KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held in the Council Chamber, Tonbridge and Malling Borough Council offices, Gibson Drive, Kings Hill, West Malling on Friday, 20 July 2007.

PRESENT: Mrs C Angell, Lord Bruce-Lockhart, Mr A R Chell, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Mr M J Fittock, Ms A Harrison, Mr G A Horne, Mr J F London (substitute for Mr B R Cope), Dr T R Robinson, Mrs P A V Stockell (substitute for Mrs S V Hohler), Mr R Tolputt, Mr R Truelove (substitute for Mrs E D Rowbotham), Mrs E M Tweed.

ALSO PRESENT: Mr P D Wickenden, Overview and Scrutiny Manager and Dr D Turner, Researcher to the NHS Overview and Scrutiny Committee

UNRESTRICTED ITEMS

40. Membership

The Overview and Scrutiny Manager reported that Lord Bruce-Lockhart and Dr T R Robinson had replaced the two Conservative Group vacancies on the Committee; and Mr B R Cope was substituting for Mr M J Angell and Mrs S V Hohler for Mrs B J Simpson.

41. Urgent Item

The Overview and Scrutiny Manager reported that Mr A R Chell had stepped down as Chairman of the NHS Overview and Scrutiny Committee. He sought and gained the Committee's approval to appoint a new Chairman, as this would enable the Committee to continue to expedite its business.

42. Election of Chairman

(1) Dr T R Robinson nominated Lord Bruce-Lockhart as Chairman of the Committee, with Mrs P A V Stockell seconding. There being no other nominations, Lord Bruce-Lockhart was duly elected Chairman without a vote.

(Lord Bruce-Lockhart presiding)

(2) Lord Bruce-Lockhart thanked the Committee for electing him as Chairman of the Committee and paid tribute to Alan Chell for all the hard work that he had undertaken during his chairmanship of the NHS Overview and Scrutiny Committee.

(3) In responding, Mr Chell informed the Committee that he had not stepped down as Chairman.

(4) Lord Bruce-Lockhart then set out his vision for the future operation of the Committee and the areas to which he saw the Committee paying particular attention.

43. Minutes

Matters Arising

(1) Mr Fittock said that he felt that it was important there was continuity in the membership of the Committee in order for it to maintain its credibility. This was acknowledged by Lord Bruce-Lockhart. He said that there should be no reason for substitutes except in case of illness.

Meeting with Maidstone & Tunbridge Wells NHS Trust Patient and Public Involvement Forum representatives

(2) Mr Fittock asked for feedback on an item of correspondence received from Maidstone & Tunbridge Wells NHS Trust Patient and Public Involvement Forum had been dealt with. Mr Chell said that he had held a very good meeting with representatives of the PPIF and explained in greater detail the role of the Committee and in particular the nature of Section 7 and Section 11 consultations.

Local Involvement Networks (LINks)

(3) Mr Fittock indicated that whilst he was aware that there was an update report later on in the agenda relating to Local Involvement Networks (LINks) he was keen to ensure that the PPIFs were kept informed of progress being made in the establishment of a LINk.

44. Mental Health Service Provision across Kent and Medway

(Peter Hasler, Director of Nursing and Human Resources, Kent and Medway NHS & Social Care Partnership Trust, Lauretta Kavanagh, Director of Commissioning – Adult Mental Health Services and Substance Misuse, and Marion Dinwoodie, Chief Executive, Medway PCT, Steve Phoenix, Chief Executive, Julia Ross, Director of Civic Engagement, Bob Deans, Director of Commissioning and Performance and Debbie Stock, Programme Manager for Mental Health, Dr James Thallon, Medical Director, West Kent PCT, were in attendance for this item)

(1) Mr Fittock declared that he had an interest in the Swanley Volunteer Centre and is a Trustee of the Invicta Advocacy Network (Dartford). Mr London declared he is a Member of Sevenoaks MIND.

(2) Further to Minute 37 of 2006, Mr Hasler gave a presentation (on behalf of Erville Millar, who was regrettably ill and unable to attend the meeting) on the first year's operation of the Kent and Medway NHS & Social Care Partnership Trust. A copy of the presentation is attached as Appendix 1 to these Minutes.

(3) Following the presentation Members of the Committee and others present raised a number of questions.

