KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on Friday 9 February 2007.

PRESENT: Mr A R Chell (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr M J Angell, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Ms A Harrison, Mr C Hibberd, Mr G A Horne, MBE, Mr J F London (substitute for Mrs P A V Stockell), Mrs E D Rowbotham, Mr R Tolputt and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr G K Gibbens, Cabinet Member for Public Health.

ALSO PRESENT: Mr J Reece, South East Coast Ambulance Patient and Public Involvement; Mr D Easton, East Kent Hospitals Patient and Public Involvement; Mrs C Swann, Kent and Medway NHS & Social Care Patient and Public Involvement; Mr R Knibbs, Kent and Medway NHS & Social Care Partnership Trust; Ms A Neal, East Kent Hospitals NHS Trust; Ms M Cleator, UNISON Invicta Health and Keep Our NHS Public; Mr G Manners, Downs Mail and Mr J Ogden, Kent County Council's Standards Committee.

IN ATTENDANCE: Mr P D Wickenden, Overview and Scrutiny Manager and Dr D Turner, Research Officer to the NHS Overview & Scrutiny.

UNRESTRICTED ITEMS

Non-pecuniary interest

Mr Angell declared a non-pecuniary interest as a non-executive director of the Kent & Medway NHS & Social Care Partnership Trust.

6. Minutes – 12 January 2007

The Overview and Scrutiny Manager reported that the Minutes of the January meeting were still being prepared and he apologised to the Committee that they were not available for this meeting to consider and approve. They would be presented to the meeting of the Committee on 9 March 2007.

7. Medway NHS Trust – application for Foundation Trust Status

(Item 3 – Mr A Horne, Chief Executive of Medway NHS Trust was in attendance for this item)

(1) Mr A Horne, Chief Executive of Medway NHS Trust made a presentation to the Committee on the Trust's proposed application for Foundation Trust Status. A copy of Mr Horne's presentation is attached as Appendix 1. The Committee were reminded that they had authorised the Overview and Scrutiny Manager, in consultation with the Chairman, Vice Chairman and Liberal

Democrat Spokesman of the Committee, to arrange a meeting and invite colleagues who represented an electoral division in Maidstone Borough Council and Swale Borough Council areas to meet with Mr Horne and other Trust colleagues regarding their application for Foundation Trust Status. This meeting had taken place on Monday 22 January 2007 and a copy of the note of that meeting was attached to the report.

(2) At the conclusion of his presentation, Mr Horne responded to a range of questions.

Emergency Care

a) In response to a question about taking on more emergency care and the capacity of the Trust to do so, Mr Horne said that the Medway NHS Trust was already taking a number of vascular emergency cases from Maidstone and Pembury hospitals. He added that, after April 2007, the Trust would also be taking vascular emergencies from Darent Valley Hospital at Dartford. He was confident that Medway NHS Trust could deal with, and had the capacity to deal with, transfers from neighbouring Trusts.

Flexibility and Freedoms of Foundation Trusts

b) Asked about the benefits of Foundation Trust Status and the role of 'Monitor', Mr Horne responded that if Foundation Trust Status was achieved it would enable the Trust to operate within a more flexible framework. Foundation Trusts also had freedom to borrow money from a wider range of lenders, in addition to the NHS bank. Monitor had been established approximately three years ago and was the body set up to assess and accredit Foundation Trusts, primarily from a financial point of view. It was a regulatory body – as such, it was similar to the Healthcare Commission, which was responsible for looking at quality standards across NHS Trusts.

Consultation Process

c) Asked how widely the consultation had been undertaken and the percentage of responses received, Mr Horne acknowledged that, whilst the consultation document had not been sent to London Boroughs, it had been widely distributed amongst the catchment area for the Medway NHS Trust – including the western part of Swale and the Isle of Sheppey. He did not have with him detailed figures regarding the rate of responses to the consultation, but would make them available to the Committee.

Car Parking and Transportation

d) Mr Horne said that the car parking at the Medway Maritime Hospital was not privatised. The car parks were run by the Trust and there were

no plans to change the charges for car parking. The Trust was continuing to look at environmental strategies, including the promotion of walking and car sharing, as well as considering the safety aspects of the issue. Mr Horne said that the Trust was continuing to invest in encouraging more people to become volunteer drivers.

Foundation Trust – Governing Bodies

e) In answer to a question about how many representatives local authorities would have on the Governing Body, Mr Horne said that he envisaged there would be one representative drawn from Medway Council and one from Kent County Council. He hoped that the representative from Kent would be drawn from the Swale area, as patients from here looked towards the Medway NHS Trust for their acute hospital services.

Patient Choice

f) Mr Horne said he recognised that the Patient Choice agenda was extremely important. His Trust was having to compete with a range of providers, including the Will Adams Independent Sector Treatment Centre at Gillingham. To ensure that the hospital retained its top hospital status, he said the Trust would have to ensure that it undertook marketing strategies to encourage patients to use the services the Trust was offering.

Facilities for Voluntary Groups and Audiology Services

g) Mr Horne stated that the Trust provided some facilities for voluntary and independent groups – but it needed to be recognised that this was an equal partnership. He said that he was not fully briefed about the Trust's relationship with the hearing charity Hi Kent, but he would follow up on specific points raised by Mrs Angell about this and get back to her.

RESOLVED that the NHS Overview and Scrutiny Committee:-

- support the Medway NHS Trust's application for Foundation Trust Status;

- request the Medway NHS Trust periodically to report back to the Committee on the progress being made towards Foundation Trust Status.

8. Fit for the Future – Draft Commissioning Plans

(Item 4 – Rebecca Sparks, Director Development and Partnerships, South East Coastal Strategic Health Authority; Steve Phoenix, Chief Executive, West Kent Primary Care Trust; Lynne Selman, Director of Communications and Dr Roger Pinnock, GP and Professional Executive Committee (PEC) member, Dr Robert Stewart, Medical Director, Eastern & Coastal Kent Primary Care Trust; Colette Glasson, Director of Communications, Heidi Shute, Community

Cardiology Manager and Marion Dinwoodie, Chief Executive, Medway Primary Care Trust were in attendance for this item)

(1) The Committee had among their papers a briefing note on commissioning. It was recognised that there was not a concise definition of commissioning, since this term actually referred to a range of activities that had changed over time and were continuing to change as a result of major NHS reforms. The briefing note referred to: the original NHS model; the internal market; commissioning and the new NHS; Payment by Results; patient choice; practice-based commissioning; the mixed economy of providers; the role of Foundation Trusts; expectations as regards PCTs undertaking commissioning and how that sat with practice-based commissioning and patient choice; how commissioning related to the reconfiguration of services; how commissioners could ensure access to services and tackle health inequalities.

(2) Health colleagues then made a presentation to the Committee, which is attached as Appendix 2 to this set of minutes.

Dental, Palliative and Respite Care

(3) Following the presentation, Mr Godfrey Horne indicated that he liked the idea of the best care being available in the best place for the best value because he felt that it added meaning for the public and it was easier to understand. He then asked a series of questions relating to how commissioning plans would improve services such as dental care, palliative care and respite care, recognising that there needed to be an holistic approach across the core agencies for delivering some of these services. Mr Phoenix responded that there was an agreement between the Primary Care Trusts and local authorities that neither would take decisions that would impinge on, and place additional financial burdens on, the other side. From a West Kent perspective, he said that there would be a review undertaken shortly on palliative care. He acknowledged that dental-care provision was an issue across many parts of Kent and this was something that the Primary Care Trusts needed to tackle collectively. However, that work had not yet started. Marion Dinwoodie said that, in Medway, the Primary Care Trust ran the Wisdom Hospice; she actually had a surplus of hospice beds, because care in the community was working so well.

Patient Choice vis-à-vis Planned Hospital Care

(4) Mr Phoenix said that there was clearly a possibility that Patient Choice would not deliver everything that was hoped. He added that there might or might not be tensions between Choice and practice-based commissioning. He said it was intended there would be a national set of standards, but the care pathways and the services offered would end up looking different in different areas. He said that devolution often led to diversity. “Postcode lotteries” were seen as bad – but local involvement and local freedoms were regarded as good things; there was a tension here. The national tariff meant that price would be standardised within the NHS market, so there could not be

competition on price between providers. Choice of provider was currently still limited – but the policy was to allow the patient unlimited choice of provider, including within the private sector. He acknowledged that the different facets of current health policy did not necessarily fit together very well and that they did, in some respects, tend to 'rub up against each other'.

