulatory care, for example.

Recommendation 9

The HOSC requests that NHS Kent and Medway produce a written report for the Committee by the end of the year detailing what success has been achieved in reducing attendance at A&E and what plans have been agreed with the NHS provider Trusts in order to further meet the challenge.

We believe that NHS Kent and Medway should take the lead on this recommendation.

Kent Community Health NHS
NHS Trust

Chairman and Chief Executive's Office
The Oast
Unit D, Hermitage Court
Hermitage Lane
Barming
Maidstone
Kent ME16 9NT
Tel. 01622.221903
e:mail: marion.dinwoodie@kentcht.nhs.uk
Web: www.kentcht.nhs.uk

Date: 11 July 2012

Dear Chairman,

Kent Community Health NHS Trust welcomes the committee's report "Not the default option" and is working with NHS Kent and Medway and the emerging Clinical Commissioning Groups to respond to the recommendations and contribute to the report which has been requested by the end of this year.

We work closely with our commissioners on the development of alternatives to A&E and on services which prevent people from having to go to hospital in an emergency or unnecessarily. Our preventative services promote good health; people are supported to manage their health in the community, especially those with long-term conditions and we are working increasingly closely with GPs, so that patients are assessed and their needs identified, and addressed, at an early stage so they stay healthier for longer.

We are working closely with KCC to develop integrated health and social care teams to deliver care which meets individual patients' needs and we are developing a multi-skilled workforce able to carry out a range of interventions.

Our specialist services for children focus on children who are seriously ill and families with high levels of need; meeting the needs of vulnerable adolescents and ensuring early support for disabled children, young people and their families. All of these services contribute to preventing ill health, avoiding emergency admission to hospital and support people who do need to go into hospital to leave earlier.

The services available at our seven Minor Injury Units, and their opening hours, are developed to respond to the needs of the local population and are kept under review. Information about them is available on our newly launched website and online Directory of Services www.kentcht.nhs.uk which provides patients and commissioners with consistent details and a search function for community health services where you live.

The Directory of Services also has:

- A patient information library with our patient leaflets in downloadable format
- Surveys for patients to tell us about their experiences of our services
- Patients can also rate services and leave comments
- Information about the Trust including board papers, reports and publications.

Yours sincerely,

Marion Dinwoodie
Chief Executive

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 November 2012

Subject: Tonbridge Cottage Hospital: Change of Use

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1. Background

(a) This matter has been brought to the attention of the Health Overview and Scrutiny Committee as concerns have been raised that there was inadequate consultation of the decision to house a stroke rehabilitation bed unit in Tonbridge Cottage Hospital.

(b) NHS Kent and Medway have been asked to provide a report covering the following areas:

1. The background and rationale behind the decision to house the stroke rehabilitation unit in Tonbridge Cottage Hospital;

2. The reasons why this was not considered a 'substantial variation' of service and so why the Kent HOSC was not consulted in advance of this change;

3. An outline of what engagement and consultation with staff, service users, the Hospital League of Friends and the wider public took place prior to the decision;

4. An outline of what plans the commissioners have to consult on this change of use at the hospital, and any future changes of use.

2. Recommendation

That the Committee consider and note the report.

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Kent and Medway

Tonbridge Cottage Hospital

1. Introduction

This report seeks to:

a. inform Members of the background and decision to house a stroke rehabilitation unit in Tonbridge Cottage Hospital
b. outline the engagement and consultation that took place with stakeholders
c. outline current and future commissioning plans for community based services in west Kent

2. Context

Tonbridge Cottage Hospital (TCH) provides rehabilitation inpatient care. There are currently 24 beds available and the hospital takes patients directly from their own homes, where they do not need to be admitted to an acute service but are unable to cope at home.

In addition it offers a service for patients within the acute sector who are medically stable but require further rehabilitation. The beds are designated as adult beds and the vast majority of patients are older people, however younger adult patients are accepted. The aim of the hospital stay is to assist patients to regain their independence where appropriate or to teach coping strategies where functional capabilities have changed significantly e.g. after a stroke.

The team caring for patients consists of a Modern Matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, care manager, pharmacist, and 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. There is also a specialist service for falls.

3. Background and decision to house the stroke rehabilitation unit in TCH

Prior to the closure of Kent and Sussex Hospital, the Primary Care Trust worked closely with its partner organisations, Maidstone and Tunbridge Wells NHS Trust (MTW) and West Kent Community Health (WKCH) in securing locations for those therapy services that would not be housed within the new hospital at Pembury; one of these services was stroke rehabilitation.

In 2004 a mapping of the community hospitals within west Kent was carried out by South West Kent Primary Care Trust. This revealed the community hospitals would be most appropriate to house the stroke rehabilitation unit as they already delivered rehabilitation care to patients and Sevenoaks Hospital was identified to host the proposed unit.

However, once MTW had had an opportunity to review this mapping, they considered Sevenoaks Hospital would be too far away from the new hospital at Pembury to be viable and that TCH was preferred.

The only other reasonable alternative, other than using TCH would have been to transfer patients to Maidstone Hospital and this was something the Primary Care Trust and MTW thought would be disadvantageous to patients, their relatives and the clinical staff who would need to provide follow up and community services.

Therefore, work commenced to assess the current bed use at TCH, the transfer of 10-12 beds to stroke rehabilitation and how the 'lost' beds would be re-provided across the cottage hospital estates.