(4) Lord Bruce-Lockhart asked about the reasons for increasing demand for mental health services across different age groups. Mr Hasler responded that there was an ageing population in the UK and, as a result, there were more cases of dementia – but people with this condition could now be managed at home for longer than previously. As far as young people were concerned, the Trust was working closely

with schools in order to take a more preventative approach. Lord Bruce-Lockhart asked whether there were clear statistics on dementia, for instance from bodies such as the Alzheimer's Society. Mrs Dinwoodie, Chief Executive of Medway PCT, said that this was a question for commissioners as well as providers. Demand and the patient pathway needed to be in alignment; this would be achieved through Local Area Agreements and needs assessments.

(5) Mr Fittock asked about the audit of Kent Drugs and Alcohol Action Team (KDAAT) in 2006, in which the service had been assessed as 'fair', and whether measures were being taken to improve the service. Mr Hasler said that the audit of the service had pre-dated its transfer to the voluntary sector. The current providers, KCA and Turning Point, both had good histories and he was confident that there would be improvement in the service.

(6) In response to a question about early intervention for young people and the need for further work, Ms Kavanagh responded that the KDAAT was a multi-agency strategic partnership, chaired by the Managing Director of Communities at Kent County Council (Ms Amanda Honey). She said that she would provide a written answer to Mr Fittock. With regard to early intervention services for young people, national targets had been achieved. A new model of care had been implemented for 14–35-year-olds who were experiencing their first episode of psychosis.

(7) Mr Fittock asked about a recent report in *The Lancet*, according to which mental-health wards were at best untherapeutic and at worst unsafe. Mr Hasler responded that there were certainly some in-patient wards within the service where clients did not feel safe. He said that the Trust was moving towards single-sex wards, which would help address safety issues. He also explained that people on in-patient wards were now a much more ill group of people than in the past, as the policy was only to admit the most severely ill patients. He informed the Committee that national standards on improving in-patient services were being used. Asked about the timetable for single sex wards, he said the first women-only wards would be available later on this year. He said that most in-patient areas consisted of single rooms anyway, rather than bays (as in the acute hospital sector).

(8) In answer to a question about the Out of Hours service, Mr Hasler said that the Out of Hours Crisis Resolution Team was making a real difference. Ms Kavanagh explained that there was a need to look at other pathways into Out of Hours care (for all levels of patient need): Accident & Emergency departments; primary-care Out of Hours services (provided by GPs); and NHS Direct. Regarding Accident & Emergency departments, she said that there was a need to improve the competence of general hospital staff in dealing with patients who had mental health needs. Likewise, GP Out of Hours services needed further support so that they could improve their competence. NHS Direct was not commissioned locally, but the Trust did work with them. The Trust was also working with KCC to commission a local mental health telephone help line during weekday evenings, weekends and Bank Holidays. Mr Sinclair added that the County Council provided an Out of Hours adult social worker service, and attempts were being made to integrate this with other provision. Ms Kavanagh responded to a question from Mrs Angell about how patient pathways were being tracked for Out of Hours services. She explained that the services that were commissioned had contracts that included performance management measures. However, it became much more challenging where patients

presented to the NHS outside mental health pathways, for instance at Accident & Emergency departments.

(Mr Fittock presiding)

(9) Mrs Angell asked where Members could find statistical information regarding these areas. Ms Kavanagh said matters were complicated by the fact that different services had different commissioners. The Trust could certainly put in writing its commitment to joining up services for people presenting in mental health need.

(10) Ms Harrison asked about age-appropriate care and specialist services for under-16s; and about the new Mental Health Act, which had just received the Royal Assent. Mr Hasler said that there was a small unit at Maidstone that admitted under-16s. Some services were also provided by the private sector, including The Priory Ticehurst House in East Sussex. Only very occasionally was an under-16-year-old admitted to an adult ward – around three or four cases per year. Mr Tolputt spoke about the consultation which had taken place on mental health services in east Kent a couple of years ago and asked a question about who paid the Trust for treatment provided: was it the PCT where the patient lived? Mr Hasler said that there were 400 properties across the county providing mental health services. Many were very small, especially those relating to learning disabilities. Services had to be safe. Often small, isolated units were not as safe as they should be and did not have the "critical mass" of clients necessary to sustain them. This was a critical consideration in the Trust's estate strategy. He went on to explain to the Committee that beds for older people with mental health needs were best co-located at acute hospital sites. Other services would be provided in purpose-built facilities at St Martin's Hospital in Canterbury. Ms Kavanagh said the outline business case for the St Martin's site would be before the PCT and Trust Boards in September.

(11) Ms Kavanagh explained that it was the GP registration of the patient that dictated which PCT paid for treatment. This was in contrast to local authority services, where charging related to the service-user's usual address.