(5) Dr Pinnock added that Choice was inevitably affected by patients' ability to access different providers, but there was a stipulation that transport should not be a barrier to Patient Choice – transport should be provided where the patient was not able to travel independently. He agreed there was a tension between Choice and practice-based commissioning. There would need to be negotiation between the GP and the patient – if the GP explained to the patient what the best service was, the patient would choose that one. Ms Dinwoodie said that the choice presented to patients should be a choice between health services of the highest quality. Medway PCT had actually withdrawn a provider from their Choice menu because of concerns about quality.

Best Practice

(6) Ms Harrison asked why, given that there were a number of good ideas in the NHS that could be copied, were not all Trusts across Kent good already? She emphasised the need to treat patients holistically to achieve the best outcomes. She also expressed concerns about NHS Direct tending to err on the side of advising callers to attend their nearest Accident and Emergency Department, thereby placing unnecessary pressure on the service. She also felt there was a need to educate the public about what truly constituted an emergency, to ensure services were used appropriately.

(7) Ms Harrison also raised concerns relating to: the shifting of services from acute hospitals into the community; the fact that Swale had for a long time been receiving a funding allocation below that stipulated by the weighted capitation formula; and the lack of GPs available, particularly on the Isle of Sheppey.

(8) Dr Stewart said that there was already a great deal of co-operation and sharing of good practice; and there were several examples across the county where health colleagues were involved in national pilots. As regards 'under-doctored' areas, he said that problems in this regard in Shepway and Swale were being addressed.

(9) Ms Sparks responded that there was much work already underway around cross-fertilisation and sharing of best practice to improve services. She referred specifically to: the Institute of Innovation (formerly the NHS Modernisation Agency); the 'Improvement Cabinet', 'Improvement Academy' and 'Clinical Champions' established by the former Kent & Medway Strategic Health Authority; and the annual 'Best of Health' awards, hosted by the South East Coast Strategic Health Authority. Regarding appropriate use of emergency services, Dr Pinnock suggested that many years of attempting to educate the public about this had not dissuaded some sections of the

population from continuing to use A&E services as a substitute for primary care. He thought that the NHS should recognise this and address it by co-locating primary-care services with A&E departments. Ms Dinwoodie said that new services had to be signposted for the public when they were commissioned, to encourage people to use them – one way this was being done was through the insertion in the Yellow Pages telephone directory of a guide to local health services.

Emergency Care provided in a Primary Care setting, Mental Health, Inter-relationship between health services Provision and Deprivation

(10) Mr Phoenix said that there were a number of emergency-care models operating across Kent. For example, at the Darent Valley Hospital in Dartford, a new model of care had started on 2 January, with a nurse-led urgent care unit; this was already taking over 30% of the work away from the Accident & Emergency Centre. A similar arrangement would be used at the new Pembury Hospital. In Gravesend, there was a Minor Injuries Unit at the Gravesham Hospital.

(11) £83 million was being spent annually on mental health – which represented approximately 11% of the budget. Mr Phoenix said that, overwhelmingly, mental-health patients were being seen in primary care. He would like to see the balance of the service shifted more towards prevention of mental illness.

(12) Mr Phoenix indicated that he would like to come back to the Committee at some stage to talk about preventive services in general and how they could be provided differently. He said that general practice was a better approach to healthcare provision than the alternatives found in other health systems. In the United States and France, secondary care could be accessed directly without going through a primary-care 'gatekeeper', and this worked less well than the system in the United Kingdom. Dr Stewart added that the interrelationship between health and deprivation was being taken very seriously. He said that hospital was not the only option for providing healthcare – intermediate care was very important. Marion Dinwoodie added that 'top-slicing' and 'ring-fencing' of monies in PCT budgets presented challenges as regards delivering services. It was vital to have Service Level Agreements with acute providers that worked. PCTs were still ploughing money into acute care and they needed to make it clear to acute providers exactly what work they were being expected to do for that money. At the same time, primary care needed to be re-engineered to reduce the number of patients being treated in the acute sector.

Patient Choice

(13) Mrs Tweed asked what would happen to the William Harvey Hospital if too many patients chose to go to, for instance, the Medway Maritime Hospital instead. Marion Dinwoodie responded that the William Harvey would still have plenty of work, especially given the planned growth in Ashford's population;

she had no doubt that people would continue to choose it. The important thing was to re-engineer systems, map out patient pathways and plan for the future.

Neurology Services in East Kent

(14) Dr Stewart said there was no plan to take neurology provision away from East Kent; the intention was simply for a few specialist cases to be dealt with at the Medway Maritime Hospital.

Fit for the Future

(15) Concern was expressed at the lack of a joined-up message coming from all the NHS bodies that were caught up in the 'Fit for the Future' review. Ms Sparks said the key messages had all been set out in the public discussion document relating to Fit for the Future. The key drivers for Fit for the Future were those set out in the national health-policy framework. There was a project board for Fit for the Future in Kent and Medway, which comprised representatives from the Primary Care Trusts, Acute Trusts, Patient and Public Involvement Forums and local-authority Social Services. In addition, there was a steering group in each Primary Care Trust, in which acute Trusts and PPIFs were involved.

Choose & Book/Independent Sector Treatment Centre

(16) Dr Pinnock said that a major challenge of the current funding system was that of unbundling the tariff – i.e. dividing the tariff up where a spell of acute care was dealt with partly by an acute provider and partly in primary care. A question was asked about Independent Sector Treatment Centres receiving guaranteed full payment of their contract for five years, regardless of how much work they actually did – and how they were able to pick and choose which patients they would treat. Mr Phoenix said that PCTs were obliged to pay ISTCs in accordance with contracts that had been negotiated by the Department of Health centrally. Mr Phoenix said that he was enthusiastic to re-negotiate the terms of the contract with the ISTC that had opened in Maidstone. Ms Dinwoodie said that the Will Adams ISTC in Gillingham was receiving a guaranteed income of £4 million a year from Medway PCT, and Eastern and Coastal Kent PCT under the terms of the ISTC's contract. The Centre was currently operating at 78% of capacity, and the fixed payment contract was a very strong incentive for her PCT to try and make as much use of the Centre as possible. She said that the Department of Health would be working on the issues of case-mix and pre-assessment of patients by ISTCs, in order to try and prevent the Centres from "cream-skimming" by excluding those patients they were reluctant to accept.

Choose & Book/Single-handed Surgeries/IT

(17) Mrs Angell asked: about recruitment and retention of primary-care staff; about the high proportion of single-handed GP practices in Medway; how doctors could find the time during consultations to use the Choose & Book system; and

whether the Minor Injuries Unit at Gravesham Community Hospital was being removed to the Darent Valley Hospital. Mr Phoenix responded that 'Agenda for Change' had addressed recruitment and retention in the NHS; and work was being done on the primary-care workforce. Marion Dinwoodie confirmed that 37 out of 64 GPs in the Medway Towns were single-handed practitioners. She said practice-based commissioning was energising GPs and encouraging them to work together. Mrs Angell also asked whether limitations in information technology were preventing people accessing a national Choice menu. Mr Phoenix said that there was currently a restricted choice of provider, but there would in due course be full choice of any provider, anywhere in the country – the extent of the choice on offer was a matter of national policy and had nothing to do with IT issues.

Accountability of Foundation Trusts/Competence of Primary Care Trusts to commission

(18) In response to several questions from Mr Daley, Mr Phoenix said that the establishment of Foundation Trusts within the NHS was a national policy. Foundation Trusts were within the 'NHS family' but were legally distinct entities and not owned by the Secretary of State for Health, as ordinary Trusts were. Monitor had been set up by the government to hold Foundation Trusts to account financially. With regard to the claim that PCTs lacked the capability to commission effectively, Mr Phoenix said that was a matter of opinion. The former structure of PCTs had not been considered appropriate – hence the new PCTs had been created. He did not think that PCTs would be done away with in the next two or three years. They would continue to be commissioning bodies, although they might take on new forms in future. What happened would depend on the success of practice-based commissioning. It was possible that there would be no change in the NHS for another four or five years – although such a period of stability was not something he had ever seen before in his 27 years in the NHS.

