
# Review of Future Health Service Provision in the Dover District

**Report of the Scrutiny (Community and Regeneration) Committee**

**June 2008**

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# Section One

# Foreword by the Chairman and Controlling Group Spokesperson

***An introduction to the review on behalf of the Scrutiny (Community and Regeneration) Committee by the Chairman, Councillor Jim Hood and the Controlling Group Spokesperson, Councillor David Lloyd-Jones.***

# Chairman's Foreword

**Councillor Jim Hood**
Chairman of the Scrutiny (Community and Regeneration) Committee

*"In this, the 60th anniversary year of the National Health Service, a once-in-a-generation decision is being made over the replacement of Buckland Hospital and key decisions are in the process of being made over the future of the wider health service provision locally.*

*As someone who has personally been involved with Buckland Hospital as a patient, I too share the strong local attachment to it. However, in taking a realistic appraisal of the future of Buckland Hospital, it is important to remember that what makes Buckland Hospital such a treasured institution is the excellent, dedicated staff and the health services it provides, not the building itself. The former 19th Century workhouse that forms the core of Buckland Hospital is no longer fit for purpose in the early 21st Century and the committee has welcomed proposals for a new high quality, accessible modern community hospital.*

*I have been particularly heartened to hear of the involvement of the two Practice Based Commissioning Consortia, the representatives of the General Practitioners of the district, in developing the models of care for service provision at the proposed new community hospital as these are medical professionals who have the greatest interaction with the local community and as a consequence have the clearest picture of local health needs. I also welcome comments from the Eastern and Coastal Kent Primary Care Trust and the East Kent Hospital Trust that services such as endoscopy will be restored in the new community hospital and that it is likely that the existing range of locally provided services will be expanded to include services such as a mobile MRI scanner which will reduce the need to travel out of the district for diagnostic services.*

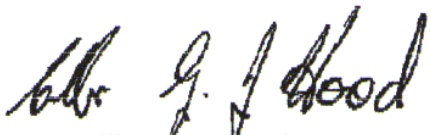
*It should be noted that this Overview and Scrutiny Review is not the end of the process but rather the beginning. It is my hope that the good relationship developed with the local NHS Trusts can be built upon in the future and I can reassure the people of Dover that this committee will continue to monitor developments relating to the proposed community hospital and the wider picture of health service provision.*

*I would like to take this opportunity to thank the members, and former members, of the Scrutiny (Community and Regeneration) Committee for their dedication and hard work over the last year in pursuing this review to its conclusion. In order to undertake this review, Members have had to undergo a steep learning curve in health services and attend additional meetings, site visits, etc. and I feel this needs to be recognised. I would also like to thank members of the Cabinet for their assistance, without which undertaking this review would have been more difficult.*

*I would also like to express my gratitude on behalf of the committee to the local NHS Trusts and all the witnesses who have met with us and who have put a great deal of effort into working with the committee. It is not an understatement to say that without their co-operation this review would not have been possible. In particular, I would like to thank Lynne Selman of the Eastern and Coastal Kent Primary Care Trust, Howard Jones of the East Kent Hospitals Trust and Geraint Davies of the South East Coast Ambulance Service for their assistance.*

*Finally, a mention should also be given to Councillors Clive Meredith and Marian Munt, who have attended a considerable number of the committee meetings in the capacity of substitute, and who have made useful contributions to this review. On behalf of the committee I would also like to those Officers who have been involved with the committee and in particular our Scrutiny Officer for her hard work.*

*In conclusion, I commend this review to the Council and urge elected representatives in all tiers of local government as well as most importantly, the local community itself, to work in a positive manner with the Eastern and Coastal Kent Primary Care Trust and the East Kent Hospitals Trust to deliver the best possible option available for health service provision for the people of Dover and the wider district."*



**Councillor G J Hood**
Chairman of the Scrutiny (Community and Regeneration) Committee

# Spokesperson's Foreword

**Councillor David Lloyd-Jones**
Controlling Group Spokesperson of the Scrutiny (Community and Regeneration) Committee

*"It is a self-evident truth that the people of the Dover District deserve access to the highest quality local healthcare services that are available. The challenge facing us all is to ensure that our local NHS Trusts and primary care providers do so, and in doing so that they provide as wide a range of services locally as is possible without compromising clinical effectiveness.*

*While I have great sympathy with those who would like to see a new acute general hospital built in Dover, that was not an achievable option open to the committee in undertaking this review given the requirements of the Royal Colleges, NHS policy, clinical training needs and working time directives. Instead the committee took the brave decision to work with our local NHS Trusts in attempt to influence the best outcome available and I hope that this review document shows that we have achieved some success in doing that.*

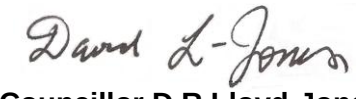
*In taking a realistic appraisal of the future healthcare needs of the district, it is important to remember that the key fact is services are more important than buildings. A new purpose built community hospital located more accessibly in Dover and offering an expanded range of high quality services beyond that on offer at Buckland Hospital currently should be seen as a key component in providing improved healthcare outcomes for the people of the Dover District.*

*However, the provision of local high quality healthcare services is only part of the picture. For these services to have the greatest benefit they must be accessible not just to the population of the locality in which the services are located but the wider population of the Dover District. As one of the members for the Eythorne and Shepherdswell Ward, many of my constituents will have to travel to a hospital by public transport and I welcome proposals from the East Kent Hospital Trust to introduce improved Patient Transport Services. It is well known that many of our rural communities have to endure irregular and often inconvenient public transport provision. The fact that someone lives in a rural community should not be a barrier to accessing local high quality healthcare services.*

*In the course of this review, the chance to have access to senior members of our local NHS Trusts has been extremely beneficial and I would like to thank everyone who attended a meeting of the committee to provide evidence for doing so in such an informative and open manner. On a personal note, I would like to thank the members of the Eastern and Coastal Kent Primary Care Trust for their assistance in respect of an issue of local concern in my own ward – that of insufficient primary healthcare provision for the people of Eythorne and Elvington. While this issue has not been fully resolved yet, I am hopeful that a satisfactory outcome can be reached to improve access to primary care services and I would urge everyone living in Eythorne and Elvington to engage constructively with the Eastern and Coastal Kent Primary Care Trust so that their voices can be heard.*

*I would also like to take this opportunity to echo the sentiments expressed by the Chairman in his foreword, that this review is not the end of the process but rather the beginning. It is the intention of this committee to build upon the positive relationships developed with our local NHS Trusts and work with everyone to deliver improved healthcare services to the people of the Dover District. I would also like to reassure the people of the Dover District that this Overview and Scrutiny Committee will continue to monitor the developments relating to the proposed new community hospital.*

*Finally, I would commend this review to the Council and urge all elected representatives in the Dover District, and most importantly the people of the District themselves, to work constructively together to achieve the best available healthcare services for the district."*



**Councillor D R Lloyd-Jones**
Controlling Group Spokesperson

# Section Two

# Acknowledgements

# Acknowledgements

2.1 The Scrutiny (Community and Regeneration) Committee wishes to thank the following individuals and organisations for their assistance during the course of the review.

**Deal, Ash and Sandwich Practice Based Commissioning Group**

**Dover and Aylesham Practice Based Commissioning Group**

**Dover District Council**

| | |
|---|---|
| Councillor Paul A Watkins | Leader of the Council |
| Councillor Patrick G Heath | Portfolio Holder for Health, Well-Being and Public Protection |
| Councillor Nigel J Collor | Portfolio Holder for Access and Property Management |

**Dover Pride**

**Eastern and Coastal Kent Primary Care Trust**

**East Kent Hospitals Trust**

**Kent County Council Health Overview and Scrutiny Committee**

**Dr J R Sewell**

**South East Health Limited**

**Stagecoach East Kent Ltd**

# Section Three

# Scope and Process Report

***An overview of the terms of reference of the review and the process of enquiry used in preparing the report***

# Scope and Process Report

## Introduction

3.1 The issue of the future of health service provision in the Dover District was first mooted by the Chief Executive during a discussion on the work programme of the Scrutiny (Community and Regeneration) Committee and was selected by members as the major review topic for the year on the basis of the high level of public concern expressed over the future of Buckland Hospital.

## Risk Assessment

3.2 In undertaking the first major overview and scrutiny health review since the Review of Access to NHS Dentists within the Dover District (October 2005), it has been important to remember the words of the Audit Commission, which stated that:

***"If local authority scrutiny of health works well, it will provide a valuable forum for review and debate, engage local people, and generate realistic suggestions to improve services. Done badly, it could duplicate effort, damage partnerships and result in little more than political point scoring".*** [1]

## Links to Corporate Plan

3.3 The provision of high quality, readily accessible health services will improve the health and well being of residents within the District. This Review has direct links with the aspirations set out under 'World Class Communities' in the Corporate Plan and the requirements of the Local Plan evolving through the Local Development Framework process.

[1] "A Healthy Outlook – Local Authority Overview and Scrutiny of Health" (Audit Commission)

**Stage 1: Methodology**

3.4 The Project Plan for the review was developed by the committee, which outlined the background to the project, terms of reference, organisational impact, timescale, and witnesses for the review.

3.5 As the review has progressed it has been necessary to maintain a clear focus on the reviews objectives rather than be sidetracked by other areas of interest that have arisen during the course of the investigation.

**Stage 2: Research**

3.6 The research for the review has involved the study of secondary source material from the media, research papers, local authority health scrutiny reviews, and Department of Health publications.

**Stage 3: Investigation**

3.7 The investigations undertaken as part of the review have involved obtaining primary source material from local medical professionals and NHS trusts.

3.8 The committee has also undertaken a series of site visits as part of the review, to gain a first hand understanding of how the NHS trusts work. This has included two visits to Buckland Hospital (the first as a guest of the East Kent Hospital Trust, the second at the invitation of StourCare), a visit to Victoria Hospital, Deal and a site visit to the South East Coastal Ambulance Trust Control Centre at Coxheath.

**Stage 4: Final Analysis**

3.9 The final report of the Review has been presented to the Scrutiny (Community and Regeneration) Committee at its meeting on Tuesday 24 June 2008. The Committee made a number of recommendations to the Council, which are set out at page 211.

# Section Four

# Review Objectives

***Details of the objectives of the review as agreed by the Scrutiny (Community and Regeneration) Committee***

# Objectives of the Review

4.1 To increase community understanding as to the issues facing the district in respect of the short and long-term hospital service provision in the district.

4.2 To identify and assess the suitability of proposals from the Eastern and Coastal Kent Primary Care Trust and East Kent Hospital Trust for the future provision of health services in the district.

4.3 To assess the implications of emergency care services being provided by hospitals outside the district.

4.4 To establish the suitability of public transport from locations within the district to William Harvey Hospital, Ashford; Queen Elizabeth the Queen Mother Hospital, Thanet; and the Kent and Canterbury Hospital, Canterbury, giving particular consideration to elderly and disabled members of the local community.

4.5 To assess the results of the Dover Project Consultation and the future role of Buckland Hospital.

4.6 To establish if a full range of proposals were considered for future health service provision in the Dover District.

4.7 To discuss the strategic health service needs and provision in the district.

4.8 To have identified the views of the public, professional, patient, community and voluntary groups over the future of health provision in the district.

4.9 To ensure that the district maintains continuous health service provision in some form.

4.10 To identify barriers to access of health services and ensure that provision exists for the people of the district to access appropriate health services.

# Section Five

# Research Report

***Details of the issues examined by the Scrutiny (Community and Regeneration) Committee***

# Research Report

***A glossary to the terms and key abbreviations used in the Research Report can be found on page 96.***

## Introduction

5.1 Access to hospital services as a result of health service reorganisation is a key issue facing not only the Dover District or Kent but the wider country as well. As in the case of Dover, where the hospital building dates from the 19th century, these institutions have often become woven into the very fabric of the local community and any reconfiguration of service provision are likely to face strong local opposition.

5.2 This reorganisation of health service provision has been undertaken under the aegis of providing the most modern facilities and efficient services through centralisation of acute hospital services to a location with a critical mass of staff and patients and the diffusion of non-acute services into local communities.

## Legislative and Policy Framework

### 'NHS Plan – A Plan for Investment, A Plan for Reform'

5.3 The NHS Plan published in 2000, set out the Government's vision for the future of the NHS. At the core of these proposals were greater integration between health and social services and refocusing the work of the NHS around the patient. It was followed up by a progress report in 2002 entitled 'Delivering the NHS Plan'.

5.4 A key part of the NHS Plan was the refocusing of services around the patient to give them greater say in how their local healthcare is developed and improve their clinical experiences in both primary and secondary care. This covered introducing reduced waiting times for treatment and greater choice for the patient in how they accessed it.

5.5 The NHS Plan also set out a new relationship between central Government and the NHS Trusts. While the Government would seek to ensure the NHS Trusts met

national standards, it would in return allow the stronger performing Trusts greater autonomy in their actions. These would become known as 'Foundation Trusts'.

5.6 As well as changing the relationship between Government and Trusts, the NHS Plan also contained proposals to extend the roles of staff within the NHS and new contracts for primary care providers and hospital doctors. It should be noted that the implementation of new contracts has been a controversial matter and achieved a mixed level of success.

5.7 The NHS Plan sets out ten core principles on which a modernised NHS is to be based. These were:

- The NHS will provide a universal service for all based on clinical need, not ability to pay
- The NHS will provide a comprehensive range of services
- The NHS will shape its services around the needs and preferences of individual patients, their families, and their carers.
- The NHS will respond to different needs of different populations
- The NHS will work continuously to improve quality services and to minimise errors.
- The NHS will support and value its staff.
- Public funds for healthcare will be devoted solely to NHS patients
- The NHS will work together with others to ensure a seamless service for patients.
- The NHS will keep people healthy and work to reduce health inequalities.
- The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment, and performance.

**'Our Health, Our Care, Our Say'**

5.8 The White Paper entitled "*Our health, Our Care, Our Say: A New Direction for Community Services*" was published in January 2006 and set out proposals for reforming health and social care. It set clear goals for the transfer of significant activities and services from acute to community settings. This new model of service provision had a much greater diversity than in the old District General Hospital model.

5.9 The key themes of the White Paper are:

- An increase in services delivered in local communities
- Supporting independence
- Supporting patient choice
- Easier access to services
- The '18-Week Promise' on waiting times
- Strong local commissioning of service
- Promoting healthy living
- More effective partnership working

5.10 The concept of patient choice is at the heart of the proposals in the White Paper. This takes the form of the empowerment of patients by giving them greater influence over their primary and secondary care and increased choice for primary (through Practice Based Commissioning) and secondary care providers over how and where the services are delivered. This was a theme previously developed for social care in the Green Paper published in March 2005 entitled 'Independence, Well-being and Choice'.

**'Our NHS, Our Future'**

5.11 The 'Our NHS, Our Future' review was announced on 4 July 2007 to the House of Commons and was undertaken by Lord Darzi, the Parliamentary Under Secretary of State at the Department of Health. The review is intended to shape the next ten years of the NHS.

5.12 The aim of the review is to deliver an NHS that is "clinically led, patient centred and locally accountable".[2] The review focuses not on the funding or structure of the NHS but instead on how it is delivered and the priorities it works too. The vision set out is one of a fair, personalised, effective, and safe NHS.

5.13 The interim report published in October 2007, set out five initial steps to achieving the reviews objectives:

- Development of a comprehensive strategy for tackling health inequalities
- More patient choice at all levels of NHS funded care, such as expanding primary care services where there is under provision, locating health centres in easily accessible locations, encouraging PCT's to deliver greater flexibility in GP opening hours.
- Establish a Health Innovation Council
- Make the NHS safer for patients through measures such as a single incident reporting centre and reduce hospital-acquired infection through measures such as enhancing Matron's responsibilities.
- Ensure that new guidelines are produced so that any major change in the pattern of local NHS service hospital services is clinically led and locally accountable.

5.14 The final report from Lord Darzi is to be published in summer 2008, although it was not available at the time the research report was finalised.

**'Healthier People, Excellent Care'**

5.15 The 'Healthier People, Excellent Care' paper was the contribution of the NHS South East Coast Strategic Health Authority to the national review led by Lord Darzi entitled 'Our NHS, Our Future' and sets out its vision for the region. The overarching aim of the paper is that by 2018 "people in Kent, Surrey and Sussex will be much healthier than now".[3]

5.16 The key aspirations of the report are that by 2018:

- There will be no avoidable hospital acquired MRSA infections.
- There will be less than 2,000 cases of C. Difficile.
- That heart attacks and major injuries will always be treated in specialist centres (by 2010).
- That diagnostic services will be available on the local High Street or in the patient's home.
- To have started reducing the number of obese people.

[2] 'Our NHS, Our Future' < http://www.ournhs.nhs.uk/2007/09/26/why-do-we-need-a-review/ >
[3] Page 5, 'Healthier People, Excellent Care', NHS South East Coast

- That there will be widely available special programmes to cope with long-term conditions such as diabetes.
- That the majority of terminal patients will be able to die at home should they so wish.
- Reduce the variation in life expectancy in the South East to ensure that all men can expect to live to 78.6 years of age and all women to 82.5 years of age.
- All patients will hold their own medical records.

5.17 The report feeds into the 'Creating an NHS Fit for the Future' document, which sets out how these objectives would be delivered.

**South East England Health Strategy**

5.18 The Health Strategy is part of a series of strategies that make up the South East Regional Sustainability Framework. For the purposes of the strategy, sustainability is defined as development that "meets the needs of the present without compromising the ability of future generations to meet their own needs".[4]

5.19 The Health Strategy covers health requirements from birth through to death and has six key objectives:

- Reducing health inequalities
- Promoting a sustainable region
- Promoting safer communities
- Increasing the positive relationship between employment and health
- Improving outcomes for children and young people
- Improving outcomes in later life

5.20 The strategy covers not just the provision of NHS services but also the wider picture of social services, improving people's general well being, and engaging with people in the management of their own health.

[4] Brundtland Commission

5.21 The Health Strategy also aims to improve the life expectancy of the most socially disadvantaged by a figure of 18 months through targeting reduced avoidable illness and death levels by increasing screening and immunisation levels and by targeting cardiovascular disease and cancer through reducing smoking and improving diet and exercise.

**Creating an NHS Fit for the Future**

5.22 The 'Creating an NHS Fit for the Future' (FFF) consultation was an attempt by the three Primary Care Trusts in Kent (Medway, West Kent, and Eastern and Coastal Kent) to improve efficiency and reorganise the delivery and location of services and ensure that health services are clinically and financially stable to 2012/13.

5.23 A key focus in this is providing more non-acute services in accessible locations closer to patients, while concentrating specialist acute services in fewer locations. The principle of concentrating specialist acute services in fewer locations is supported by the Royal Colleges, as it allows doctors to see a sufficient critical mass of patients to maintain and develop their specialist skills which in turn results in better outcomes for patients. It also enables hospitals to staff services more flexibly and conform to European directives on working times.

5.24 The provision of an increased range of non-acute and diagnostic services locally is in keeping with guidance from the Department of Health and ties in with the work of the primary care providers in the district. This is particularly relevant given that 80% of NHS care is provided through GP surgeries[5], health centres/clinics, or patients' homes rather than at hospitals. In areas such as the Dover District where there is no acute hospital, an expansion of the services provided through a community setting would reduce the number of patients who are required to travel to an acute hospital outside of the district.

5.25 The two Practice Based Commissioning consortia in the Dover District, the Dover and Aylesham Consortium and the Deal, Ash and Sandwich Consortium, are an important element in delivering the FFF objectives.

[5] 'Creating an NHS Fit for the Future'

**'Choose and Book'**

5.26 The traditional method of the hospital allocating a time and location without consulting the patient often led to appointments being missed or patients undergoing considerable inconvenience in travelling long distances. The 'Choose and Book' service was introduced to give patients greater choice in when and where their first outpatient appointment (usually the first appointment with a consultant) is accessed.

5.27 The 'Choose and Book' system is accessed by patients through their local General Practitioner (GP) who will discuss the clinically appropriate options available to patients for the treatment of their conditions. This enables the patient to leave their GP surgery with a confirmed time and location for their appointment, which is suitable to their needs or the needs of their carers. There is also the option to take an appointment request letter away and book an appointment by telephone if a patient is unable to commit to a date at the time of their meeting with their local GP.

5.28 The NHS Choices website contains most of the clinical details that patients and GP's will need to make informed decisions as to where they wish their appointment to be held. The information held is broken down by each medical condition and covers the following:

- Waiting times
- In-patient requirement (if any)
- Chance of readmission
- Experience of surgical department
- Hospital acquired infection
- Healthcare Commission rating of the hospital
- Mixed sex ward situation (if in-patient requirement)
- Patient experience feedback

5.29 The advantages of the 'Choose and Book' system are:

- Greater convenience and certainty
- Patients can check the status/change/cancel an appointment over the telephone or online

- Patients can manage their own appointments and fit it around their carers/family/existing treatment schedule/or work commitments.
- Reduced likelihood of patients appointments being lost as the system is computer based

5.30 The disadvantages of the 'Choose and Book' system are:

- Not all hospitals or GP's in England are on the 'Choose and Book' system
- Public awareness of the system is relatively low
- Patients can be dependent on their GP providing them with the relevant information (such as on NHS Choices) if they are to make an informed choice at that point.

5.31 The National Patient Choice Survey for England (January 2008) found that nearly half of all patients (46%) recalled being offered a choice of hospital for their first outpatient appointment. In selecting hospitals for in-patient treatment, patients usually cited cleanliness and low hospital acquired infection rates as a key factor in their decision. The survey findings indicate that those patients offered a choice of hospital have higher satisfaction rates than those who are not.

**NHS South East Coast**

5.32 The NHS South East Coast is the Strategic Health Authorities (SHA) for Kent, Sussex and Surrey and nationally one of ten for England. It was established on 1 July 2006 and replaced the previous Kent and Medway SHA and Surrey and Sussex SHA.

5.33 It has responsibility for providing strategic leadership to the NHS Trusts in the South East; ensuring that NHS Trusts and their staff develop appropriately; and ensure the effective delivery of NHS services and ongoing improvements.

5.34 In addition to working with the Eastern and Coastal Kent Primary Care Trust in delivering its objectives, it is also the body to which the Primary Care Trust is responsible to for its performance. The SHA in turn is accountable to the Department of Health for its performance.

**Eastern and Coastal Kent Primary Care Trust**

5.35 The Eastern and Coastal Kent Primary Care Trust (henceforth referred to as the 'PCT') was formed on 1 October 2006 as a result of a merger between smaller Primary Care Trusts. It serves approximately 710,000 people living in the six districts of Ashford, Canterbury, Dover, Shepway, Swale, and Thanet with a budget of just over £1 billion.

5.36 The PCT has three primary functions as follows:

- Engaging with the local population to improve their health and well-being
- To act as the commissioning body for a comprehensive and equitable range of high quality responsive and efficient services
- To act as the service deliverer where to do so will provide high quality responsive and efficient services at best value

5.37 The mission statement of the PCT is "to improve patients experience, well-being and health outcomes and to tackle health inequalities for our local population, through intelligent (and where appropriate) integrated commissioning".[6]

5.38 While the bulk of services are provided through other bodies such as the Hospital Trust, the PCT will provide some services directly where it is the option that provides best value without compromising service delivery. It delivers services at 5 community hospitals in East Kent in addition to the 5 hospitals owned by the East Kent Hospitals NHS Trust. These are:

- Faversham Cottage Hospital, Faversham
- Queen Victoria Memorial Hospital, Herne Bay
- Sheppey Community Hospital, Minster
- Sittingbourne Memorial Hospital, Sittingbourne
- Victoria Hospital, Deal
- Whitstable and Tankerton Hospital, Tankerton

5.39 The PCT also commissions NHS primary care services such as dentists, General Practitioners, pharmacists, and opticians to ensure that there is sufficient NHS provision to fulfil the clinical needs of the local community.

**Healthcare Commission Assessment 2006/07**

5.40 The Healthcare Commission is the watchdog for healthcare in England and provides an assessment of the services provided by NHS trusts.

5.41 The overall verdict of the Healthcare Commission was that the PCT was providing an adequate quality of services to patients and patients found the provision to be satisfactory. The assessment undertaken in 2006/07 assessed the PCT as 'Weak' in terms of the quality of services it provided and 'Fair' in terms of its overall organisational Use of Resources. It should be noted however; that these scores reflect a transitional period following the merger of several smaller PCT's to form the Eastern and Coastal Kent PCT.

## East Kent Hospitals NHS Trust

5.42 The East Kent Hospitals NHS Trust (henceforth referred to as 'EKHT') manages five hospital sites in East Kent and is one of the largest hospital Trusts in England. The objective of the EKHT is to be one of the top ten hospital trusts in England by providing "safe, patient focused and sustainable health services with and for the people of Kent". [7]

5.43 The EKHT employs 6,000 staff across not just the five hospital sites but also teams of health care professionals working in locations such as child care centres. It estimated that its income for the year 2007/08 would be approximately £376 million.

5.44 The five hospitals it comprises of are:

- William Harvey Hospital, Ashford (Acute)
- Queen Elizabeth the Queen Mother Hospital, Thanet (Acute)

[6] Eastern and Coastal Kent Primary Care Trust website
[7] East Kent Hospitals NHS Trust Website

- Kent and Canterbury Hospital, Canterbury (In-patient specialist services)
- Buckland Hospital, Dover (Non-Acute)
- Royal Victoria Hospital, Folkestone (Non-Acute)

5.45 The current network of health service provision in East Kent was set in 1998 when the then Secretary of State for Health, Mr Frank Dobson MP, agreed to focus acute service provision at the William Harvey and Queen Elizabeth the Queen Mother (henceforth referred to as the 'QEQM') and downgrade the status of the Kent and Canterbury Hospital from full acute status. The 'Tomorrow's Healthcare' document set out the options for delivering the Secretary of State's decision.

5.46 It is important to emphasise that no single hospital provides every service a patient requires and in that context, the five EKHT and six PCT hospitals should be viewed as forming part of an overall multi-hospital network rather than as separate isolated sites. For example, the William Harvey is the only hospital in the network to provide in-patient maxillo facial services and Kent and Canterbury Hospital (henceforth referred to as the 'KCH') the only provider of in-patient urology services.

5.47 The Trust has recently completed a £24 million investment programme of major building and refurbishment work primarily focused on improving the two acute hospitals and the KCH.

5.48 These improvements have also seen the development of specialist acute services in East Kent that would have traditionally required a patient to travel to London, such as the East Kent Cardiac Catheter Suite at the William Harvey Hospital; a state-of-the-art operating theatre at the QEQM for specialist cardiac diagnostic procedures; and one of only 21 specialist haemophilia centres in the UK for inpatient urology, vascular and renal services at the KCH.

**NHS Foundation Hospital Trusts**

5.49 The Government introduced the concept of the Foundation Trust as a method of providing greater independence for local NHS Trusts in their decision-making and giving local communities greater influence in the way services are provided.

5.50 Although the Secretary of State for Health has no powers of direction over Foundation Trusts it is still expected that it will operate in a manner that is consistent with the standards and principles of the NHS. In addition, clinical activity for private patients is strictly limited for Foundation Trusts.

5.51 The NHS Foundation Trusts will be given the following powers:

- Freedom from Department of Health control
- Freedom from Strategic Health Authority performance management
- Freedom to access capital on the basis of affordability instead of through centrally controlled allocations
- Freedom to invest any surpluses in new services for local people
- Freedom of local flexibility to tailor new governance arrangements

5.52 The Healthcare Commission has responsibility for inspecting the Foundation Trusts and to report on compliance with healthcare standards and targets as with all NHS Trusts. In addition, the Foundation Trusts are to be overseen by an independent regulatory, Monitor, which will have powers of intervention where there is non-compliance with statutory obligations.

5.53 In the absence of Department of Health accountability, a Foundation Trust is expected to have members of the local community and representatives from patients and staff on its Board. The Trust Board in turn elects the Governors.

5.54 The first Foundation Trusts were appointed in 2004, and currently there are 99 in England including 1 in Kent (Medway). The EKHT made a submission to the Department of Health to be awarded Foundation Hospital status in early 2008

**18-Week Promise**

5.55 The EKHT is an early implementer pilot for the 18-week treatment promise. This will mean that from 2008 no patient should have to wait more than 18 weeks from the time of referral by a General Practitioner (GP) to the start of his or her hospital treatment. This is a significant improvement on the previous regime where a patient would have to wait 13 weeks from the referral by their GP to being seen by a

consultant followed by a further 13 week wait for diagnostic tests and a final 26 week wait for an operation making a total of one year from referral to operation.

5.56 The 18-week Promise also represents a drive for significant improvements in service provision. The 2006/07 assessment of EKHT waiting times by the Healthcare Commission while identifying that all the eleven basic standards were achieved an unacceptable number of patients had to wait for more than 13 weeks for diagnostic tests and more than 20 weeks from consultant appointment to hospital admission.

5.57 The introduction of 'Choose and Book' facilities at GP surgeries is an important tool in enabling the patient to access services quickly. The GP is able to offer the patient a choice of locations and dates for their appointments at the time of the referral and this should also reduce the number of missed appointments (currently 1 in 10 of all appointments).

**Hospital at Night**

5.58 The concept of the Hospital at Night (H@N) is a response to changes in the working time directive and proposes that the way to achieve the most effective clinical care is to "have one or more multi-professional teams who between them have the full range of skills and competences to meet patients' immediate needs".[8] The formation of multi-professional teams makes best use of trainee doctor's time and helps meet their training needs.

**Healthcare Commission Assessment 2006/07**

5.59 The overall verdict of the Healthcare Commission was that the EKHT was providing an adequate quality of services to patients. The assessment undertaken in 2006/07 assessed the EKHT as 'Fair' in terms of the quality of services it provided and 'Weak' in terms of its overall organisational Use of Resources. The 'Weak' score was a result of the EKHT missing one or more of its financial targets. These figures were unchanged from the assessment made in 2005/06 by the Healthcare Commission.

5.60 In terms of particular service provision, the Commission rated EKHT as 'Weak' for its diagnostic (endoscopy, imaging and pathology) services, although the service was

[8] Healthcareworkforce.nhs.uk < http://www.healthcareworkforce.nhs.uk/hospitalatnight.html >

still provided at an acceptable level. The EKHT scored particularly badly in respect of endoscopy services receiving 1 out of 5 for waiting times, patient focus, and unit management.

5.61 The maternity service, admissions management, and inpatient children's services all received 'Fair' ratings and the EKHT received a 'Good' rating for its medicines management. In terms of hospital cleanliness, in 2006/07 the EKHT was assessed as achieving 11 out of 12 basic standards (a technical failure as the expectation is that all 12 basic standards will be met) and did not meet the higher standard, as there was not a reduction in MRSA blood infections for the period 2006/07.

**South East Coast Ambulance Trust**

5.62 The South East Coast Ambulance Service NHS Trust (SECambs) is contracted by the Eastern and Coastal Kent Primary Care Trust to provide emergency medical care for its area. In addition to providing ambulance services for Kent, SECambs also provide emergency medical services for East and West Sussex, Surry and North East Hampshire.