(12) Mr Daley noted that the Trust appeared to be financially sound, having actually made a profit. Regarding the Trust's plans for applying for Foundation Trust (FT) status, Mr Daley wondered whether FT status was appropriate in respect of mental health. Mr Hasler said that the Trust had not made a "profit"; it was in a surplus situation. Regarding FT status, he said the Trust saw many aspects of the FT "journey" as beneficial, especially the opportunity to engage the public more through the appointment of a Board of Governors. This was actually more in keeping with the philosophy in mental health than with that in the acute sector. Also, the fact that FTs had legally binding contracts meant that long-term planning was possible, instead of operating on a year-by-year basis. He acknowledged that FT status would mean there was no longer a line of accountability to the Strategic Health Authority. However, there would still be strong input from the NHS Overview and Scrutiny Committee. Mr Crowther indicated that he was pleased to hear that the NHS Overview and Scrutiny Committee would still have scrutiny powers, although he felt that the committee was already fairly toothless and might have fewer powers over a Foundation Trust. Mr Chell asked about the sum of £500,000 that had been taken from the Trust's budget in 2006–7. He also asked about the extent to which the Trust took responsibility for people living at home who had dementia problems. Mr Hasler responded that the £500,000 which had been lost to the Trust had been the subject

of arbitration with the Primary Care Trusts, but the Partnership Trust had lost the case. Dealing with patients with dementia in their own home was a complex issue as it meant the Partnership dealing with district nurses, voluntary organisations, the Primary Care Trust, etc. Ms Dinwoodie added that people were living longer and 30% of the adult population over 85 years of age would develop dementia. Many of the services for people with dementia were provided by Adult Social Services.

(13) Ms Dinwoodie spoke to the committee about arrangements for commissioning mental health services. She said that it was exciting to have a joint NHS–local authority commissioning team. Only North and South Tyneside had a similar arrangement. She said that FT status for the Partnership Trust would mean that it had to have an integrated business plan, taking account of commissioners' needs.

(14) She said that Patient Choice and Payment by Results were coming to mental health and would give commissioners a much sharper edge, with the Trust being paid per patient rather than through block contracts.

(15) Mr Dean of the West Kent Primary Care Trust spoke about commissioning in his area. National initiatives indicated a shift towards a more preventive approach in mental health. A strategic review across the pathways of care was being carried out. He said there was a dearth of services at Levels 1 and 2 for Child and Adolescent Mental Health services. He added that some services, despite being known and loved by users, were not well used any more; they were costing money and needed to be reviewed. Rather than providing a sub-optimal mental health service which was spread thinly, there needed to be centres of excellence, providing a service that was therapeutic and safe.

(16) Mrs Joyce Epps of the East Kent Mental Health Carers Forum spoke about the Out of Hours service in east Kent, which had been dismantled with the advent of the Crisis Team. As a consequence, she said, since early 2004 there had been no access for those persons who had a lesser need. She added that 20% of people calling the help line needed intervention – the Crisis Team would not help people who could wait until morning. She said there was still the risk of violence and harm in such cases, but the Crisis Team would not intervene. Mrs Epps informed the Committee that the Department of Health had promised carers looking after persons with mental health needs that they would get the support that they required; however, this was not happening. She said it was not appropriate to keep on being put off and given assurances that the services would be there when they were not. There had been no attempt by commissioners to measure the scale of need. Health colleagues responded that they were very sorry that people felt fobbed off; they reassured Mrs Epps that lobbying was not a waste of time. It was pointed out that good planned care could minimise crises requiring Out of Hours intervention. Mrs Epps responded that the need for Out of Hours services could never be entirely eliminated. It was pointed out that there was also a social care dimension to Out of Hours care. Mrs Epps said it was important that there was seamless working between health and social care colleagues. Ms Kavanagh and Mr Leidecker undertook to take this forward having listened to the concerns of Mrs Epps.

(17) In answer to a number of questions from Mrs Witherden, Ms Moorland and Ms Hughes, health and social care colleagues indicated that service users, carers and the public would be fully involved in the Partnership Trust's application for FT status. Health and social care colleagues pointed out that £170,000 was spent annually on

service-user forums. Mr Leidecker said that the County Council had committed resources for two commissioners, David Woodward for East Kent and Paul Absolon for West Kent.

(18) A summit meeting was to take place that afternoon with service users which would seek to address the concerns being expressed before the Committee on service-user involvement. Currently a number of the service users felt excluded from the process.