RESOLVED that the Primary Care Trusts be thanked for their presentations on their Commissioning Plans

9. Commissioning Homeopathy – West Kent Primary Care Trust
(Item 5 – Julia Ross, Director of Civic Engagement West Kent Primary Care Trust was in attendance for this item)

(1) The Committee had before them the proposals (tabled at the meeting) for a review process around Commissioning Homeopathy. The Committee noted that, in 2006, the South West Kent and Maidstone Weald PCTs had undertaken a formal turnaround process. The nature of turnaround was such that every possible area of savings – both efficiency improvements and the review of service provision – had to be considered.

(2) The Turnaround Plan had identified a number of service areas for review – of which one was homeopathy. The Primary Care Trusts had initially proposed to direct all referrals for homeopathic therapy through a Treatment Panel, so

that each case could be considered on the basis of clinical need before the referral went ahead. This proposal, however, had caused concern among some stakeholders and it had, therefore, been agreed to conduct a review of the demand for homeopathic services and the cost-benefit of such treatment. The Committee noted that the Tunbridge Wells Homeopathic Hospital was one of only five such hospitals run by the NHS.

(3) Mrs Ross stated that the review was not about closing the Homeopathic Hospital, it was about reviewing and establishing the demand for homeopathic services and whether the cost-benefit of such treatments was appropriate for provision from NHS funds. The review process would include four distinct stages:-

1. a review of existing activity and spending on homeopathic services;

2. an external review and evaluation of the evidence for homeopathy;

3. a discussion phase, where both reviews were shared and discussed amongst the stakeholders, options presented and developed, and decision-making criteria agreed in conjunction with the PCT Board; and

4. the decision-making process, where the PCT Board would apply weight, and score by the agreed criteria.

(4) The Committee noted that a reference group of key stakeholders had been established and that Paul Wickenden was the representative for the NHS Overview and Scrutiny Committee on this reference group. The first meeting of the reference group was to take place on 13th February 2007.

(5) Mrs Ross said that the review might come up with a range of options. She hoped that a decision by the PCT Board would be taken in April. The issues around the homeopathy review were particularly sensitive. There were polarised opinions as to both the effectiveness of treatments and the use of NHS funding for providing the service.

(7) The Committee noted that there were 400 referrals to the Homeopathic Hospital from West Kent PCT each year. This was a very small part of the commissioning done by the PCT, but it was important that the PCT looked at every service that it commissioned.

(8) The Committee noted that the reference group included individuals who came from both sides of the debate on homeopathy, in order to ensure balance.

RESOLVED that the position be noted

10. NHS Overview and Scrutiny Committee – Work Programme Update
(Item 6 – report by Paul Wickenden, Overview and Scrutiny Manager)

(1) The Overview and Scrutiny Manager reported on the potential work programme for the next two meetings of the Committee, based on approaches made to the Chairman and Spokesmen of the Committee or direct to him.

Maidstone & Tunbridge Wells NHS Trust – a new direction for surgical and orthopaedic care

(2) Following the decision of the Committee on 12 January 2007, all the evidence had been re-examined and a meeting had taken place with the Chairman, Vice Chairman and Liberal Democrat Spokesman of the Committee to agree the reasons underlying the Committee's decision. The Committee were invited to endorse the action which had been taken retrospectively by the Overview and Scrutiny Manager, with the approval of the Chairman, Vice Chairman and Liberal Democrat Spokesman of the Committee.

(3) The reasons for opposing the proposals, as agreed by the Chairman, Vice Chairman and Liberal Democrat Spokesman, had been sent to Mr Phoenix, Chief Executive of West Kent Primary Care Trust and Ms Gibb, Chief Executive of Maidstone & Tunbridge Wells NHS Trust (see Appendix 1).

(4) Members were reminded that the Committee had the power to refer matters to the Secretary of State for Health on grounds of inadequate consultation, or on the basis that what was proposed was not in the interests of health services in Kent. However, this right of referral was only to be exercised as a last resort, once all avenues of possibility to resolve the matter locally been exhausted.

Meeting – 9 March 2007

(5) Issues emerging for potential inclusion on the NHS Overview and Scrutiny Committee's agenda for the meeting on 9 March 2007 were:-

- services provided for residents of north west Kent at the Gravesham Community Hospital, and the removal of some of these to the Darent Valley Hospital; and

- Audiology Services, which the Committee had discussed at its meeting in January 2006 and agreed to review in a year's time.

(6) Other concerns had been raised relating to cancer services at the Kent and Canterbury Hospital and the proposed development of a polyclinic at Whitstable. The Committee were asked to consider whether they would want to hold one meeting split between two locations – with the first half in north west Kent and the second half in east Kent.

(7) The Committee concluded that it would be far more appropriate to have two separate meetings, one each to deal with the east Kent issues and the north west Kent ones.

Healthcare Commission Core Standards

(8) The Committee considered whether it wished to make a submission in the spring for the Healthcare Commission's annual healthcheck. Each NHS Body was required to submit its self-assessment to the Healthcare Commission by 1 May 2007.

(9) Three types of body had the opportunity to add a commentary to these self-assessments against the Healthcare Commission Core Standards, namely NHS Overview and Scrutiny Committees, Patient and Public Involvement Fora and Strategic Health Authorities.

(10) The Committee agreed that it would be useful to collate throughout the year evidence that it might wish to submit to the Healthcare Commission, so that compiling a submission in the spring was not too onerous a task. The Committee noted that a new set of Healthcare Commission Core Standards was being piloted in 2007 and would be introduced in 2008.

(11) Considerable discussion took place around the idea of "enhanced two-tier working" between county councils and borough/district councils. Other aspects of the Local Government and Public Involvement in Health Bill (which was currently before Parliament) were also discussed, including Community Calls for Action. The Committee agreed that it would be useful to look at the structure of the NHS Overview and Scrutiny Committee, with a view to the Committee operating in future more at a strategic level, while devolving more local issues to borough/district authorities and other partners. The Committee noted that protocols had already been agreed by the Kent Association of Local Authorities in 2001 regarding the delegation of more local-level issues to committees or joint committees of borough/district councils.

(12) It was noted that, under provisions contained in the Bill, the County Council would also acquire the responsibility to establish a Local Involvement Network (LINk), which would replace the Patient and Public Involvement Fora in the county. It was already planned to abolish the Commission for Patient and Public Involvement in Health.

(13) Consideration was also given to the possibility of organising an event for all Members of the County Council to explain the concept of Patient Pathways for accessing health services.

(14) The Committee asked that the provision of mental-health services should also be an item for a discussion at a future meeting.

RESOLVED that:-

a) the action taken by the Overview and Scrutiny Manager, in consultation with the Chairman, Vice Chairman and Liberal Democrat Spokesman, in taking forward the dialogue with health colleagues following the decision of the

Committee on Maidstone & Tunbridge Wells NHS Trust's consultation on 'A new direction for surgical and orthopaedic care', be agreed;

b) the Work Programme and venues for the next two meetings of the Committee be as set out in the sub-paragraphs above;

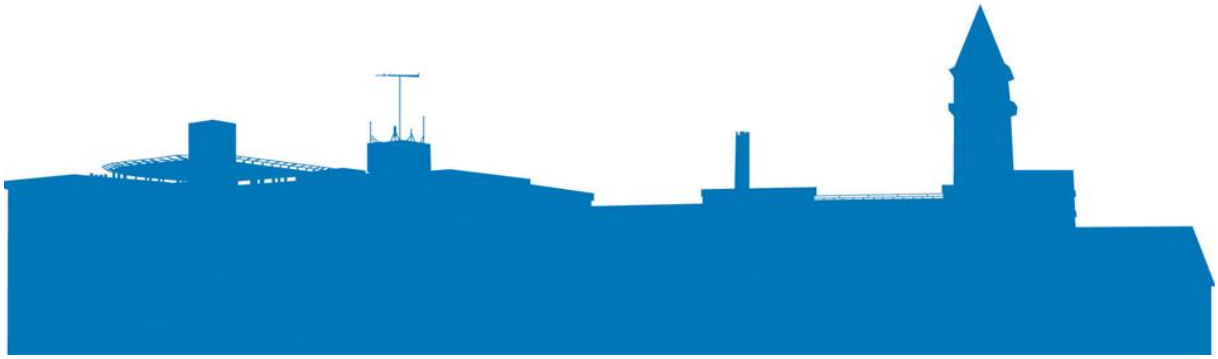
c) the Overview and Scrutiny Manager should continue to work with all stakeholders in looking at the possible devolution of health overview and scrutiny in the key issues to a more local level; and

d) the Overview and Scrutiny Manager should investigate making arrangements for a seminar for all Members of the County Council on Patient Pathways for accessing health services.