5.63 In the Dover District, SECambs provides ambulance stations at Deal and Dover, although ambulances are also stationed at strategic satellite points in the district to reduce journey time to emergencies. If required ambulances will be moved to cover the Dover District from neighbouring districts.

5.64 SECambs also provide non-emergency Patient Transport Services (PTS) for patients in Kent and Sussex.

5.65 The ambulance service control centre for the Dover District is located at Coxheath, Maidstone. In March 2008 the committee undertook a site visit to Coxheath to observe the control centre in operation and see how real life emergencies were handled.

**Dover District Health Profile**

5.66 In considering the health profile of the district it is important to remember that the district is not a homogenous block in terms of health needs and that individual health

needs are dependent on a number of socio-economic factors that vary between groups and even within district wards.

**The Health Consequences of Income Inequality**

5.67 In terms of national income inequalities, the District Wards of Buckland, St Radigunds and part of Tower Hamlets are among the most income deprived fifth of areas in England, while in contrast the neighbouring wards of River and Whitfield are among the top two fifths of least income deprived areas in England.

5.68 In terms of variation within the local authority administrative area, the District Wards of Buckland; Town and Pier; and significant parts of the wards of Maxton, Elms Vale and Priory; St Radigunds; and Tower Hamlets are among the most income deprived fifth of areas. In contrast the wards of Capel-le-Ferne and Ringwould and part of the ward of Maxton, Elms Vale and Priory are among the least income deprived fifth of areas in the local authority administrative area.

5.69 There are over 12,000 people in the district claiming means tested benefits and 4,513 children are classified as living in low-income households.[9]

5.70 It should be emphasised that belonging to a low-income household does not universally lead to a reduced quality of health, as income deprivation is just one of several factors determining health quality for individuals. However, studies have shown that there is a significantly increased statistical chance of low-income households having a reduced quality of health and life expectancy.[10]

5.71 Overall, the premature mortality rates for both infants and adults are statistically higher for low-income households and there is a reduction in average life expectancy when compared to high-income households. The impact of a diet containing poor or inappropriate nutrition significantly increases the likelihood of low birth weights for children, which in turn can lead to poor physical and cognitive development. In addition, the combination of poor physical development, a low nutrition diet and a lack of physical exercise can lead to longer-term health problems. An increased

[9] Dover Health Profile 2007
[10] London Health Observatory "Determinants of Health – Income"

occurrence of mental health problems, such as stress and depression, reduce the level of stimulation that a child receives and can affect emotional development.

5.72 Finally, low-income households also have an increase in the levels of injuries to children. For example, children in households without cars are more likely to cross roads as part of accessing public transport and this increases the chance of them being involved in a road accident as a pedestrian.

**Births**

5.73 The birth rate in the district has been broadly constant between 2000 and 2006, as shown in the table set out below, with an average of 1,084 live births per annum from 2000 to 2006.

***Table 1:Summary of Live Births for Dover Local Authority Area (Source: ONS)***

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|
| Live Births | 1,106 | 1,078 | 1,003 | 1,036 | 1,079 | 1,151 | 1,139 |

**Underweight Births**

5.74 In the district from 2003 to 2005, there were 6.90 underweight births per 100 total births. This was the fifth lowest figure in Kent, from a range of 6.31 underweight births per 100 total births in Tunbridge Wells Borough Council's area through to 8.71 underweight births per 100 total births in Thanet District Council's area. The health consequences of being born underweight are an increased risk of death and disability, diabetes, heart disease, Attention Deficit Hyperactivity Disorder (ADHD) and depression. [11]

**Infant Mortality**

5.75 The definition of infant mortality is the death of a child under one year of age. In 1901, a quarter of all deaths nationally were due to infant mortality. This figure reduced over the course of the 20th Century and by the early 21st Century this figure had changed to less than 1% of all deaths resulting from infant mortality.

[11] Royal College of Paediatrics and Child Health, Archives of Disease in Childhood

5.76 In the Dover District for the period 2003 to 2005, there were eighteen stillbirths, which equated an average of 5.38 stillbirths per thousand live births. This was the fourth highest level in Kent for the period 2003-05. The authority with the highest level was Tunbridge Wells Borough Council with 5.89 stillbirths per thousand live births and the lowest was Thanet District Council with 4.07 stillbirths per thousand live births.

5.77 Overall, for the period 2003 to 2005, there were 24 perinatal (aged less than 7 days old including stillborn infants) deaths which equated to 7.31 deaths per 1000 total births; 9 neonatal (aged between 7 and 28 days old) deaths which equated to 2.75 deaths per 1000 live births; and 2 post-neonatal (over 28 days but less than 1 year of age) deaths which equated to 0.61 deaths per 1,000 live births.

5.78 The overall level of infant mortality for the period 2003 to 2005 in the Dover District was 3.37 per 1,000 live births, which was the fourth best figure in Kent. The authority with the highest level of overall infant deaths per 1,000 live births was Shepway District Council with 6.72 deaths and the lowest was Sevenoaks District Council with 2.24 deaths per thousand live births.

**Health Inequalities in Young People**

5.79 The key health concerns for young people in the South East are an increasing prevalence of obesity, high smoking rates, high teenage pregnancy rates, and increasing levels of sexually transmitted infections. In the case of obesity, the impact of changing lifestyles for young people is the potential for the trend of increasing life expectancy each generation could be reversed.[12]

5.80 An estimated 1 in 10 young people have mental health problems, and this level rises to nearly 1 in 2 for children in care. In addition, those young people with behavioural disorders are more likely to turn to anti-social behaviour.

5.81 The impact of poor physical or mental health in young people manifests itself as reduced school performance which in turn leads to the poor qualifications on leaving school and reduced employment and earning potential. As those children from income deprived households are at greater risk of poor physical or mental health it can lead to a generational cycle of generational deprivation.

[12] House of Commons Health Committee, Obesity: 3rd Report of Session 2003-04

5.82 In the Dover District, 21.4% of children live in low-income households. This compares to an average for the South East as a whole of 15% and an English average of 21.3% of children.

5.83 In the Dover District, the teenage pregnancy rate is 39.1 females per 1,000 females aged 15 to 17 years of age. This is slightly better than the English average of 42.1 females per 1,000 females aged 15 to 17 years but still far higher than some European nations such as the Netherlands or Sweden where the teenage pregnancy rate is less than 7 females per 1,000 females aged 15 to 17 years of age. In the developed world, only the United States of America has a higher teenage pregnancy rate.

5.84 In educational terms, the district also has slightly better levels of GCSE achievement than nationally for England with 64.5% of young people achieving 5 A* to C grades compared to 57.5% nationally. Tackling health inequalities in young people can lead to improved school performance, a reduction in anti-social behaviour and greater chance of escaping from the cycle of income deprivation.

5.85 The June 2008 update to the Dover Health Summary indicates that potential new health inequality issues may also be emerging in the district in respect of smoking during pregnancy (20.1% of mothers as opposed to 16.1% for England); the number of Under 15 year olds categorised as not being in 'good health' (15.4% as opposed to 11.6% for England based on self-assessment); and the number of physically active children (83.1% of 5 to 16 year olds who spend at least 2 hours per week on high quality sports/PE as opposed to 85.7% for England).

**Limiting Long Term Illness**

5.86 A limiting long-term illness is defined as any health problem or disability that restricts a person's daily activity and, if of working age, the work that they can perform. This can be in the form of either a physical or mental illness. It is estimated that in the United Kingdom stress related and mental health problems cost the economy £77 billion per year.

5.87 The 2001 census records that 19.7% (or roughly 1 in 5) of the districts population suffer from a limiting long-term illness. This is the second highest figure in the county, with only Thanet exceeding it with 21.7% and it compares with a Kent wide average of 16.4%. The national average figure is 17.3%. It should however be noted that the Census is based on self-certification and this may be different from the clinical definition.

5.88 Those people suffering from a limiting long-term illness are more likely on average to be older, less economically active, and in receipt of health related benefits than those people in good health.[13]

5.89 The most immediate impact on health service provision of a higher proportion of people with limiting long-term illness will be greater demand for regular access to primary care services to monitor and manage the condition. A pilot joint venture between the Eastern and Coastal Kent Primary Care Trust and Kent County Council known as telecare is being trialled as a way of assisting people with chronic long term conditions care for themselves in their homes.

**Adult Mortality**

5.90 The Standardised Mortality Ratio (SMR)[14] for the Dover District in 2001 was 93 deaths, which was slightly better than the national average for England and Wales of 100 deaths and the second best in the East Kent cluster behind Canterbury City Council with an SMR of 87. In Kent, only Swale Borough Council (SMR 104) and Dartford Borough Council (SMR 115) had levels worse than the national average and the best level was Sevenoaks District Council with an SMR of 82. The overall Kent average was an SMR of 94.

5.91 The single most common cause of death for ages in 2005 for the Eastern and Coastal Kent Primary Care Trust [15] area was malignant neoplasm's (more commonly known as cancer), affecting 1 in 4 people (26%). The remainder of the top five most common causes of death were Coronary Heart Disease (CHD) at 18%, diseases of the respiratory system at 16%, Stroke at 10% and circulatory diseases excluding

[13] SEPHO, '2001 Census Bulletin: Limiting Long Term Illness in South East England'
[14] It should be noted that this is a standardised figure to enable the Office for National Statistics to compare areas with different population sizes and compositions and not the actual number of deaths.
[15] Covering the districts of Ashford, Canterbury, Dover, Shepway, Swale, and Thanet.

heart disease and stroke, at 9%. In total, the top five causes of death accounted for 79% of all deaths in the Eastern and Coastal Kent Primary Care Trust area. These figures broadly reflect the national levels of mortality for England.

5.92 However, when causes of early deaths (people under the age of 75 years) are examined for the Eastern and Coastal Kent Primary Care Trust area, a slightly different pattern emerges. In this instance, although the top five causes of mortality are the same, the number of deaths due to cancer increases to 38% of all deaths with CHD next at 16% of all deaths. The number of strokes halves to 5% of all deaths. These figures again broadly reflect the national levels of mortality for England.

5.93 Overall, for the Dover District the levels of early mortality for cancer was slightly worse than the national average at 124.8 deaths per 100,000 population compared with 119.0 deaths per 100,000 population for England. In terms of CHD and Stroke combined, the district was slightly better than the national average at 88.8 deaths per 100,000 population compared with the figure for England of 90.5 deaths per 100,000.

**Life Expectancy**

5.94 In the early 1850's at the time the first Dover Hospital was built, the national average life expectancy for males and females was just over 40 years of age. As a result of improved housing, sanitation, and access to basic medical care in the later part of the 19th Century, average life expectancy had risen to 52.4 years for women and 48.5 years for men by 1901. In the century between 1901 and 2001, average life expectancy increased by approximately 56% for males and 53% for females.

5.95 The average life expectancy at birth for the district as a whole is slowly rising and stands 79.0 years of age (76.5 years for men and 81.5 years for women), which compares well with the Kent average life expectancy of 79.3 years of age (77.5 years and 81.5 years respectively) and the English average life expectancy of 78.9 years of age (76.9 years and 81.1 years respectively). [16]

5.96 However, while the district wide figures compare relatively well with the Kentish and English averages, when the figures are broken down to district ward level there are

[16] Office of National Statistics 2003 – 2005 Figures

significant and concerning variations. The lowest life expectancy at birth (both sexes) is to be found in the St Radigunds Ward with a figure of 74.0 years. This figure is also the third worst figure for any district ward in the Kent County Council area of 273 district wards, with only Cliftonville West Ward in Thanet (72.3 years) and Folkestone Harvey Central Ward in Shepway (72.8 years) experiencing a worse average life expectancy at birth.

5.97 This compares with the highest average life expectancy at birth in the district of 82.5 years (both sexes) in the St Margaret's-at-Cliffe Ward. [17] Countywide, the highest average life expectancy at birth is Ightham Ward in Tonbridge and Malling with 86.6 years. All West Kent authority areas show a higher district average life expectancy at birth.

5.98 For the Dover District, the resulting difference in average life expectancy at birth between the lowest ward, St Radigund's, and the highest ward, St Margaret's-at-Cliffe, is 8.5 years despite the two population centres being less than six kilometres apart. Given that this figure is based on an amalgamation of average male and female life expectancy, it is reasonable to assume that the average life expectancy at birth for a male child born in the St Radigunds Ward is slightly less than 74 years.

5.99 There are four District Wards with a life expectancy above the Kent average of 79.3 years:

- St Margaret's-at-Cliffe – 82.5 years;
- River – 81.8 years;
- Sandwich – 80.6 years;
- Walmer – 80.1 years.

5.100 There are five District Wards in the lowest 10% of average life expectancy in Kent, which is the third highest number of wards in a district after Shepway District Council and Thanet District Council with six wards each.

- St Radigunds – 74.0 years;
- Capel-le-Ferne – 74.6 years;

[17] Figures for period 1998 – 2002, The First Annual Report for Kent of the Director of Public Health 2006

- Tower Hamlets – 74.9 years;
- Lydden and Temple Ewell – 75.1 years;
- Castle – 75.2 years.

5.101 It is a target contained within the Kent Agreement 2 (the county's Local Area Agreement) that the current countywide average disparity of 6.5 years in life expectancy between the 20% of areas with highest life expectancy and the 20% of areas with the lowest life expectancy be reduced. [18]

5.102 In addition to life expectancy at birth, there is also a measure known as 'Healthy Life Expectancy at Birth', which measures the period on average when people are in overall good health and free from disability. For the Dover District as a whole this figure was 70.75 years, which was broken down was an average of 69.0 years for males and 72.5 years for females.

**An Ageing Population**

5.103 As of the early 1850's the District's population was just over 50,000 people, of which approximately 6% were over 65 years of age. Nationally, throughout the 19th Century the average percentage remained approximately 5% of total population. By the 2001 Census, the population of Dover had risen to 104,490 of which approximately 19% were over 65 years of age.[19] In certain wards (such as Castle and Walmer) this figure was even higher as a percentage of the total ward population. In comparison, nationally, 16% of the United Kingdom's population are aged over 65 years.

5.104 The United Kingdom's population is expected to see a significant growth in over 65 year olds between 2010 and 2020 as the post-war 'Baby Boomers' reach retirement age. In the next thirty years, nationally the number of octogenarians is expected to treble and the number of centenarians is expected to quintuple. By 2011, the mean average age of the United Kingdom's population is expected to exceed 40 years and by 2018 there will be more people aged over 40 years of age than under.

[18] Kent Agreement 2, NI120, Improved Health, Care and Well-Being Theme
[19] 'A Vision of Britain Through Time', Great Britain Historical GIS Project

5.105 The Government's Actuary Department (GAD) expects that by 2040, nearly 1 in 4 people in the UK will be aged 65 years or older. The lowest prediction from GAD is that 1 in 5 people will over 65 years of age.[20]

5.106 In the Dover District, how this figure will change will be influenced by several factors such as the eventual housing growth resulting from Local Development Framework (LDF), population migration, whether health policy is able to tackle the higher mortality rate in certain wards, and the number of people choosing to retire to the district from outside (coastal regions have disproportionately higher rates of retirees than inland urban areas).

5.107 Under the four options set out in the LDF Core Strategy, the number of people aged between 65 to 84 years of age could increase by between 51% (Option 1) to 61% (Option 4) by 2026 against the 2006 levels.[21] To put this into context, the overall population change proposed under the LDF ranges from a decrease of nearly 2% under Option 1 to an increase of 14% under Option 4 by 2026.

5.108 The Eastern and Coastal Kent Primary Care Trust is predicting that the districts of Dover, Shepway, and Thanet will all have, as a percentage of the total population, a figure of over 65 year olds in excess of that predicted nationally. When the predictions of the LDF and GAD are considered together, it is not unreasonable to suggest a figure of at least 30% of the districts population being over 65 years of age by 2026.

5.109 The overall impact of having a high percentage of people over 65 years of age will be an increase on the number of people with mild to moderate health problems in most cases, although the number of people with severe disabilities will also see a smaller increase. In addition, across the South East as a whole women aged over 65 years of age have significantly higher hospitalisation rates for dementia than elsewhere in England.

5.110 There are also social problems associated with people over the age of 65 years that will need to be tackled. It is estimate that nationally, approximately thirty percent of people aged over 65 years of age do not see any friends at least once a week and 1

[20] Shaw, C. 'United Kingdom population trends in the 21st Century'
[21] Local Development Framework Core Strategy, Page 36, Figure 4.10

in 6 people aged over 65 years are affected by depression. In addition, increased longevity for people with learning disabilities is increasing the number of very elderly parents who are responsible for their care.

5.111 In terms of health care provision, people aged over 65 years of age already incur a greater per capita expenditure on health services and this is not expected to change. What will change is the volume of expenditure required for the district to meet the greater per capita expenditure. In specific terms this is most likely to result in increased pressure on capacity for in-patient and intermediary care beds with as a consequence a greater chance of bed blocking occurring; increased use of primary care services (including for winter influenza vaccinations) and social services; more resources for Coronary Heart Disease, Strokes and Cancer services which are all significant causes of mortality; and increased demand for geriatric services.

5.112 A key component in tackling the health implications of an aging population is the concept of 'active aging'.[22] This is achieved through promoting healthy living, encouraging active citizenship and community involvement to combat social exclusion; developing local services to support healthy living and promote independence; and encouraging older workers to remain in productive employment. Studies have shown that those individuals in employment tend to be less likely to suffer from social exclusion or mental health problems than people not in employment.

## Health Inequalities

5.113 The three main health inequalities for the Dover District were mental health problems, obesity, and diabetes.[23] As the paragraphs below will show, there is a strong link between these three areas, the consequences of an aging population and lower life expectancy.

### Mental Health Problems

5.114 The Eastern and Coastal Kent Primary Care Trust define mental health services as those services that "support people who have conditions that affect their feelings and

[22] Opportunity Age, the national strategy for older people.
[23] Dover Health Profile 2007

behaviour".[24]. In providing care for people with mental health problems, there is a significant level of partnership working been the NHS and Kent County Council Social Services through the Kent and Medway NHS and Social Care Partnership Trust.

5.115 In the United Kingdom only 21% of those with long-term mental illnesses are in employment, which is the lowest level for any disability group.[25] This is particularly relevant as studies have shown that being in employment protects people's mental well-being.

5.116 The South East Public Health Observatory (SEPHO) places the level of mental health problems in the Dover District Council as 28.9 people per 1,000 people of working age. This compares to the average for England of 27.4 people per 1,000 people of working age. It should however be noted that this is an estimate based on the number of people claiming benefits for mental or behavioural disorders.

5.117 Mental Health services cover a diverse range of conditions from patients who are able to manage their conditions in the home to those staying as in-patients at mental health hospitals such as St Martin's Hospital, Canterbury or those who have to be detained in a secure unit under the provisions of the Mental Health Act. It should also be remembered that people with mental health problems might also suffer from long-term physical illnesses.

5.118 An important area of mental health and social service interaction applies to conditions such as dementia, which without adequate support in the home environment can lead to reduced quality of life through unnecessarily prolonged hospital stays, and inappropriate admission to acute mental health hospital facilities or long term residential care.

**Obesity**

5.119 It is the view of the Department of Health that the significant changes in lifestyle that occurred in the post-war years are a key factor in explaining the rising levels of obesity in England. Although there are other factors such as genetics, physical

[24] Page 10, 'Creating an NHS Fit for the Future', Summer 2007 Update
[25] The South East England Health Strategy

environment, health, and culture that are influencing factors, diet and activity are a clearly identifiable cause in the majority of cases.

5.120 The Department of Health estimates that two thirds of adults and one third of children are either overweight or obese as defined by the Body Mass Index and by 2050 this level could rise to nine in ten adults and two thirds of all children unless action is taken to reverse the trend.

5.121 The clinical definition of obesity is an individual with a Body Mass Index (BMI) in excess of 30. The BMI level is calculated as follows: [26]

$$\frac{\textbf{(Weight} \div \textbf{Height)}}{\textbf{Height}} = \textbf{BMI}$$

5.122 For example, if Person A weighed 70 kilograms and was 1.75 metres tall, then their BMI would be calculated as 70 divided 1.75 equals 40, and 40 divided by 1.75 equals a BMI of 22.9. There are numerous websites that will do this calculation for you.

5.123 A BMI between 18.5 and 24.9 would indicate a person was of an ideal weight. A BMI below 18.5 would indicate someone was underweight and a BMI between 25 and 29.9 would be overweight. A BMI over 30 is classified as obese and over 40 as very obese. NHS Direct recommend that any individual with a BMI between 25 and 30 consider making changes to their lifestyle to reduce weight or risk an increased risk health problems. In the cases of a BMI in excess of 30, NHS Direct recommend immediate lifestyle changes.

5.124 The South East Public Health Observatory (SEPHO) places the level of obesity in the Dover District Council as 24.0% of adults. However, it is important to remember that this figure is a synthetic estimate based on the results of the Health Survey for England and as such is on only approximation of the true level. The Health Survey for England estimates that the national level of Obesity is 21.8% of adults. In comparative terms, the World Health Organisation[27] estimates that 300 million people worldwide are obese, with the highest levels in nations such as Scotland (25.5%), the

[26] 'What is the Body Mass Index', NHS Direct

United States of America (32.2%), and Australia (26%). However, these figures are based on estimates and recent studies have shown that Australia may actually have the highest level of obesity in the world. [28]

5.125 Studies have shown that those individuals who are classified as clinically obese have double the chance of being affected by illnesses such as diabetes; arthritis; certain types of malignant neoplasm's; coronary heart disease; and asthma. There is also an increased prevalence of chronic musculoskeletal problems, skin disease, and infertility. It should however be noted that many of these illnesses all impact on an individuals ability to exercise which in turn can lead to a cycle of potential weight gain.

5.126 The solution in most cases to the problem of obesity is in essence, a mathematical one. If people reduced the quantity, and improved the quality, of the food they consumed (the "energy in") while balancing this with regular exercise (the "energy out"), they will be able to control their weight more effectively and reduce the chance of becoming obese.

5.127 Education is a key tool in tackling obesity and changing the lifestyles of families and individuals. An important part of this is in changing attitudes in the home environment as shown by a recent study undertaken by the National Centre for Social Research, which found that only three percent of obese children had parents who were not overweight or obese, themselves. When surveyed, the parents of obese children tended to overestimate their children's physical activity levels and underestimate the volume of high fat, high sugar foods consumed. [29]

**Diabetes**

5.128 The South East Public Health Observatory (SEPHO) places the level of diabetes in the Dover District Council as 3.9% of adults. This compares with an average level for England of 3.7% of adults.

[27] 'Global Strategy on Diet, Physical Activity and Health', World Health Organisation
[28] The Times Online, 20 June 2008
[29] 'Healthy Weight, Healthy Lives: A Cross-Government Strategy for England'

5.129 Diabetes is "a chronic condition caused by too much glucose (sugar) in your blood"[30] which is usually a result of the pancreas not producing sufficient (or any) quantities of the hormone insulin (Type 1) or the cells in your body not reacting correctly to the presence of insulin (Type 2). If it is not treated diabetes can cause damage to blood vessels and lead to arterial diseases.

5.130 In the case of Type 1 diabetes, which is an autoimmune disease, patients with this type need treatment for the rest of their life and they must check the levels of glucose in their blood regularly and monitor for complications. Patients with Type 1 diabetes will be required to take insulin for the rest of their lives. Type 1 is also known as juvenile diabetes, or early onset diabetes because it usually develops before the age of 40, often in their teenage years.

5.131 In the case of Type 2 diabetes, which is known as insulin resistant or non-insulin dependent diabetes, there is a strong link with obesity. For Type 2 diabetes, treatment is through a combination of diet, exercise, and blood glucose controlling medication. It is sometimes referred to as maturity onset diabetes because it occurs mostly in people over the age of 40. Given that the district has above national average levels of obesity, it is a logical conclusion that this is a significant factor in the district having above national average levels of diabetes. If the problem of obesity is not tackled, the level of diabetes in the district will continue to rise.

5.132 The health consequences of diabetes are increased risk of suffering from a cardiovascular disease; increased mortality rates; diabetic eye disease; renal disease; neuropathy and diabetic foot problems; and depression.

**(a) Health Consequences of Diabetes – Cardiovascular Disease**

5.133 Studies have shown that people with diabetes are between two and four times more likely to have a cardiovascular disease and this accounts for the majority of the increased mortality rate associated with diabetes. Studies suggest that 50% of diabetics die from cardiovascular diseases. [31]

[30] NHS Direct Health Encyclopaedia
[31] BMJ Health Intelligence, 2007

### (b) Health Consequences of Diabetes – Premature Mortality

5.134 Males suffering from diabetes are also more likely to experience reduced life expectancy, although there is no conclusive evidence in respect of the impact of diabetes on female life expectancy. [32] A person diagnosed with Type 2 diabetes at the forty years of age could potentially face a reduction of eight years in their life expectancy. It is difficult to accurately predict the number of deaths attributable to diabetes as death certificates usually refer only to the cause of mortality (for example heart attack) and don't list that the patient was also diabetic. However, studies in the UK estimate that approximately 7% of all deaths in 2007 were attributable to diabetes.

### (c) Health Consequences of Diabetes – Eye Disease

5.135 In the developed world, diabetes is the number one cause of blindness in adults aged over 25 years of age.[33] The majority of patients with Type 1 will have diabetic retinopathy twenty years of diagnosis. In Type 2 diabetes, the level is between forty and sixty percent of patients. Diabetes also increases the risk of glaucoma and cataracts.

### (d) Health Consequences of Diabetes – Renal Disease

5.136 Arterial degradation can lead to diabetic renal disease through blockages to small blood vessels in the kidney and is the single biggest cause of renal failure in developed countries. It is estimated to affect 1 in 10 Type 1 diabetics and 1 in 7 Type 2 diabetics to varying degrees.

### (e) Health Consequences of Diabetes – Neuropathy and Diabetic Foot Problems

5.137 Diabetes can cause damage to the peripheral and autonomic nerves, which in turn can affect digestion, heart and blood pressure, urination, peripheral sensation and musculature. Damage to the peripheral nerves of the foot can lead to the development of foot ulcers in approximately 10 to 15% of diabetics and in up to 15%

[32] BMJ Health Intelligence, 2007
[33] Klein R, Klein BE. Vision disorders in diabetes. In: National Diabetes Data Group, eds. Diabetes in America. 2nd ed. Bethesda, MD: National Institutes of Health, 1995:293-338.

of cases this in turn can lead to amputation. In the developed world, diabetes is the single biggest cause of non-traumatic lower limb amputation. Regular visits to chiropodists/podiatrists are recommended to ensure that any problems are found in the early stages.

### (f) Health Consequences of Diabetes – Depression

5.138 Studies have shown that people suffering from Type 2 diabetes have a significantly greater chance of suffering from depression than people without diabetes. The occurrence rate is nearly 1 in 5 compared to approximately 1 in 10 for non-diabetics. This usually manifests as poorer self-care, which in turn leads to further health complications arising from poor health management.

## Historical Hospital Provision in Dover

5.139 Prior to Buckland Hospital there have been three other hospitals in Dover since the early 1820's.

### (a) The Dover Dispensary

5.140 A charitable organisation, the Dover Dispensary, opened in 1823 for the purpose of assisting "*all persons in sickness, really necessitous and not receiving Parish relief, being properly recommended, whether resident in Dover or the neighbouring villages".*[34] The Dover Dispensary dealt with a limited range of conditions and had defined admission criteria as to the types of patient it would accommodate. It would continue operating until its incorporation into the Dover Hospital in the 1850's.

### (b) The Royal Victoria Hospital

5.141 The first hospital in Dover, known originally as the Dover Hospital and from 1902 as the Royal Victoria Hospital, was based in a converted private residence known as Brook House located on the High Street. It was opened on 1st May 1851 following a campaign of public subscription to raise funds, and the building was further expanded over the remainder of the 19th Century with new wings added. The hospital finally

[34] 'The Annual Report of the Committee of the Dover Dispensary" (1829), www.dover.freeuk.com

closed in May 1987 as a result of the transfer of services to Buckland Hospital and it was converted for residential use.

**(c) Dover Isolation Hospital**

5.142 In addition to the Royal Victoria Hospital, there was also an infectious diseases hospital known as the Dover Isolation Hospital, which was a former cottage hospital leased by Dover Borough Council in 1872. The Borough Council purchased the hospital in 1894 and the building was extensively reconstructed in 1928. In 1948, geriatric services were added. However, its services would be transferred to the Buckland Hospital upon its closure in September 1974.

**(d) Buckland Hospital**

5.143 The building that would become Buckland Hospital was built in 1836 as the Dover Union Workhouse, for the poor people of Dover. By 1930, responsibility for the poor of Dover had passed to Kent County Council (KCC) and the building was known as the Dover Institution. During the Second World War, the building was used as a casualty hospital before being renamed the County Hospital in 1943 when it was taken over by Kent County Council's Public Health Department.

5.144 The creation of the National Health Service (NHS) led to the renaming of the County Hospital to Buckland Hospital in 1948. In the mid-1950's parts of the building underwent modernisation to create the Ramsay and Churchill Wards. By the late 1980's, Buckland Hospital was the sole NHS hospital in the town with the closure of the Royal Victoria Hospital and the Dover Isolation Hospital.

5.145 The early 1990's saw Buckland Hospital lose its acute services, with the closure of its Accident and Emergency Unit and the gradual transfer of the remaining acute medicine and surgical services to the William Harvey Hospital at Ashford and the Queen Elizabeth the Queen Mother (QEQM) Hospital at Thanet.

5.146 The timeline for the changes in service provision at Buckland Hospital has been as follows:

- 1991 Accident & Emergency Unit changes to a Minor Injuries Unit

- 1995 Closure of the Dunkirk Ward
- 2001 Closure of the cardiac ward and Churchill Ward
  Temporary establishment of Neuro-rehabilitation Ward
- 2005 Day Surgery ceases
- 2006 Closure of Ramsey Ward, pharmacy and the mortuary
  Suspension of endoscopy service for clinical governance reasons
  Closure of Hospital Radio Service
- 2007 Montgomery Ward closure

5.147 The closure of the Montgomery Ward in Summer 2007, three months ahead of schedule, meant that there were would no longer be any long stay in-patient care beds remaining in Buckland Hospital, with the exception of the temporary Neuro-Rehabilitation beds. The reason given for the closure of the Montgomery Ward was that it was no longer fit for purpose and had been superseded by community-based forms of intermediate care.

## Current Hospital Provision in Dover

5.148 As of June 2008, Buckland Hospital provides a Minor Injury Unit, the Dunkirk Renal Satellite Unit, the Dover Family Birthing Centre, outpatient services, and the Neuro-rehabilitation unit. Only two of these have inpatient services at Buckland Hospital. There are ten low risk maternity beds at the Birthing Unit and twenty-two inpatient beds at the East Kent Neuro-rehabilitation unit.

5.149 Those patients requiring emergency medical care or acute medical services who are resident in the Dover District are required to travel to the one of the East Kent acute hospitals based in either Ashford and Thanet.