(19) Service users had made it clear that they felt that they could do a lot more between meetings to assist. All these points would be picked up by the summit which was to take place. Mrs Tweed indicated that she was concerned to hear about the experiences of carers and users. She felt that unless these issues were addressed by the Trust and Adult Social Services then the carers and users had no alternative but to draw their experiences to the attention of this Committee.

(20) Asked about Heathside House at Coxheath, which provided in-patient mental health beds for older people, Mr Hasler answered that there was an oversupply of in-patient beds and that those currently at Heathside were no longer needed.

(21) Responding to a question about Kingswood Community Mental Health Centre in Maidstone, Mr Hasler said that there was no proposal at all to close this establishment. He said Kingswood was in an ideal location, although the building was not in a good condition. A very small element of the service there was being closed, namely the drop-in service. This was a historical throwback – nowadays such services were usually provided by the voluntary sector, with the NHS concentrating on providing therapeutic services. Alternative services were already being provided in the Maidstone area by voluntary-sector providers.

(22) RESOLVED that:-

a) health colleagues be thanked for the information they had provided; and

b) a further update on the progress made in the provision of mental health services provided by the Kent and Medway NHS & Social Care Partnership Trust be given to the meeting of the Committee in January 2008.

45. West Kent Community Hospitals Review

(Julia Ross, Director of Civic Engagement, Barrie Collins, Director of Nursing & Professional Development, Sharon Jones, Director of Community Services and Debbie Lyndon-Taylor, Assistant Director Adult Services, West Kent PCT were in attendance for this item)

(1) The following Members made declaration of interest:-

- Mr Fittock - Member of Benenden Hospital
- Mr Horne – Member of the League of Friends, Tonbridge Cottage Hospital
- Mr London – Member of the League of Friends, Sevenoaks Hospital

(2) A copy of the presentation given on the West Kent Community Hospitals Review is set out as Appendix 2 to these Minutes. The Committee was informed that the recommendations in the West Kent Primary Care Trust Board report for July 2007 had been approved. Mrs Ross spoke about the further work that needed to be done relating to the Minor Injuries Unit (MIU) at Edenbridge, the Tonbridge Cottage Hospital and the Livingstone Hospital in Dartford. Ms Harrison said she felt that, where beds were being done away with, it was important that the Primary Care Trust explain what they were replacing these beds with; communication with the public was key to service-change. This was acknowledged by Mrs Ross who very much hoped that local authorities would act as community leaders in concert with health colleagues.

(3) Health colleagues said they aimed to reduce the number of unnecessary journeys and provide more services in community hospitals, including bed-based "step up" and "step down" services, end-of-life care and neuro-rehabilitation. Mrs Ross informed the Committee that the Pembury Private Finance Initiative (PFI) hospital plans were predicated on the idea of a whole lot of services being provided in the community. Turning to specific local issues, Mr Horne said that the original review of community hospitals undertaken by the consultancy firm Tribal had not been favourably perceived in the community. The failure to come up with split tariff arrangements with local acute-service providers was detrimental to service-provision in the community hospitals. The need for 24-hour and seven-days-a-week care in some cases had not been properly acknowledged. Local GPs in the Tonbridge area had not been consulted, which ran counter to the idea of Practice-based Commissioning. Mrs Ross said in response that the plans for Tonbridge Cottage Hospital still had not been finalised, that consultation would take place and that Mr Horne would be fully involved in this process.

(4) Mrs Ross also confirmed that consultation would take place on the proposals for the Livingstone Hospital at Dartford when these had been finalised. With regard to the split tariff Mrs Ross said that this was still being discussed and that there were no outcomes to report yet. Ms Jones added that she had met with GPs on at least two occasions to discuss issues that had been raised in a letter to the Primary Care Trust. She argued that achieving an optimal length of stay in community hospitals would allow more people to be treated using fewer beds. She said that it would not be possible to keep surplus beds open in case they might be required. She acknowledged that there was always the need for some 24-hour seven-days-a-week care; and this would be provided in other parts of the system. She added that some care could take place at home, in a hospice or in a residential care home. She said that there would never be a situation where no beds at all would be required in community hospitals. Mrs Ross said that one option for the currently unused space at Tonbridge Cottage Hospital would be for some form of bed-based care. Mr Horne noted that Maidstone and Tunbridge Wells NHS Trust had been buying beds in the private nursing home sector, when there were perfectly good beds going unused at Tonbridge Cottage Hospital. He noted that the Hospice in the Weald was experiencing bed-blocking problems while beds remained closed at the Cottage Hospital and were under threat of being permanently closed. Dr Thallon said that the Primary Care Trust was desperate to get agreement on tariff splitting, as achieving this would be essential for the success of the new PFI hospital. The issue would have to be resolved, either locally or nationally. Mr Lake spoke as the local Member for Edenbridge and Sevenoaks. He said that the community he represented had no GP care at weekends and, as such, needed the MIU at the Edenbridge War Memorial

Hospital. He referred to a letter from Julian Webb, Emergency Care Consultant with Maidstone & Tunbridge Wells NHS Trust, about the quality of the service being provided at Edenbridge. Mr Lake said that the Edenbridge Hospital was being closed by the back door and local people did not understand what this was all about, they believed that it was effectively becoming a residential care home.