Appendix 1

The journey to Foundation Trust status for The Medway NHS Trust

By Andrew Horne, Chief Executive



National drivers

To deliver a patient led NHS there is a commitment to prepare all NHS Trusts for Foundation Trust status by April 2008.

- Health and Social Care Act 2003
- Commissioning a patient led service 2005
- Choice / Practice Based Commissioners
- Payment by results
- Secondary to Primary care shift

The Medway NHS Trust your first choice

What is an NHS Foundation Trust?

- A new organisation – only the 3rd across KSS
- A clear direction
- A commercial business – customers first
- Quality, responsiveness and access
- Affordability & Value for Money
- Modernisation and innovation
- Transparency and accountability
- Risk management

The Medway NHS Trust your first choice

Strategic vision

- A major district general hospital (supporting local DGHs)
- Joined up hospital and community services
- Acute emergency services to a wider population
- Some planned work to other locations
- Chronic conditions to primary care
- More diagnostic workup in primary care
- A changing workforce (MMC, EWTD, etc)
- Capital investment

The Medway NHS Trust
your first choice

How will we be structured?

The Medway NHS Trust
your first choice

Membership of the Medway NHS Foundation Trust

↓

Council of Governors

↓

Board of Directors (Trust Board)

Membership Groups

Two groups have been proposed:

PUBLIC & PATIENT GROUP

- Medway
- Swale
- Rest of Kent and beyond

STAFF GROUP

- Open to all equally across the Trust

Stakeholder members

From partners such as:

- Primary care groups
- Local authorities
- Local Universities
- Business &voluntary groups

The Medway NHS Trust your first choice

Council of Governors

- Staff Governors 5
- Stakeholder Governors
  - PCTs 3
  - Local authorities 2
  - Partners 3
- Total staff and stakeholders 13
- Patient & Public Governors 14

- Chaired by Chairman of Board

The Medway NHS Trust your first choice

What are the benefits of becoming a member?

The Medway NHS Trust
your first choice

- Helping the services to improve through discussing experiences
- Being consulted on proposed changes to services
- Receiving updates and information about the Hospital
- Opportunity to become a Governor
- Electing Governors

The Medway NHS Trust
your first choice

What do we need to do to become a Foundation Trust from where we are today?

The application – process/assessment

- **Phase 1** starts 6th Nov 2006
  - Consultation
  - DH development phase
- **Phase 2**
  - Historical due diligence
- **Phase 3** ends 1st July 2007
  - Monitor assessment

In Conclusion

History

– A 100 years of caring at Medway Hospital

– Built on dedication, quality and service

Strategy

– Support from our local community

– Respected clinical services

Our success will be based on

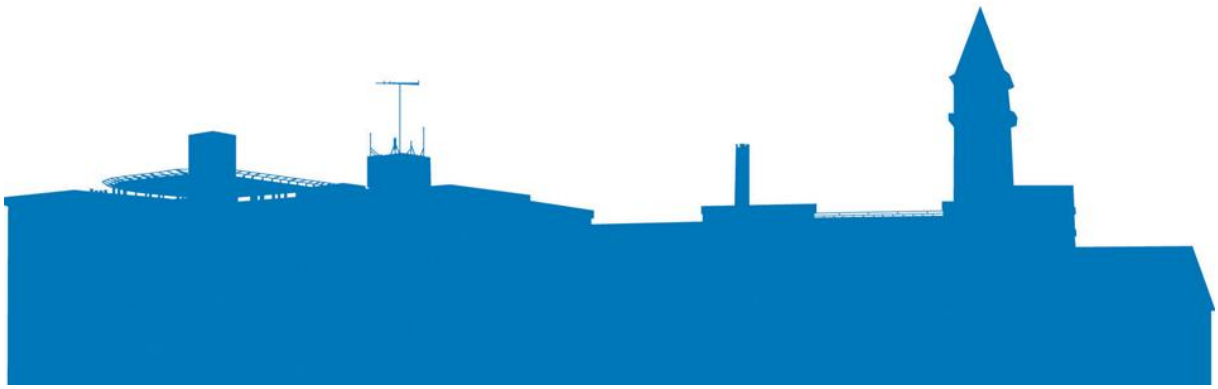
– Listening to our patients, our public, our members

– Being "Your First Choice" for local people

– Knowing that status quo is not an option

- Do you support NHS FT status?
- Do you agree with our future plans?
- Do you agree with the minimum age of 14?
- Do you agree with the geographical split
- How should we communicate?
- Do you agree with partner Governor proposals?
- Do you agree with the overall number of Governors?
- Do you agree with the transitional arrangements ?
- Any other comments?

Thank you for attending.



Appendix 2

NHS South East Coast

Kent and Medway NHS

PCT Commissioning Plans

NHS South East Coast

What we will cover…

1. Roles and responsibilities
2. National policy context
3. The commissioning cycle
4. What commissioning needs to take account of…
5. West Kent PCT / East Kent PCT / Medway PCT:
   i. Vision
   ii. Profiling future demand
   iii. Commissioning initiatives
   iv. Fit for the Future engagement timeline
6. Questions and Answers

NHS South East Coast

SHA role

Strategic Leadership

Organisational and workforce development

Ensuring local systems operate effectively and deliver improved performance

PCT role

Engaging with its local population to improve health and well-being

Commissioning a comprehensive and equitable range of high quality responsive and efficient services

Directly providing high quality responsive and efficient services where this gives best value

Source: DH Guidance May 2006

NHS South East Coast

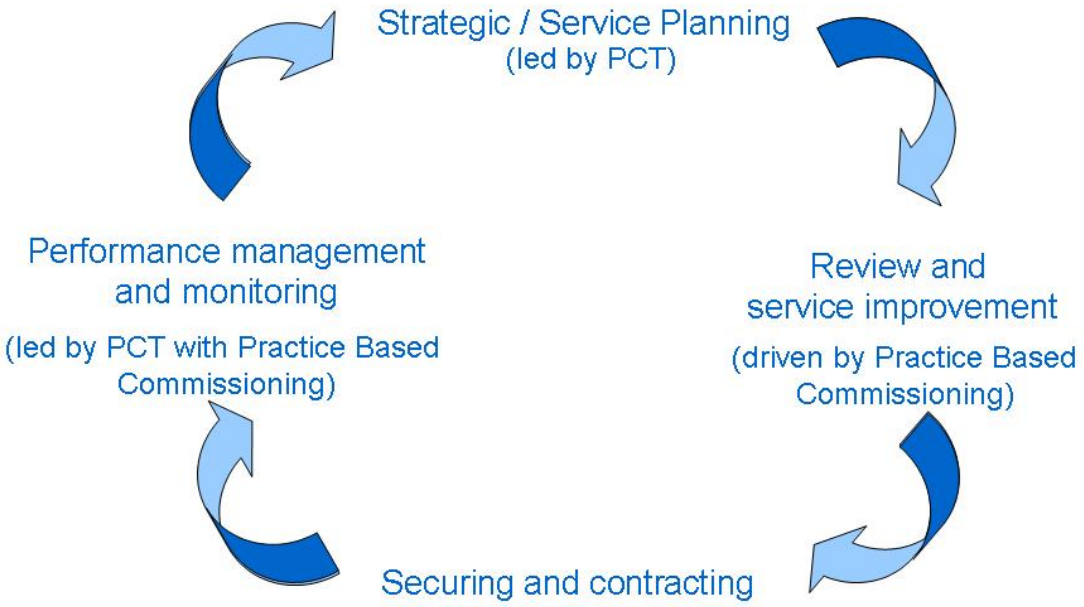
National Policy: three key policy drivers