### The Minor Injury Unit

5.150 The Minor Injury Unit is open from 9.00am to 8.00pm everyday except for Christmas Day and Boxing Day. In addition, South East Health Ltd operates an Out-of-Hours (OOH) primary care service from the Minor Injury Unit between 6.30pm and 8.00am. It is operated by experienced nurse practitioners, although there is an on-call General Practitioner who may be called upon as required. The Minor Injuries Unit can provide treatments such as dressing and stitching minor wounds, removing foreign bodies

from ears and nose and treating minor burns. In the event of an emergency care case presenting his or herself to a Minor Injury Unit, an ambulance will be summoned for the patient.

**Dover Family Birthing Centre**

5.151 The Dover Family Birthing Centre is an award winning midwifery led unit that deals with low risk births. Higher risk births are dealt with at the William Harvey, Queen Elizabeth The Queen Mother and the Kent and Canterbury Hospitals where full obstetric services and special care baby units are located.

5.152 The centre deals with an average number of 370 births per year, with the majority of the women using the birthing centre drawn from Dover, Deal, and Folkestone. A very small number of women travel from Ashford and Thanet, as most women prefer to give birth locally at the acute hospitals in those towns.

5.153 The Dover Family Birthing Unit provides one-on-one midwifery care during labour, which reduces the need for clinical intervention, which in turn reduces the cost of the birthing process. The Unit is staffed 24 hours a day by core midwives, nursery and auxiliary nurses and was converted to a midwifery led unit in 1999 on the back of concerns that the previous consultant led unit lacked the required training and experience.

5.154 As the centre only deals with 'low risk' births, it operates in a less clinical environment than that at the acute hospitals and there are no restrictions on visitors. There are three birthing pools and ten short stay maternity beds in the unit. The unit also operated parent education sessions, 'drop in' coffee mornings, and an aromatherapy service.

**Dunkirk Renal Satellite Unit**

5.155 The Dunkirk Renal Satellite Unit is one of six haemodialysis units in East and West Kent operated by the Kent and Canterbury Hospital renal unit. The unit, which is based in the old Dunkirk Ward, cost £1 million and has ten dialysis stations, two barrier rooms, consultation rooms, and a waiting area. Each unit is supervised by

Consultant Nephrologists or Associate specialists and supported by a Unit Manager with registered nurses and dialysis assistants.

**East Kent Neuro-rehabilitation Unit**

5.156 The East Kent Neuro-rehabilitation Unit provides a co-ordinated multi-disciplinary rehabilitation service for people with Epilepsy, Multiple Sclerosis (MS), Motor Neurone Disease (MND), Parkinson Disease (PD) or suffering from a traumatic brain injury.

5.157 The unit acts as an intermediary stage in the treatment pathway between a specialist unit such as Kings College Hospital, London and the patient returning home (with or without ongoing support).

5.158 It was established at Buckland Hospital in 2001, as there was insufficient space available to accommodate it at the preferred location of the Kent and Canterbury Hospital. In November 2007, following a consultation exercise in early 2007, the Eastern and Coastal Kent Primary Care Trust and the East Kent Hospitals Trust agreed that the Neuro-Rehabilitation Unit would be relocated to the Harvey Ward at the Kent and Canterbury Hospital once the necessary upgrade work had been undertaken.

5.159 The decision to relocate the service to the KCH was supported by the results of a consultation undertaken between 14 February and 30 March 2007. There were 1200 consultation documents produced which were targeted to past and current neuro-rehabilitation patients, staff and supporting voluntary and community organisations.

5.160 Question Four of the consultation asked if:

"The neuro-rehabilitation unit, currently based in Dover, provides an East Kent wide service. If, in order to improve the service, the unit needs to be moved from Dover to a different location in East Kent how would you feel about this?"

The result was that 57% (102 respondents) would support such a move if it improved the service.

**Outpatient Services**

5.161 Buckland Hospital provides the following clinics on an outpatient basis:

- Rheumatology clinics
- Paediatrics (Carousel Ward)
- Orthodontics
- Dunkirk Renal Satellite Unit
- Children and Adult Mental Health Service (CAMHS)
- Clinical Haematology Services
- Lymphoedema Services
- Cardiology
- Dermatology
- General Gynaecology
- Colposcopy
- Specialist MS Clinic
- Obstetrics (antenatal services)
- Phlebotomy
- Radiology
- Respiratory

5.162 The Scrutiny (Community and Regeneration) Committee conducted a site visit to Buckland Hospital on Tuesday 11 September 2007 at 10.00 am.

**The Victoria Hospital, Deal**

5.163 In addition to the hospitals in Dover, there has also been hospital provision in Deal since the late 19th Century. As with Dover, a similar pattern of hospital provision emerged from the voluntary sector with the founding of the Deal and Walmer Provident Dispensary in 1862. This would become the Deal and Walmer Provident Dispensary and Victoria Cottage Hospital in 1898.

5.164 The Deal Walmer and District War Memorial Hospital was officially opened in 1924 as a permanent memorial to those who had lost their lives in World War One.

5.165 The Victoria Hospital currently has six outpatient rooms, 36 intermediary care beds, and a minor injury unit. It provides hospital outpatient clinics for:

- Dermatology
- Diabetes
- General Gynaecology
- Obstetrics (general antenatal)
- Radiology
- Respiratory
- Rheumatology

5.166 There are no proposals for reductions in service provision at Victoria Hospital and comments contained in Inquiry Report 9, suggests the possibility that services may even be expanded in the future due to the work of the Deal, Ash and Sandwich (DASH) Practice Based Commissioning consortium.

5.167 The Scrutiny (Community and Regeneration) Committee conducted a site visit to the Victoria Hospital, Deal on Monday 16 June 2008, where it was shown the minor injuries unit, outpatient clinics, and intermediary care beds.

## FUTURE HEALTH SERVICE PROVISION IN THE DOVER DISTRICT

### The Dover Project

5.168 This Dover Project consultation formed the first phase in the development of future service provision. The second phase in the process is currently being concluded by the Practice Based Commissioning Consortia, which will determine the final range of services to be approved in August 2008.

5.169 The Dover Project was a twelve weeks consultation on health and social care services and was undertaken between 16 June to 8 September 2006 by the East Kent NHS Trusts and used as the basis upon which to make recommendations from which to develop models of service provision for eleven service areas that did not have to based in an acute hospital setting.

5.170 A multi-agency steering group was set up under the chairmanship of the Primary Care Trust which met monthly to oversee the consultation process and the implementation of the project. In addition to the East Kent NHS Trusts, the steering group had representatives from the Public and Patient Involvement Forum's (PPIF) for the two NHS Trusts, Kent County Council, Dover District Council, and Dover Pride.

5.171 The basis underpinning the consultation was that patients in many cases were travelling unacceptable distances for certain diagnostic services and treatments that could be provided closer to the local community.

5.172 The seven core principles of the consultation were:

- Improved outcomes for local people
- Improved access to primary care services for our population
- Integrated services with primary care, social services and other partners
- Services which are driven by the needs of local people
- Improved opportunities for staff development
- Safe and sustainable services
- Services that can be implemented and continued within the Trusts resources

5.173 Prior to undertaking the consultation, the Trusts held discussions with NHS professional staff, members of the Patient's Forum, the KCC Health Overview and Scrutiny Committee and other local interested people. The Dover Citizens Panel was also contacted. The outcome of these initial discussions were as follows:

- That people did not want to travel too far for outpatient appointments
- Services such as blood testing should be provided as locally as possible
- A central, accessible location for the most common treatments is essential
- Parking must be a consideration when looking at the location of service provision
- Transport issues are important to most people
- A minor injuries unit must have proximity to X-Ray
- People understand the necessity to travel for acute and specialist treatment but do not want to travel for primary care
- The location of services is not as important as accessibility

- It is not always essential to see the same consultant all the time, sometimes seeing someone locally is more important.

5.174 The eleven service areas in the consultation contained a summary of the particular service and then set out a range of alternative models of care. These were care of the elderly; GP Services; Dental Services; Pharmacy Services; Optician Services; Minor Injuries; Outpatient Services; children's services in the community; children's day ward services; midwifery services; and improving health and well-being.

5.175 The consultation document was produced in two versions – a twenty-page full consultation document and an eight page summary document. These were distributed through GP surgeries, Buckland Hospital, Dover Library, Dover Town Council (given one thousand documents to distribute at their request), public events such as the Buckland Hospital fete, road shows, and public meetings. In addition, patients using services at either Buckland Hospital or the Dover Health Centre were offered copies at their appointments.

5.176 In total, 20,000 copies of the summary document were printed, of which 19,500 were distributed, and 5,000 copies of the full document were printed, of which 4,800 were distributed. This amounted to a total of 24,300 consultation documents distributed. To put this into context the total population of the urban Dover area (Maxton, Elms Vale and Priory; Castle; Tower Hamlets; Town and Pier; St Radigunds; Buckland; and River) is 32,598 (or 25,699 people[35] over the age of sixteen years of age).

5.177 In total there were 888 responses (3.65%) received to the consultation, although not all respondents commented on all of the eleven service areas.

5.178 The consultation options were based on 'forced choices' of practical alternative models (including a no change option) and did not offer options considered impractical such as restoring full acute services to Buckland Hospital. This is not unusual for a consultation exercise as it prevents unrealistic expectations being developed by the consultees and ensures that any data collected is a meaningful expression of public choice. To assist people in visualising the proposals there were examples of the patient experience provided for each option.

[35] Census 2001, Office for National Statistics (ONS)

5.179 In total, out of the eleven services in the consultation, six services had one option, which garnered 50% or more of consultee's votes. None of these six options advocated a reduction in service and four advocated an expansion of the service.

5.180 However, it should be noted that in four cases the steering group advocated a model of care for development that was either a variation on the consultation options, an entirely new option or a different option from the one that received the most favourable consultation response. The Scrutiny (Community and Regeneration) Committee addressed this decision in greater detail in Inquiry Reports 2 and 3.

**Model A: Care of the Elderly – Intermediate Care**

5.181 At the time the consultation took place, there were three settings for intermediate care operating in Dover. The first was home based, with patients returning to their own homes after treatment with support provided by the Dover based community intermediate care team.

5.182 The second was in a hospital setting following transfer from one of the acute hospitals after the completion of the patient's main treatment. Although when the consultation was undertaken, there were intermediate care beds in both Dover and Deal hospitals, as of 2008 intermediate care beds in a hospital setting in the district is only provided at the Victoria Hospital, Deal.

5.183 The third was in partnership with adult social care homes at Alexander House and Cornfields, where designated intermediary care beds were located for the purpose of providing recuperation and rehabilitation for people until they had recovered to the level where they were able to return home.

5.184 There were three alternative future models of care set out in the consultation for people to comment upon. A total of 735 responses were received as part of the consultation. The result of the consultation was as follows:

***Table 1: Consultation Results – Care of the Elderly***

| Model | Description | Response |
|---|---|---|
| **A1** | Expand intermediate care services provided in a community setting, including local intermediate care beds which can be accessed according to need, and reduce the hospital based service. | 367 (50%) |
| **A2** | Make no changes to community intermediate care but remove inpatient beds from Dover and provide intermediate care beds on the acute hospital sites at Canterbury, Ashford and Margate. | 23 (3%) |
| **A3** | Keep providing care the way it is at the moment as described above. | 345 (47%) |

5.185 The appraisal team that evaluated the responses to the alternative models of care consisted of members of the Dover Adults Strategic Partnership, a consultant geriatrician from Buckland Hospital and staff from the Eastern and Coastal Kent Primary Care Trust.

5.186 In considering the final model of care to be progressed, consideration was given to Department of Health guidance and the impact on local service development and provision. The decision to reject the location of in-patient intermediate care beds in acute hospitals was based on concerns that the rehabilitation process can be protracted and inhibited in a hospital setting.

5.187 A recommendation was made by the Dover Project Steering Group that model of care **A1** should be adopted, which was in accordance with the preferences indicated in the consultation.

**Model B: General Practitioner Services**

5.188 At the time the consultation took place there were 30 General Practitioners (GPs) providing primary care from nine practices in Dover. Although all provided the same core services, so practices provided additional services such as physiotherapy or minor surgery.

5.189 For the period 2001 to 2004, the Dover District had seen a reduction in the number of emergency (acute) hospital admissions for chronic conditions usually managed by a primary care provider (General Practitioner) from 163.4 admissions (age standardised) per 100,000 people to 147.6 admissions per 100,000 people.

5.190 This figure was the second lowest for the six authorities covered by the Eastern and Coastal Kent Primary Care Trust, with only Ashford lower at 137.8 admissions per 100,000 people. It is also fewer than the average for the Kent and Medway Strategic Health Authority area (165.5 admissions per 100,000 people) and significantly fewer than the average for England (183.7 admissions per 100,000 people). [36] This high standard of chronic illness management provided through primary care providers in the district seems to be supported through the results of the consultation with 1 in 4 respondents satisfied with the existing GP service provision.

5.191 There were five alternative future models of care set out in the consultation for people to comment upon. A total of 740 responses were received as part of the consultation. The result of the consultation was as follows:

***Table 2: Consultation Results – General Practitioner Services***

| Model | Description | Response |
|---|---|---|
| **B1** | Keep GP Practice based services as they are and also provide a broader range of services delivered in the practice. | 261 (35%) |
| **B2** | Keep GP Practice based services and also provide a broader range of services delivered from a different single central Dover location. | 131 (17%) |
| **B3** | Move all GP practices to a central Dover location so that they are based next to specialist services. | 41 (6%) |
| **B4** | Keep GP practice based services and also provide a broader range of services in community facilities such as children's centres, pharmacies, and extra care sheltered housing. | 117 (16%) |
| **B5** | Keep GP services as they are. | 190 (26%) |

[36] Page 74, The First Annual Report for Kent of the Director of Public Health 2006 – Reference Document

5.192 The appraisal team that evaluated the responses to the alternative models of care consisted of members of the PCT's Primary Care Sub Group and the views of local GPs were also sought.

5.193 In considering the final model of care to be progressed, consideration was given to the emerging Practice Based Commissioning consortia's in Dover and the need for additional funding should existing GP Practices have to be expanded to accommodate new services.

5.194 A recommendation was made by the Dover Project Steering Group that model of care **B1** be adopted, which was in accordance with the preference indicated in the consultation.

**Model C: Dental Services**

5.195 At the time the consultation took place there were nine NHS dentists working in five practices in Dover that provided regular dental services for patients and the two Dental Access Centres located in Deal and Dover that provided one off treatments for patients who didn't have a regular dentist. The emergency out-of-hours provision was located at the Kent and Canterbury Hospital and the QEQM.

5.196 There were three alternative future models of care set out in the consultation for people to comment upon. A total of 708 responses were received as part of the consultation. The result of the consultation was as follows:

***Table 3: Consultation Results – Dental Services***

| Model | Description | Response |
|---|---|---|
| **C1** | An increase in the regular dental provision and a reduction in the dental access service. | 184 (26%) |
| **C2** | An increase in the dental access service and maintenance of current regular dental provision. | 277 (39%) |
| **C3** | Keep the balance between a regular dental provision and the dental access services as it is now. | 247 (34%) |

5.197 The appraisal team that evaluated the responses to the alternative models of care consisted of members of the PCT's Primary Care Sub Group.

5.198 In considering the final model of care to be progressed, the perception of the appraisal team was that local people who were struggling to find an NHS dentist due to a shortage of provision had opted for model C2 on the basis "*that increasing the [dental] access service…[would] provide a greater opportunity to access NHS dental care*". [37]

5.199 There was concern expressed by the appraisal group that the dental access service existed to treat people in acute pain and provide one off courses of treatment and that the consequences of a significant increase in demand or changes to the pattern of use to less out-of-hours provision would have significant resource implications. The alternative option of expanding local NHS dental provision to meet demand was seen as the most efficient solution.

5.200 In light of the above, a recommendation was made by the Dover Project Steering Group that the model of care to be adopted would be a variation on Option C3 as follows:

**"Keep the balance between regular dental provision and the dental access services as it is now and provide an increase in overall provision with an emphasis on regular dental care".**

5.201 Inquiry Report 2 sets out in further detail the rationale behind the decision of the PCT to adopt a variant Option C3.

**Model D: Pharmacy Services**

5.202 At the time the consultation took place there were five pharmacies in the Dover area. All provided core services around the dispensing of medicines prescribed by patients GPs while some provided additional services such as smoking cessation counselling and advice or treatment for minor injuries.

[37] Page 18, The Dover Project – Report and recommendations from the consultation phase, East Kent Coastal Teaching Primary Care Trust

5.203 There were two alternative future models of care set out in the consultation for people to comment upon. A total of 734 responses were received as part of the consultation. The result of the consultation was as follows:

***Table 4: Consultation Results – Pharmacy Services***

| Model | Description | Response |
|---|---|---|
| **D1** | Expand the service provided by pharmacies to include services such as health care checks and addition 'over the counter' advice from the pharmacist. | 422 (57%) |
| **D2** | Keep pharmacy services as they are at the moment. | 312 (43%) |

5.204 The appraisal team that evaluated the responses to the alternative models of care consisted of members of the PCT's Primary Care Sub Group who consulted local pharmacists through a workshop held during the consultation period.

5.205 In considering the final model of care to be progressed, consideration was given to the fact that pharmacies wanted to expand the number of services on offer and had historically always offered a variety of additional services in order to remain competitive in the marketplace. In order for model D1 to be progressed there would need to be a resolution of issues relating to patient record management and an assessment of the financial impact of any additional provision, such as the provision of separate consulting rooms.

5.206 The advantages of enhancing the services provided through pharmacies were that it would relieve pressure on GP's; provide patients with greater choice and increased access; develop pharmacist's clinical skills; and integrate pharmacists into the wider primary care team.

5.207 The disadvantages of enhancing the services provided through pharmacies, was that they had no access to the patients clinical history; danger of pharmacists 'cherry picking' the most profitable services from GP Practices and weakening their financial positions; and issues with the reconciliation of payments to GP Practices.

5.208 A recommendation was made by the Dover Project Steering Group that model of care **D1** be adopted, which was in accordance with the preference indicated in the consultation.

**Model E: Optician Services**

5.209 At the time the consultation took place there were five opticians in Dover. There were two alternative future models of care set out in the consultation for people to comment upon. A total of 733 responses were received as part of the consultation. The result of the consultation was as follows:

***Table 5: Consultation Results – Optician Services***

| Model | Description | Response |
|---|---|---|
| **E1** | Expand services provided by opticians to include services such as health care checks and health promotion advice. | 283 (39%) |
| **E2** | Keep providing optician services the way they are at the moment. | 450 (61%) |

5.210 The appraisal team that evaluated the responses to the alternative models of care consisted of members of the PCT's Primary Care Sub Group and the views of local opticians were sought as part of the consultation process.

5.211 In considering the final model of care to be progressed, consideration was given to the potential for optometrists to provide additional services in addition to the diagnostic services provided for diabetes and glaucoma. At the time of the consultation, a new national contract for NHS Optometry Services was expected and it was agreed that no changes to the model of care would be proposed until there had been chance to analyse the provisions of the contract.

5.212 A recommendation was made by the Dover Project Steering Group that model of care **E2** be adopted, which was in accordance with the overwhelming preference indicated during the consultation by both members of the public and opticians.

**Model F: Minor Injuries Unit**

5.213 The Minor Injuries Unit (MIU) deals with a wide range of non-life threatening conditions that can be dealt with by a nursing led unit.

5.214 There were four alternative future models of care set out in the consultation for people to comment upon. A total of 729 responses were received as part of the consultation. The results of the consultation was as follows:

***Table 6: Consultation Results – Minor Injuries Unit***

| Model | Description | Response |
|---|---|---|
| **F1** | Develop a walk-in centre in central Dover offering a comprehensive rang of services including minor injuries and minor illness. | 358 (49%) |
| **F2** | Integrate the minor injuries and minor illness service into other services such as GPs and pharmacies. | 32 (4%) |
| **F3** | Move the minor injuries service to A&E in Ashford and Margate and provide support from the Minor Injuries Unit in Deal and the Emergency Care Centre in Canterbury and the Walk-In Centre at Folkestone. | 1 (0%) |
| **F4** | Keep providing minor injuries care the way it is provided at the moment. | 338 (47%) |

5.215 The appraisal team that evaluated the responses to the alternative models of care consisted of Minor Injuries Unit service managers and staff.

5.216 In considering the final model of care to be progressed, consideration was given to the opportunities for health promotion and referrals to other local services such as family planning clinics that would be possible through an expanded service and the resource implications that would accompany any expanded service.

5.217 A recommendation was made by the Dover Project Steering Group that model of care **F1** be adopted, which was in accordance with the preference indicated during the consultation.

**Model G: Outpatient Services**

5.218 Buckland Hospital provides outpatient services for the people of Dover and the surrounding areas. A full list of currently provided outpatient services available at Buckland Hospital can be found under paragraph 5.161.

5.219 There were three alternative future models of care set out in the consultation for people to comment upon. A total of 726 responses were received as part of the consultation. The results of the consultation was as follows:

***Table 7: Consultation Results – Outpatient Services***

| Model | Description | Response |
|---|---|---|
| **G1** | More outpatient clinic appointments as close to home as possible – e.g. in a GP Surgery or central Dover location. | 451 (62%) |
| **G2** | More outpatient clinic appointments in an acute hospital – e.g. Ashford, Canterbury or Thanet. | 36 (5%) |
| **G3** | Keep the existing balance of outpatient appointments in Dover and elsewhere. | 239 (33%) |

5.220 The appraisal team that evaluated the responses to the alternative models of care consisted of managers and staff from the outpatient's services at the East Kent Hospital Trust. In addition, a questionnaire was given to 76 outpatients attending the outpatient department of Buckland Hospital and the results of this reflected the wider consultation with option G1 emerging as the preferred option.

5.221 In contrast to this, the appraisal team favoured option G3 to keep the balance as it was between outpatient appointments at the acute hospitals and Buckland Hospital. This view was reached on the basis that there was insufficient capacity available to expand the outpatient service at either Buckland Hospital or local GP surgeries and that any reduction in service would place additional burden on the acute hospitals.

5.222 In considering the final model of care to be progressed, consideration was given to available capacity, interdependence in service provision, and the availability of x-ray services.

5.223 A recommendation was made by the Dover Project Steering Group that model of care **G1** be adopted, which was in accordance with the preference indicated during the consultation by the public and patients. The basis for this decision was the emerging proposals from the Practice Based Commissioning groups to develop facilities in a number of specialities and the discussions concerning the replacement of Buckland Hospital.

**Model H: Children's Services in the Community**

5.224 For the purpose of the consultation, children's services delivered in the community were defined as health visiting, school nursing, child developmental assessment, speech and language therapy, occupational therapy and physiotherapy. However, the focus of the consultation was not on the level of service provision but the location of service provision.

5.225 There were four alternative future models of care set out in the consultation for people to comment upon. A total of 690 responses were received as part of the consultation. The results of the consultation was as follows:

***Table 8: Consultation Results – Children's Services in the Community***

| Model | Description | Response |
|---|---|---|
| **H1** | Offer a broader range of community services in a central Dover location dedicated to children's services. | 240 (35%) |
| **H2** | Offer a broader range of community services in a central Dover location dedicated to children's services. | 197 (28%) |
| **H3** | Offer a broader range of services in non-traditional/non-NHS settings such as community centres. | 96 (14%) |
| **H4** | Keep children's services as they are currently provided. | 157 (23%) |

5.226 The appraisal team that evaluated the responses to the alternative models of care consisted of the Dover Child Health Forum. It was acknowledged that there was an interdependence between children's services and other services such as outpatient and x-ray services and that this would need to be considered in any model of care developed.

5.227 As part of the consultation there was a significant opinion expressed in favour of locating children's services as close together as possible to provide a more comprehensive model of care.

5.228 In light of the above, a recommendation was made by the Dover Project Steering Group that the model of care to be adopted would be a new Option **H5** as follows:

**"Provide enhanced and specialist services from a central Dover location, whether this is dedicated to Children's Services or linked to other NHS provision. Low level and more generic services to be delivered in a range of community and NHS facilities."**

5.229 Inquiry Report 2 sets out in further detail the rationale behind the decision of the PCT to adopt Option H5.

**Model I: Children's Day Ward Services**

5.230 Although Buckland Hospital had previously provided in-patient children's services, but the time of the Dover Project consultation the only service provided was a Day Ward ambulatory service based in the Carousel Ward. Any children requiring in-patient care were located at one of the acute hospitals.

5.231 There were two alternative future models of care set out in the consultation for people to comment upon. A total of 714 responses were received as part of the consultation. The results of the consultation was as follows:

***Table 9: Consultation Results – Children's Day Ward Services***

| Model | Description | Response |
|---|---|---|
| **I1** | Provide children's day ward services on acute hospital sites in Kent | 80 (11%) |
| **I2** | No change to the current service. Continue to provide children's day ward services in Dover. | 634 (89%) |

5.232 The appraisal team that evaluated the responses to the alternative models of care consisted of a team from the East Kent Hospitals Trust. In addition, views were also sought from staff and members of the Dover Child Health Forum.

5.233 The most cost effective option in the provision of children's ambulatory services would be to centralise the provision at one of the acute hospital sites and it would generate efficiency savings.[38] It would also enable patients to be provided with a

[38] The Dover Project, Report and Recommendations from the Consultation Phase, East Kent Coastal Teaching Primary Care Trust

single service, with no need to transfer to a different location if further diagnostic tests were necessary.

5.234 In light of the consultation responses in respect of children's services in the community and the overwhelming opposition to transferring ambulatory children's services to the acute hospitals, a recommendation was made by the Dover Project Steering Group that the model of care to be adopted would be a variation on Option I2 as follows:

**"Continue to provide ambulatory care services in Dover and co-locate them with other Dover children's services on the same site such as radiology, minor injuries outpatients and some elements of community services."**

5.235 Inquiry Report 2 sets out in further detail the rationale behind the decision of the PCT to adopt a variant Option I2.

**Model J: Midwifery Services**

5.236 The Dover Birthing Unit located at Buckland Hospital, is a midwife led unit dealing with 'low risk' births. It also provides pre-natal and ante-natal services.

5.237 There were three alternative future models of care set out in the consultation for people to comment upon. A total of 717 responses were received as part of the consultation. The results of the consultation was as follows:

***Table 10: Consultation Results – Midwifery Services***

| Model | Description | Response |
|---|---|---|
| **J1** | Expand the service at the birthing unit so that more women with low births can be cared for. | 446 (62%) |
| **J2** | Close the birthing unit. | 18 (3%) |
| **J3** | Make no changes and keep the birthing unit the way it is at the moment. | 253 (35%) |

5.238 The appraisal team that evaluated the responses to the alternative models of care consisted of a group of managers and staff from the East Kent Hospitals Trust

Midwifery service. In addition, the Maternity Liaison Committee was also consulted as part of the appraisal process.

5.239 The overwhelmingly most popular choice of expanding the unit was rejected on the grounds that the unit currently met the local demand for low risk births and there was little evidence to support a case that more women from outside the existing catchment area of the unit would voluntarily choose it for birthing. In addition, there were concerns that expanding the service would detrimentally impact on the level of service provided at the award-winning unit.

5.240 In comparison, the option of closing the centre was rejected on the grounds that it would restrict the choice for Dover women to home births or births at the acute hospitals outside the district and that with an average of 370 births a year at the centre, any closure would place significant strains on the capacity of the birthing units based at Ashford and Thanet.

5.241 The option of maintaining the status quo was justified on the grounds of high patient satisfaction scores with the birthing centre; the quality of personal care that could be delivered; the relaxed 'home-from-home' environment that had been developed; and the preservation of high levels of targeted support for mothers in the post-natal period. However, the steering group did identified concerns over the 'footprint' of the centre, which was currently not cost effective.

5.242 A recommendation was made by the Dover Project Steering Group that model of care **J3** be adopted, which was **not** in accordance with the preference indicated during the consultation by the public and patients who had identified option J1 as the preferred model.

**Model K: Improving Health and Well-Being**

5.243 Health promotion can play a significant role in preventative medicine but changing the way people act. At the time of the consultation exercise, the Primary Care Trust was active in promoting improved health and well being in all three areas specified.

5.244 There were three alternative focuses for models of care set out in the consultation for people to comment upon. A total of 712 responses were received as part of the consultation. The results of the consultation was as follows:

***Table 11: Consultation Results – Improving Health and Well-Being***

| Model | Description | Response |
|---|---|---|
| **K1** | To focus health promotion on specific areas of health such as smoking cessation, sexual health, obesity, drug and alcohol dependency. | 237 (33%) |
| **K2** | To focus health promotion activities on specific groups, e.g. young people, older people, lone parents, minority groups. | 140 (20%) |
| **K3** | To focus delivering health promotion activities in partnership with non-health agencies, e.g. schools, community centres, leisure centres, supermarkets. | 334 (47%) |

5.245 The appraisal team that evaluated the responses to the alternative models of care consisted of the Primary Care Trust's Public Health team. It agreed with the consultation, that through delivering the service in association with partners, it could reach a wider range of the public than currently engaged.

5.246 A recommendation was made by the Dover Project Steering Group that model of care **K3** be adopted, which was in accordance with the preference indicated during the consultation by the public.

**Additional Issues**

5.247 The report on the consultative phase recognised that there were some specific issues that affected a patient's experience of health and social care provision in Dover. The **"most significant issues included, transport, location, opening hours, parking and the environment in which services were provided including**

**design and layout of buildings, cleanliness and decorative repair of patient areas and office accommodation". [39]**

5.248 These concerns were pursued by the Scrutiny (Community and Regeneration) Committee in its questioning of witnesses and further details can be found in the Inquiry Report section.

## HOSPITAL SERVICES PROVISION

### Acute General Hospitals

5.249 An acute general hospital is one that provides a wide variety of consultant led specialist services such as specialist surgery or trauma and emergency surgery. The provision of Type 1 and 2 Accident and Emergency departments require a core provision of acute services to function effectively and safely.

5.250 The National Leadership Network (NLN) define this minimum set of on-site requirements to support an Accident and Emergency department as:

- Acute medicine
- Level 2 Critical Care
- Non-interventional Coronary Care Unit
- Essential Services Laboratory (ESL)
  (Provides rapid access to biochemistry, haematology, blood transfusion, basic microbiology, infection control and mortuary services)
- Diagnostic Radiology
  (X-ray, ultrasound, and CT scan)

5.251 The NLN also identify the following services required by an A&E department that do not necessarily have to be on site, but would benefit from being so:

- Emergency Surgery
- Trauma and Orthopaedics
- Paediatrics

[39] The Dover Project, Report and Recommendations from the Consultation Phase, East Kent Coastal Teaching Primary Care Trust

- Obstetrics and Gynaecology
- Mental Health
- Specialist Surgery
- Interventional Radiology

5.252 It should however be noted that there are local variations to this, particularly in respect of the optionally off-site services.