(5) Dr Andrew Russell, Chairman of the League of Friends of Edenbridge War Memorial Hospital, then addressed the Committee. He said that he was a retired GP. He did not share Mr Lake's perception that the hospital was becoming a rest home for the elderly. He said that it was a very vibrant hospital and he explained to the Committee the various consultant clinics that were available. What the League of Friends was petitioning against was the decision to change the name of the Minor Injuries Unit at Edenbridge before any consultation had taken place. He said that the Unit saw 4,000 patients per annum, with 28% of these receiving follow-up care. This was comparable to the services provided at Crowborough and Uckfield. Dr Russell said it was disingenuous of the Primary Care Trust to argue that the Edenbridge MIU was in reality just a "treatment clinic" because it was dealing with so many follow-up cases. There was only one nurse at Edenbridge Hospital who was kept very busy, often working beyond the hours for which she was paid. He said that changing the name now, in advance of the formal consultation on the future of the MIU, undermined the service. Dr Thallon made it clear to the Committee that he did not agree with the contents of Julian Webb's letter. Turning to the Livingstone Hospital, Mrs Angell said that the service provided by the Hospital was an exemplar of good practice. If the service was to be relocated to another site in Dartford she very much hoped that it would continue to be provided by the Primary Care Trust.

(6) Mrs Hall of the Tonbridge Cottage Hospital League of Friends expressed concern about Maidstone and Tunbridge Wells NHS Trust buying services from residential care homes in the independent sector, rather than using Tonbridge Cottage Hospital. Unlike care homes, the hospital provided rehabilitation and had a resident doctor. In some cases elderly patients from Tonbridge who had never left the town before were being sent to Rochester when they could be cared for in their local cottage hospital.

(7) She said that it was important that the closed beds at Tonbridge Cottage Hospital were reopened immediately. Finally, in response to a question as to whether or not there was provision for a community hospital in the Maidstone area, to provide "step up" and "step down" care, Dr Thallon answered that there were no such plans.

(8) RESOLVED that the report be noted.

46. Chronic Pain Services

(Dr Joan Hester, Consultant in Pain Management at King's College Hospital NHS Trust and President of the British Pain Society, was in attendance for this item)

(1) A copy of Dr Hester's presentation is attached as Appendix 3 to these Minutes. Members expressed concern that colleagues from the Primary Care Trusts and acute Trusts were not present for this item and asked that the Committee's disappointment be communicated to them.

(2) The Committee discussed and questioned with Dr Hester a range of issues around the complex matter of dealing with pain management at various levels. Dr Hester acknowledged that the Committee was in advance of its counterparts elsewhere in addressing the issue and inviting her to speak on it.

(3) Members were unanimous that this was a very important issue and one that they should seek to continue to address with colleagues in the Primary Care Trusts and acute Trusts. Health colleagues did not appear to have a strategy or a uniform approach to this important issue, which affected much of the population at some time during their lives.

(4) RESOLVED that Dr Hester be thanked for a very informative presentation.

47. LINks update

(1) The Overview and Scrutiny Manager updated the Committee on the development of LINks. The Local Government and Public Involvement in Health Bill, which set out the proposals for the development of a LINk, was expected to receive the Royal Assent in the autumn.

(2) The proposal was that the Commission for Patient and Public Involvement in Health, and the Patient and Public Involvement Fora would be abolished on 31 March 2008 and LINks would be operational from 1 April 2008.

(3) The Committee was reminded that it was often overlooked in the discussion on LINks that they would also be encompassing social care, as well as health services.

(4) The Committee noted the issues that were emerging from those authorities that had been identified as “early adopter” sites.

(5) Local Authorities across the country continued to struggle with the concept of LINks in the absence of any guidance. However, the Department of Health was clear that this presented an opportunity for local authorities to do what was right for them within the LINk framework.

(6) A number of documents that had been delayed several times already were expected to be published shortly. These included:-

a) a model contract for procuring the host organisation to establish the LINk;
b) what a model LINk might look like; and
c) an interim report on the outcomes of the “early adopter” sites.