4. Bed numbers, use and impact on local patients

When Tonbridge Cottage Hospital was identified as being the most appropriate site to house the stroke rehabilitation service, £400k was invested to create the unit.

12 of the existing 22 rehabilitation beds were designated as specialist stroke rehabilitation and the remaining 10 continued to be available for patients with more general rehabilitation needs. A further two beds were also created at Tonbridge Cottage Hospital for general rehabilitation use. Therefore at this point there were 12 beds for specialist stroke rehabilitation and 12 for general rehabilitation use.

Further investment into community services meant that a further 10 general rehabilitation beds were also identified across sites in west Kent. These continue to be provided. The 10 beds are available at Edenbridge and District War Memorial Hospital - two beds, Sevenoaks Hospital - two beds, and Gravesham Community Hospital – six beds.

This provision strongly supports the role community hospitals have to play in delivering care to the local community; ensuring patients do not stay in an acute setting for longer than is necessary. Many more services are now provided in people's own homes, which bring benefits to patients, their families, and their carers.

Therefore it is important to note there has been no loss of beds at TCH. There are still 22 general rehabilitation beds. 12 are provided at Tonbridge Cottage Hospital, alongside the 12 stroke rehabilitation beds, and a further 10 in the sites detailed in the previous paragraph.

With regard to the impact on local patients not being able to access rehabilitation care at TCH, whilst every effort is made for community hospitals to care for patients who are local, the funding is not ring-fenced to locality based provision and there are times when patients will be cared for at other community hospitals within west Kent. What is assured is that patients from other trust areas, such as Sussex will not be cared for within west Kent community hospitals, ensuring beds are for west Kent patients.

5. Consultation and engagement in respect of the decision to house the stroke rehabilitation unit at TCH

With regard to engagement throughout the process, it was agreed between the PCT and the provider organisations that, unlike some of the major changes to service provision that were proposed in 2004 especially around services for women and children, for which a formal public consultation took place, stroke rehabilitation in many respects would be a continuation of what was currently being provided at TCH. As there was no major change of service use a formal consultation was considered not to be appropriate.

The PCT worked with the Strategic Health Authority on the appropriate engagement to ensure the implementing of the stroke rehabilitation unit at TCH was shared with the local stakeholders involved. The commissioning managers met with the League of Friends, Council representatives and LINks to discuss concerns around the proposal and the benefits for TCH were identified and shared and the response received was very positive.

In the final stages of closure of the Kent and Sussex Hospital and the opening of Pembury Hospital, the League of Friends and Sir John Stanley MP were invited to tour the new building and feedback at this stage was extremely positive and the associated investment of £400k, to TCH, as part of the development was welcomed.

However, on reflection, it is acknowledged that the engagement and consultation around the changes which took place in 2010 and early 2011 detailed above fell some way short of best practice.

Although NHS West Kent concluded that the planned changes to stroke services were not a substantial change and therefore did not undertake formal consultation, this decision would more properly have been made by this committee.

In retrospect we acknowledge that the PCT should have approached the Health Overview and Scrutiny Committee to consider this matter.

On a more positive note Kent Community Healthcare Trust has informed us that Maidstone and Tunbridge Wells NHS Trust has received positive feedback about the stroke rehabilitation unit at TCH. It is very pleased with the way the service has integrated into the community setting and how this has contributed to an overall positive patient experience.

6. Current and future commissioning plans for community based services in west Kent

West Kent Clinical Commissioning Group (WKCCG) is currently assessing the need for community based services, including beds, in the whole west Kent area and in localities within that. Recognising that there is a significant flow of Maidstone residents to community hospitals in other parts of west Kent, including Tonbridge, WKCCG proposes to pilot a step-down facility in Maidstone, starting on December 3 2012.

The provision of this facility will release capacity in other community hospitals and so improve the access to beds closer to home for all those who need them in west Kent, and specifically in Tonbridge.

WKCCG will evaluate the impact of this additional facility, which will be provided in partnership between Kent County Council, Kent Community Health NHS Trust and Maidstone and Tunbridge Wells NHS Trust, over the winter period.

7. Conclusion

We hope this report goes some way in providing Members with assurance that whilst the consultation and engagement process around the re-designation of beds at TCH was, on reflection, not as robust as it could have been, the discussions that did take place were at the time positive towards the changes that were introduced in 2010/ 2011.

This does not excuse the fact that the planned changes should have been bought to this committee's attention. We are still of the opinion that the re-designation of the beds at TCH was not a substantial variation but we absolutely acknowledge that the evidence to support this decision should have been discussed with Kent HOSC.

Members will also be aware that requests have been made to undertake a retrospective consultation on accommodating the stroke rehabilitation service at TCH.

Related to this we recently met with representatives from the Tonbridge Cottage Hospital League of Friends and discussed the shortcomings of the consultation and engagement process around the introduction of the stroke rehabilitation unit at Tonbridge Cottage Hospital. On a more positive note we also discussed the pilot step-down project being led by WKCCG. We have agreed to share the monitoring information from the pilot with Tonbridge Cottage Hospital League of Friends and have also agreed they will be involved in the final evaluation process.

For Members information, NHS Kent and Medway and the Tonbridge Cottage Hospital League of Friends agree that a retrospective consultation will divert valuable resources, halt the proposed commissioning plans referred to and delay the potential benefits for Tonbridge and Tunbridge Wells residents.