5.253 The requirements of Working Time Directives, the need to provide training environments and the minimum volume of patients identified by the Royal College's in order to maintain and improve doctor's skills mean that acute hospitals require a minimum population base to support. It is usually suggested that a population of 300,000 to 600,000 is necessary to provide a sufficient patient base for an acute hospital. Given that the total population for the PCT area is just over 710,000 and each of the East Kent district have a population of just over 100,000 people each, it is not possible on this basis for each district to have an acute hospital. On this basis, the two acute hospitals provided by the PCT conform to this requirement.

5.254 This does not however, mean that all services traditionally associated with acute hospitals have to be provided at one. Advancements in medical technology and government policy requiring more locally provided services where it is safe and efficient to do so will see certain aspects of planned care transferred to community hospitals and polyclinics in the future on an outpatient basis.

**Major Trauma Centre Proposals**

5.255 The Royal College of Surgeons in its 'Provision of Trauma Care Policy Briefing' argues for a further regional class of hospital is needed, serving a population base of 3 to 4 million people. These 'Major Trauma Centres' would be in addition to the normal hospital network and would provide specialised treatment for major traumas, receiving a minimum of 250 major trauma cases per year.

5.256 The definition of a major trauma centres would be "a unit [providing] 24-hours a day, a fully staffed emergency department, a consultant-led resuscitative trauma team, dedicated trauma theatres and operating lists, the presence of all major surgical specialties on a single site (orthopaedic trauma, general and vascular surgery,

neurosurgery, plastic surgery, cardiothoracic surgery, head and neck surgery, urology), interventional radiology (which uses radiological techniques to place wires, tubes or other instruments inside a patient to diagnose and treat various conditions) and anaesthesia with appropriate intensive care facilities".

5.257 Currently, major trauma patients wait an average of six hours for transfer to specialist units. Under the Royal College's proposals patients fitting the major trauma criteria would be initially dealt with at a local acute hospital before being transferred to a major trauma centre and the critical time frame for a patient would be the period from time of injury to definitive surgery. The proposals suggest that a major trauma network of 12 to 16 hospitals nationally would cut this time dramatically. In the United States where this model has been applied, mortality rates for severely injured trauma patients are 40% lower.

5.258 At present the National Health Service has not adopted these proposals, although specialist hospital centres such as the burns unit at East Grinstead do exist.

**Community Hospitals**

5.259 The White Paper 'Our Health, Our Care, Our Say' published in January 2006 set out a commitment to develop a new generation of community hospitals by 2011 and this was further defined by the 'Our Health, Our Say, Our Community' paper. As part of this commitment the Department of Health announced that £750 million of capital funding would be invested to provide these new community hospitals.

5.260 The Director of Citizen Engagement and Communications for the PCT, Lynne Selman, defines a community hospital as:

***"A local health facility which enables people to receive most of the day-to-day NHS treatments such as x-ray, scans, blood tests, minor injuries and minor illnesses, outpatient appointments, post and antenatal care, outpatient rehabilitation, physiotherapy and speech and language therapy. In Dover, it is considered desirable to also retain the birthing centre".***

5.261 The White Paper envisaged that some minor day surgery could be provided in a community hospital. Community hospitals may or may not include inpatient

rehabilitation beds depending on what facilities are available locally for intermediate care.

5.262 The design principals set out for a community hospital were that it should:

- be locally led
- provide high quality services
- re-design patient pathways
- anticipate future needs as the population changes
- adopt new technologies
- plan across primary and secondary care
- be affordable for the whole health economy
- promote integrated service solutions
- engage and harness the potential of staff
- enable the transition of staff
- engage the public, the whole health and social care system and be innovative.

5.263 The first wave of community hospitals announced on 18 December 2007 that would benefit from this funding were Malvern Community Hospital; Horsea, Beverley and Driffield Community Hospitals in the East Riding; Selby Community Hospital; Moreton and Bourton Community Hospitals in the North Cotswolds; Keynsham Park Hospital in Bath; St Mary's Hospital in Portsmouth; Berkley Vale Hospital in Gloucestershire and St Charles in London.

5.264 It has been announced that the replacement for Buckland Hospital will be a community hospital. The PCT and EKHT are considering a range of options including refurbishing the existing site (approximately £7 million) or constructing a new building either at Buckland or an alternative Dover town centre location (approximately £11 million). The final design will be dependent on the range of services to be offered at the community hospital.

**Emergency Medicine**

5.265 The College of Emergency Medicine defines emergency medicine as:

"***A field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development***". [40]

5.266 In considering emergency medicine, there are broadly speaking two types of patients, those who were in good health but have undergone a trauma (or multiple traumas) of some kind and those who emergency is related to a medical condition such as cardiac arrest or stroke. In terms of the emergency cases with the greatest mortality risk it is important to remember that the major cause of death across all age groups is trauma (road traffic accidents, falls, and armed or unarmed physical assaults) which account for 16,000 deaths a year in England and Wales.[41]

5.267 The key components of emergency medicine provision are the ambulance service (pre-hospital) and the Accident and Emergency (A&E) departments (in-hospital). In considering the impact of transporting emergency patients from the Dover District to the acute Accident and Emergency Units at the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital the impact on mortality rates resulting from the distance and time of transportation is usually cited as a key concern.

5.268 However, this is only part of a more complex overall picture. In considering the factors that affect mortality rates, consideration should be given to the following pre- and in-hospital emergency medical systems (EMS).

**Pre-Hospital EMS: The response time of the ambulance in reaching the patient**

5.269 The initial point a patient will come into contact with emergency medical systems is when an ambulance is called in the event of an emergency. There are three categories of emergency response under the National Response Standards for emergency incidents, which are as follows:

[40] College of Emergency Medicine website < http://www.collemergencymed.ac.uk/CEM/default.asp >
[41] Royal College of Surgeons of England

- **Category A:** These are life threatening conditions where speed of response may be critical in saving a life or improving the health outcome for the patient. Typically this is a heart attack, serious bleeding, or stroke. In the period 2006/07, SECambs received a total of 142,376 calls in this category across its area of operation. The Department of Health target is for 75% of all Category A calls are to be responded too within 8 minutes and 95% within 19 minutes.

- **Category B:** These are conditions where a slower response will not lead to a deterioration in condition or endanger life but still require a fast response. In the period 2006/07, SECambs received a total of 191,677 calls in this category across its area of operation. The Department of Health target is for 75% of Category A calls to be responded too within 8 minutes and 95% within 19 minutes.

- **Category C:** These are non-life threatening conditions where someone usually requires assistance. Typically this covers incidents such as falls where no significant injury was sustained. In the period 2006/07, SECambs received a total of 87,533 calls in this category across its area of operation. There are no national targets for response times to Category C calls.

5.270 The stated goal of an responding to a Category A or Category B call within eight minute will require the ambulance service to be properly resourced and adopt innovative measures, such as the use of a motorcycle based Single Response Vehicle (SRV). The SRV is a fast response paramedic who can provide initial assessments and provide treatment until an ambulance arrives.

5.271 The eight-minute goal is based on the critical time period during which patients who receive emergency medical treatment have the highest survival rate and best medical outcome. For example, cardiac arrest can cause death or brain damage within four to six minutes in certain cases.

5.272 Internationally, there are a variety of standards applied for Category A and B response times. In the Netherlands[42] an eight-minute response time is recommended

[42] Council for Public Health and Health Care (RVZ), Netherlands

while in American urban areas such as Seattle[43] a five-minute response time is the goal.

**Pre-Hospital EMS: The diagnosis and treatment applied by the emergency response**

5.273 It is the role of the paramedic crew to provide initial triage and medical treatment and then convey the patient to the appropriate hospital A&E department. To undertake this role effectively, the paramedic crews are highly trained and have access to resources such as medicines (i.e. clot busting drugs for strokes) and medical technology (such as defibrillators or diagnostic tools).

5.274 While the number of emergency calls received continues to rise each year, not all of these calls are for emergencies and some could be dealt with through primary care provision. As part of tackling this issue, the ambulance service has introduced a new paramedic practitioner position.

5.275 Paramedic Practitioners are paramedics who have undergone additional training to enable them to undertake tasks that would normally be undertaken by a GP or nurse. This includes prescribing medication; ordering further tests such as x-rays; refer patients to alternative health and social services; and treating minor illness and injury within the remit of unscheduled care. Paramedic Practitioners work to guidelines developed by the Joint Royal Colleges Ambulance Liaison Committee. A study published in October 2007 concluded that paramedic practitioners were particularly effective in providing alternatives to an A&E department admission for elderly patients with minor acute conditions.

5.276 In addition to the more holistic role of the Paramedic Practitioner, there are proposals to develop a new category of paramedic known as the Critical Care Paramedic (CCP). A key driver in the development of the CCP is the rationalisation of acute trauma services into fewer locations, requiring either longer journeys or more frequent critical care transfers between hospitals. A CCP will have an expanded skill base that will allow them to undertake tasks normally associated with an Intensive Therapy Unit (ITU).

[43] San Francisco Chronicle, 'Seattle a model for emergency response', 14 April 2008

**Pre-Hospital EMS: The distance from the patient to the appropriate A&E Unit**

5.277 In considering the impact on conveying emergency patients from the Dover District to A&E Units outside of the district, it is important to first discuss the concept of the 'Golden Hour'.

5.278 The Golden Hour concept was developed by Dr R Adams Cowley, an American physician who is considered a pioneer in emergency medicine following his experiences in World War 2 and as Head of Shock Trauma Centre at the University of Maryland. The essence of this concept is that in cases of major trauma, the most effective method of treatment is surgery and as a consequence the time between injury and treatment must be kept to the absolute minimum in order to prevent the patient from deteriorating to such a point that they cannot be saved through surgery. The Golden Hour theory states that after sixty minutes the mortality rate for patients increases significantly.

5.279 Medical professionals have challenged the Golden Hour theory in more recent times as too simplistic due to the number of variables involved in determining the outcome for a patient. Instead, a theory based on condition specific treatment is more universally accepted, which still retains the basic premise of the Golden Hour that delays between injury and treatment are undesirable but doesn't apply the rigid sixty minute criteria. An example of this is the case of a stroke, where the danger of applying clot-busting drugs in the first three hours after injury outweighs the risk of major internal bleeding in a patient. As paramedics are able to administer these clot busting drugs, the actual critical period is often the first eight-minutes.

5.280 The relationship between the distance travelled by patient in an ambulance and the level of mortality is a contentious issue. A study by the University of Sheffield in 2007 concluded that there was a relationship between the distance conveyed by ambulance and the level of mortality in certain categories of high-risk patients.[44] The clearest link was for patients who were unconscious, not breathing, or suffering chest pains. For example, the chance of death increased by 1% for every 6.2 miles travelled by a patient suffering from breathing problems or chest pain.

[44] Journal of Emergency Medicine, August 2007

5.281 Overall, for the specific categories of high-risk patients identified in the report, those travelling further than 13 miles had a mortality rate that was 3 points higher at 8.3% than that of patients travelling less than 6 miles (5.3%). It should however, be noted that the overall chance of survival remained in excess of 90% for all distances considered by the report and the figure of 91.2% survival rate for distances over 21 kilometres was less than 3% lower than the 94% survival rate for distances under 10 kilometres.

***Table 12: Shortest Road Distance to Accident and Emergency Departments in PCT area[45]***

| | William Harvey Hospital | QEQM Hospital |
|---|---|---|
| Deal | 46.83 km (29.1 miles) | 23.42 km (14.55 miles) |
| Dover | 34.34 km (21.34 miles) | 31.41 km (21.38 miles) |
| Sandwich | 42.95 km (26.69 miles) | 14.1 km (8.76 miles) |

5.282 A critique of the Sheffield paper issued in the Emergency Medicine Journal raised concerns over the scoring and age of the source data, although it did accept that for the sub-group of patients with breathing conditions the report was relevant. In addition, a report by the Council for Public Health and Health Care (RVZ) in the Netherlands considers a journey time to an acute medical centre of more than thirty minutes as clinically undesirable.

5.283 In summary, in terms pre-hospital emergency medical services, the evidence points to the conclusion that in the majority of cases, it is the time taken for the ambulance to reach the patient that is most critical in health outcomes as paramedics are able to apply life saving treatment in the first eight minutes that can significantly improve in mortality and morbidity outcomes for patients.

5.284 However, there does seem to be evidence to support a slightly elevated mortality risk for certain categories of patient travelling for more than twenty miles or thirty minutes and the committee may wish to explore this connection further in future discussions.

[45] Departing from Victoria Hospital, Deal; Buckland Hospital, Dover; and Sandwich Guildhall according to Multi-map shortest road distance.

**In-Hospital Emergency Medical Systems**

5.285 In considering the impact on clinical outcomes for emergency patients, the time it takes for a patient to be triaged and treated and the quality of medical care received are crucial.

5.286 In East Kent there are full acute Accident and Emergency departments at the William Harvey and QEQM Hospitals and an Emergency Care Centre at the KCH. Buckland Hospital and Victoria Hospital, Deal have Minor Injury Units and as such do not receive emergency patients. As of 2007/08, there were 272 Accident and Emergency (A&E) departments and 280 Minor Injury Units in England.[46] These are divided in three types.

5.287 **Type One:** There are 203 of the Type 1 A&E departments, which are major acute Accident and Emergency departments covering a wide range of conditions and include the William Harvey Hospital, Ashford and the QEQM Hospital, Thanet. These A&E departments are 24-hour consultant led services with full resuscitation facilities and have designated accommodation for the reception of A&E patients.

5.288 **Type Two:** The 69 Type 2 A&E departments are single speciality (such as ophthalmology) consultant led services with designated accommodation for the reception of A&E patients.

5.289 **Type Three:** The 280 Type 3 (minor injury units) may be either doctor or nurse led and deal with minor injury and illness on a walk-in rather an appointment basis. These can be located alongside Type 1 or 2 A&E departments or separately. The minor units were usually in downsized former acute hospitals or in community hospitals such as Victoria Hospital, Deal and Buckland Hospital and are nursing led Minor Injury Units.

5.290 The South East Coast Ambulance Service stated during the site visit by the committee to the Coxheath Control Centre that ambulance crews had autonomy in

[46] Parliamentary written answer from the Minister of State, Department of Health, Mr Ben Bradshaw MP, to the Shadow Secretary of State for Health, Mr Andrew Lansley MP (27 February 2008)

deciding which was the most medically appropriate hospital for a patient to be taken too.

5.291 The basing of Accident and Emergency departments at acute hospitals is intended to ensure that the necessary level of multi-disciplinary clinical support is available to deliver high quality medical care for a range of conditions.

5.292 While the basic principle of high quality multi-disciplinary care is not disputed, the charity National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has expressed concerns over its delivery. In its report published in late 2007 it stated that that there were problems across the country with inexperienced junior doctors treating trauma patients admitted during the night.[47]

5.293 In conclusion, in considering the impact on patients travelling from the Dover District to an acute hospital by emergency ambulance, it is a combination of response time, initial paramedic treatment, patient medical condition, the distance and time to hospital, and quality of medical care received at the A&E department that produces the total mortality and morbidity risk to a patient.

**Out Of Hours Care**

5.294 The Primary Care Trust has responsibility for ensuring the provision of Out Of Hours (OOH) services and does so through South East Health Ltd. South East Health Ltd was formed through a merger between StourCare Community Interest Company and South East Health Ltd. StourCare was itself formed from the amalgamation of Canterbury Doctors on Call (CANDOC) and East Kent Doctors (EKDOC) on Call, both of which had an established track record having operated since 1992.

5.295 In East Kent, South East Health Ltd (formerly known as Stourcare CIC) provided OOH care prior to the 2004 contracts, which resulted in very little change to the existing arrangements. OOH care is conducted on an appointment-based system to cover the period when GP practices in East Kent are unavailable (6.30pm to 8.00am weekdays and all weekends and public holidays).

[47] The Guardian, '*Half of Trauma Patients in A&E receive poor care, say doctors'*, November 2007

5.296 South East Health Ltd operates from multiple locations across East Kent, based in either in the minor injury units or with an Accident and Emergency departments and its doctors are drawn from local GP practices across East Kent.

5.297 Recent negotiations between the British Medical Association (BMA) and the Government have resulted in a ballot of BMA members accepting the latest Government proposals on opening times. Although the proposals do not force surgeries to open additional hours, the arrangements would mean that any surgeries that refused to open for extended periods would lose approximately £18,000, which be given to the local Primary Care Trust to pay for out of hours services (via South East Health Ltd). As part of the agreement, GP's will still not be allowed to vary the existing core hours of 8am to 6.30pm. As with the changes in 2004, other than changes in capacity this will not have a significant impact on the existing provision of OOH care in East Kent.

5.298 The BMA expects that the average surgery with 6,000 patients will have to open for an additional 3 hours per week, with two 90 minute sessions held between 6.30pm and 8.00pm as the most likely option, although some surgeries may choose to provide the three hours on a Saturday.

5.299 The Scrutiny (Community and Regeneration) Committee explored the subject of Out of Hours Care in greater detail in Inquiry Report 8.

**Polyclinics**

5.300 A polyclinic is a small healthcare facility, which provides a wide range of primary health care services to the local community such as diagnostic, primary care and in some cases, secondary health care services such as minor surgery that would traditionally be provided by the NHS by an acute hospital, community hospital, or primary care practitioner. While a relatively recent health care concept in the UK, polyclinics are well established in many other countries in North America, the Caribbean, and Europe.

5.301 In Europe polyclinics are prevalent throughout Eastern Europe and Germany inherited a large number of polyclinics from the former East Germany. As part of a

series of wide-ranging healthcare reforms Germany has since established a series of new polyclinics.

5.302 In the UK, Health Minister Lord Darzai is conducting a yearlong review of the NHS, which produced its final findings in June 2008.

5.303 While the introduction of polyclinics in the UK remains a controversial issue, particularly where one is changing the existing provision, the five basic principles underpinning polyclinics are less so. These are as follows:

1. To create a critical mass of primary care professionals to enable the provision of an expanded range of services accessible for a longer period.

2. Use economies of scale to provide greater diagnostic support and a quicker turnaround of a range of services.

3. Provide more high volume services in the community and reduce the need for patients to travel to hospital. The use of a more familiar environment where patients were used to using for primary care services could also be of benefit to those patients who may find the thought of a visit to a hospital daunting.

4. Improved access to specialist care and greater integration between primary and secondary care services. More effective relationships between primary and secondary care providers could ensure better diagnostic and treatment pathways.

5. Co-location of services such as community health, social care, leisure and local authority services to provide further economies of scale and easier access for patients.

5.304 An existing example of a working polyclinic can be found in Hove, East Sussex. It was opened in 1998 to replace the community services offered at the old Hove General Hospital. The polyclinic provides services similar to that of an outpatient unit in a community hospital and shares its site with a mental health unit, part of a medical school specialising in psychiatry and housing community care services. It's outpatient clinics are consultant led and includes radiology services (x-ray and

ultrasound). Although there was provision made for primary care services to operate from the polyclinic, no GP practices moved to it in 1998. There are however, proposals for this to change.

5.305 In Kent, there are proposals for a £5 million polyclinic in Seasalter that would be operated by the Whitstable Medical Practice (an existing PCT commissioned GP practice) and a private health care company. It would be co-located with a pharmacy, an NHS ambulance response base and a PCT surgical polyclinic and would provide the following services:

- Consultant led surgical outpatient services
- Day surgery (with an operating theatre suite)
- Diagnostic Services (X-Ray, Ultrasound, and visiting CT and MRI Facilities)
- Primary Care Services

5.306 The model of care for the polyclinic is, it is claimed, in keeping with the American Kaiser Permanente model[48] of polyclinic in that it will offer integrated care pathways and be owned and run by the clinical staff rather than a non-clinical board. Kaiser Permanente is the largest provider of managed care in the United States.

5.307 The "*Healthcare For London: A Framework For Action*" document proposes that London based polyclinics should provide most outpatient services (including antenatal and postnatal care), urgent care, health promotion facilities (such as healthy living classes), proactive management of long term conditions and other health professionals such as dentists or opticians. Alternative models of service provision through polyclinics are being developed in several other cities such Liverpool, Sunderland, and Birmingham although all are based around the five key principles.

5.308 The critics of the polyclinic model, such as the Patient's Association argue it is primarily about saving money through the generation of economies of scale and only secondarily about improving patient care. There is also considerable professional opposition from primary care providers to being compelled to become part of a polyclinic, although at this point it is not clear as to whether participation will be voluntary in all cases.

5.309 The British Medical Association (BMA) has also expressed concerns that while the polyclinic model currently under development is suitable for urban environments it is inappropriate for areas with large rural populations. There were also concerns expressed by the Royal College of General Practitioners (RCGP) in relation to patient care, which stated that:

*"Unfortunately, the polyclinic or super surgery idea as it stands plays down the importance of general practice in favour of 'Martini' healthcare, which is fine for people who only need to see a doctor occasionally and are otherwise healthy and able bodied, but will be a very different story for more vulnerable patients who need their GP"* [49]

**Intermediate Care**

5.310 Intermediate care is a short period in-patient care(normally no longer than 6 weeks) of intensive rehabilitation and treatment. The aim is to ensure that people who would otherwise be admitted to hospital or who would need to stay as an in-patient in hospital for a long period are as independent as possible.

5.311 Intermediate care is accessed on a 'step up, step down' basis, in that patients are either transferred from an acute centre once they no longer require continued acute care but are unable to return directly home ('step down') or from their home to intermediate care where they do not require acute medical care but are unable to look after themselves safely ('step up').

5.312 In accordance with Department of Health guidelines, patients in intermediate care should have a structured individual care plan (including active rehabilitation) with the aim of making the patient as independent as possible by the end of the treatment. This type of care has particular benefits for elderly patients who risk becoming institutionalised as a consequence of long stay at an acute hospital.

5.313 Patients are 'stepped up' by GP's, social services, and occupational therapists/physiotherapists who believe that intermediate care provides a more

[48] Finch, R. 'When is a polyclinic not a polyclinic?' BMJ 2008
[49] Royal College of General Practitioners (RCGP) statement, 20 February 2008

effective alternative to admission to an acute hospital. Patients who are 'stepped down' are referred by hospital discharge co-ordinators and medical staff.

5.314 At the end of the six week stay, patients are usually either reassessed and kept or discharged to their home or nursing home. In the Dover District, intermediate care is provided at Victoria Hospital, Deal and Cornfields and Alexander House nursing homes in Dover.

5.315 The committee undertook a site visit to the intermediate care beds at Victoria Hospital, Deal on 16 June 2008 and a site visit is being arranged for July 2008 to see the intermediate care beds at either Alexander House or Cornfields nursing homes.

**Community Based Care**

5.316 The consolidation of specialist acute services to two hospitals in East Kent means that for the residents of the Dover District, accessing acute services involves travelling a considerable distance. The alternative to the option of hospital care is the community-based diagnosis and management of conditions. However, as the acute hospitals become more specialized, there is the potential to provide more non-acute out patient services in people's own localities.

5.317 The provision of services outside an acute hospital environment also has advantages in terms of reduced exposure to health care associated infections such as MRSA, psychological problems arising from institutional care (particularly for older people), health risks associated with prolonged bed rest and cost savings by not occupying expensive acute care beds.

5.318 In providing community based care, the role of primary care in monitoring health and providing routine maintenance of conditions becomes more important. It does however require increased investment in equipment and facilities and transferring skills traditionally associated with outpatient services to local GP practices.

5.319 However, it is not just non-acute services that can be incorporated into the concept of 'home hospital care'. Advances in medical technology mean that acute conditions such as Deep Vein Thrombosis (DVT) can be diagnosed and the resulting anti-clotting therapy delivered through primary care services. Studies have shown that

oxygen therapy, intravenous antibiotics and enteral/parenteral nutrition can be delivered to clinically acceptable standards in the patients home.

5.320 The home environment also has significant benefits in the provision of end of life care for terminal patients, although service provision in this area is patchy.[50] Studies have shown that home care for terminal patients increases patient satisfaction and functional capacity while at the same time reducing cost and length of institutional stay.

**TeleHealth/Telecare**

5.321 Kent County Council Social Services in partnership with the East and West Kent Primary Care Trusts undertook the Kent TeleHealth scheme and approximately 250 people in the county currently use it.

5.322 TeleHealth uses wireless technology to transmit specific critical clinical information such as blood pressure or heart rate directly to their GP's surgery where community nurses monitor it. This allows patient's to remain active in his or her own home and reduces the need for unplanned acute hospitalisation, which in turn reduces the cost of the patient's acute care.

5.323 In contrast to TeleHealth, Telecare is any service, which brings health and social care directly to the users home using information and communication technology. An example of this would be motion monitoring to detect falls in a persons home.

## Practice Based Commissioning

5.324 The Department of Health describes Practice Based Commissioning as "a radical shift in emphasis from top-down targets and performance management (from PCTs), to bottom-up leadership and innovation (to GP's)"

5.325 Although Practice Based Commissioning (PBC) was first identified in the 1998 White Paper 'The New NHS', the current PBC arrangements have their origin in a number of schemes developed from 1991 to 1997 by the Department of Health. The proposals in the White Paper were further refined by the Department of Health in

[50] The First Annual Report for Kent of the Director of Public Health 2006

guidance issued in 2004. The common objective of all these schemes has been to improve the level of care received by patients through devolving more power to local service providers and empowering patients to take more decisions over their own health care.

**What is commissioning?**

5.326 Commissioning is defined by the Department of Health as the means by which services are procured in order to secure the best value for patients and taxpayers. It should result in the best possible health care outcomes, including reducing health inequalities, while ensuring the budget is within that set by the Government.

**How is PBC better than the existing PCT commissioning model?**

5.327 By devolving the responsibilities closer to the patient, it will enable clinicians to construct more individual care packages as opposed to the larger scale 'one size fits all' approach of the PCT to commissioning. However, the PCT will still be the statutorily responsible body for commissioning and cannot totally divorce itself from that role.

5.328 The devolution of indicative budgets to PBC consortia means there is the potential for blurring the boundaries between primary and specialist care in that the commissioners of services could also be the service providers. For example, a PBC consortium could commission the existing clinical specialists or expand its own skills mix and provide the service directly.

**How does PBC work?**

5.329 Practice Based Commissioning can be focussed on a specific practice, a group of practices working in association or through a full multi-agency corporate entity taking collective responsibility for its decisions. The most popular choice has been the formation of a PBC consortium, such as in the Dover District.

5.330 The Department of Health believes that the commissioning of services based around the patients individual needs results in lower costs, lower mortality rates and fewer hospital readmissions through matching the treatment to the patients needs first time.

5.331 The PBC system is intended to work as follows:

(a) The PCT will provide the PBC consortia with information, budgets, a public health needs assessment, analysis of cost-effectiveness of interventions and training and development support. It will also establish strategies for care and resource use and remain responsible for ensuring financial balance overall.

(b) The PBC consortia will through its business plan develop proposals for the commissioning and redesign of services and the release of budgets and drive out unnecessary costs. As a result, each referral by a GP becomes a small scale commissioning decision, with more options available in choosing which organisation will provide the service.

(c) Patients should receive more personalised care packages with greater choice (where practical) and improved services as well as influencing service development through reporting on the patient experience. Patients also become the driver of service provision, with funds following the patient and not as previously, the other way round.

(d) The views of third sector and private sector organisations should also be considered in the commissioning practice in terms of specialist advice and commissioning.

5.332 It should be noted that the commissioning of very specialist services would be governed by the arrangements proposed under the Cater Review and not part of PBC.

5.333 In summary, the PCT will set the strategic direction for local services, identifying overarching priorities to the PBC consortium and in most cases communicating with potential service providers, including in the voluntary and private sector.

5.334 The 26 GP practices in the Dover District are members of the two PBC consortia – the Dover and Aylesham group and the Deal, Ash and Sandwich group. In addition to basic primary care service provision practices can offer a range of services such as:

- Diabetes Clinics
- Phlebotomy
- Minor surgery
- Well Man/Woman Clinics
- Maternity services

**Payment by Results**

5.335 Payment by Results (PbR) is intended to replace the traditional system of funding based on population estimates rather than specific patient need. The Department of Health consider PbR as an important tool in reducing waiting lists, shortening hospital stays and expanding patient choice, as hospitals earn their income through the provision of medical care. All non-emergency treatments (excluding mental health related conditions) have had an assigned tariff since 2005.

5.336 Under PbR, each patient has a specific nationally set tariff for his or her medical condition. For example, each patient requiring a hip replacement will be accompanied by a tariff of £4,830 per person. This tariff is determined by the Department of Health based on the average cost of a procedure across the NHS, and depending on the efficiency of each particular hospital trust, this may or may not be an accurate reflection of their actual costs. Indeed, the Kings Fund suggests that as much as half of all NHS hospitals costs exceed that of the national tariff levels.

5.337 A consequence for patient choice is that as the funding follows the patient, they are not locked into having the treatment provided by a NHS Hospital within their PCT area, and there is the potential to 'shop around' in search of shorter waiting lists.

5.338 In addition to clinical benefits, the Department of Health intends that PbR will encourage hospitals to improve efficiency, introduce transparency of funding, improve record keeping, and bring down costs in order to maximise the revenue that can be earned under the PbR tariffs. Studies undertaken of the PbR system in Australia and Sweden have demonstrated that both the clinical and non-clinical benefits are achievable.

5.339 It should however, be noted that NHS hospitals have an existing duty to be financially balanced over a specified period and given that patients are a finite resource it would

seem logical to suggest there is a potential for overcapacity in provision (which arguably has implications for the volume of patients required to maintain and improve clinical skills) as hospitals compete for patients.

5.340 In addition, there are over 1,000 Healthcare Resource Group (HRG) codes for the tariff system, which raises the possibility of inefficiency through miscoding or poor record keeping.