(7) The Overview and Scrutiny Manager acknowledged that Patient and Public involvement Fora representatives were becoming disheartened by the lack of progress. However, existing Patent and Public Involvement Fora representatives had so much knowledge and experience that they would represent a key component of the LINk. He affirmed his offer to speak with Patient and Public involvement Fora, or their Locality Groups, to reassure them of their continuing contribution as the new structure emerged.

(8) The Committee noted that a steering group led by the Cabinet member with responsibility for Public Health (Mr G Gibbens), supported by a representative of the

Chief Executive's Directorate, was to be established to take the development of the Kent LINk forward. The NHS Overview and Scrutiny Committee would have representation on this steering group.

(9) RESOLVED that the report be noted.

Appendix 1

Kent and Medway NHS
NHS and Social Care Partnership Trust

The Partnership Trust One Year On

20 April 2007

Erville Millar
Chief Executive

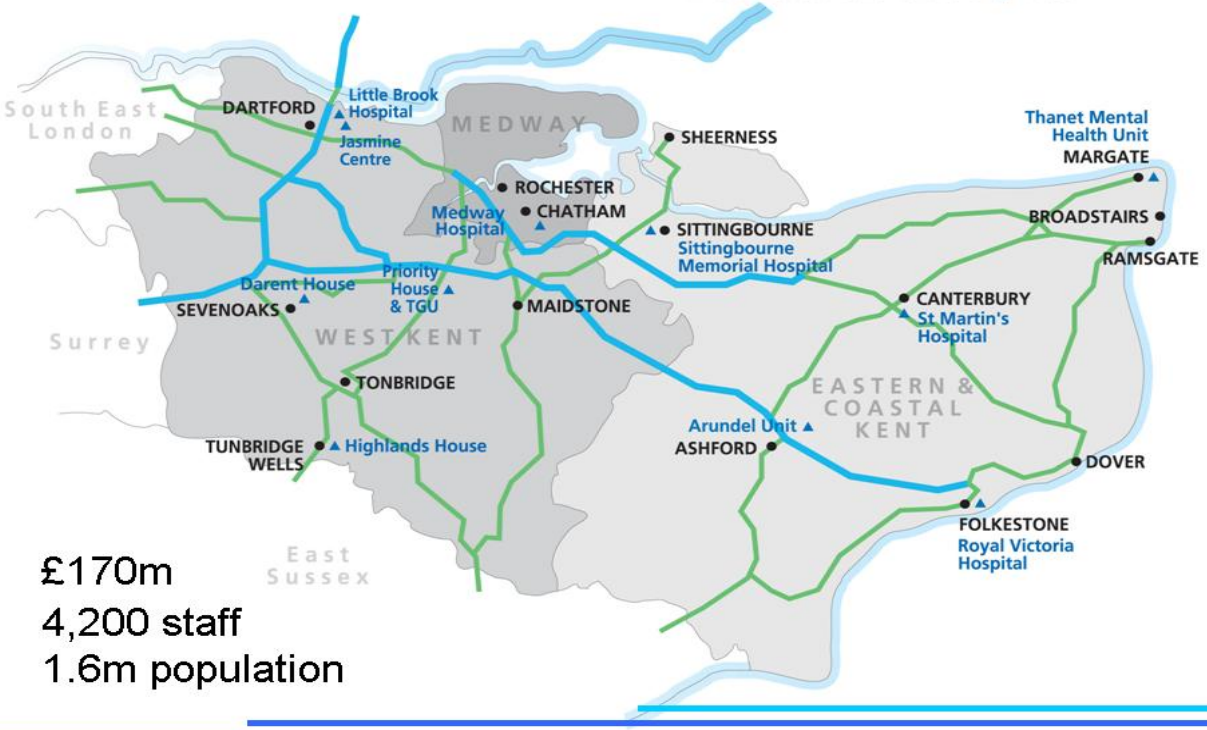
Kent and Medway NHS
NHS and Social Care Partnership Trust

About the Trust

- The Trust was established on 1 April 2006
- The Trust was formed from West Kent NHS and Social Care Trust and East Kent NHS and Social Care Partnership Trust
- The establishment of this new Trust on 1 April 2006 focused on the organisational and senior management arrangements, with current service improvements and planned development projects continuing

About the Trust

Kent and Medway NHS
NHS and Social Care Partnership Trust



- £170m
- 4,200 staff
- 1.6m population

Kent and Medway NHS
NHS and Social Care Partnership Trust

Services

- Mental health services for adults
- Older persons mental health services
- Child and adolescent mental health services
- Substance misuse services
- Services for people with learning disability
- Some specialist services for both local populations and extended areas