❑ ***Choice***	not only with respect to choice of provider but also patients wanting to take responsibility for their own care
❑ ***Diversity***	variety of providers for people to choose from, including the development of Foundation Trusts
❑ ***Payment By Results***	standardised pay structure and further adoption of national tariff

N.B. Delivered through clinical leadership, e.g. practice based commissioning

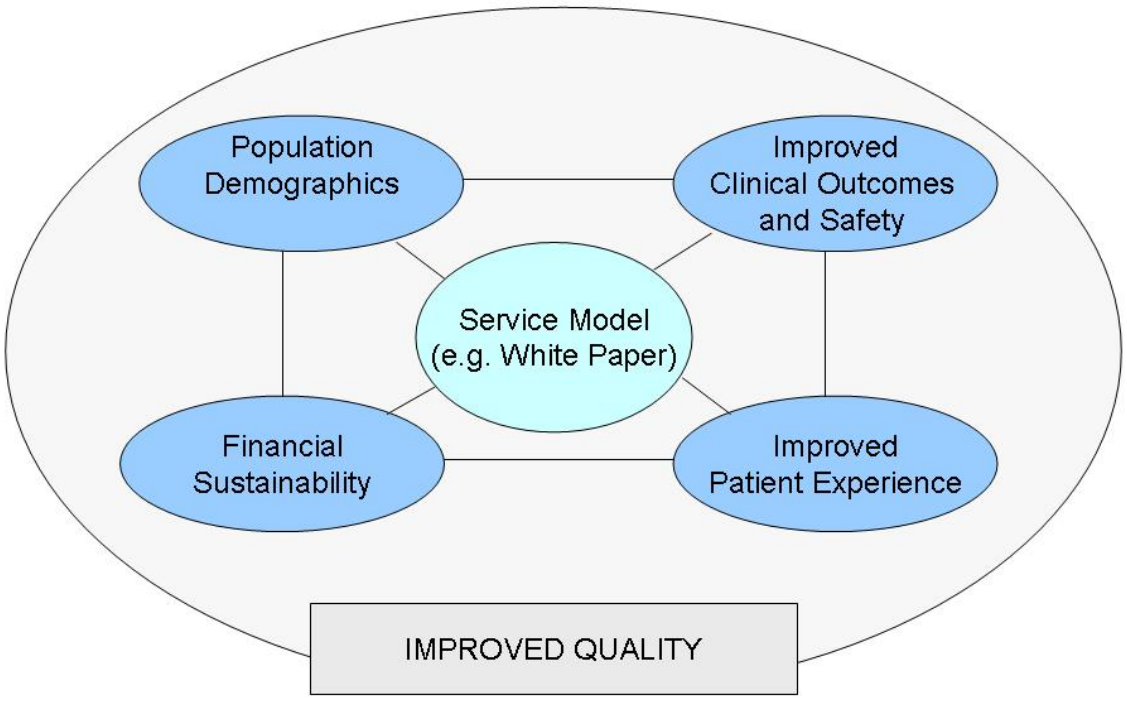
The Commissioning Cycle: The Local Delivery Plan

NHS South East Coast



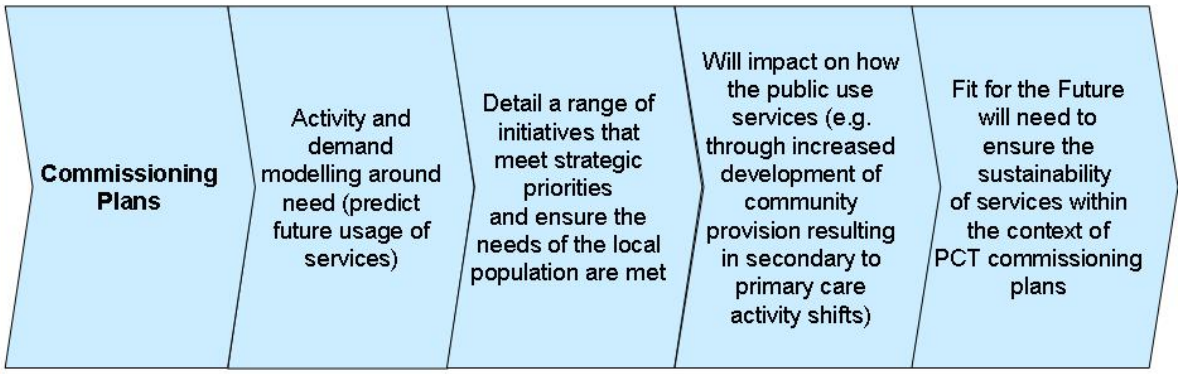
NHS South East Coast

Commissioning needs to take account of....



Commissioning Plans: Fit for the Future

NHS South East Coast



West Kent PCT: Overarching vision

NHS South East Coast

- In 2007 the Trust will adopt a new strategic plan 'Best care, Best place, Best value', this will set out our priorities over the next five years.
- BEST CARE We will provide and commission services which hold the full confidence of local people and which will earn us a reputation for excellence. Skilled motivated and friendly staff will deliver high standards of clinical care.
- BEST PLACE We aim to provide our local communities with fast, convenient and local access to as wide a range of services as possible working with the local authority.
- BEST VALUE:The commissioning decisions that we take to achieve these priorities will ensure that we do so within the resources available to the Trust.

West Kent PCT: Profiling future demand

NHS South East Coast

- Age related demographics
  - The expected activity in 2008 has been adjusted by a weighting derived from expected changes in age group cohorts of the population
- Non-age related demographics
  - Weights were applied to specific disease groups. The weighting was derived from morbidity projections identified in the general household survey
- Other factors
  - This included information from current plans. For example cancer and cardiology networks and technical predictions

West Kent PCT: Commissioning Initiatives

NHS South East Coast

- **INITIATIVE 1** – Elective Management: £1.360m

  Examples: Introduction of Clinical Assessment Services in Orthopaedics, rheumatology, Dermatology, Ophthalmology; Reprovision of minor surgical procedures in Primary Care Settings; Changes in Care Pathways to make them faster and less convoluted.

- **INITIATIVE 2** – Non Elective Management: £2.568m

  Examples: Improving the emergency pathway into care, as in the Maidstone Urgent Care centre reducing waiting times, reducing short stay admissions and ensuring patients receive treatment centred around their home , rather than the hospital

- **INITIATIVE 3** – Benchmarking: £888k

  Examples: Improving performance in New : Follow Up appointment ratios to National best practise averages, and gaining the economies of scale that moving into a new PFI building will release, or using this as an opportunity to improve Care Pathways to make them faster and less convoluted.

- **INITIATIVE 4** – Outpatient Management: £717k

  Examples: ensuring that referrals between Consultants add value to the quality of the diagnosis and treatment decision, ensuring that the need to be seen in an outpatient setting is the best place to receive care.

NHS South East Coast

West Kent PCT:
Clinical example of a commissioning initiative

The Plan: To perform minor general surgical procedures (on conditions such as the removal of non-malignant moles) that can be provided quickly and safely, with minimal inconvenience to the patient, in a GP's surgery, instead of a hospital

The Gain: 165 first outpatient appointments, 107 follow up appointments and 132 minor surgical procedures re-provided in GP surgeries and gain a Return on Investment of 130-150% (up to £167K)

Reality: Service now offered by a GP who also has a FRCS qualification in Borough Green Surgery, which is being extended to other areas depending on the skills of local GPs.

NHS South East Coast

West Kent PCT: Fit for the Future engagement

- November – December 2006
  - 4000 discussion documents distributed
  - Presentations to 98 stakeholder groups across West Kent
  - Co-design events x2 – 83 participants in total
  - Clinical workshop – 40+ participants
- January – March 2007
  - Locality based stakeholder workshops x5 – 400+ participants
  - Establish Patient Reference Group to support development of consultation options & document
  - Social research & deliberative event (24/03)
  - Clinical workshop – 40+ participants
- March onwards
  - Detailed development of consultation document with stakeholders

Eastern & Coastal Kent PCT: Strategic Vision

NHS South East Coast

The PCT will work with clinicians, our different communities,

and other key partners to reduce ill health and to deliver high quality health services as close to home as possible

Eastern & Coastal Kent PCT: Strategic Vision

NHS South East Coast

We will commission

- Accessible, high quality primary care
- Integrated community services that reduce avoidable unscheduled admissions.
- Routine elective care more efficiently and closer to people's homes
- Safe and effective secondary and specialised care.