5.341 At the time of writing, the tariffs for emergency care were still in the development phase and not yet in place.

# Glossary of Terms

| Term | Definition |
|---|---|
| ***Acute Medicine*** | The Royal College of Physicians defines acute medicine as "a part of general (internal) medicine concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions". |
| ***Ambulant*** | (a) Not confined to bed; able or strong enough to walk (i.e. an ambulatory patient)<br>(b) Serving patients who are able to walk (i.e. an ambulatory care centre). |
| ***East Kent Hospitals Trust (EKHT)*** | The provider of five hospitals in East Kent, including the two acute hospitals. It is commissioned by the PCT to provide these services. |
| ***Emergency Care*** | Emergency Care is treatment for immediately life threatening conditions such as major accidents, heart attacks, and strokes. |
| **General Practitioner (GP)** | General Practitioners (or GP's) are physicians who have completed four to five years of post-medical school training including three to four years based in hospitals and one year attached to a training general practitioner in the community. |
| ***Intermediary Care*** | This is the term used for health and social care services which ensure that people can get the help and support they need after an illness, surgery or an accident which has left them unable to cope on this own or with the support of their family or friends. |
| ***Major Trauma*** | The term 'major trauma' is therefore used to describe multiple injuries involving different tissues and organ systems that are, or have the potential to be, life threatening. |

| Term | Definition |
|---|---|
| ***Morbidity*** | Morbidity can refer to either a diseased condition/state or the incidence of a disease. It can also be used to refer to disability irrespective of cause (such as disability caused by trauma). |
| ***Out of Hours (OOH)*** | This is generally defined as the hours outside of the core hours provided by General Practitioners under their contract with the NHS. This is in effect between 6.30pm and 8.00am during the week and all weekends and bank holidays. It should however, be noted that the Hospitals often define it as between 10.00pm and 6.00am. |
| ***Primary Care*** | This is in essence the "medical home" for a patient, ideally providing continuity and integration for health care services that play a central role in the local community. The aims of primary care are to provide the patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives. Primary Care providers are General Practitioners, pharmacists, dentists and midwives. If a patient has a more serious condition, a primary care provider will refer the patient to a secondary care provider. |
| ***Primary Care Trust (PCT)*** | The Primary Care Trust acts as the lead organization for the local health trusts, answering to the Strategic Health Authority and the Kent County Council Health Overview and Scrutiny Committee for its actions. It is responsible for commissioning and contracting a full range of NHS provision and ensuring partner organizations deliver those services in pursuit of equality, quality, responsiveness, innovation, efficiency and affordability. |
| ***Secondary Care*** | The term secondary care describes the service provided by medical specialists who usually do not have first contact with patients. This is normally specialists such as cardiologists, urologists, etc. who patients are referred too. |

| Term | Definition |
|---|---|
| ***Strategic Health Authority (SHA)*** | The Strategic Health Authorities hold Primary Care Trusts to account for their actions and in turn answer directly to the Department of Health. It is the role of the SHA to provider regional strategic leadership. |
| ***Trauma*** | Trauma can be defined as physical injury caused by events such as road traffic accidents, falls, explosions, shootings, or stabbings. |
| ***Urgent Care*** | Urgent care is defined as patients who require same day treatment but are not suffering from immediately life threatening conditions. |

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# Section Six

# Inquiry Reports

***Evidence gathered during the course of the review by the Scrutiny (Community and Regeneration) Committee***

# Inquiry Report One

## Patient Advice and Liaison Services (PALS)

Mrs Beverley Hyham, the Head of PALS & PPI for the East Kent Hospitals NHS Trust gave a presentation to the Scrutiny (Community and Regeneration) Committee at its meeting held on 10 July 2007 on the key areas raised through the Patient Advice and Liaison Service (PALS).

For the period April 2003 to present, a total of 173 submissions had been made through PALS in respect of Buckland Hospital, Dover. The content of the submissions had been varied, though the key issues raised were as follows:

- Difficulty in contacting services operated on a part-time basis at Buckland Hospital.

- Complaints concerning the difficulty in travelling by public transport to acute services located at the William Harvey Hospital, Ashford and Queen Elizabeth the Queen Mother, Thanet.

- No Accident and Emergency facility or 24 hour Minor Injury Unit at Buckland Hospital.

- The opening hours of the Blood Clinic.

In considering these issues raised, the Committee was advised that people can traditionally be reticent about using the formal complaints process, particularly while either they or a relative were receiving medical care. Often, where concerns were made they were made on an informal basis to relatives and friends, which meant that there was no record of them. It was hoped that through encouraging people to use PALS rather than making informal comments it would assist the Hospital Trust in driving forward service improvements.

In respect of formal complaints, for the period April 2003 to present there had been 103 received in respect of Buckland Hospital. These could be grouped into the following key areas:

- Clinical Matters – 57 complaints
- Staff Attitude – 15 complaints
- Delays – 14 complaints

Other significant areas of complaint were in respect of rescheduled appointments and waiting lists. There had been a total of three complaints in respect of public transport during this period. Two had been received in respect of transport from William Harvey Hospital to Buckland Hospital and one in respect of transport from Canterbury to Dover. There had been no complaints received concerning transport to/from Queen Elizabeth Queen Mother Hospital.

It was stated that an internal 'Fit for the Future' project had been examining the issue of hospital transport in greater depth and the Committee was advised that should they wish to discuss health care transport further they should contact Irene Haywood, the Head of Health Care Transport for the East Kent Hospitals NHS Trust.

Overall, the intention is to engage with patients through PALS, internal patient and public involvement mechanisms and the external Patient and Public Involvement Forum (PPIF), which offers an opportunity for them to influence the way services are developed.

In response to a question from Councillor C E Kirby, Mrs B Hyham advised that when an inpatient area is looking at obtaining feedback from patients on their services, where possible and appropriate it is best to wait approximately four weeks after treatment in order for patients to openly and honestly answer the questions, however a number of patient involvement projects are carried out with the consent of patients during their treatment period. The questionnaires use a combination of tick boxes and freeform written answers. The subjects for the questionnaires were selected randomly from different departments.

The Trust has a generic questionnaire format, however the questions were tailored to specific areas. Other forms of patient involvement include focus groups, one-to-one interviews, patient diaries, patient shadowing and suggestion boxes. The objective is to collect information from patients in the most effective manner possible and not rely on a single method of gathering feedback. It was unrealistic to try to capture the views of everyone, however it was necessary to involve as many patients and members of the public as possible. The Trust also engaged with voluntary sector groups such as the Thanet Hard of Hearing Club who were ideally placed to provide feedback on specific services.

Councillor G J Hood advised that he had participated in the neuro-rehabilitation focus group following his own stay in hospital and had found it to be useful. However, issues around transport had been raised in the focus group.

An example of a change in service delivery as part of patient feedback was the change in the relationship with the cleaning contractor following comments concerning hospital cleansing.

In addition to its main area of work, PALS was also responsible for volunteers working in the health service. In terms of staffing, there were approximately 8,000 employees in the East Kent Hospitals NHS Trust, with the equivalent of eight PALS staff, four full time and four part time plus two PALS staff working for Eastern and Coastal Kent Primary Care Trust. This was broken down into approximately two PALS staff per hospital.

Overall, the role of PALS was to act as a pathfinder, assisting patients in effectively influencing the development of services.

# Inquiry Report Two

## Eastern and Coastal Kent Primary Care Trust

Lynne Selman, Director of Citizen Engagement and Communications, and Su Brown, Project Manager, of the Eastern and Coastal Kent Primary Care Trust gave a presentation to the Scrutiny (Community and Regeneration) Committee at its meetings held on 17 July 2007 and 4 September 2007.

Prior to answering the key questions, Mrs L Selman gave a short presentation to the committee on the nature of the area served by the Eastern and Coastal Kent Primary Care Trust and its organisational background.

(a) Functions

The Eastern and Coastal Kent Primary Care Trust was formed from the amalgamation of 5 smaller Primary Care Trusts (PCT) and served a population in excess of 700,000 people. It was the sixth largest PCT in the United Kingdom covering an area of 700 square miles and had an annual budget of approximately £1 billion.

Having been formed through the amalgamation of five smaller PCTs, it needed to invest funds to ensure that there was consistent service delivery across the whole PCT area through the levelling-up of standards. Due to the financial position it inherited from its five precursors it was financial stable.

The three functions of the Eastern and Coastal Kent PCT were to engage with its local community to improve health and well-being; commission a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources; and directly provide high quality responsive and efficient services where this gives best value.

(b) Strategic Context

Against the national backdrop of changes in medical science and technology and increasing patient expectations, the Eastern and Coastal Kent PCT faced local challenges in changing demographics increases in the average age of the population, higher than the national

average number of cancer deaths; childhood disease mortality; mental health needs; child poverty and the number of life years lost through accidents.

It was a national pilot area for an 18-week maximum time for referral to treatment ahead of national timescales, improved urgent care and through whole system working and the use of technology. For urgent care, a "phone before you go" approach helped determine the best place to go for treatment. Through the use of "telehealth" and "telecare" schemes, patients could receive medical supervision at home reducing the amount of time they had to spend in hospital. The "telehealth" scheme allowed for the remote monitoring of certain conditions while the "telecare" scheme provided remote environment monitoring linked to a response.

(c) Vision

A key aspiration was effective public engagement to ensure that it remained accountable to local people and delivered value for money. It also needed to maintain relationships with key partner organisations such District Council's, social services and clinicians. The outcome of the vision would be reductions in health inequalities; preventing ill health; promoting independence and delivering high quality services in the most appropriate settings.

(d) Local Plans

In its role as a commissioning body, ECKPCT sought to commission accessible, high quality primary care and invest in specialist care, such as stroke units, and safe and effective secondary care, such as hip and knee operations. Trials of specialist care centres, such as the stroke unit, had been found to deliver excellent results.

In order to utilise resources more effectively, it was intended that avoidable emergency admissions into hospital care would be reduced through the use of intermediate care and other community based treatments. This could also be achieved through the location of chronic pain clinics at doctor's surgeries or other local community facilities.

It was planned to promote self-care and independence and provide access to services in areas of most need. This included the treatment of outpatients in non-acute care settings, the use of extended paramedics, better integration of mental health and physical services

and expanded end of life care at home. The use of expert patient programmes had been found to assist people undergoing treatment and led to the recommendation of service improvements.

Supplementary questions asked by Members of the committee were prefixed with the letters 'SQ'.

**Dover Project Consultation**

Q1. How many responses did you receive in respect of the Dover Project consultation and was this in keeping with the expected response rate?

There were 888 individual responses made to 11 different questions, although not every respondent answered every question. The lowest level of response for a question was just under 700 responses. The overall level of response (10%) was in keeping with expectations. The consultation was publicised through GP surgeries, radio, DDC News, the paid and free press, and other methods. As personal details were not a mandatory part of the consultation, it was not possible to breakdown the consultation responses into categories of respondent.

Q2. How did you feel the Dover Project consultation went?

It was felt that the consultation went well. Kent County Council's Overview and Scrutiny Committee on health commended the consultation for its efforts in trying to involve hard reaching groups.

Q3. The consultation responses indicated that the preferred options for service delivery were based around local provision as opposed to transferring services to health facilities outside of the District. Are there any plans to relocate further services currently provided in the District to Thanet, Canterbury, or Ashford?

The services that were the subject of the consultation will continue to be provided locally and there were no plans to relocate them. In the future, it was possible that Practice Based Commissioning might lead to an expansion in the services provided locally.

Q4. Will the future service delivery options under development ensure that sufficient services are retained to preserve a critical mass of skills and experience in the District to ensure robustness in service delivery?

As the Eastern and Coastal Kent Primary Care Trust were the commissioning body it was the responsibility of the service providers to ensure that skills were maintained.

Q5. The responses to the consultation were guided through multiple-choice options. What factors were considered in determining which options would be offered as part of the consultation?

No answer provided.

SQ1. What new services will Practice Based Commissioning provide?

In response to Councillor R S Walkden's question, it was stated that this depended on the plans of local GP's but it was most likely to affect the minor injuries unit and the provision of intermediate care beds.

Practice Based Commissioning could also affect the way services were delivered by determining how they would be accessed. It was stated that one example of this could be in extending opening hours of services.

**Strategic Health Service Provision**

Q6. The District is due to receive its final housing growth numbers during the summer. What plans have been made to ensure existing and future health service provision can cope with this population growth?

The Eastern and Coastal Kent Primary Care Trust had undertaken modelling on the amount and type of health care as part of its planning process.

The Director of Assurance and Strategic Development of the Eastern and Coastal Kent PCT stated that they were working with Dover District Council in respect of the growth numbers proposed under the Local Development Framework. It was hoped that funding for public health could be utilised through Section 106 agreements, although this was not one of the

criteria in Dover District Council's agreements. However, the PCT always worked to ensure that it met the current level of need in the local community.

SQ2. Are you in the position to undertake specific assessments for each area of deprivation to identify needs and plan accordingly?

In response to Councillor Ms S M Le Chevalier's question, the Committee was advised that the South East Public Health Observatory (SEPHO) published booklets containing exactly that information and that these were also available from its website.

Q7. The 'Fit for the Future' document sets out the intention to provide a wider range of services, including mental health services, in community locations and centralise specialist treatment in the two acute general hospitals. How do you ensure that this decentralised approach delivers better service standards than could be achieved through the traditional model of local general hospitals?

The intention was to deliver acute services through specialised centralised care, while working to deliver non-acute services closer to people's homes. The use of shorter stay in acute care meant that there was a higher patient turnover, which reduced waiting lists, and by joining services effectively, improved the patient experience. In addition, by treating people in their local community or home it benefited their recovery.

Q8. The 'Fit for the Future' document recognises that one of the biggest frustrations felt by people is the lack of co-ordination between services. How do you intend to improve this situation, especially given the need to work closer with Kent County Council Social Services in the future?

The delivery of joined up services would tackle the frustration felt by patients in having to deal with many different people. As part of this Eastern and Coastal Kent PCT was speaking to a wide range of organisations as well as with the public and patients. The capturing of feedback on the patient experience was seen as vital to improving the delivery of service and the ongoing neuro-rehab consultation was cited as an example of this work.

The feedback from the Dover Project Consultation had identified transport as a significant issue of patient concern and work was underway to examine how to make transport easier to

access and with more flexible times. The Eastern and Coastal Kent PCT had also joined Dover District Council's Transport Working Group.

In respect of Kent County Council, there were several areas where it was working with Eastern and Coastal Kent PCT, including transportation, Social Services, and education.

SQ3. Can you provide examples of how you would work with Children's Trusts and Kent County Council adult services?

In response to Councillor A Friend's question, it was stated that the Children's Trust was a joint arrangement between Eastern and Coastal Kent PCT and Kent County Council and acted as a commissioner of services. In a similar way to doctor's surgeries currently, in the future schools would also commission the health care that they required. This also allowed for closer working with clusters of schools.

In respect of Kent County Council adult services, joint teams were used to deliver services as well as utilising the 'telehealth' and 'telecare' models.

SQ4. How much has Kent County Council subsidised East Kent Hospital Trust/Eastern and Coastal Kent Primary Care Trust during last year to avoid bed blocking?

In response to Councillor R S Walkden's question, it was stated that across the whole health economy it was important to make the best use of bed space. Eastern and Coastal Kent PCT did not receive a subsidy from Kent County Council, as the funds allocated by social services would have been spent on care home stays. Instead, the funds were reallocated towards preventing delayed discharges which saved the cost of "excess bed days" beyond those allocated for the particular treatment being charged to Kent County Council Social Services and the Eastern and Coastal Kent PCT.

SQ5. What plans were there for introducing a full-time GP Surgery in Whitfield given that the number of houses is set to double under the Local Development Framework proposals?

In response to Councillor C J Meredith's question, it was stated that new homes do not always equal new people as in some cases existing residents may relocate. The key factor

was the number of people per household as the average GP list was 2000 people. However, it was expected that a full time GP would be required for Whitfield.

SQ6. What plans were there to utilise the fully equipped empty GP surgery in the Eythorne and Shepherdswell Ward?

In response to Councillor D R Lloyd-Jones question, it was stated that the PCT could not dictate how GP's chose to provide services, as it was only the commissioning body. However, the PCT did have a duty to ensure that people had access to GP services.

**Health Inequalities**

Q9. Given that urban Dover contains five district council wards suffering from high levels of economic deprivation, how have you taken this into consideration in your strategic planning for health service provision?

This was tackled through a combination of examining areas of under provision of services and planning based on the area health profiles. There was also work underway to tackle key problem areas, such as the use of school nurses in reducing childhood obesity.

SQ7. What do you intend to do to tackle the issue of life expectancy in the five urban Dover wards being significantly lower than the average for England?

In response to Councillor C E Kirby's question, it was stated that Eastern and Coastal Kent PCT was investing in preventative measures and controlling symptoms. The effective targeting of resources at the root cause of the issue was vital in identifying measures that would change the behaviour of people for the better. An example of this was developing strategies to tackle diabetics who did not follow their medical advice.

Q10. The Dover Health Profile 2007 indicates that the Dover District has significantly worse levels of diabetes, obesity and mental health problems than the average level for England. How have you taken this into account in your planning?

This was taken into account through joint working with Kent County Council's social services, early intervention to prevent problems becoming worse, working with the local

community to identify tipping points and use of the expert patient programme to identify areas of service improvement.

SQ8. Will non-acute treatment for diabetics be provided within the district under proposals for future health service provision?

It was stated in response to Councillor Miss C M Edwards question that Doctor's surgeries in the future would provide more services for non-acute diabetic care. There would also be specialist staff working across areas to supplement this provision. An example of this was cited as the use of a diabetic nurses in doctor's surgeries to perform routine treatment as way of taking pressure off acute hospitals in order to allow them to focus on treating more serious cases.

SQ9. Eastern and Coastal Kent PCT was working towards specialist care in some areas and preventive care in others. What would be at the end of the path?

In response to Councillor C J Meredith's question, it was stated that specialist skills could be deployed in local environments for outpatient care if there was no need for specialist diagnostic equipment to be present. In addition, some doctor's surgeries had interests in specific specialisations and they would be able to provide a more detailed level of care in those areas.

SQ10. There are concerns locally that the renal satellite unit will be removed from Dover if Buckland Hospital is replaced with a new facility. Will any new medical centre facility contain a renal satellite unit?

In response to Councillor Ms S M Le Chevalier's question, it was stated that at this point the options were still being examined and the provision of renal satellite unit had yet to be ruled in or out.

SQ11. Had Eastern and Coastal Kent PCT made provision for school dentist and optician services?

In response to Councillor A Friend's question, it was stated that although the school nursing system would screen for certain things, there would be no community optician service provided. The Children's Trust was responsible for the commissioning of school medical

services in response to specific needs. There was however, a community dental facility commissioned by the Eastern and Coastal Kent PCT.

**Future Health Service Provision**

Q11. What are your proposals for the future of the existing Buckland Hospital site?

The East Kent Hospital NHS Trust owned the Buckland site, as the PCT was just the commissioning body. The PCT did not set the details on how the services were provided other than to ensure that people had access to the required services. However, the PCT did require that the East Kent Hospital NHS Trust provide services on the Buckland site until a suitable alternative site was operational.

Q12. As part of health service reconfiguration in Kent, Buckland Hospital was one of several hospitals downgraded in status, leaving just the Queen Elizabeth the Queen Mother Hospital, Thanet and the William Harvey Hospital, Ashford as acute general hospitals within the Eastern and Coastal Kent Primary Care Trust area. What is the possibility that Dover could regain a general hospital in the future?

There was no possibility of Dover regaining a general hospital in the future at Buckland or any other site. Instead, Eastern and Coastal Kent PCT would seek to deliver services through a new "poly clinic" facility rather than a general hospital.

This decision was in keeping with the Department of Health's "Our health, our care, our say" White Paper which discussed community hospitals and the method of service delivery would be different from the traditional image of a general hospital in most peoples minds. For example, changes in medical technology meant that the removal of tonsils, which once required a one-week stay in hospital, could now be undertaken as outpatient surgery.

The Director of Assurance and Strategic Development of the Eastern and Coastal Kent PCT stated that the current approach was for care in local community combined with specialised centres for acute services. Under this model there was no chance of Buckland Hospital being restored to an acute service centre.

The immediate care team was being increased in size and there had been no negative comments received concerning its capacity. In addition, the District nursing team was

operating at full strength and recruitment was done on anticipated need rather than current need.

SQ12. It could it be argued given recent local press coverage that you have failed to demonstrate to the people of Dover that by not having a hospital you will still be able to deliver health care. How do you intend to engage with people to reassure them?

In response to Councillor R S Walkden's question, it was stated that people were wedded to buildings and that it was difficult for them to accept change. It was hoped that through engaging with expert patient and local focus groups, the community could be engaged with in shaping service delivery. An example of this was cited as the using of feedback gained from people's experiences of the Shepway walk-in minor injury unit in shaping the Dover view.

Q13. There is strong local concern over the future of health service provision in Dover, particularly around the future of the Buckland site. Can you relate to this concern?

Mrs L Selman stated that she could relate to the strong local concern over the future of health service provision in Dover and acknowledged that public meetings such as the one conducted in Dover Town Hall recently, were not the best method of communicating with people. Eastern and Coastal Kent PCT had commissioned MORI to investigate peoples concerns over health service provision and the intention was to invest resources in tackling these issues.

The Director of Assurance and Strategic Development of the Eastern and Coastal Kent PCT stated that the main emphasis of local concern was over the Buckland Hospital building rather than the services it provided. However, from the viewpoint of the PCT the most important thing was the standards of patient care provided and in that respect the Buckland Hospital building was not fit for purpose.

The nature of the replacement for Buckland Hospital would be dictated by the services provided and it was possible that the best way of delivering this would be through a multi-site facility.

Q14. On the assumption that your proposals go ahead for replacing the existing Buckland Hospital building, how are you seeking to deliver the Government objectives that high quality services should be provided in accessible locations close to the community it serves?

The public was also involved in shaping the future of health service provision in Dover through the Public Patient Involvement Forum (PPIF), which had a representative on the Dover Project Steering Group. This group would in conjunction with officers from Dover District Council's planning section be taken to potential sites for the new health care facility.

SQ13. Do you accept that publicising the new proposals might release the local communities attachment to the Buckland Hospital building?

In response to Councillor C E Kirby's question, it was stated that there were plans to involve the public in discussions over the development of future services such as the minor injuries unit for example. The aim was to meet people's needs locally wherever possible.

Q15. While acknowledging that a specific site cannot be identified at this time, what are your key infrastructural and environmental requirements for any new site?

The PCT was fully engaged with its partners, which included Dover District Council, in discussing potential new sites. This included the potential of developing a shared use site with one of its partners. In terms of location, a mid-town Dover site would be attractive in that it was more accessible for public and private transport than the current site at Buckland.

SQ14. Accepting that there are other sites than Buckland for a future health centre, do you believe that a mid-town site would be able to meet your spatial requirements?

In response to Councillor Ms S M Le Chevalier's question, it was stated that this would be addressed at the next meeting of the committee.

SQ15. What other partners are you talking to in determining a future site to replace Buckland?

In response to Councillor R S Walkden's question, it was stated that partners included Dover District Council. However, at this point no site had been identified due to the complex

process involved. There were questions on funding and the mechanics of service provision that had to be resolved before a site could be selected.

The Committee was assured that the model of care proposed would keep a local birthing unit and that this would be part of service provision needs considered in identifying a potential site.

SQ16. Will the existing Buckland Hospital site be shut down prior to the new health service facility becoming operational?

In response to Councillor Mrs J F Tranter's question, it was stated that although no guarantee could be given that Buckland Hospital would not shut prior to the opening of the new health service facility, Eastern and Coastal Kent PCT was able to guarantee that local services would continue to be delivered throughout any interim period.

Q16. How do you intend to finance the provision of a new health facility?

This was a matter for discussion with the East Kent Hospital NHS Trust.

Q17. Will the transfer of health service provision to a new site result in any gap in service provision?

It was stated that there would be no gap in service provision in the replacement of Buckland Hospital.

**Dover Project Proposed Models of Care**

Q18. In the case of Dental Services the most popular option for service delivery among respondents (39%) favoured option C2 as follows: 'An increase in the dental access service and maintenance of current regular dental provision'. However, in the recommendations arising from the consultation the Primary Care Trust is proposing that services be delivered through a variation of option C3 as follows: 'Keep the balance between a regular dental provision and the dental access service as it is now and provide an increase in overall provision with an emphasis on regular dental care'. How will the amended option C3 deliver services more effectively than option C2?

The dental access service was important if a person did not have or could not get to a dentist but the preferred model was for regular dental care provided by a dental surgery. It was acknowledged that Dover's high level of deprivation affected the access of the local community to local dental care and steps had been taken to increase the level of dental provision. The PCT could not change the cost of NHS dental care as the levels were set nationally but there were fee exemptions available for certain categories of people.

Q19. What is the significance in the removal of the reference to the dental access service?

There was no significance in the removal of reference to an increase in the dental access service as the preferred model was for regular dental care provided through dental surgeries.

It was emphasised that the PCT was still purchasing the same level of dental care as it had historically, however the issue was around dentists not wanting to undertake dental work on the current NHS contracts.

Q20. In the case of children's services in the community, the most popular choice among respondents was option H1 (35%) as follows: 'Offer a broader range of community services in a central Dover location dedicated to children's services'. However, in the recommendations arising from the consultation the Primary Care Trust is proposing that services be delivered through a new option not contained within the four possible consultation responses, known as H5, which was as follows: 'Provide enhanced and specialist services from a central Dover location, whether this is dedicated to Children's Services or linked to other NHS provision. Low level and more generic services to be delivered in a range of community and NHS facilities'. How will option H5 deliver services more effectively than option H1?

The most effective way of providing child services was through organisations such as Sure Start, which had access to a wider group of people. This was also part of the recognition that more universal services are often better provided outside of hospitals in order to achieve the best results.

Q21. In the case of children's day ward services, the most popular choice among respondents was option I2 (89%) as follows: 'No change to the current service. Continue to provide children's day ward services in Dover'. However, in the recommendations arising from the consultation the Primary Care Trust is proposing that services be delivered through a variation of option I2 as follows: 'Continue to provide ambulatory care services in Dover and co-locate them with other Dover children's services on the same site such as radiology, minor injuries, outpatients and some elements of community services'. How will the variation of option I2 deliver services more effectively than the option I2 set out in the consultation document?

The co-location of services offered greater efficiency and there was a synergy between ambulatory childcare services and that of the minor injuries unit.

Q22. In the case of midwifery services the most popular choice among respondents was option J1 (62%) as follows: 'Expand the service at the birthing unit so that more women with low risk births can be cared for'. However, in the recommendations arising from the consultation the Primary Care Trust is proposing that services be delivered through a variation of option J3 as follows: 'Make no changes and keep the birthing unit the way it is at the moment'. What was the rationale for rejecting the expanded service proposed under option J1?

The model of care proposed had changed since the decision to progress with a variation of option J3 and every woman in the Dover area was guaranteed a delivery at the birthing unit unless there were medical complications. This was because antenatal and post-natal care was best provided in a smaller, less busy environment and both Social Services and Midwives supported this approach.

**Out of Hours and Emergency Care**

Q23. The current proposals outlined as part of the service redesign in response to the Dover Project consultation are for a walk-in minor injuries unit as opposed to an accident and emergency centre. Given that the road links with Ashford and Thanet are often congested during peak periods, has consideration been given to establishing an Emergency Care Centre in Dover along the lines of that provided at the Kent and Canterbury Hospital?

The intention was to deliver more services locally except where acute care was required which would be dealt with at a specialist centre. It was noted that the model at Canterbury Hospital has been well received by the PPIF.

Councillor C E Kirby expressed concerns that it would take ambulance crews too long to reach acute hospitals in Thanet or Ashford in an emergency. An article from the Daily Express newspaper, dated 10 July 2007, was cited which stated that the recent re-categorising of strokes to Category A priority meant that ambulance crews had to try and get stroke patients to hospital within eight minutes under the new National Stroke Strategy. The Committee expressed concerns that even under emergency lights, eight minutes would not be possible from central Dover to one of the two acute hospital sites.

Mrs L Selman stated that it could be difficult for an ambulance crew in Canterbury to get to the stroke unit at Canterbury Hospital in less than eight minutes and that the key to getting the right outcome was for the paramedics to make an accurate diagnosis at initial contact. If the correct diagnosis and standards of care were applied by the paramedic, a patient who took longer than eight minutes to get to a stroke unit could still have the same medical outcome as one who reached a hospital in under eight minutes.

The Eastern and Coastal Kent Primary Care Trust was constantly seeking out national best practice and using it to benchmark its own systems and services. Once benchmarking against national standards had been completed, it would be in a better position to make plans.

However, a stroke centre with focussed care and specialist staff on the model of the neuro-rehab unit was cited as providing better service than if it was spread over diverse facilities as it contained the necessary critical mass of skills honed through regular use.

The Director of Assurance and Strategic Development of the Eastern and Coastal Kent PCT stated that the provision of emergency care requires a level of specialist support to operate that is only found in acute care centres.

Q24. What is the proposed opening hours for the walk-in minor injuries unit?

The opening hours were part of an urgent care review and were about the utilisation of services. There was a degree of 24-hour minor injury care already through the provision offered by GP surgeries and Stour Care's out of hours work.

Q25. Has the consequences of an emergency at the Port of Dover been considered in the proposals for a minor injury unit?

In the event of a major emergency, Eastern and Coastal Kent PCT would bring in medical personnel from outside the district to the area rather than rely on local services. An example of this in practice was the recent serious accident on the A20 between Dover and Folkestone, which had diverted medical personnel from other areas to the scene and required the opening of local pharmacies to provide required medications.

In addition to this, the Port of Dover, the Channel Tunnel, and Dungeness Nuclear Power Station all had multi-agency emergency plans in place and following the events of 7/7, Eastern and Coastal Kent PCT was well rehearsed in emergency planning.

Q26. Out of Hours services are currently commissioned from Stour Care. What are the intended future care pathways for Out of Hours services?

Eastern and Coastal Kent PCT was trying to move away from a 'out of hours' mentality towards one of twenty-four hour service provision. The key to this was the provision of primary care and who could deliver it. This would be tendered through the normal NHS process and there would be an element of public engagement in the process.

It was stated that the decision by general practitioners to opt out of 'out of hours' services locally and use Stour Care was a long-standing one, and predated the introduction of Practice Based Commissioning and more recent opting out arrangements.

SQ17. The recent A20 accident found areas where emergency care services could be improved. What is the PCT doing concerning this?

In response to Councillor C E Kirby's question, it was stated that the PCT commissioned services from the South East Coast Ambulance Service NHS Trust to operate at a certain

level of standard and it was accepted that in the case of the recent A20 accident that the standards fell below those expected. In its role as performance manager of the services it commissions, it would discuss the matter with the ambulance service.

As part of the learning process, the major incident plan would be re-examined to identify areas where improvements could be made but it had to be accepted that in any major incident there would be exceptional circumstances. An example of this was that the fog prevented the air ambulance from attending the scene. Overall, the key was to get emergency care to the incident as soon as possible and then move any patients to an acute centre from there.

**Intermediary Care Provision**

Q27. Given the high number of elderly and economically deprived residents in the urban Dover wards, what are the proposed plans for intermediary care beds in the new Dover health facility?

The overriding emphasis was on providing intermediary care in the home where possible. There were currently intermediary care beds provided at Victoria Hospital, Deal and Alexander House, Dover. The intermediary care beds previously provided at Buckland Hospital had been transferred to Alexander House, as it was considered a more suitable location and there were currently no plans to provide intermediary care beds in the new Dover health facility.

Q28. The Victoria Hospital, Deal currently provides a minor injuries unit, six outpatient rooms and 36 intermediary care beds. What are the plans for the future of the hospital?

The PCT was in the process of reviewing all its community hospitals as part of a service review. In the case of Victoria Hospital, Deal this review would take the same form as the recent Dover Project as to how to best provide services. As with the Dover Project consultation, it would be about services as opposed to buildings.

There were no intermediary care beds in Dover for children currently and there were no proposals for introducing them in the future as it was felt children were most suited for intermediary care in the home environment.

SQ18. Is it right to purchase services from different groups?

In response to Councillor Miss C M Edwards question, it was stated that it was considered a viable model of care under the current approach, as there was a need for specialisation in service provision.

**Practice Based Commissioning**

Q29. The Government has indicated since 1998 that Practice Based Commissioning will play a key role in service provision. How has this affected the proposals for future health service provision?