Kent and Medway NHS
NHS and Social Care Partnership Trust

Our Vision and Statement of Mission

"We will work in partnership to provide responsive and dependable mental health and substance misuse services to the communities we serve in Kent & Medway. We aim to provide hope, **recovery**, **well-being** and social inclusion, individual **choice** and independence through high quality care and environments; Services that are **safe**, sustainable and stigma-free and a culture of development and continuous improvement, taking account of ethnicity, culture and gender. In this mission we shall endeavour to keep the child, younger person or adult, with their family – at the centre of everything we do"

Kent and Medway NHS
NHS and Social Care Partnership Trust

Key Strategic Objectives

- Commissioning
- Financial Management
- Service Provision
- National Care Records Service
- Strategy Development
- Foundation Status

Kent and Medway NHS
NHS and Social Care Partnership Trust

Strategy Development

- Service User Involvement
- Carer Involvement
- Staff Involvement
- Community Involvement
- Service Strategy
- Estates Strategy

Kent and Medway NHS
NHS and Social Care Partnership Trust

Foundation Trust [FT] Status

- The Trust is aiming to achieve Foundation Trust status by 2008
- Foundation Trust status will mean the Trust is locally accountable with legally binding contracts and local people will have more say

Kent and Medway NHS
NHS and Social Care Partnership Trust

A successful NHS FT has to …

- Meet and exceed national standards
- Have a continually growing membership base to which the NHS FT is responsive
- Be financially stable
- Be locally innovative in how you use your freedoms
- Meet your statutory duty of being run effectively, efficiently and economically

Kent and Medway NHS
NHS and Social Care Partnership Trust

What are the benefits?

- Accountability to local people through membership and Board of Governors
- Builds upon relationships with stakeholders
- Greater protection for investment in mental health
- Legally binding and clear contracts
- Complete consistency of systems across Trust
- Freedom to enter into joint ventures
- Freedom to retain financial surpluses and freedom to borrow from commercial sources
- Opportunity to think more holistically and enter into partnerships to provide more employment and housing opportunities to service users

Kent and Medway NHS
NHS and Social Care Partnership Trust

Next FT Steps

- Finish SHA Diagnostic – a range of financial based tests
- Ensure plans in place for future development and governance
- Decide if we are ready to make an application to gain FT status
- Recruit members

Kent and Medway NHS
NHS and Social Care Partnership Trust

Financial Performance 06/07

Target	Actual	Target Achieved
Break Even	£123,0000 surplus	Yes
Remain within External Financing Limit	£50,000 under shoot	Yes
Remain within Capital Resource Limit	£484,000 under spend	Yes
Achieve a 3.5% Capital Cost Absorption Duty *(with a margin of +/- 0.5% flexibility)*	4.3% achieved	No *

Kent and Medway NHS
NHS and Social Care Partnership Trust

Financial Outlook 07/08

- Contracts
- Targets
- Progress to date
- Key challenges

Kent and Medway NHS
NHS and Social Care Partnership Trust

In Summary

- It has been a busy and challenging 1st year
- We have made progress, but there is much to do
- The journey to FT status will help our cause
- Continuous involvement and dialogue with service users and carers is critical

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West Kent PCT
Community Hospitals Review

Sharon Jones
Director of Community Services

West Kent NHS
Primary Care Trust

Principles

- Quality of care
- Safety & governance
- Efficiency
- Quality of environment
- Equity
- National and local policy
- Affordability and sustainability

West Kent NHS
Primary Care Trust

Process

- Stakeholder events
- Commissioners and what they wish to purchase
- Benchmarking
- Capacity planning & modelling
- Best practice review
- Estates advice

Findings

- Unnecessary variations in average length of stay
  - Potential to improve to 18 days
- Rehabilitative focus
- Inconsistent admission and referral criteria, operational policies and service standards
- No service level agreements in the south
- Day centres not consistently optimised for health gain

West Kent NHS
Primary Care Trust

Outcomes of the Review

Potential future for all in line with White Paper

Will be providing high quality clinical care and expanding this in **ALL** sites

But to be sustainable we need to:

- Modernise service models, appropriate to individual need across all sites
- Be more effective and efficient
- Develop and provide services in a different manner

Recommendations

- Re-open closed beds in Hawkhurst & Edenbridge over next 3-6 months
- Re-open closed beds in Sevenoaks in a phased approach to allow for refurbishment
- Pursue opportunity for renal dialysis unit in Tonbridge
- Submit a capital bid to the Department of Health