We will invest in measures

- To reduce health inequality, and
- Promote independence

NHS South East Coast

Eastern & Coastal Kent PCT : Context

Health Status and Trends

Population Trends

6% overall population growth by 2010; 16% by 2020

18% population is age 65+ (v Eng & W 16%); rise of 42% in numbers of residents aged 65+ by 2020

Health Inequality

17% live in 20% most deprived wards (-43.3% national average)

Within ECK 57% difference in CHD mortality rates between most and least deprived 20%; (+29.3%)

teenage pregnancy; (+3.3%)

NHS South East Coast

Eastern & Coastal Kent PCT:

Health Status and Trends (continued)

Significant Mortality/Disease Pressures

Cancer <75s (+2.7%)

Accidents all age 18+ (+15.4%)

Mental Health (+9.2%)

Diabetes (+4.1%)

COPD (+2.9%)

Hypertension (+6.8%)

Eastern & Coastal Kent PCT : Context (continued)

NHS South East Coast

National Policy/Targets e.g.

- Deliver 18 week target
- Deliver Choose and Book
- Sexual Health access target

Settings of Care e.g.

- Reduce unscheduled care demand and avoidable admissions
- Delivery MH in-patient redesign
- Government White Paper – more routine care closer to home
- Infrastructure improvement and rationalisation

Finances e.g.

- Deliver community service efficiency/financial surplus to reinvest in prevention as per LAA, choosing health, self care and inc independence in older people
- Work in partnership to deliver clinical/productivity improvements in secondary care.

Eastern & Coastal Kent PCT: Commissioning Initiatives

NHS South East Coast

Integrated Commissioning Programmes

"Choosing Health"

- including Local Area Agreement Targets, national Sexual Health Targets targets and reducing health inequality gap in CHD.

Mental Health

- continued programme of in-patient redesign and specific focus on Older Peoples' Community Mental Health Services.

Children and Young People

- integrated commissioning across health and local government against key policy areas, including Child & Adolescent Mental Health; continuation of targeted programmes in communities of need.

NHS South East Coast

Eastern & Coastal Kent PCT:
Commissioning Initiatives (continued)

Elective Care

Significant changes to elective pathways, more routine care delivered in primary & community settings; focus on best practice in delivery of care. Delivery 18 week from GP referral to treatment.

Urgent Care

Demonstration site – whole system approach to include prevention and supported self-care, emergency responses in community; triage in A&E; and effective discharge arrangements for those who are admitted.

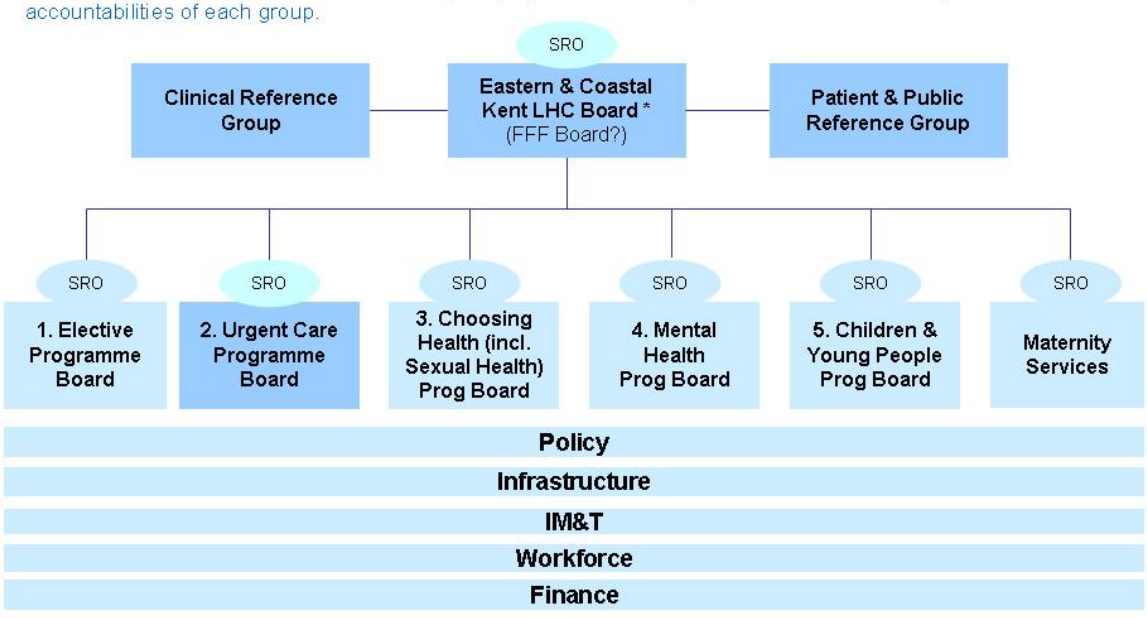
Community Infrastructure

Services, IT solutions and facilities to deliver care closer to patients.

NHS South East Coast

Eastern & Coastal Kent Local Health Community:
Proposed Overall Programme Structure

The proposed overall structure of the programme for transforming services across Eastern & Coastal Kent Local Health Community is set out below. Subsequent pages outline the specific roles, functions, responsibilities and accountabilities of each group.



** Note: representatives on the LHC Board will provide the link back to Organisation Management Boards, e.g. SHA, Trusts, KCC, etc*

Eastern & Coastal Kent PCT: Urgent Care Exemplar

NHS South East Coast

- Selected for national programme which offers high profile opportunity to influence policy.
- Programme to deliver step changes across health and social care to support better urgent care outcomes for all stakeholders.
- Joint working groups to deliver change.
- Demonstrate clear benefits e.g. palliative care patients.
- Outcomes to include improved patient experience, improved public confidence in services, better value for money/better use of facilities, effective use of workforce and skills.

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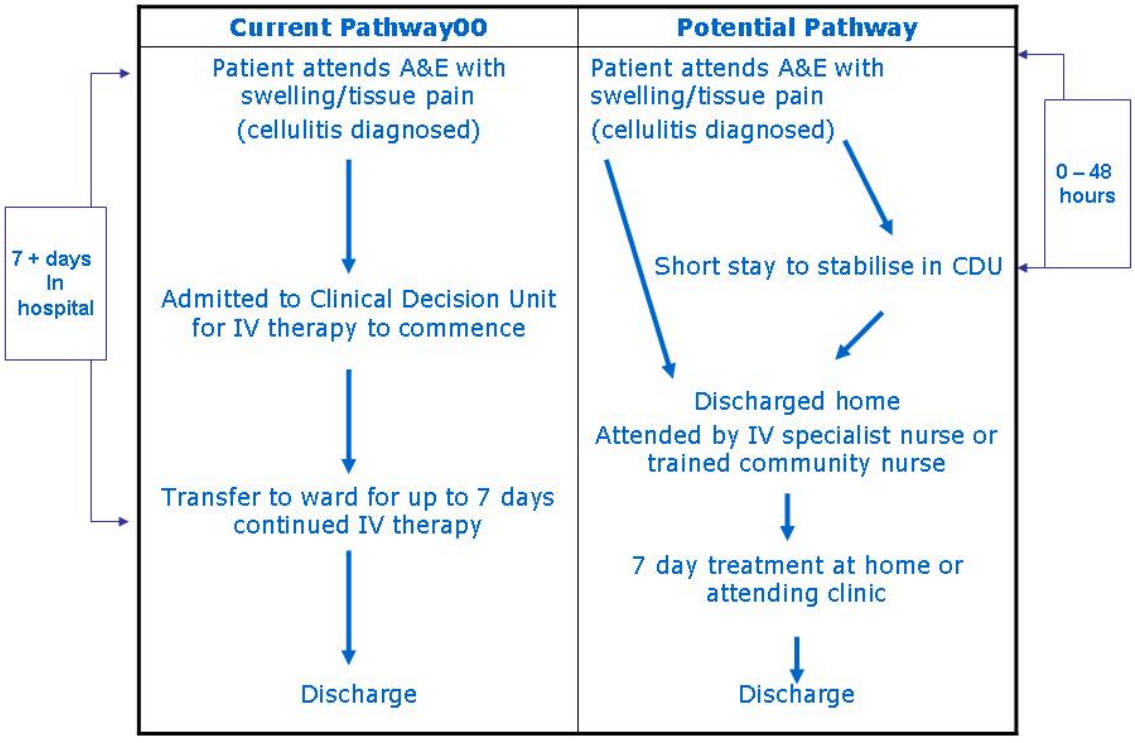
Eastern & Coastal Kent PCT :

Urgent Care Case Study – Intravenous Antibiotics



NHS South East Coast

Eastern & Coastal Kent PCT:
Commissioning and Public Engagement Timeline

See also detailed timeline in handouts

Oct-Dec 06:

- 6000 discussion documents issued – 900+ returned
- Stakeholder discussion events x 3 locations
- Co-design events x 3 locations
- Ongoing presentations to PPIF; staff groups; vol/com groups etc.