It was stated that funds were allocated to groups of general practitioners and this was used to purchase services locally. Examples of this process could be found in Dover and Aylesham.

SQ19. How influential have local General Practitioners been in steering local health services and delivery?

In response to Councillor Mrs J F Tranter's question, it was stated that it was too early to tell at this point as it had only recently started. The process was very complex financially, and general practitioners had to learn new skills to do it. In addition, general practitioners played two roles as both service commissioners and deliverers.

The Aylesham and Dover Practice Based Commissioning groups seemed to be working effectively and had brought in some cost savings and improved communication.

Q30. How will the introduction of 'payment by results' affect the proposals for future health service provision?

An example of 'payment by results' (PBR) was cited as excess bed day charges. A tariff was assigned to each patient depending on their care need and Eastern and Coastal Kent PCT paid an excess fee for each day over that. For example, a standard stroke case would be assigned a tariff of thirty bed days and if the patient had to stay for 35 days, then Eastern

and Coastal Kent PCT would pay an excess bed day fee of five days to the East Kent Hospital Trust.

There were problems with the excess bed day system, in that Eastern and Coastal Kent PCT would not receive any refund on the standard tariff if the patient spent less than the expected bed days in hospital. For example, a standard stroke patient who spent only ten days in hospital would not see a refund of twenty days awarded to Eastern and Coastal Kent PCT. In addition, the emphasis on local care also created problems in accurately allocating the tariff. If a patient spent twenty days in hospital and ten days home care, the East Kent Hospital Trust would still receive the full thirty-day tariff.

The same system was also applied to other areas such as outpatient care and accident and emergency units.

Health Service Transportation

Q31. Given the high level of economic deprivation in the urban wards and the poor public transport links from Dover to Ashford and Thanet, do you have any plans to expand the 'Health Hopper' bus network to include direct services from either the Royal Victoria Hospital or Buckland Hospital to the Queen Elizabeth Queen Mother Hospital, Thanet or the William Harvey Hospital, Ashford?

Transportation had been identified as one of top priorities to tackle and discussions were underway with Kent County Council and commercial transport in an attempt to resolve the matter. It was expected that the emphasis on local care would reduce the need for transportation use but it was recognised that there were problems around local transportation within the district.

SQ20. What consideration is given to integrating the 'Health Hopper' bus times with commercial services, especially given that people aged over sixty years of age are entitled to free bus travel?

In response to Councillor C E Kirby's question, although it was acknowledged that the situation required improvement, it was stated that an audit needed to be completed before the matter could be tackled. The review of transport would include examining the case of carers and dependents that were not currently entitled to use the 'Health Hopper' service.

It was expected that the "choose and book" appointment system would also assist in helping people by allowing them to select more suitable appointment times to fit in within transport schedules. Although the service was available online, patients without access to the Internet could access the system via doctor's surgeries. Councillor Ms S M Le Chevalier informed the Committee that she had used the system online and found it to be simple to use.

At this point in the meeting, Councillor G J Hood invited questions from Councillors present that were not members of the Committee.

SQ21. Are the visits of consultants to doctor's surgeries to see patients locally the most effective use of resources? For example, a patient may only have to travel for fifteen minutes to see the consultant but the consultant may have to have travelled for thirty minutes to see the patient.

In response to Councillor N J Collor's question, it was stated that if the consultant were to see multiple patients during the visit, then it became an effective use of resources.

# Inquiry Report Three

# East Kent Hospitals Trust

Mr Howard Jones, Director of Facilities of the East Kent Hospitals Trust, was invited to the meeting to respond to questions from the Scrutiny (Community and Regeneration) Committee at its meetings held on 18 September 2007. Supplementary questions asked by Members of the committee were prefixed with the letters 'SQ'.

Prior to answering the key questions, a site visit had been conducted at Buckland Hospital by the Committee.

Foundation Trust Status

Q1. The East Kent Hospitals Trust Annual Report 2006/07 ('Getting you better faster') states that you are making preparations for a future application for Foundation Trust status. What do you see as the principle benefits in becoming a Foundation Trust?

The principle benefits of becoming a Foundation Trust were:

- Greater autonomy and freedom to design and deliver services appropriate to the needs of our patients.
- Greater staff and public involvement.
- Stronger links to the community.
- The protected list of services the Trust provided.
- Greater access to capital through borrowing.
- A greater focus on systems and structures to ensure they were effective.
- It ensured that the Trust worked toward best practice in all areas of management and practice.
- Become one of the leading NHS Trusts and the advantages that brings.

Q2. When do you anticipate making your application for Foundation Trust status and how advanced are your preparations?

The Trust has recently appointed a new Chief Executive and would be making its decision at the end of 2007.

Q3. What are the strengths and weaknesses of the East Kent Hospital Trust in respect of it meeting the criterion for becoming a Foundation Trust?

The strengths were:

- Historical track record of hitting financial savings plan.
- Strong links with commissioner/partners.
- Strong commitment from local populations to local services and hospitals.
- Large organisation – 11th largest Trust in England.
- Strong provision of core services – A&E targets etc
- Key delivery and investment in specialist services – renal, vascular, cardiac.
- Committed staff at all levels.
- Geography – more stable market.

The weaknesses were:

- Complex organisation – lots of sites to ensure are operating efficiently.
- The increased risk of competition from the West Kent Trust in the provision of services and in particular in the area of specialist services.
- The attachment of local communities to a building as opposed to a service.
- Current financial position of the Trust

Q4. Are there any financial implications involved in undertaking your preparations and making your eventual application for Foundation Trust status?

Increasingly, the standards and methodologies put forward by Monitor were becoming the norm in terms of NHS practice. This was advantageous because it was good practice and would improve the way in which the organisation was managed. It also would enable the Trust to focus its current resources on achieving a successful application.

In the short term, it was likely that a small amount of resource would need to be purchased externally in the form of project management and guidance and information. However, people currently employed by the Trust will do the majority of work.

SQ1. How optimistic are you of your application for Foundation Trust status being approved?

In response to Councillor D R Lloyd-Jones' question, it was stated that the application process was tough but that they were optimistic as to their chances.

SQ2. What happens if you are unsuccessful in your application?

In response to Councillor R S Walkden's question, it was stated that the East Kent Hospital Trust would reapply once it had made the necessary changes to be successful.

Q5. What are the proposed governance arrangements for East Kent Hospital Trust if it is successful in its eventual application for Foundation Trust status?

The governance arrangements follow the detailed guidance issued by Monitor but it was likely that the Trust would have:

- A membership from public constituencies based on the local authority areas served by the Trust; a patient constituency of patients and carers who do not live in the public constituencies; and a staff constituency.

- Members Council consisting of the Trust Chairman appointed by the Members Council; elected governors from the public constituencies, patient constituency and from the staff and stakeholder governors nominated by the Eastern and Coastal Kent Teaching Primary Care Trust and local authorities served by the Trust and the Trust's key partners.

- A Board of Directors consisting as a minimum of Trust Chairman, Non-Executive Directors, Chief Executive, Finance Director, Medical Director and Nursing/Midwifery Director.

- A statutory Remuneration Committee and a statutory Audit Committee, both composed of non-executive directors.

Q6. Assuming that you achieve Foundation Trust status, how will you ensure that the Board of Governors is representative of the local community and in particular those groups who are traditionally under represented on public bodies?

By implementing the arrangements outlined in answer to question five and continuing to attend meetings such as this Overview and Scrutiny Committee meeting, working with partner agencies and continuing to consult the public on the Trusts plans.

East Kent Hospital Trust Financial Management

Q7. According to the East Kent Hospitals Trust Annual Report 2006/07 ('Getting you better faster'), you have been in 'financial recovery' since 2002/03 and you were predicted to have a deficit of £17 million at the end of the year 2006/07. What measures did you take to deliver the improved final figure of a deficit of £4.7 million for the year 2006/07?

Recovery and efficiency programme managed by a specific board with the Chairman. The issues which contributed most to the end of year figures were improvements on length of stay; speed of access to diagnostics, procurement savings and contract value with PCT's.

Q8. How does the East Kent Hospital Trust plan to cope with the efficiency requirements of 2.5% built into the National Tariff and the £2.5 million reduction in the transitional relief arrangements under the Payment by Results system?

This would be achieved through ongoing efficiency requirements through specific Board with each directorate having been set savings targets to achieve.

Q9. Is the predicted financial situation of a cumulatively balanced budget by 2008/09 sustainable in the medium and longer term?

A balanced budget is a statutory requirement and all planning is carried out on this basis. This situation is a national picture and not just one for East Kent.

SQ3. What would be the one single area you would increase funding for, if you had access to more money?

While acknowledging that a clinician would have a different set of priorities, Mr Jones identified improving the fabric of the Trust's buildings as the area he would increase funding if he could.

Practice Based Commissioning

Q10. What do you anticipate the future impact of Practice Based Commissioning to be on the East Kent Hospital NHS Trust?

It was too early to tell what the impact would be at this point. All the clinical leads met regularly including medical speciality 'away days'.

Q11. How do you see your relationship with GP's developing in the future?

The desire was to improve local services working hand in hand with GPs. New technology would aid discharge and referral information, which in turn would improve liaison between the acute sector and GP's.

SQ3. In your opinion, how do you see the development of increased patient choice and Practiced Based Commissioning affecting staffing and finances?

The development of Practice Based Commissioning (PBC) was both a threat and an opportunity for the Hospital Trust.

For example, a potential threat would be if a private company was contracted to provide a specific service rather than the NHS. This would result in the Hospital Trust losing the income that service generated and it would also impact on the development of the Trusts skill base. As a private company would not be attracted to loss making services (such as maternity) it would leave the Hospital Trust providing those without the income from the profitable services to offset it.

SQ4. Does the Hospital Trust reduce services if it is not paid enough to make it profitable?

In response to Councillor R S Walkden's question, it was stated that the Hospital Trusts primary concern was the delivery of services rather than the profitability of services. However, it was making representations to address the issues around some tariff levels being too low.

Buckland Hospital

Q12. There is some concern over the future of health service provision in Dover, particularly around the future of the Buckland Hospital site. Can you relate to this concern?

The provision of health services in Buckland Hospital had to be seen in the context of increased investment and service improvement to the whole of the population through all of the acute sites. The tension between access and quality of clinical care was well understood and the East Kent Hospital Trust was not alone in this situation.

The Hospital Trust was also affected by limitations imposed under the working time directive and the requirements of the Royal Colleges for a critical mass of patients to ensure skills were maintained.

Q13. What difficulty does an older building such as Buckland Hospital present in the delivery of high quality modern services?

Buckland Hospital was designed as a workhouse at the end of the 19th Century and its design did not promote good clinical working. An example of the fact that the building was not fit for purpose was that despite upgrading Ramsey Ward there was nothing that could be done about the sloping floor of the ward.

Q14. How would a new building be an improvement over the existing Buckland Hospital building?

Any new building would be designed to ensure that it was fit for the purpose for which it was built.

SQ5. Can you guarantee that the provision of locally based services will continue in the event of their being an interim period between Buckland Hospital closing and the new facility opening?

The Committee was advised that the continued provision of locally based services in the event of any interim period could be guaranteed.

SQ6. Can you guarantee that Buckland Hospital will be replaced by a new building, accepting that it may possibly be on a different site?

The Hospital Trust was committed to ensuring that services remained local in Dover with the exception of in-patient services, which would cease to be provided locally. The ideal approach was to build the new facility first and then transfer services to it but it would be dependent on timescales.

There was a clinical need to maintain Buckland Hospital until the new site was ready. There were no plans for satellite split sites in replacing Buckland Hospital.

Q15. What do you see as the future role of a Dover 'hospital'?

A healthcare facility in Dover would more likely be designed around the new Polyclinics, which were emerging with a focus on outpatient and day services. However, the design would also be determined by future commissioning needs described by the local GP's under Practice Based Commissioning.

Mr H Jones stated that the possibility of a mid-town location for the new healthcare facility was an exciting idea in principle. However, there were a lot of variables to be considered. There had been meetings with key partners, including Dover District Council to examine the possible site options for replacing Buckland Hospital.

An example of partnership working between a Hospital Trust and local authorities was in Burnley, where a combined health and leisure centre was built.

Q16. Will the replacement health facility for Buckland Hospital contain inpatient beds?

There were no plans for in-patient beds in the replacement facility for Buckland Hospital. The only exception would be possible in-patient beds for maternity services within a new birthing centre design.

Dover Project Proposed Models of Care

Q17. What was the role of the East Kent Hospital Trust in the Dover Project Consultation?

The Primary Care Trust principally managed the Dover Project consultation and the Hospital Trust responded formally as a statutory body within the locality. The Director of Nursing and Quality was an active member of the Dover Project steering group and the Hospital Trust was part of the working groups examining future models of care.

Q18. Did you approach your involvement in the Dover Project purely from the perspective of a service provider, or did you try and see it from the perspective of the patient?

All the decisions that the Trust Board made were tested against the needs of those whom it served. The Trust always tried to look at things from the view of the patient.

Q19. In the case of Dental Services the most popular option for service delivery among respondents (39%) favoured option C2 as follows: 'An increase in the dental access service and maintenance of current regular dental provision'. However, in contrast the preferred 'Model of Care' proposes that services be delivered through a variation of option C3 as follows: 'Keep the balance between a regular dental provision and the dental access service as it is now and provide an increase in overall provision with an emphasis on regular dental care'. How will the amended option C3 deliver services more effectively than option C2?

This was a question for Eastern and Coastal Kent Primary Care Trust.

Q20. In the case of children's services in the community, the most popular choice among respondents was option H1 (35%) as follows: 'Offer a broader range of community services in a central Dover location dedicated to children's services'. However, in contrast the preferred 'Model of Care' proposes that services be delivered through a new option not contained within the four possible consultation responses, known as H5, which was as follows: 'Provide enhanced and specialist services from a central Dover location, whether this is dedicated to Children's Services or linked to other NHS provision. Low level and more generic services to be delivered in a range of community and NHS facilities'. How will option H5 deliver services more effectively than option H1?

It was stated that Option H5 was an improved version of H1 in respect of improved collaborative working solutions across the community with the Hospital Trust providing a more child focussed service.

Q21. In the case of children's day ward services, the most popular choice among respondents was option I2 (89%) as follows: 'No change to the current service. Continue to provide children's day ward services in Dover'. However, in contrast the preferred 'Model of Care' proposes that services be delivered through a variation of option I2 as follows: 'Continue to provide ambulatory care services in Dover and co-locate them with other Dover children's services on the same site such as radiology, minor injuries, outpatients and some elements of community services'. How will the variation of option I2 deliver services more effectively than the option I2 set out in the consultation document?

The variation of Option I2 described it with greater detail and recognised partnership working with the Eastern and Coastal Kent Primary Care Trust.

Q22. In the case of midwifery services the most popular choice among respondents was option J1 (62%) as follows: 'Expand the service at the birthing unit so that more women with low risk births can be cared for'. However, in contrast the preferred 'Model of Care' proposes that services be delivered through a variation of option J3 as follows: 'Make no changes and keep the birthing unit the way it is at the moment'. What was the rationale for rejecting the expanded service proposed under option J1?

The birthing unit service had in fact expanded since the document was published and it was now delivering approximately 100 more babies than when the unit first opened. It was a popular service and used by patients from all over East Kent. All low risk women could opt to have their babies at this unit and as such, the limitation was one of clinical risk rather than investment in the service.

The Maternity Working Group explored the feasibility of expanding the service but reached the conclusion that the service presently met the needs of Dover mothers-to-be and beyond.

SQ7. Did the Hospital Trusts need for financial stability as part of its preparations prior to any application for Foundation Trust status result in the decisions to adopt different Models of Care from those preferred by the public?

The financial requirements necessary for Foundation Trust status did not play any role in determining the preferred Models of Care, as clinical needs were more important. The savings made by the Hospital Trust were not based on cutting services.

Staffing

Q23. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 10: Redesign and extend roles?

There has been considerable progress made in this area and five of the new roles introduced are set out below.

- Vascular Nurse Practitioner: These act as first assistant to the consultant surgeon instead of a doctor.

- Radiography Assistant Practitioners (Band 4): These can take x-rays freeing up radiographers (Band 6) to report images.

- Assistant Theatre Practitioners (Band 4): These can take the place of a Scrub Nurse (Band 5/6) that are in short supply.

- Assistant Practitioners in Nuclear Medicine: These were able to do biopsies.

- Generic Workers: These act as HCA's and Porters in theatres.

The Hospital Trust was working with Canterbury Christchurch College to create new medical degrees for nurses, which was part of the changes being made to the Doctor/Nurse relationship.

Q24. Do you have sufficient trained medical staff to deliver a high quality service in all areas?

The Hospital Trust currently had more doctors and consultants than it had ever had previously, although in common with other Trusts there were some shortage areas. However, the situation had improved significantly in recent years.

There were some concerns about the number of junior doctors given the reduction in working hours and the Hospital Trust was seeking to recruit more junior doctors as a result.

SQ8. What was being done in respect of the 'Hospital at Night' concept?

In response to Councillor Mrs S S Chandler's question, it was stated that the Hospital Trust had recognised the need to adjust staffing in keeping with the 'Hospital at Night' concept.

SQ9. Does Buckland Hospital still have porters?

In response to Councillor Mrs J M Munt's question, it was stated that Buckland Hospital had hospital porters on site. This was corroborated by members of the committee who recalled seeing porters during the site visit to Buckland Hospital.

Q25. How have the changes to working practices for junior doctors impacted on their training needs and performance?

Doctors in training were now educated differently under the Modernising Medical Careers initiative and could only work an average of 56 hours (to be reduced to 48 hours in 2009). This was beyond the control of the Hospital Trust and required an increase in consultant administration but it was looking at ways of ensuring that patient care was improved by team working such as the Hospital at Night concept and constantly reviewing the 24/7 medical coverage.

Waiting Times

Q26. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 8 (Improve patient access by reducing the number of queues)?

The measures identified in the ten high impact changes were being encompassed in a rigorous project managed under the heading of 'clinical systems improvements'. It was based on 'lean thinking technology' with the patient at the heart of the care pathway. Implicit within this was reducing the number of queues.

As an early implementer of the eighteen-week promise, the Hospital Trust had undertaken a lot of work to reduce the number of queues. For example it had extended the use of a range of professionals such as ESPs (Extended Scope Practitioners) so those patients who were more seriously ill could get quicker access to a doctor. The Hospital Trust was working jointly with the Eastern and Coastal Kent Primary Care Trust to implement ICATs so that patients did not queue in hospital but could be seen elsewhere more quickly.

The Hospital Trust aimed to deliver as much as possible in terms of clinical services in East Kent and had achieved a waiting list of only a few weeks for some surgeries. Overall, only 4.5% of its budget was spent on administrative functions and this compared well against other organisations of the same size in the private sector. This included both clerical and clinical administration.

Q27. Are you on course to meet your '18 Week Promise' between referral by a GP to the start of a patient's hospital treatment?

The 18-week programme was a huge complicated project that the Hospital Trust was managed as an early implementer site. At present the Hospital Trust was approximately four to six weeks behind programme but the clinical staff remained committed to meeting the target date. The delays arose from the challenges in implementing such a complex programme.

Q28. Is there any variation in performance by different diagnostic categories in achieving the '18 Week Promise'?

It was stated that all diagnostic pathways were working hard to achieve the 18 week programme.

SQ10. What role, if any, do you expect the independent sector to have in fulfilling the 18 Week Promise?

In response to Councillor D R Lloyd-Jones question, it was stated that the independent sector would have a role in fulfilling the eighteen-week promise by reducing waiting lists. However, the private sector would only be paid the NHS tariff level for the work.

Q29. What is the current average waiting period from referral by GP to the start of a patient's hospital treatment for inpatient treatment?

The current average waiting period from referral by a GP to the start of a patient's hospital treatment for inpatient treatment was 25 weeks.

Q30. What is the current average waiting period from referral by GP to the start of a patient's hospital treatment for outpatient treatment?

The current average waiting period from referral by a GP to the start of a patient's hospital treatment was 13 weeks.

Q31. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 2 (Improve access to key diagnostic tests)?

This was included within the clinical systems improvement programme. However, portable MRI scanners have been introduced as well as evening and weekend appointments for ultrasounds to make services more accessible to patients.

'Choose and Book'

Q32. What do you see as the main benefits of the 'Choose and Book' system?

There were six main benefits to the 'Choose and Book' system:

- The patient could choose from at least four hospital providers to attend. If patient chooses EKHT they can also choose by hospital site subject to where speciality services were available.

- The patient can choose the date and time of their appointment.

- The patient experiences greater convenience and certainty. With 'Choose and Book' the choice is theirs.

- There is less chance that information will get lost in the post because more correspondence takes place through computers.

- The system becomes more streamlined as the number of steps administratively is significantly reduced.

- The number of missed appointments (the 'DNA' rate) for patients allocated an appointment by 'Choose and Book' is lower because the time and date have been agreed.

Q33. When selecting a clinical consultant via the 'Choose and Book' system, does the patients GP have easy access to data on hospital cleanliness, mortality rates and consultant experience in order to help them make an informed choice with the patient?

This information could be accessed by the GP or by the patient, by logging onto East Kent Hospitals own website or by accessing NHS Choices website. The website listed the consultants and the cleanliness along with MRSA infection rates. The Hospital Trust was working on developing a website that was user friendly and fully comprehensive.

The Patient Experience – Admission

Q34. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 4 (Manage variation in patient admission)?

As part of both the 18-week work and NHS Care Records Service the Hospital Trust had been looking at the pathways patients currently use both from within the hospital and in primary care. These have been analysed with a view to streamlining them to make sure patients only access services and diagnostics they required. Most patients were admitted on the day of surgery straight to the ward that they would stay on rather than being moved between wards.

Q35. What feedback have you received from patients in respect of the new 'Patient Service Centre'?

The Patient Service Centre was opened at the Kent and Canterbury Hospital and its success had created problems in terms of capacity but these had been recently addressed and it was presently working very efficiently in dealing with many patient queries on inpatient and outpatient appointments.

Emergency Care

Q36. A recent study conducted by the University of Sheffield estimated that the mortality rate for patients transported by ambulance increased by 1% percent for every six miles travelled and for people with breathing problems who had to travel over twelve miles, the mortality rate rose to 20%. What has the trend for mortality rates been over the last five years for emergency cases taken from Dover and Deal to Accident and Emergency centres in Thanet and Ashford?

Mortality rates in the Trust have been falling over the last two years. There was no evidence that emergency cases from Dover and Deal were treated less favourably in terms of clinical outcomes.

The replacement of the previous "swoop and scoop" approach had been replaced by a new system where the treatment given by the paramedic reduces the importance of the travelling time in the final clinical outcome.

The local experience was that taking patients to a fully equipped Accident and Emergency Unit had a much better outcome and that mortality rates had fallen over the last few years. However, the Hospital Trust did not hold specific times for patients from the Dover District.

Q37. What challenges does dealing with emergency cases from towns of Dover and Deal at Accident and Emergency centres outside of the District present?

There were no particular difficulties in dealing with emergency cases from all the rural areas covered by the Hospital Trust. There was good partnership working between the acute trust and the South East Coast Ambulance Service and the new fully trained paramedics in ambulances were now part of the care pathway for those presenting with emergencies.

Q38. What is the average waiting time for an ambulance at the Accident and Emergency units at the William Harvey Hospital, Ashford and the Queen Elizabeth the Queen Mother Hospital, Thanet?

This was a question for the South East Coast Ambulance Service.

The Patient Experience – Service Delivery

Q39. The mission statement of the East Kent Hospital Trust emphasises the intention to 'put patients first'. How are you working to achieve this?

Patients were at the heart of all the decision-making of the Trust Board and indeed that of the Healthcare Commission and the Government. The Hospital Trusts investment plans and strategic planning models were made on the basis that there would be an improvement in patient care as a result of its actions.

In addition, the Hospital Trust was audited to ensure that it is putting patient care at the heart of decision-making and the Audit Commission could make spot checks to confirm that this was the case.

Q40. What plans are there for investment in services in the District of Dover over the next three years?

The investment plans for Dover were centred on the future of Buckland Hospital as leaving it in its present state was not an option.

Q41. Are there any services currently offered locally by the East Kent Hospital Trust that are 'clinically unsustainable' in the longer term?

There were no specific plans to reduce services at any of the Trusts hospital sites. The Trust was in fact expanding services in a number of areas, including renal and vascular. In the last year the Trust had opened new cardiology services replacing work that had previously been undertaken by London hospitals. The Trusts intention was, where possible, to bring as much care back into the local community as it was clinically and financially possible to do.

Q42. Are there any new services that you are seeking to provide locally in the future?

This was answered in the previous question.

Q43. How do you marry a good patient experience with the need to maintain the necessary volume of patients required to develop and maintain the skills of staff?

This was a challenge for all hospital trusts at present as shown by the changes proposed within Hastings and Eastbourne, Maidstone and Tunbridge Wells, Brighton and Haywards Heath, Frimley Park and Ashford St Peters.

The provision of good quality acute care was dependent upon having the right people in the right place at the right time – ie those clinicians with experience and the diagnostic equipment and theatre capacity to back this up. Inevitably this would lead to certain acute services being concentrated on a reduced number of sites, with the resulting tension between access and quality of care/clinical governance.

Q44. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 1 (Treat day surgery as the norm for elective surgery)?

The percentage of elective surgery carried out as day surgery was rising year on year. Currently, eighty percent of the basket of cases commended for day surgery was undertaken on that basis, which was near the target. The Hospital Trust had put in place a mechanism, which made sure that each patient who required surgery automatically defaulted to being admitted as a day case unless the surgeon specified that the patient should be an inpatient. This meant that patients were no longer kept in a hospital bed inappropriately.

The Committee commended the quality of the environment it witnessed at the renal dialysis unit during its site visit.

Q45. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 9 (Optimise patient flow using process templates)?

This was part of the clinical systems improvement programme.

Q46. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 6 (Increase the reliability of performing therapeutic interventions through a 'Care Bundle' approach)?

The Trust had a programme of care bundles that it was in the process of implementing. It was currently working on implementing the sepsis care bundle and was working across pathology to define the tests that patients with specific conditions should have ordered to minimise wastage in the system. In addition, the Trust had already implemented the ventilator care bundle.

Q47. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 7 (Apply a systematic approach to care for people with long-term conditions)?

The Trust had worked with the Primary Care Trusts for a number of years on implementing an intermediate care strategy, which focused on these patients. It had agreed pathways with the Primary Care Trust for COPD, diabetes, and heart failure, which ensured that patients were managed in the community and were only transferred to hospital when they had an acute episode.

Antenatal Service Provision

Q51. The East Kent Hospital Trust was awarded the Royal College of Midwives Award for Innovation in Mid-Wifery Practice for the first Ante-Natal Clinic in the county to be provided in a supermarket (Sainsbury's at Westwood Cross, Thanet). What do you see the benefits of operating an Anti-Natal Clinic in a non-traditional environment such as a supermarket?

The benefits were easier access for patients and encouraging mothers to be seen in a non-threatening and informal environment. In doing this it ensured that all mothers received good quality antenatal care. The clinic was particularly popular with teenage mothers as it was a less threatening environment than a traditional clinic. In addition, Sainsbury's benefited financially from the arrangement through increased baby product sales.

SQ11. Have you experienced any problems with operating an Anti-Natal Clinic at a supermarket?

In response to Councillor C E Kirby's question, it was stated tat there had been no significant problems operating the Anti-Natal Clinic in a supermarket.

Q52. Are there any plans to expand this innovative idea to locations within the District of Dover?

There were no specific plans at present but the lessons learned from the Thanet model would certainly be applied elsewhere and developed if it was possible.

Hospital Environment and Cleanliness

Q53. While you should be congratulated on achieving Patient Environment Action Team (PEAT) scores of Good or Excellent in terms of Environment, Food and Privacy/Dignity, what measures are you taking to ensure consistent standards across all your hospitals in East Kent?

A huge amount of work went into achieving good PEAT scores including the investment of £300,000 in direct patient care facilities. The PEAT programme operated across all sites and Medirest, who provide catering and cleaning services for the Trust. The objective was to ensure that investment and best practice were shared across each site.

Q54. What progress have you made in meeting targets for reduction in the number of cases of hospital-acquired infection, and particularly in respect of MRSA and Clostridium Difficile?

For the period April to August 2007, the Hospital Trust had 15 reported cases of MRSA and 17 of Clostridium Difficile. This was a reduction on the levels for the same period in 2006 for both types of infection.

When broken down into monthly figures, the Hospital Trust had shown a significant decrease in the occurrence of MRSA since June 2007, with only one new case per month recorded in June and July and two cases in August.

For Clostridium Difficile, the occurrence rate had decreased from 2.9 new cases per 1,000 bed days in January 2006 to 0.8 new cases per 1,000 bed days in August 2007. In terms of total new recorded cases, the figure for August 2007 was 17 cases compared to 63 in January 2006.

SQ12. Do you screen surgery patients for infections?

In response to Councillor R S Walkden's question, it was stated that surgery patients were screened for infections. The Hospital Trust had a strong infection control team, which worked with the cleaning teams to reduce the levels of hospital-acquired infection.

SQ13. Is there any link between the levels of hospital-acquired infection and the PEAT scores for environment?

There was a link between the PEAT scores for environment and the levels of hospital-acquired infection as a clean ward was not only desirable but also better for patient health. The Hospital Trust worked to national NHS cleaning standards and where any infections were found the ward would be blitzed to remove it.

The Role of the Independent Sector

Q55. What impact does the independent sector have on the provision of health services in East Kent and particularly in the Dover District?

The independent sector was a complementary service, which could assist in the provision of elective surgery to patients in East Kent. As part of the eighteen-week programme the Hospital Trust would use private healthcare facilities to enable it to meet the target. However, the Hospital Trust's focus and investment plans were primarily within the NHS.

The Patient Experience – Discharge

Q56. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 3 (Manage variation in patient discharge)?

The Hospital Trust endeavours to discharge patients in the morning whenever possible and it discharged patients seven days a week to ensure there was no delay in the system. All patients were given an estimated date of discharge on their admission. However, discharge was not just the responsibility of the hospital and the Hospital Trust had to rely on its partners, such as Social Services, to progress high impact change.

In the event that a patient was unable to make their way home following discharge, the Hospital Trust would pay for the patient to be taken home. Although this was rare, it tended to occur most often at night when public transport was not operating. This also covered the patients who were discharged at night after being taken to hospital by an ambulance.

Q57. How do you ensure that a clinical criterion rather than 'bed management' drives patient discharge from hospital?

This is a key clinical question, which was addressed by the clinical team managing the patient's discharge.

Q58. For patients from vulnerable sections of the community, the experience of discharge from hospital to either home or intermediate care can be a stressful time. What steps do you take to ensure that the necessary post-discharge support services, such as social services, are involved in the discharge process?

Kent County Council Social Services were based at each of the hospital sites and work in partnership with the ward management and the clinical teams to ensure that the discharge process operated correctly for each patient. The team covered every facet of the discharge process.