West Kent NHS
Primary Care Trust

Edenbridge MIU

- Rename as a treatment clinic with immediate effect
- Consult on the future of the treatment clinic (formerly the MIU)
- Provide a redressing clinic for 1 to 2 days a week for existing patients
- Redirect new redressing patients to other services

Livingstone Hospital

- A successful nationally recognised model of care, *but …* the building no longer meets modern standards
- Cost benefit analysis of possible refurbishment, reprovision or rebuilding to be undertaken
- Working assumption that reprovision is most likely to be the most cost-effective option
- Retain a dedicated 'Livingstone Unit' run and managed by PCT staff on another site

West Kent NHS
Primary Care Trust

Tonbridge

- Original proposal for a renal dialysis unit fell through
- Now working up alternative options with GPs and local stakeholders
- Options paper to go to September Board
- Public consultation later in the year

Other recommendations

- Modernise day centres to get maximum health gain
- Assess value for money of hotel services
  - 3 providers
  - Appears to be significant variance in costs
- Review model of medical cover across the hospitals
  - Work with GPs and practice based commissioners

Capital Bid

- £6m bid supported by the SHA
- Sevenoaks
  - Outpatients
  - Ward areas
  - Rehabilitation facilities
  - MIU
- Edenbridge
  - X-ray
  - PACS
  - Equipment & Room
- Tonbridge
  - To be agreed
- Need to use funding to ensure estate is as flexible as possible – future proofing

West Kent NHS
Primary Care Trust

Summary

- Overall very good news – hospitals that were at threat of closure now have a secure future
- The PCT is committed to investing in all the hospitals to develop and expand services
- Community Hospitals will deliver a consistently high quality of care to best practice standards

West Kent NHS
Primary Care Trust

"Community hospitals can act as a hub for local health and social care services providing a centre of excellence in integrated care"

A Recipe for Care – not a single ingredient

Department of Health, 2006

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Chronic Pain Services

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Strengths

- Chronic pain services do improve outcomes and reduce use of healthcare resources
- Multidisciplinary team
  - Doctor, specialist nurse, physio, psychologist, occupational therapist, admin staff
- Out-patient based with small proportion requiring day-case procedures/more complex interventions
- Holistic approach; suitable for shift to primary care if delivered in the right way, with specialist pain service available for more complex cases

Weaknesses

- Unlimited supply of referrals; 21% prevalence of chronic pain in the population
- No quick fixes
- Requires training and expertise
- Difficult
- Many patients with chronic pain have complex biopsychosocial problems

Opportunities

- Can really improve quality of life
- Can reduce referrals to orthopaedics, rheumatology, neurosciences
- Training opportunities for healthcare professionals
- Can lead the field in chronic illness management
- Self help/self management programmes

Threats

- "Cinderella" service
- Perceived as being low turnover and unimportant
- Lack of understanding
- Can be done very badly if personnel not properly trained
- Poor management
- "Burn out" of staff/overwhelmed by numbers of referrals

Best practice 2007:primary care

- Trained GPswiSI; established competencies
- Consultant input into the service (weekly presence)
- Careful assessment which includes psychosocial
- Training programme
- Trained specialist nurses and physios, psychologist
- Patient support groups
- Can offer a wide range of therapies
  - TENS, acupuncture, drugs, simple injections, exercise programmes, relaxation, pain management programmes, education classes

When to refer to specialist pain service

- Clear guidelines for GPs and specialist nurses in primary care
- Complex cases with multiple problems
- Neuropathic pain not easily treated
- Acute sciatic or nerve root pain
- Psychological morbidity
- Second opinion
- Problem drug use (opioids)
- Specialist investigation required (MRI)

When to refer to regional pain service

- Complex Neuropathic Pain
- Central Pain (e.g. after stroke, spinal cord injury)
- Severe cancer pain
- Complex co-morbidities
- Pain Management Programmes
- Spinal drug therapies
- Neurosurgical procedures/blocks

18 week Commissioning Pathway for Chronic Pain: DH

- In early stage of development
- Lists assessment, diagnostic possibilities, and treatments that can be expected in primary care, specialist pain services and supra specialist (regional) pain services

Chronic Pain Policy Coalition

- www. paincoalition.org.uk
- **PAIN [the 5th vital sign]** is designed to raise **awareness** and encourage **early assessment** of pain in order to help improve the **prevention**, **management** and **treatment** of chronic pain in the UK.