Jan-March 07

- presentation to c100 staff at EK Hospitals Trust
- Stakeholder half-day event – exploring themes from discussion/co-design
- MORI-led research and deliberative event
- On-going development of "virtual panel" and meetings with stakeholders.

April onwards

- Development of consultation document/process (if required) with stakeholders

NHS South East Coast

Medway PCT: Overarching vision

Making Medway a good place to live, work and thrive by:

Improving the health of the population and reducing health inequalities *

Commissioning local, responsive access to health and social care in a value-for-money delivery system of high quality providers which include:

- well-developed extended primary care services
- robust health and social care trust
- acute care in foundation trusts
- increased provision by private and third tier sectors

* Public Health Annual Report published 2006

Medway PCT: Profiling future demand

NHS South East Coast

- Public health needs
- Historical under investment in health services in Medway
- Commissioning 'preventative' health services rather than reactive 'illness' services
- Improved access to primary and community services
- Health audits will continue to profile the needs of the population in Medway
- Need for emergency in-patient capacity will reduce as care pathways for long-term conditions continue to develop
- Up to 75 per cent of people treated in A&E could be treated in improved primary care settings

Medway PCT: Commissioning initiatives

NHS South East Coast

- Planned care changes
- Unscheduled care changes
- Trauma and Orthopaedic – clinical assessment
- Chronic disease management
- Practice-based commissioning
- Emergency care pathways for children

NHS South East Coast

Medway Kent PCT:
Clinical example of a commissioning initiatives

A patient journey
Heidi Shute – Community Cardiology Manager

NHS South East Coast

Medway PCT:
Clinical example of a commissioning initiatives

NHS South East Coast

Medway PCT:
Clinical example of a commissioning initiatives

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Clinical example of a commissioning initiatives

NHS South East Coast

Medway PCT:
Clinical example of a commissioning initiatives

In Summary

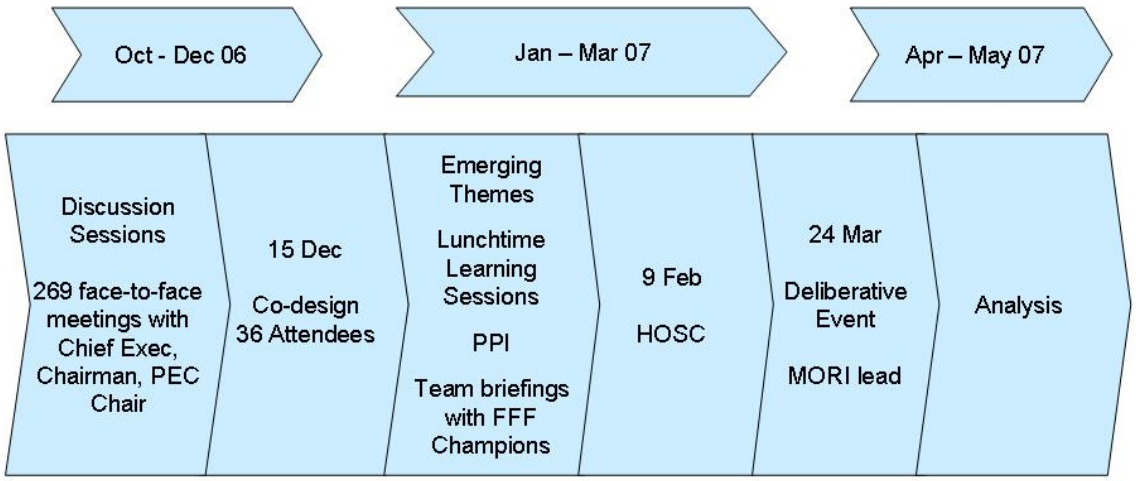
- Heart care moving from hospital to community
- Rehabilitation service available for all heart attack/heart surgery (234→850)
- Community diagnostics (2,500 per year)
- Heart Failure (209 new referrals) Saved admissions March-Dec 06 =28 Medway, 7 Swale
- Cost saving Medway= £70,000

NHS South East Coast

Medway PCT:
Clinical example of a commissioning initiatives

NHS South East Coast

Medway PCT:
Fit for the Future engagement timeline



Reasons based on the written and verbal evidence that the NHS Overview and Scrutiny Committee has received for rejecting the proposals for orthopaedic surgery and emergency care within the Maidstone and Tunbridge Wells NHS Trust

1. The committee feels that the Trust's consultation document gives a skewed presentation of this matter, failing to acknowledge the true balance of costs and benefits involved in both the proposals and the alternative options. The committee believes that the issue is rather less straightforward and clear-cut than is apparent from the account given by the Trust.

   We note also the factual inaccuracy in the report as regards the number of cases that would be affected by the proposals. The report states that this figure is 12 per day and that this amounts to 2,500 per year; however, 12 cases per day would actually give an annual figure of 4,380.[1]

2. The Trust has stated that clinical evidence clearly shows the optimal minimum catchment population for an acute hospital with full A&E capacity to be 500,000. Services operated with a smaller catchment population than this, it is claimed, will inevitably be clinically substandard, as the throughput of patients will be inadequate to guarantee the case-mix needed to maintain consultants' clinical skills at an appropriate level. Consequently, it is argued, the MTW Trust – which has a catchment population of 500,000 – can only have one acute hospital with full A&E capacity.

   However, the committee is aware that the evidence base for these claims appears to be less strong than has been asserted – as indicated by two published systematic reviews.[2]

   The views of the Royal College of Surgeons and the Institute for Public Policy Research have been cited by the Trust in support of its proposals. But we note that recent publications by both these bodies accept that a catchment population as low as 300,000 is realistic, achievable and clinically acceptable.[3]

   At the NHS OSC meeting on 12 January, the committee heard from Dr Thom, representing the Maidstone Division of the British Medical Association, that a catchment population of 250,000 was entirely workable and viable.

   The committee notes that the current catchment population for Maidstone Hospital is around 250,000 – and that a further 10,000 houses are to be built in the area.

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[1] *A new direction for surgical and orthopaedic care*, p. 7.

[2] Ferguson *et al.*, "Concentration and Choice in the Provision of Hospital Services", 8th Report of the NHS Centre for Reviews and Dissemination, University of York (1997); Halm, Lee and Chassin, "Is Volume Related to Outcome in Health Care? A Systematic Review and Methodological Critique of the Literature", *Annals of Internal Medicine*, 137, 511–520 (2002).

[3] RCSEng, *Delivering High-quality Surgical Services for the Future* (March 2006), p. 28; ippr, *Hospital reconfiguration: ippr briefing* (September 2006).

3. The committee does not accept that configuring local health services is simply a matter of crudely applying a universal "one-size-fits-all" template. Full account must be taken of any detrimental consequences of centralisation, as well as anticipated benefits. In doing so, a range of local factors needs to be taken into consideration, including:

   - population distribution;
   - facilities available in surrounding areas;
   - future population growth; and
   - transport connections.