Q59. The NHS modernisation agency identified ten high impact changes that could be adopted to make significant, measurable improvements in the way care is delivered. What progress has been made in advancing Change Number 5 (Avoid unnecessary follow ups)?

The Hospital Trust had agreed target ratios for all conditions to ensure that patients were not brought back to the organisation inappropriately.

Q60. In order to assist the Members of the Committee in developing an understanding of how the 'patient journey' works could you explain the various stages that a patient will progress through in these hypothetical examples from the point an ambulance is called to the post-discharge process.

(a) "So what happens if I'm a patient who has a heart attack in Dover?"

Either the GP or the patient's family will call for an ambulance. The ambulance had a skilled crew onboard who would assess, diagnose and provide immediate treatment. The patient would then be transported to the nearest Accident and Emergency Unit or Emergency Care Centre where they would have clot-busting drugs administered if appropriate before being transferred to a cardiac care unit.

(b) "So what happens if I'm an elderly patient who falls at home and breaks a hip?"

Either the GP or the patient's family will call for an ambulance. The ambulance had a skilled crew onboard who would assess, diagnose and provide immediate treatment. The patient would then be transported to the nearest Accident and Emergency Unit or Emergency Care Centre.

In order to ensure that the ambulance response time is kept as short as possible ambulances were positioned in strategic locations.

Major Incidents in the Dover District

Q61. There is strong local concern over the absence of an Accident and Emergency Unit in the town given the high numbers of people moving through the Port of Dover and surrounding roads. What would you say to reassure people that acute general hospitals located outside of the district could deliver the same quality of emergency care as an acute general hospital located in Dover would in the event of a major incident?

This was something that has been raised many times over the last 20 years. The number of attendances generated by people using Dover and surrounding routes was absolutely minimal. The reality was that to maintain clinical expertise and to have the skills required to

deliver care in the 21st century means it was just not possible to provide Accident and Emergency Units in every town.

The volume of work generated would not be adequate to justify the overheads to provide such a service and even if the resources were available, there were not the numbers of appropriately trained clinicians available to run a full Accident and Emergency service in all our towns. National guidance was that a population of 500,000 is the ideal population required to maintain skill levels. This was obviously challenging for the Hospital Trust given the distribution of the local populace in East Kent.

# Inquiry Report Four

## Patient and Public Involvement Forums

Mrs Maureen Moore and Mrs Janet Bentley, Chairs of the East Kent Hospitals Patient and Public Involvement Forum and Eastern and Coastal Kent Patient and Public Involvement Forum respectively, were invited to the meeting the Scrutiny (Community and Regeneration) Committee at its meetings held on 25 September 2007.

(a) Patient and Public Involvement Forums

Patient and Public Involvement Forums (PPIF) were established four years ago with the intention of giving the public a voice in the operation of local NHS trusts. Although each PPIF was associated with a specific NHS health trust, such as the East Kent Hospital Trust or South East Coast Ambulance Service for example, it remained independent of it. The PPIF's were also independent of the Patient Advice and Liaison Services (PALS), although they did receive reports from them.

As part of its role in monitoring health services and safeguarding the public interest, representatives from the PPIF's sit on trust boards and groups. The PPIF also oversees engagement between the trusts and patient and public groups to ensure that proper consultation processes were in place.

The PPIF for the Eastern and Coastal Kent Primary Care Trust comprised of a main forum and five locality groups based on the boundaries of the five antecedent Primary Care Trusts. When the five Primary Care Trusts merged to form the Eastern and Coastal Kent Primary Care Trust, the PPIFs for each trust also merged.

The PPIF's were composed of members of the public who had volunteered to join it. The East Kent Hospital Trust PPIF held monthly meetings and the Eastern and Coastal Kent Primary Care Trust PPIF held bi-monthly meetings. The meetings were open to the public. In addition, locality meetings were held between the main meetings. The meetings promoted awareness of important local health issues, such as the proposed models of care emerging from the Dover Project consultation, through road shows and other events. A recent meeting held at Dover Town Hall on the Dover Project attracted approximately 150 people.

(b) Service Delivery

The PPIF's influence on service delivery was subtle and exercised through ongoing dialogue with the individual health trusts. Each PPIF prioritised its workload, selecting key issues for consideration. Recent items on the work programme included the stroke unit and endoscopy services.

In response to Councillor Mrs J M Munt's question, it was stated that only Queen Elizabeth Queen Mother Hospital, Thanet and William Harvey Hospital, Ashford had in-patient beds for children.

(c) Dover Project

The PPIF's were not involved in the design and content of the Dover Project consultation leaflets and the low level of responses received to the consultation was a surprise. The PPIF's had representation on the Dover Project Steering Group, which was discussing the proposed models of care to be developed.

The PPIF supported the concerns raised through the Dover Project consultation that transport from local communities to the acute hospitals was in need of significant improvement. It was noted that the transport service provided by East Kent Hospital Trust was a clinical service and that those people who were fit to travel were expected to use public or private transport. This issue was also part of the discussions arising from the "Fit for the Future" programme.

In response to a question from Councillor C E Kirby, it was stated that as far as the PPIF's understood some carers were allowed to travel on the hospital transport.

(d) Choose and Book

The PPIF had been pushing for a wider use of the 'Choose and Book' system by the public and GP's. The Committee expressed concerns that this service, while an excellent idea, had not been effectively promoted to the local community and that many elected Members were also unaware of its existence.

At present approximately 49% of appointments were made through the system and it was hoped that through wider promotion of the service, take up would increase.

(e) LINks

The PPIF's were due to be replaced by the new LINks in 2008, which would be financed by Kent County Council (KCC) and delivered by a host organisation.

Although the PPIF's had not taken a formal view on the LINks, there was support for the wider remit of the LINks, which would embrace all aspects of NHS medical care as the various individual PPIF's work frequently overlapped. The expansion of remit to include KCC Social Care was also welcomed.

However, there were concerns that a single LINks for the whole of Kent, excluding the Medway Unitary Authority, would have difficulty in co-ordinating a large number of different NHS trusts. There was also concern that without locality groups, it would be a difficult task for a Kent wide LINks to effectively focus on local issues.

# Inquiry Report Five

## South East Coast Ambulance Service Trust

Mr Geraint Davies, the Director of Corporate Affairs and Service Development, of the South East Coast Ambulance Service, was invited to the meeting the Scrutiny (Community and Regeneration) Committee at its meetings held on 30 October 2007. Supplementary questions asked by Members of the committee were prefixed with the letters 'SQ'.

Q1. What are the key challenges facing the South East Coast Ambulance Service in delivering a high quality service?

The current South East Coast Ambulance Service NHS Trust was formed when three ambulance trusts were merged together. The new Trust covered an area of approximately 3,500 square miles, providing services to a population of 4.5 million and employing over 3,000 staff.

In meeting its aims of delivering a high quality service, the Trust was changing the way in which the service was provided. It was introducing a new university degree course that would result in all its paramedics being university trained in five years time. The Trust was also introducing a new role of Critical Care Practitioner to provide services to the most seriously ill patients and was also performing triage over the telephone for the less seriously ill.

In respect of the work undertaken by the Trust, 95% of it was classed as Category A or B patients, where the patient had a potentially serious but non-life threatening medical condition. It was important to ensure that in these 'exacerbated care' cases that the patient was delivered to the right place in order to avoid a 'revolving door' situation at the hospital, where they were discharged soon after being admitted.

The remaining 5% of emergency calls answered by the Trust were in respect of Category A patients who had life threatening conditions such as cardiac, stroke or major trauma. For these patients, key clinical skills, adequate funding and sufficient capacity were vital.

For all categories of patient, it was important to ensure that the patient received the appropriate type of intervention.

In keeping with clinical opinion, services would be concentrated to ensure that a critical mass of skills could be maintained. While this would mean that acute centres would be located further apart, the formation of services such as specialist cardiac and stroke units with the required associated services meant that patients would receive better care. In relation to areas such as Dover where there was no acute hospital, this was not an issue as the nearest acute hospitals were within the 1-3 hour travel distance required to give a patient the best clinical outcome.

There did need to be changes to the way many acute hospitals were designed to assist ambulance arrivals, although the Trust was encouraged that this was now being considered. In order to save lives most effectively, the ambulance service needed the right skills, at the right time in the right place.

SQ1. Is the Ambulance Trust able to recruit sufficient staff?

In response to Councillor R S Walkden's question, it was stated that there was a waiting list for applicants who wished to join the South East Coast Ambulance Service.

The Trust had occupational welfare services and a chaplaincy staff to look after the needs of staff and its average sickness levels and staff turnover rates were lower than the public sector average. In terms of pay, the Agenda for Change programme meant that national pay rates were set with no significant premium for London working, which meant there was no draining of staff away from the Trust to London Trusts.

Q2. How many ambulances are there in the Dover District and how are they distributed?

The ambulance crews were not kept at ambulance stations and instead were on 'active deployment' located in response to need. In determining where the ambulances were to be located, the Trust had developed an active deployment plan, plotted on demand on a one square kilometre grid. This system enabled the Trust to position the six ambulances in the Dover District most effectively.

The Trust was also able to performance manage ambulances in real time so that the locations matched current areas of demand. There were also seasonal factors that affected the demand for ambulances and these were considered in placing an ambulance on active deployment. An example of this was on Bonfire Night, where the town of Lewes underwent a sharp increase in demand for ambulances.

SQ2. How many people are there in an ambulance crew?

In response to Councillor R S Walkden's question, it was stated that the current ambulance crews consisted of two people on a double-crewed vehicle and one on a fast response vehicle.

Q3. What is the average response time for an ambulance called in an emergency to Dover?

In keeping with all ambulance trusts in the country, South East Coast Ambulance Service worked to a national target of 75% of responses to be with the patient within eight minutes of the emergency call for Category A calls. Although the Trust could not guarantee to reach every incident within eight minutes, it ensured that its resources were most effectively used.

In respect of the Dover District, the Trust met all its performance targets set by the Eastern and Coastal Kent Primary Care Trust.

Q4. How has the role of ambulance medical personnel changed since the move away from the traditional 'swoop and scoop' model and how do you see it developing in the future?

The Trust considered every call to be a genuine emergency 999 call and was legally accountable for how it handled calls. Those calls identified as 'pester' calls were traceable and appropriate action would be taken. The Trust had changed the way in which they were dealt with and where the patients were taken.

It had been recognised that in future an ambulance would only take a patient to a safe place and not to a 'staging place' hospital. Although it was often thought by people that there was a 'Golden Hour' in which patients had to reach hospital, this was in fact an assumption based

on discredited research conducted in the United States during the 1970's. Based on clinical evidence, the critical period was between one and three hours.

New technology, procedures and medical advancements had also changed the way the ambulance service worked. For example, the new Protocol C that had been piloted for cardiac patients in Brighton and had achieved a 300% success rate. For stroke patients a new diagnostic tool had been introduced that would allow the ambulance crews to determine whether a patient was a bleed or clot case and apply the appropriate treatment.

The new practitioner roles would also transform the future of the ambulance service. At present, 40% of ambulance patients did not need to go to an acute hospital and new alternative care pathways such as polyclinics would enable them to access services outside of an acute hospital setting for patients. A Mori survey had indicated that 95% of people questioned wanted to be reached quickly by the ambulance, treated quickly and taken to hospital quickly.

It was stated that the Trust would only support health service reconfiguration if it was confident that it did not endanger lives, though it was acknowledged that the NHS needed to convey information about change to the public in a more effective and more mature way.

Q5. (a) How long does it take on average for an ambulance under 'blue lights' to travel from central Dover to William Harvey Hospital, Ashford?

The average time it took an ambulance under 'blue lights' to travel from the CT16 post code area to William Harvey Hospital, Ashford was 26 minutes and 18 seconds.

Q5. (b) How long does it take on average for an ambulance under 'blue lights' to travel from central Dover to Queen Elizabeth Queen Mother Hospital, Thanet?

The average time it took an ambulance under 'blue lights' to travel from the CT16 post code area to Queen Elizabeth Queen Mother Hospital, Thanet was 33 minutes and 8 seconds.

SQ3. What criteria is used to determine which hospital a patient is taken too?

In response to the Councillor N J Collor's question, it was stated that the ambulance crew made the decision based on a clinical assessment of the patient and information on road conditions supplied from the control room. The only time an ambulance crew's decision would be overturned was in the event that a hospital was not admitting patients.

Q6. Have you seen an increase in mortality rates with the concentration of accident and emergency units at the two acute hospitals?

The Committee was advised that this information would have to be supplied subsequent to the meeting. The Trust did monitor mortality rates and in particular incidents known as SUI's (Serious Untoward Incident) where there was concern that the ambulance crew might be at fault.

Historically, the ambulance services involvement with a patient ended once they were delivered to an Accident and Emergency Unit. The Trust was currently developing performance indicators to understand the bigger picture and would have these in place by the end of the financial year.

Q7. How long on average does an ambulance wait at the accident and emergency units of William Harvey Hospital and Queen Elizabeth Queen Mother Hospital?

Ambulance crews were required to be available for call within 20 minutes of arriving at a hospital. The average waiting time was 16 minutes, although the exact time was dependent upon the different Accident and Emergency configurations. The worst waiting time was 30 minutes. The Trust reported excessive waiting times to the East Kent Hospital Trust.

Q8. What, if any, role does the private or voluntary sector have with the south east coast ambulance service in delivering ambulance services?

The voluntary sector was used in major incidents to convey patients classed as 'GP Urgent' (Category C) and to supplement the ambulance service during periods of peak demand such as New Year's Eve. In terms of voluntary organisations used, it was predominantly the Red Cross.

Although the ambulance service did not use the private sector, there was competition between the Trust and private sector companies over the provision of tendered services classed as Patient Transport Services (PTS) for Hospital Trusts. A key difference between the Trust and private companies was the level of clinical skills that the ambulance crews possessed, with the Trust crews being skilled to a higher level. The Trust did have a commercial arm that provided services at public events for a fee.

Although in Kent the Trust was gaining contracts for PTS, and would welcome more, in London PTS services were largely provided by the private sector. The Trust had a 98% patient satisfaction rate for PTS contracts it provided.

The East Kent Hospital Trust set the criteria for patient eligibility for the PTS and if a patient did not meet the criteria set out then they would be required to arrange for their own transportation.

Q9. What is the plan for the future development of the ambulance service in the Dover District?

South East Coast Ambulance Service was reviewing its deployment plan in preparation for the new ambulance crew positions that were to be introduced. It was intended that within the next five years there would be 60 Critical Care Practitioners who would act as single responders, 300 Paramedic Practitioners co-located with the Primary Care Trust and the remainder would be paramedics and emergency care assistants.

Due to the way ambulance crews were deployed there was no intention to change the number assigned to the Dover District.

SQ4. Did the Ambulance Trust have any plans to change the current ambulance vehicle?

In response to Councillor G J Hood's question, it was stated that the Trust would always have a two-crew member ambulance. While the width of the ambulance had not changed recently, the length of the ambulance has increased slightly in response to the ambulance crew's requirements for ease of access for patients. While some Trusts had purchased the wider American Chevrolet ambulance, South East Coast Ambulance Service had not.

The internal configuration of the ambulance had been developed in consultation with the ambulance crews to achieve the most efficient design. Each ambulance was purpose built for the Trust at a cost of approximately £300,000 each and the specification was unique to each Trust. As a consequence of the building cost and the 5% compound demand increase year on year, each ambulance had to be used in the most cost effective manner. The Trust intended to achieve this through changing working practices.

Q10. "What happens if I live in Dover and call an ambulance in an emergency?"

The ambulance would be on active deployment at a location determined on the basis of historical demand data. Rather than being located at the ambulance station it would be located at a response post that would allow it to respond most efficiently to any calls.

Upon receiving the call, the ambulance would be despatched to its destination under 'blue lights' and on arrival the ambulance crew would undertake a clinical assessment of the patient. At that point a decision would be made as to whether to convey the patient to an acute hospital or another location.

In the event that the patient is assessed as requiring treatment at an acute hospital, the ambulance would while on route transmit patient data to the Accident and Emergency. After delivering the patient to the Accident and Emergency centre the ambulance would then be available for duty again.

Q11. Given the absence of an accident and emergency unit and the topographic, environmental and infrastructural limitations of Dover does the South East Coast Ambulance Trust believe that it has sufficient resources to cope with a significant emergency in Dover?

The South East Coast Ambulance Trust was a Category 1 responder in respect of emergency preparedness and had developed as major incident plan. The Trust undertook regular exercises planning for incidents such as maritime catastrophes, and worked closely with the Primary Care Trusts in its area.

The Trust employed five full time emergency preparedness planners on its staff and its Chief Executive was the national lead for emergency preparedness. In addition to physical exercises, the Trust undertook theoretical desktop exercises.

An example of a recent use of the emergency preparedness plan was the earthquake in Folkestone. While the extent of the damage resulting from the earthquake was being established the Trust stopped all non-emergency work to allow it to redeploy ambulance crews to the affected area.

SQ5. Are there many attacks on ambulance crews?

In response to Councillor D R Lloyd-Jones's question, it was stated that the Trust was currently taking three people through civil courts over assaults on staff. Despite this, Kent ambulance crews did not routinely wear stab vests like some other ambulance services.

# Inquiry Report Six

# Dover Pride/Dr J R Sewell

The Dover Pride Programme Manager and Dr J R Sewell, Consultant Physician and Rheumatologist and Member of the Buckland Hospital Re-development Steering Group, were invited to the meeting held on 13 November 2007. Supplementary questions asked by Members of the committee were prefixed with the letters 'SQ'.

**Dr J R Sewell**

Dr Sewell advised that he had worked for twenty-seven years at Buckland Hospital and had been involved in five previous steering groups before the current one. The current steering group met every two months and was chaired by Mr Howard Jones, Facilities Director of the East Kent Hospitals NHS Trust.

It was emphasised by Dr Sewell that in developing proposals to replace the existing Buckland Hospital building there was a need for the various partner organisations to work together to ensure that the provision of health services in Dover were safeguarded for the future.

The current proposals were for services to be provided from Buckland Hospital for at least four more years due to the lead time required for planning approval and construction. Buckland Hospital would be fit for purpose until then but the current building was unable to withstand the changes required for the future.

The proposals for replacing Buckland Hospital did include retaining the renal satellite unit in Dover, although the neuro-rehabilitation unit would relocate to Kent and Canterbury Hospital in 2008, as had always been the intention.

Dr Sewell advised that there was a need to co-locate services in a single location for efficiency rather than dividing services across satellite sites. To that end, there would be merit in bidding for central funding to finance a new hospital building.

Councillor P G Heath, Portfolio Holder for Public Health and Protection, stated that the replacement of Buckland Hospital and the Council's regeneration plans for Dover, while linked, was not conditional upon each other. While the regeneration of the district was an issue stretching over decades, the decision on the replacement of Buckland Hospital would have to be taken in the next couple of years.

In response to Councillor R S Walkden's comment that to many people the word 'hospital' implied in-patient beds, Dr J R Sewell advised that other than maternity beds it was intended that there would be no in-patient beds at the successor to Buckland Hospital.

In terms of Accident and Emergency care, it was stated that the best that could be hoped for in Dover was a minor injuries and minor illness unit as the criteria for a second Accident and Emergency unit in East Kent had not been met. The walk-in minor injury unit in Folkestone was cited as an example of how Dover could develop its unit.

**Dover Pride Programme Manager**

A key part of the work of Dover Pride was co-ordinating the strategies of different organisations in the district. The Dover Pride regeneration strategy included numerous community and health issues. It was hoped that the Director of Public Health of the Eastern and Coastal Kent Primary Care Trust, Meradin Peachey, would join the Dover Pride Board in the near future.

Dover Pride's plans for the redevelopment of mid-town Dover complimented the needs of the Primary Care Trust, who wanted a modern, centrally located facility and there was an opportunity for partnership working between the two groups. One of the key advantages of mid-town was that a lot of the land was in public sector ownership and this would help speed up the regeneration process.

The East Kent Hospitals NHS Trust owned the current Buckland Hospital site and in the event a decision was made not to redevelop the existing site, any proceeds from the sale of the land would go directly to it. The Trust would be required to get the best possible value for the land, which meant there was a large probability that it would be sold to developers for housing.

In response to Councillor G J Hood's question about the development of the nighttime economy, it was stated that it was a long-term project that formed part of the town centre regeneration plans. The growth of the cruise industry and other physical developments would lead to an organic growth. The redevelopment of the waterfront would draw in tourists and this would be a key spur for local regeneration. The approach being taken was evolutionary rather than revolutionary, allowing the local economy to shape it.

# Inquiry Report Seven

## Eastern and Coastal Kent Primary Care Trust
## Stagecoach East Kent

Ms Helen Tremble, Patient Transport Commissioning Manager of the Eastern and Coastal Kent Primary Care Trust, and Paul Clark, Operations Manager for Stagecoach East Kent, were invited to the meeting held on 11 December 2007. Supplementary questions asked by Members of the committee were prefixed with the letters 'SQ'.

**Ms Helen Tremble – Eastern and Coastal Kent Primary Care Trust**

Ms Tremble advised that her role for Eastern and Coastal Kent Primary Care Trust (henceforth referred to as the 'PCT') was to commission patient transport services, with particular responsibility for those patients attending services traditionally provided through an acute general hospital. Currently, these services were commissioned from the East Kent Hospital Trust and the South East Coast Ambulance Trust.

The PCT was in the process of standardising patient transport service provision following the merger of the five former Primary Care Trusts, although there were separate issues relating to patients in the Swale area whose closest acute general hospital was in the West Kent Primary Care Trust area.

A multi-agency Integrated Transport Working Group, chaired by the PCT, had been formed to improve patient access to transport services. As part of its work it considered reports from the Patient Advice and Liaison Services (PALS) in respect of patient experiences with transport.

Q1. What is the policy in respect of travel to and from hospital for vulnerable patients?

The East Kent Hospital Trust set the eligibility criteria for patient travel based on Department of Health guidance. While patients whose medical condition impacted on their mobility were eligible for patient transport services there were restrictions on the eligibility of carers and family members and spouses were not automatically eligible. The parent or guardian of children were however eligible.

In respect of patients who are discharged from an Accident and Emergency Unit during the night there was no automatic transport provision made available to them. If a patient were in receipt of certain benefits then they would be able to reclaim the cost of the transportation home and the Accident and Emergency Unit had a small taxi budget for use in certain circumstances.

The PCT was currently gathering evidence on the historical and largely informal processes that were a legacy of the preceding Primary Care Trusts and this would feed into a patient needs driven transport provision.

In response to a case highlighted by Councillor D R Lloyd-Jones where a former constituent had been discharged after being taken to the hospital by ambulance from the William Harvey Hospital's Accident and Emergency Unit outside of normal hours and was forced to spend £40.00 on a taxi fare in order to return to Dover. It was stated that the PCT was aware that this was an issue and accepted in principle that there might be a social or time based need for patient transport provision for Accident and Emergency Units. The suggested method for reporting such incidents was through PALS although the feedback needed to be specific and verifiable to be of value to the PCT.

Q2. What is the nature of the relationship between the Eastern and Coastal Kent Primary Care Trust and private transport providers?

The PCT did not commission any private transport providers directly, although it was aware that the East Kent Hospitals Trust did.

Q3. What is the nature of the relationship between the Eastern and Coastal Kent Primary Care Trust and KCC transport and provision?

The PCT worked closely with Kent County Council, which considered access to health care to be a significant issue. The 'Dial-a-Ride' service was subsidised by Kent County Council and assisted those people who did not have reasonable access to commercial bus routes.

To promote awareness of the accessibility of the three acute hospital sites, a leaflet would be produced by the PCT in partnership with Kent County Council, Stagecoach East Kent and

the East Kent Hospital Trust. It would explain how people could access the acute hospitals using public transport and it was hoped that this would be available from March 2008.

Q4. What is the Eastern and Coastal Kent Primary Care Trust doing to improve transport access to hospitals and between hospitals?

The multi-agency Integrated Transport Working Group was gathering information on transport issues. In respect of the 'health hopper' bus, the East Kent Hospitals Trust was reviewing it with the intention of making the service more accessible to staff and visitors to hospital sites.

East Kent Hospitals Trust was also intending to provide information on transport options to acute hospitals via its website and it was expected that this would be available from February 2008.

Q5. What is the role of the Eastern and Coastal Kent Primary Care Trust in relation to the East Kent Hospital Trust in respect of transport provision?

The PCT was the commissioning body for patient transport services and it monitored the service provision that East Kent Hospitals Trust delivered. The two organisations worked closely together on strategic and operation issues relating to patient transport services.

In the future this role may change, as an increase in local service delivery through Practitioner Based Commissioning may reduce the demand for patient transport services.

Q6. What does the Eastern and Coastal Kent Primary Care Trust see is the role of Patient Transport Services?

The role of patient transport services is to provide high quality transport provision to all patients requiring it in accordance with Department of Health guidelines.

**Paul Clark – Stagecoach East Kent**

Stagecoach had spent £3 million on improving transport in the District, which built upon its traditional strength of linking population centres through regular services. In the rural areas, Stagecoach operated those routes that were commercially viable while Kent County Council

subsidised travel on the remaining routes deemed to be of social necessity but not commercially viable.

Bus services operated to Queen Elizabeth Queen Mother Hospital, Thanet every 7-8 minutes during the day, William Harvey Hospital, Ashford every 15 minutes during the day and Kent and Canterbury Hospital every 20 minutes during the day. The No 15 bus service, which operated the Deal-Dover-Canterbury route, had been the subject of a trial where the frequency was increased to every 30 minutes and consideration was being given to making this change permanent.

It was recognised that the bus journey time between the District and acute centres could be a significant obstacle to people travelling and an integrated transport solution involving train and bus was suggested as the quickest public transport travel method. The website www.traveline.org.uk promoted the use of integrated transport and provided travel advice.

Ms H Tremble advised that Kent Highways would be undertaking an audit of pedestrian access routes to health care facilities and a report on the findings would be published during the summer of 2008.

# Inquiry Report Eight

# South East Health Ltd

The Chief Executive of StourCare Community Interest Company (CIC), Ms Lynne Whiteford, the Chairman of StourCare CIC, Dr Mike Parks, the Chief Executive of South East Health Limited Mr Ron Owttrim, and Ms Sarah Bull of StourCare CIC were invited to attend a meeting held on 25 March 2007. Supplementary questions asked by Members of the committee were prefixed with the letters 'SQ'.

Q1. How did the 2004 General Medical Services Contract which allowed GP's to opt out of providing out of hour services affect StourCare given it had been in existence since 1992?

When the 2004 changes were proposed, the two Primary Care Trusts (PCT's) then in existence (Canterbury and Coastal PCT and East Kent Coastal PCT) undertook a process of review of out-of-hours (OOH) provision. The culmination of this process was the merger of the existing providers of OOH Care in their commissioning areas.

These organisations were two GP Co-operatives, Canterbury Doctors On Call (CANDOC) and East Kent Doctors On Call (EKDOC), which were merged into a new organisation called StourCare. StourCare commenced operation on 1 September 2004 and was led by members of the key clinical and managerial staff from the two precursor organisations and staffed by a combination of individuals from CANDOC and EKDOC who wished to TUPE across to StourCare and some new employees.

StourCare was fortunate to retain the services of its local GP principals who staffed the GP rota and developed nurse triage and nurse practitioner services. StourCare had operated successfully since 1 September 2004.

Q2. What are the key performance indicators for StourCare?

StourCare had compulsory key performance indicators set by the National Quality Standards and had developed an action plan to address the discretionary Standards for Better Health.

There was no additional Key Performance Indicators arising from the Service Level Agreement (SLA) with the PCT.

Q3. How is StourCare performing against these targets?

Generally, StourCare met all of the 13 National Quality Requirements (NQR) and where there was an exception, a thorough investigation would be carried out and reported to the commissioning PCT.

There were four NQR that StourCare did not and could not meet, which were:

- NQR 2 (Providers send details of all consultations to the patients practice by 8.00 am), which was not achievable due to the possibility that patient consultation would be still active at 8.00 am. Instead a more appropriate timescale had been agreed with the practices.

- NQR 8a (No more than 0.1% of calls engaged), which was due to the high call volumes, particularly between 7.00 am and 8.00 am.

- NQR 12a (Emergency face-to-face consultation at the centre within 1 hour), which were not undertaken by StourCare. Instead, emergency cases were immediately referred to the appropriate provider such as an Accident and Emergency Unit or the Ambulance Trust.

- NQR 12d (Emergency face-to-face consultation at the patients home within 1 hour), which were referred to the appropriate emergency service provider.

Full details of performance were set out in the accompanying handout circulated at the meeting.

The average cost per patient, which was calculated by dividing the annual budget for StourCare by the number of patients covered, was £9.45. StourCare worked to keep its management structure operating at a low cost, which included having a part-time Chief Executive, as there was no requirement for a full time one.

Q4. Is there a mechanism, such as through a Public Patient Involvement Forum, for members of the public to be involved in the development and provision of StourCare services?

Prior to becoming a Community Interest Company, StourCare appointed Mrs June Binfield (a previous Non-Executive Director of the East Kent Coastal PCT) as a Non-Executive Director to StourCare. It was intended that her main remit would be to liaise with the Public Patient Involvement Forum and act as the eyes and ears of StourCare within the community. Contact was also established with a number of voluntary groups in the health care and educational arena.

More recently Mrs Binfield had become StourCare's Community Interest Officer. In this role she would be transferring to the new organisation, which was interested in exploring further the idea of the community consultative body that StourCare had intended to establish. In addition to this, Eastern and Coastal Kent Primary Care Trust was creating a virtual patient forum that will provide a community consultation role.

Following the co-location of OOH services at the Queen Elizabeth the Queen Mother hospital (QEQM) and the Kent at Canterbury hospital (KCH), StourCare carried out surveys of patients' experience. StourCare worked closely with the Public Patient Involvement Forum regarding the retention of weekend cover at the Queen Victoria Memorial Hospital in Herne Bay following the move to the KCH.

StourCare CIC will be retained as a company within the suite of companies within the wider South East Health Limited organisation.

Q5. What is the nature of your relationship with:

(a) The Primary Care Trust

The Eastern and Coastal Kent Primary Care Trust was the commissioner of OOH services.

(b) East Kent Hospital Trust

StourCare was a LHC partner organisation with the East Kent Hospital Trust (EKHT) and was engaged in joint working regarding the East Kent Health Reform Demonstration System (HRDS) pilots. The EKHT was also the host organisation for co-located bases.

(c) The South East Coast Ambulance Service

StourCare was a LHC partner organisation with the South East Coast Ambulance Service (SECAMBS). The two organisations were working on several joint projects including Paramedic Practitioner rollout and IM&T links.

(d) Local GP's and Other Health Care Professionals

Many local GPs staff StourCare's rotas for OOH services and three local GPs were part of StourCare's senior management structure (the Chair, Medical Director and Medical Manager). StourCare and the GP practices within its operating area were closely linked via visits and liaison regarding day-to-day clinical feedback and patients with particular needs, such as palliative care. StourCare's nursing and managerial infrastructure had similar links with GP practices. A monthly newsletter was sent to all GPs on StourCare's workforce.