   We note that the NHS National Leadership Network report *Strengthening Local Services: The Future of the Acute Hospital*, which has been cited in support of the Trust's proposals, acknowledges the need for local flexibility in applying the preferred service model to local circumstances. The illustrative scenarios provided in Appendix 2 of the report include one relating to a District General Hospital covering a rural area and a medium-sized town. This shows Acute Medicine, General Surgery and Trauma & Orthopaedics all provided on one site in support of a 24-hour A&E department.[4]

4. The Trust argues that the quality of modern paramedical services means that journey-times to hospital can be lengthened without adversely affecting clinical outcomes for emergency patients. However, the committee notes that – even allowing for how well-equipped and well-trained paramedics now are – the time taken in transporting emergency patients to hospital still matters.

   The committee notes that, under the current proposals, ambulances will have to travel significant additional distances (and along a poor road connection, in respect of the journey between Maidstone and Tunbridge Wells). We are concerned that this will lengthen journey times to an extent that will, in some cases, compromise clinical outcomes – even as far as causing a higher mortality rate.

5. The committee has not been reassured that proper account has been taken of how far, under the proposals, the resources of the ambulance service will be put under greater strain – due to increased journey-times and more time being spent by paramedics stabilising patients. If the ambulance service's resources were to be overstretched, it could take longer for ambulances to reach patients than is currently the case.

   The committee was not given a cast-iron reassurance that sufficient compensating additional resources will be made available to the ambulance service if the Trust's proposals are implemented.

[4] NHS National Leadership Network Local Hospitals Project, *Strengthening Local Services: The Future of the Acute Hospital – Reference and Resource Report* (March 2006), pp. 58–9.

6. The committee noted the evidence given at the meeting on 12 January by Mr David Philpott, Chief Executive of the Kent Air Ambulance Trust. Mr Philpott stated that, while his organisation agreed in principle with the reconfiguration of A&E services, it could not support the current proposals.

   The Air Ambulance Trust felt that the proposals failed to take account of the "big picture" of services across Kent and Medway, and the need for the appropriate supporting infrastructure to be in place before such changes could occur. Mr Philpott noted that the Kent and Sussex Hospital, unlike Maidstone Hospital, does not have a helipad. He explained that, as well as preventing the Air Ambulance bringing emergency patients in, this would also prevent emergency cases being taken on to specialist services elsewhere (as the service had done at Maidstone in respect of some 37 cases in recent years, thereby undoubtedly saving a number lives).

7. The committee was informed by the Trust on 12 January that the "Fit for the Future" review of health services across Kent and Medway was primarily concerned with financial issues. Therefore, it was argued, it was appropriate for the Trust to address this particular reconfiguration issue before the completion of "Fit for the Future".

   However, this account of "Fit for the Future" clearly runs counter to statements made to the committee by representatives of the South East Coast Strategic Health Authority and of the local Primary Care Trusts. They have clearly stated that "Fit for the Future" is concerned with much broader issues than purely financial ones, and involves considering how health services across Kent and Medway – and, to an extent, beyond – will fit together. Confirmation that this is the case came in the meeting from Mr Philpott, of the Air Ambulance Trust, who directly contradicted the evidence given by the Trust to the meeting about "Fit for the Future".

   The committee finds itself bound to agree with the view, expressed by Mr Philpott, that the reconfiguration of A&E services within MTW Trust must be wholly subsumed into "Fit for the Future". The Trust, however, insists that reconfiguration must be dealt with as a discrete matter apart from, and prior to, this overarching review. It is suspected that the Trust is actually trying to influence the outcome of "Fit for the Future" by rushing through a pre-emptive decision on the reconfiguration of A&E services within the Trust.

8. The committee has not been convincingly reassured that the A&E departments in Dartford, Medway, Ashford and Tunbridge Wells will all be able to cope adequately with the emergency caseload that will be displaced from Maidstone as a result of these proposals – given that there are no plans to allocate additional compensating resources.

   We are particularly concerned that this may become a significant issue in the longer term, with both the Thames Gateway and Ashford being designated by the government as Growth Areas. Further, Maidstone itself has now been

awarded New Growth Point status (meaning the construction of a further 10,000 houses in the area – as already noted above).

9. The committee accepts the clinical benefits attached to the separation of emergency and elective surgery – and notes that the wish to achieve this separation is apparently a significant factor in the support that the Trust's surgeons are giving to these proposals.

However, we do not accept that the only way this can be accomplished is by providing the two services at separate locations, as the Trust maintains. We note that emergency and elective orthopaedics have already been successfully split within one location, at Maidstone.

We further note that the Trust's proposals will actually achieve an imperfect separation of emergency and elective patients at Maidstone. The plans do not allow for elective general surgery beds to be ringfenced at Maidstone – meaning it is highly likely that some general surgery beds will end up being used by unscreened emergency medical patients.

We would ask the Trust to reconsider the possibility of achieving the separation of emergency and elective surgery while retaining both at the Maidstone site.

10. The committee notes that medical consultants at Maidstone Hospital have argued, through the local BMA division, that the removal of emergency surgery from the hospital will compromise the quality of clinical outcomes. They state that it is not uncommon for some patients to be admitted to A&E with symptoms indicating the need for medical intervention, but subsequently turn out to need surgical intervention. If the Trust's proposals are implemented, such patients will need to be treated elsewhere, leading, it is argued, to poorer outcomes – including a higher mortality rate.

11. The Trust has clearly stated that its plans do not involve the removal from the A&E department at Maidstone of emergency medicine – which accounts for the bulk of "blue-light" admissions.

However, the committee heard at its meeting from consultants in emergency medicine at Maidstone Hospital that they feared the future of their specialty would be jeopardised. This, it was argued, was due to the anticipated consequences of removing emergency surgery, which is closely linked to emergency medicine.

The committee notes that, while the Trust gave reassurances about the future of emergency medicine at Maidstone, it was stated that detailed plans to allow this still had yet to be formulated. The committee would expect such plans to be in place, and to be acceptable to the clinicians involved, as an important precondition of proceeding to the proposed reconfiguration.

12. The committee notes the apparent willingness of the BMA representatives at the meeting on 12 January to consider a compromise, involving the centralisation of emergency orthopaedic surgery at the Kent and Sussex Hospital, with emergency general surgery continuing to be provided at both Maidstone Hospital and the K&S.

The Trust stated at the meeting that such a compromise would be unacceptable on clinical grounds. The committee would want to know in detail why this is the case and to be reassured that the Trust has explored this option fully before rejecting it.

13. The Trust has accepted that the poor road and public-transport connections between Maidstone and Tunbridge Wells will mean considerable inconvenience for some patients, as well as for the relatives and friends of patients who wish to visit them, if the proposed changes go ahead. However, the Trust maintains that any inconvenience thereby caused is heavily outweighed by the clinical benefits of change.

The committee would contend that, since the purported clinical benefits of the proposals are clearly open to doubt, the inconvenience the proposals would cause to patients and the public can less easily be dismissed in weighing up the costs and benefits attached to options for change.

14. The committee notes that, as was apparent at the meeting on 12 January, there is clearly a sharp division in clinical opinion within the Trust (and beyond) on these proposals. Whilst the surgeons seem strongly in support of the changes, their physician colleagues (both medical consultants and general practitioners) are clearly overwhelmingly opposed.

The Trust appears to take the view that it has achieved adequate clinical engagement as the surgeons are supporting the proposals – and that, whilst the opposition of other clinicians is unfortunate, it is not possible to please everyone all the time. The committee takes the view that, whilst it is clearly unrealistic to expect complete unanimity among clinicians, the clear split between surgeons and physicians on these proposals greatly weakens the claim that there is proper clinical engagement.

The medical consultants argued on 12 January that, while the surgeons had been involved in formulating the proposals, the physicians had not – they were simply presented with a *fait accompli*. We are concerned that these proposals do appear to have been developed without reference to clinicians in a specialty on which they are bound to have a significant impact.

The views of GPs in Maidstone have also clearly not been taken into account in framing the proposals. These views were expressed on 12 January by the BMA's Dr Debbie Taylor, who stated starkly that "people will die" as a result of longer ambulance journey times if the proposals are implemented.

The committee believes that the Trust's claim to have adequate clinical engagement in respect of its proposals is not tenable. We would want to see evidence that the Trust has achieved full clinical engagement, involving physicians as well as surgeons, and primary-care practitioners as well as consultants.

Chairman _____

Date _____