The links with other healthcare professionals were as stated in the answers to parts (a) to (c) of the question.

Q6. What do you see as the advantages and disadvantages of providing out of hours services at co-located sites with the East Kent Hospital Trust, such as Buckland Hospital, and a dedicated sites such as Manston?

StourCare had always advocated the benefits of co-location and proper integrated working (full integration) with its partner provider organisations. The OOH Providers were members of the Board of the East Kent Health Reform Demonstration System (HRDS), which was a national Department of Health sponsored service improvement process that was working through a series of pilots.

Two of these pilots (one for adults and one for children) were to extend what was currently OOH co-location into full integration with GPs receiving patients that arrived at A&E. The

WHH pilot was now in its evaluation stage following a sixteen-week trial. The initial results were very positive and there are plans for wider rollout upon successful conclusion of the evaluation process.

Current acute co-location (but not full integration) is in place at KCH, QEQM, and Buckland Hospitals. Full service integration was hoped to follow via the HRDS pilot rollout.

Manston was not a patient related site, but currently StourCare's HQ. Other patient related bases were on community hospital sites at Herne Bay and Deal.

The advantages of full co-location/integration included:

- One stop for the patient if on an acute site (if further acute services are required).
- Acute hospital sites are served by good transport access, ie public transport.
- Better use of resources for the local health system.
- Right professional at the right time (skill mix advantages).
- Reduction in duplication of consultation/requested investigations.
- Potentially reduced overall attendance times from appointment to treatment.
- Access to expertise within secondary care.
- Access to diagnostic facilities upon the achievement of full integration.

The disadvantages of full co-location/integration were:

- Could potentially limit the number and geographical spread of bases thus impacting upon access for some patients.

- Access for patients to services is via multiple routes, (ie out of hours through initial telephone access and allocated appointment time (if required), Walk-In Centres (dedicated) and traditional walk in/self referral via A&E. This can cause confusion for patients.

Q7. <u>As you may be aware, there is ongoing discussion over the future of Buckland Hospital and the eventual replacement for it. As StourCare provides out of hours services from Buckland Hospital currently, have you been consulted as to your requirements for any new building?</u>

There had been no detailed consultation at this stage, other than broad discussions in relation to the model for urgent care being developed via the HRDS process. StourCare worked closely with the ECKPCT and would respond to its requirements when it was in a position to advise them. It was anticipated that this would be part of ECKPCT's procurement process for the new contract. It is also likely that this would be informed by the outcome of the HRDS pilots.

Q8. Does StourCare provide out of hours provision for just GPs or a wider range of healthcare providers?

StourCare currently provided services to the following organisations:

- GP Out of Hours (OOH) Services.
- OOH Service to Canterbury Prison.
- OOH Service to the Dover Harbour Board at the Immigration Short Term Holding Facility.
- OOH Service to Howe Barracks, Canterbury.
- Message handle, and provide medical support to Community Nursing and Care Teams.
- GP cover for training afternoons.

Q9. Demonstrate how you make the needs of the patient the focal point of services?

StourCare's service was planned with the patient at the centre of its processes. The following were examples of how it strived to achieve a patient centred service:

(a) Clinical Effectiveness:

- Demographic patient details
- ILT protocols
- Triage process
- Urgency standards
- Palliative and Community Care integrated handover forms
- Application for GPs to provide Special Patient Information

- Application for Child Protection Risk register (collaboration between PCT and StourCare)
- Service Model Review
- Ongoing skill and case mix analysis
- Sound Clinical Governance processes

(b) Patient convenience: understanding the patient's circumstances and attempting to provide the best fit for service provision within StourCare's operating guidelines (ie advice, base visit, home visit, referral onwards).

(c) Access: StourCare strived to provide its services from as wide a location of bases as possible, working closely with the ECKPCT to respond to the needs and requirements of the population.

(d) IM&T & Voice Communications: The technical infrastructure had been designed to support both StourCare's clinical and non-clinical workforces in delivering better and safer care to its patients. In addition to providing suitable backup, fallover, and disaster recovery measures, the Governance arrangements established ensure that StourCare was able to constantly review and update its systems for patient benefit.

(e) Continual learning: StourCare operated a comprehensive process to learn from comments from patients and other service users which was fully integrated with all of its internal processes, including:

- Patient questionnaires - sent to 1:30 patients, on a monthly basis.

- Complaints - 0.01% (approx 75,000 consultations per annum).

- Multi-organisational working and co-operation – StourCare worked with its partner organisations regarding any boundary issues, with input from the PCT where appropriate.

- Operational and Clinical Reviews – StourCare held weekly meetings with the operational staff to review all issues arising; a weekly Executive Team meeting to discuss and agree change/service improvements/issues; and the Clinical Services Group met every six weeks to discuss clinical risk

management and where clinical issues required further detailed discussion and review. A corporate risk management process sat above all of these processes.

Q10. How do you determine the appropriate staffing levels to ensure that patients get to see the appropriate medical professional out of hours?

Each site had been individually assessed regarding the working times and numbers of clinicians required to meet patient demand. These were consistently reviewed and catered for seasonal variation. Historic patient volumes had been used to indicate the required number of nursing triage staff in order to ensure NQRs were met, and this was reviewed on a monthly basis.

The area covered by the OOH service provision was also considered in determining staffing levels. For example, in Ashford where there was a younger, more mobile population more doctors were focused at the centre. In contrast, in Eastbourne with an older, less mobile population there was more focus on mobile doctors for home visits.

However, there was concern that a home visit was a 'second class' visit, as the doctor would not have the same degree of support that was available at the centres.

Q11. Is there a minimum requirement for the number of doctors and other health care professionals on call for a District of 104,000 people?

There was no national standard relating to minimum staffing levels other than compliance with the NQS. The number of doctors and other Health Care Professionals was dependent on patient need and how this need was required to be met, such as telephone advice, home visit, or base consultation.

StourCare had five operational bases, plus administrative offices at Manston. The three full time OOH bases were located in Canterbury, Thanet, and Dover (apart from overnight at Dover, i.e. between midnight and 0800) and the two part-time OOH bases were at Deal and Herne Bay. It provided OOH services for 113 hours per week.

An example of staffing levels was cited as Saturday morning at the QEQM Hospital, Thanet where there would be four GP's, one nurse practitioner, and a team of nurse advisors.

Q12. How is access to StourCare Services promoted to the public?

Information on how to access StourCare was available within public places, including most prominently at GPs' surgeries, through the provision of posters, patient leaflets, and presentation to local community forums by the Community Interest Officer. In addition, StourCare's telephone number was advertised on recorded messages and web sites throughout the LHC.

SQ1. Is it a requirement for GP's, and if appropriate other medical professionals, to put a referral number for StourCare on their answer phone?

GPs had to ensure that their patients had access to unscheduled health care in the OOH period. This could either be via an answering machine or by directly switching their phones to StourCare's number. Direct switching was supported by a payment in the GP contract (Quality Outcomes Framework).

It was down to individual GP practices to determine which method they used. In the event that there was a problem with OOH patients being referred to StourCare via their GP's, StourCare would investigate the matter.

Q13. What provisions do you make for members of the public from vulnerable or minority groups with limited English language skills?

The following provision was made:

- RNID – BT Talktype service for the hard if hearing.
- Language Line provides interpretation services for all foreign languages.
- Visual Aids – for foreign nationals and prompt cards for vulnerable patients.
- Chaperoning services.

Q14. Can members of the public access StourCare Services on a walk-in basis?

The service was an appointment only system, as per StourCare's Service Level Agreement (SLA) with the ECKPCT. If patients did walk in, StourCare would not turn them away.

However, they were assessed via the Immediate and Life Threatening protocols and any urgent care need that could not wait until the patients GP surgery was open was met.

Q15. How do you undertake the triage of members of the public who contact you to determine which ones need to be seen, which ones can wait until normal opening hours to see their usual health care professional and which ones need to be seen at an accident and emergency unit?

It was emphasised that StourCare turned no patient away, even if it would be possible for him or her to wait until morning to see his or her GP. The triage process was as follows:

1. Initial protocol led ILT triage was undertaken by non-clinicians to decide urgency and instigate referral to 999 and Accident and Emergency (A&E) services. All call handlers had the ability to upgrade a call if they felt it appropriate but never to downgrade it.

2. Subsequent Clinical assessment was undertaken by either a GP or Nurse:

    - GPs undertook telephone consultations using own clinical judgement to determine appropriate pathway.

    - Nurses undertook a triage process using clinical symptom prompt tools in conjunction with personal clinical decision-making and own clinical judgement to determine pathway.

    - All clinical pathways were determined in respect of (a) the patient needing emergency care (ie 'now'); (b) the patient needing urgent care (ie 'today'); or the patient requiring non-urgent care (via own GP surgery).

    - All patients referred for non-urgent care were provided with help in self care advice, analgesic etc

All calls were 'safety netted' and patients were advised to ring back if symptoms worsened, changed, or new symptoms developed. In East Anglia, the ambulance trust acted as the co-ordinator of all emergency calls and had GP's undertaking triage work through the call centre.

The recent 16 week pilot operating at the Accident and Emergency (A&E) Unit of the William Harvey Hospital, Ashford had seen the placement of a GP in the A&E Unit who would make the initial assessment of all walk-in patients needs. The serious cases would continue to be treated by the A&E Unit as normal, but the minor (primary care) cases would be treated by the GP. As a consequence of the pilot, fewer patients were admitted into hospital via the A&E Unit.

Q16. In what ways will the merger between StourCare CIC and South East Health Limited benefit local people in the Dover District?

The key areas of benefit were:

- Combined resources, expertise and complimentary skills.
- Larger pool of GP Principals, Nurses and non-clinical staff.
- 1 provider for the whole of East Kent with developmental benefits.
- Critical mass benefits (which related strongly to future procurement.
- A stronger organisation and senior team.
- Potential for stronger relationship with partner organisations (particularly the acute trust) due to East Kent wide focus.

As the Dover District was on the boundary between StourCare and South East Health Limited, a key benefit would be access to a larger pool of doctors from both areas rather than from just one area. The merger would also reduce competition between the two OOH services for GP's.

Q17. Although StourCare CIC and South East Health Limited provide similar services, a key difference in being a CIC is extra safeguards for the community through the provision of a monitored and regulated 'community interest test' and 'asset lock'. What will the status be of the merged company?

South East Health Limited was the vehicle for the merger and it was a not for profit (NFP) company limited by guarantee. Its current membership comprised the doctors who formerly ran the OOH service in its operational area. Whilst it did not have a community interest requirement or asset lock within its articles, its prime purpose was to provide high quality

unscheduled care services to the patients in its locality and there would be little apparent difference to patients.

The PCT had always encouraged the organisation providing OOH services to have not for profit status, which allowed for any operating profit to be ploughed back into services rather than going to shareholders.

StourCare's budget was monitored by the PCT and any operating profit was either held for future use or invested in services and equipment. A decision would be made as to the future of the Community Interest Company in November 2008.

Q18. Do you anticipate that the recent agreement between the government and the BMA on extending surgery opening hours for GP practices will affect the provision of out of hour's services by StourCare?

There was no firm view at this stage but as it was currently understood, the extended hours were to provide for more pre-bookable appointments during the OOH period and not to address unscheduled care issues. However, it remained to be seen whether this would be what transpired in practice.

The actual details of the enhanced service that dealt with extended hours was not know at the time of the meeting. The ECKPCT might wish to also commission other services in the extended hours period, such as unscheduled care or practice nurse provision. The main risk was to StourCare's workforce who if they are working in their practice could not also be simultaneously working for an OOH organisation.

In summary therefore:

- There might be an increase in minor illness needs of patients due to a perception of increased access for this type of complaint and an expectation of care.

- A possible decrease in the number of contacts with patients with complex, medical and progressive illnesses which instead might be dealt with by the extended hours GP provision.

- A potential for reduction in the availability of the local GP workforce due to competing needs for local GP principals. This linked to the benefits of the merger raised in Q16, in that the new organisation would have access to a larger pool of GP principals.

Q19. "What happens if I need to see a GP out of hours?"

A patient pathway map was circulated, which illustrated the process for a patient wishing to use OOH services.

SQ2. How often does the Primary Care Trust's tender for OOH providers?

In response to Councillor R S Walkden's question, it was stated that the initial tender was undertaken by the PCT's in 2004 on a three-year basis. However, in most cases this contract had been extended until March 2009.

The increasing competition from the private sector in the provision of OOH services was one of the reasons why the merger between South East Health Limited and StourCare CIC was necessary, as it gave the new group sufficient clinical and commercial critical mass to enable it to be able to tender effectively. Private competitors included SERCO, Virgin Healthcare and Harmony.

SQ3. Does StourCare have access to patients GP records?

At present StourCare did not have access to patient records held by the patients GP's, Accident and Emergency Units or social services child protection, although there was a target for this to be achieved by 2012. As a consequence, StourCare had taken steps to develop its own basic register of child protection issues and palliative/terminal care cases. However, while StourCare did not have access to GP records, it did update GP's concerning the patients it had seen OOH.

SQ4. Does StourCare provider OOH dental services?

In response to Councillor D R Lloyd-Jones question, it was stated that DentaLine currently provided OOH dental services and any dental calls received were referred to it. However, in

the future the new merged company could consider providing OOH provision in areas such as dental and pharmacy services.

SQ5. Has the loss of secondary care beds in the District led to an increase in calls to StourCare?

In response to Councillor N J Collor's question, it was stated that StourCare had seen no significant increase in its call volume. The most likely impact of any shortage of secondary care beds on StourCare would be seen anecdotally through an increase in inappropriately discharged patients using its services.

# Inquiry Report Nine

# Practice Based Commissioning

Mr David Meikle, Director of Finance and Commissioning at the East Kent Coastal Primary Care Trust, Ms Sheila Pitt (Head of Strategic Commissioning (Dover/Thanet) at the East Kent Coastal Primary Care Trust), Mr Allan Stibbs (Dover Consortium Business Manager) and Dr Darren Cocker (Dover Practice Based Commissioning Consortium) were invited to the meeting held on 25 March 2008. Supplementary questions asked by Members of the committee were prefixed with the letters 'SQ'.

Q1. What are the Practice Based Commissioning arrangements for the Dover District?

There were two consortia covering all the GP practices in the Dover District area. These were the Dover and Aylesham Consortium, which consisted of 10 practices, and the Deal, Ash and Sandwich Health Consortium (DASH), which consisted of 8 practices. Each of the consortia had a GP lead (Dr Joe Chaudhuri for the Dover and Aylesham Consortium and Dr Rick Browning for DASH) and was supported by a Business Manager and Administrative Assistant.

Q2. What is the relationship between the GP Consortia and the PCT?

The two Consortia were expected to work independently within the framework determined by the PCT and in line with Department of Health guidance. The Eastern and Coastal Kent Primary Care Trust (henceforth, referred to as the 'PCT') remained the statutory body responsible for contracting health services based on the commissioning intentions of the PBC consortia.

Q3. What are the priorities for the Practice Based Commissioning?

The two consortia had written individual annual commissioning plans, which were informed through the health needs profile of the District. The main focus was to improve health outcomes for patients and reduce health inequalities by commissioning services closer to home.

Q4. How will Practice Based Commissioning deliver patient choice?

PBC did not restrict patient choice in the current definition of choice of secondary care provider. In the longer term it would develop a wider range of choice for patient care within secondary care, community services and primary care.

Q5. At what stage is the implementation of Practice Based Commissioning?

Although the guidance on Practice Based Commissioning had been in place since October 2004, locally the PCT was at different stages of implementation across the areas of the five former PCT's. This year was the first full year of co-ordinated implementation across the new PCT area.

As a consequence, some consortia were further forward in development than others and the PCT was aiming to focus resources to support each consortium, as it required. Both the consortia in the Dover District were well established and all practices were involved.

Q6. What is the scope of services planned under Practice Based Commissioning for the Dover District?

The indicative commissioning budget covered all aspects of healthcare spend through the PCT area, although for some areas such as cancer services or neurological services the commissioning reverted to the PCT as it was difficult to provide services locally and the PCT was able to achieve greater economies of scale.

SQ1. How is the commissioning budget determined?

In response to Councillor G J Hood's question, it was stated that the commissioning budget was based on the population number with additional weighting for the level of deprivation and other factors. This resulted in a 75% per capita element and a 25% 'fair share' element. It was hoped that the fair share element could be increased to provide resources needed to tackle the effects of deprivation in the district.

Q7. What are the priorities in respect of Practice Based Commissioning for the (a) Deal, Ash, and Sandwich PBC Consortia and Dover PBC Consortia; and (b) the Primary Care Trust?

(a) Practice Based Commissioning Consortia

All GPs were keen to see as many health services as feasible provided 'closer to home' and specific priorities were expressed in the respective commissioning plans.

In addition to traditional commissioning there was an increasing emphasis on improving health education, the promotion of well-being and healthy lifestyles and investment in preventative services.

(b) Primary Care Trust

The PCT's priorities were to ensure robust clinical engagement and the mainstreaming of PBC commissioning into all PCT strategic commissioning decisions. This would ensure that the PBC consortia were signed up to planning within the agreed strategic direction.

Q8. What are the advantages and disadvantages of Practice Based Commissioning over the old General Practitioner Fund Holding (GPFH) and total purchasing arrangements for GP's and the PCT?

Firstly, the budget now held is indicative only which results in less bureaucracy involved in the administration process. The PCT held the overall responsibility for ensuring that services commissioned met the health needs of the population, which ensured consistency in clinical and corporate governance.

Secondly, an advantage for both parties was the increased level of clinical engagement. The engagement by individual practice was 100% in the Dover District, which helped to ensure equity of service to the population.

The disadvantage from the practice's point of view was the reduction of freedom to contract directly with providers as the commissioning was undertaken through the PCT.

SQ2. Does the commissioning budget have to stay out of the red?

In response to Councillor A Friend's question, it was stated that the budget was continually monitored and managed to avoid that situation. However, in the event that the budget did go into the red there would be no reduction in services.

Q9. What are the constraints, barriers, and risks faced in delivering Practice Based Commissioning over the longer term?

The PCT's ability to offer continued financial support mitigates many of the risks associated with delivering PBC in the longer term. If the PCT's financial position were to change then the risk would be heightened.

There was always a risk that GPs would become disengaged if the PCT failed to deliver on the commissioning decisions made at consortium level. The commissioning capacity was a constraint from both a clinical and administrative time element and developing GP commissioner skills was time consuming.

If social, political and health partnerships did not have common aims there was a risk in introducing any change that affected local health provision.

Q10. Do the GP Consortia possess the required non-clinical skills to deliver effective commissioning?

The PCT acknowledged that clinical time should not be diluted by any additional management responsibility and recognised at an early stage that for Practice Based Commissioning to be successful, there would need to be funding to support the non-clinical commissioning input at the consortium level. To assist with this issue, the PCT funded a business manager post in each PCT locality.

The two consortia within the Dover District had employed a shared business manager who has previous commissioning and practice management experience. This experience was reflected in the progress made by both consortia over the last year.

Q11. What is the relationship of Practice Based Commissioning in the wider health care context, with (a) other primary care providers such as opticians and pharmacists and (b) the East Kent Hospital Trust?

To date this has not been the focus of either of the two consortia. However, as commissioning plans and skills developed in the longer term, the consortia were anticipating working more closely with a range of other independent contractors and providers.

There has always been an expectation by the consortia of a close working relationship with the main provider of secondary care services in East Kent. This had not materialised as quickly as anticipated but communication continued to improve.

The commissioners were expected to develop working relationships with many other providers such as the Kent & Medway Social Care and Partnership Trust, the provider arm of the PCT, social services, and local authorities. In addition, relationships also needed to be maintained with other NHS and independent providers external to the immediate PCT area.

Q12. What are the performance indicators, if any, for Practice Based Commissioning?

A framework was under development to enable the PCT to performance manage practices in 2008/09. The key performance indicators were likely to be level of GP referrals, actual spend versus indicative budget, and progress against the incentive scheme targets.

Previously GP referral rates had been monitored and where rates showed significant variation from the average levels it was discussed with the practice and audits on the variances had been carried out.

There are no formal performance indicators in respect of PBC by which the PCT itself was monitored.

Q13. Is the level of funding available for Practice Based Commissioning groups linked to performance?

In relation to the group's indicative commissioning budget it had been set using a formula of 75% historic activity and 25% fair shares allocation, in accordance with national guidance formula.

Practices had the right to reinvest Freed Up Resources (FUR's) generated by improved commissioning decisions. There was also the opportunity for practices to earn additional funding through the incentive scheme by meeting the incentive targets and activities set out by the PCT.

Q14. What effect will payment by results have on the commissioning of services by Practice Based Commissioning Consortia?

The system of Payment by Results (PbR) was fundamental to the success of Practice Based Commissioning. It provided the flexibility to commission services from all willing providers as the funding followed the activity.

It also reinforced the philosophy of patient choice, which gave commissioners the freedom to procure the most appropriate care in the most appropriate location. However, it needed to be recognised that this freedom had to be managed responsibly to ensure that established providers are not destabilised. Future changes to the national tariff would add to the flexibility.

Q15. Have the Practice Based Commissioning Consortia had any involvement in the Dover Project and discussions on the future of Buckland Hospital?

The Dover and Aylesham consortium was now leading on taking forward the outputs from the Dover Project. The project phase had concluded and had evolved into the commissioning phase. The PBC Clinical lead was a participating member of the Dover Project Board throughout the project phase.

The consortium and PCT were part way through an intensive piece of work to develop a clear plan for the commissioning intention of 'Future Delivery of Healthcare Services in Dover'. This is expected to be complete by the end of June 2008.

Once the model of service provision was confirmed, the commissioning stage would identify who would provide the service, where they would provide it, and how it was funded. The PCT and PBC consortia would ensure that the service commissioned matched the need of the local population.

Q16. A GP practice in Whitstable has developed proposals for a polyclinic providing a mixture of primary care, diagnostic, consultant and minor surgical services. Are there any proposals for a similar facility in the Dover District as part of Practice Based Commissioning?

It was not possible to give a definitive answer to this question, as the output of the work on 'Future Delivery of Healthcare Services in Dover' would not be delivered until the end of June 2008. This plan would define the range of services most appropriate to be provided within Dover, which, in turn would determine the type of facility that may be required.

The principle of co-locating services into a comprehensive 'centre' was a key commissioning intention of the Dover and Aylesham consortium.

The development of enhanced service provision at the Deal hospital site was a key commissioning intention of the DASH consortium.

There were four options open to the replacement of Buckland Hospital which were:

- Refurbish the existing Buckland Hospital building
- Build a new hospital on the existing Buckland site
- Build a new hospital in the centre of Dover
- Build a new hospital at another location

The traffic travelling to and from the Port of Dover was excluded from the calculations for population in Dover.

Q17. Given that the Department of Health emphasises the principle of "patient choice as a driver of quality and empowerment" in Practice Based Commissioning, are there any plans in the future to establish intermediary care beds locally?

This issue was one of the key outcomes of the Dover Project work. Intermediate Care beds had already been successfully established at Cornfields and Alexander House. A Dover GP practice had been contracted to provide medical cover for these beds.

Deal hospital continued to have intermediate care beds and there were no plans to change this. Similarly a Deal GP practice was contracted to provide medical cover for these beds.

Developments in the way intermediate care services were provided would result in even more patients being able to access the appropriate care within their own homes. This included the development of the Telehealth service, where patients could be monitored through mobile communication with health professionals.

Q18. In the longer term, how is increased patient choice and Practice Based Commissioning likely to change the way that patients access services?

A patient-led NHS drove the requirement for patient choice. In turn, patient choice drove the need for commissioning to change. As a result, patient choice would increasingly influence where the GP commissioners procured services.

It was anticipated that there would be a wider range of services accessed more locally as it was acknowledged that easier access for all patients resulted in improved health outcomes. The aim was to provide better, faster care closer to home.

SQ3. Are there sufficient intermediary care beds in the district?

In response to Councillor C E Kirby's question, it was stated that intermediary care beds were provided at the Victoria Hospital (36 beds), Deal; Alexander House, Dover; and the Cornfields Residential Care Home, Dover (12 beds in total). The total of 48 intermediary care beds was felt to be sufficient as there was not a waiting list for them; although it was acknowledged that there were 'pinch points' occasionally where a patient's discharge could be delayed.

There was a five percent limit on bed blocking at the Queen Elizabeth the Queen Mother Hospital, Margate (QEQM), which equated to 50 of the 1,000 beds available at the hospital.

Mr A Stibbs advised that the DASH consortium was committed to maintaining services at Deal Hospital and if possible expanding them. Furthermore, the PBC consortia recognised the transport difficulties faced by many people in the district meant that if a service was locally accessible it was a wasted service.

SQ4. Has the Eastern and Coastal Kent Primary Care Trust investigated expanding the validity of concessionary fares to before 9.30am for patients attending early morning appointments?

In response to Councillor D R Lloyd-Jones question, it was stated that this had been considered but the bus companies and Kent County Council had been unable to reach an agreement on the matter.

SQ5. What is the definition of 'citizen engagement'?

In response to Councillor C E Kirby's question, it was stated that it was engaging with the public and patients about service reconfiguration prior to making any changes. This was strongly supported by both the GP consortium and the DASH had engaged with the Neighbourhood Forums as part of this.

SQ6. Is there a problem of people not being registered with GP's in the District?

In response to Councillor G J Hood's question, it was stated that this was not a significant issue in the district. However, it was important for people to be registered with GP practices as it took pressure off the Accident and Emergency and Out of Hours Services. The PCT was required by the Government to provide 'equitable access centres' for hard to reach groups and this was on the agenda of the PBC consortia.

# Inquiry Report Ten

## Patient Transport Services

Irene Hayward (Head of Healthcare Transport, East Kent Hospitals Trust) was invited to the meeting held on 10 June 2008. Supplementary questions asked by Members of the committee were prefixed with the letters 'SQ'.

Q1. What is the relationship between the Eastern and Coastal Kent Primary Care Trust and the East Kent Hospitals Trust in respect of providing Patient Transport Services?

The Eastern and Coastal Kent Primary Care Trust (henceforth referred to as the 'PCT') was responsible for commissioning services.

Q2. Does the Hospital Trust work with other organisations in the provision of patient transport services?

The Integrated Transport Working Group (ITWG) was a multi-agency group examining the means by which patients were accessing hospitals. Apart from the East Kent Hospital Trust (EKHT) it comprised of representatives from the PCT, the PPIF's, Kent County Council, and private transport providers Ariva and Stagecoach.

Q3 Is there a role for volunteer operated/provided transport in patient transport services?

The volunteer operated Patient Transport Services (PTS) was a combination of individual and voluntary organisation provision, which were paid an amount based on mileage to collect and return patients from hospitals. The EKHT had access to a pool of approximately 100 volunteer drivers. However, as they were volunteer drivers they determined there own hours of availability and could sometimes be subject to short notice changes in these arrangements.

Q4. What is the involvement, if any, of private transport providers in passenger transport services in East Kent?

The EKHT did use private ambulance services for PTS where necessary to cover spikes in demand, particularly in the winter. However, these providers were vetted against the same

quality assurance as the normal service. The decision to use private ambulance services was based on a cost versus need basis, as the preferred option was wherever possible to use the existing NHS provider, as it was more cost effective.

Q5. The Dover Project Consultation acknowledged that there were issues with transportation for patients using the East Kent Hospital network. What is being done to improve transport access for the public to hospitals and between hospitals?

There were proposals to create a new free 'health shuttle' system which would operate 7 days a week and provide a door-to-door service for patients. The drivers for this service would all have First Aid and CPR training and work hours specified by the EKHT. This proposal was also different to the existing 'health hopper' system, which ran a limited service between the East Kent hospitals.

SQ1. How soon could the health shuttle be introduced?

In response to Councillor Mrs J F Tranter's question, it was stated that it would take six weeks for the initial implementation stage and a further three months to completely roll out.

Q6. How many patients are discharged from Accident and Emergency Units at the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital outside of normal hours?

Using the clinical definition of 10.00pm to 6.00 am, there were approximately 12 patients per week using this service at the William Harvey Hospital, and at the three other sites where it was available, approximately 60 patients per week in total.

The ITWG had acknowledged that public transport provision reduced considerably after 6.00 pm in many areas and was working with private operators in an attempt to improve the situation.

Q7. Constituents have told Members of the committee of instances where a patient discharged from an Accident and Emergency Unit during the night after being brought to the hospital by ambulance, has had to pay in excess of £30.00 for a taxi home. What is the current policy in respect of providing transport home for patients discharged from Accident and Emergency Units outside of normal working hours?

Since September 2007 at the William Harvey Hospital, and January 2008 at the other sites, there was a clerical assistant on duty between 10.00pm and 6.00am who was responsible for arranging free transport home for discharged Accident and Emergency department patients.

SQ2. If there is a policy, is there any eligibility requirement to qualify? For example, that the patient is claiming benefits?

The out of hours 'pyjama service' was a universal service free to all patients.

SQ3. How aware are patients of this service?

In response to Councillor A Friend's question, it was stated that it was promoted in the Accident and Emergency departments through posters and flyers and it was also referred to on the website and articles in the Health News publication. The EKHT was also piloting information kiosks that included the information.

SQ4. What happens during the day?

In response to Councillor D R Lloyd-Jones's question, it was stated that normal PTS arrangements and travel by public transport applied. In order to qualify for PTS, a patient would have to meet the eligibility criteria for non-emergency healthcare transport.

Q8. Are there any plans to establish a waiting area where patients discharged outside normal hours could wait?

This was been given consideration as OOH patients are currently held in a single location and this had been found to be more efficient than having patients spread out across multiple locations.

Q9. What are the times of operation of the health hopper service?

The 'Health Hopper' was a 16-seater service used to provide inter-hospital transport for patients, staff, and post. While the service suited the requirements of the time, it was no longer the most efficient way of transporting patients as only five people (staff and patients)

used each bus on average. It was intended that the 'Health Shuttle' would supersede it in the longer term as a door-to-door service, rather than a hospital-to-hospital service, was better suited for patients.

Q10. What are the eligibility requirements for patients to be able to use the Health Hopper Service?

There were no eligibility requirements for the Health Hopper service.

Q11. What is the policy in respect of travel to and from hospital for vulnerable patients?

The 'Health Hopper' was not considered a suitable service for patients needing significant levels of care as it was primarily intended for able-bodied people with minimal support requirements. Those patients needing significant levels of care were better suited to using the regular PTS.

SQ5. Does health transport cover the transportation of patients from acute to intermediate care and from intermediate care to home?

In response to Councillor Mrs S S Chandler's question it was stated that a service of this type was currently being piloted at the KCH.

Q12. Are carers or spouses/dependents permitted to travel on the health hopper service with the patient?

There were no restrictions on carers or dependents using the Health Hopper service.

Q13. Does events such as Operation Stack have an impact on the provision of patient transport services?

There was an impact from Operation Stack on Patient Transport Services that was unavoidable unless advance notice could be given prior to the introduction of it. The ambulance service operated separately from the PTS and was informed of road problems via its own control centres.

Q14. How would patients find out about the Health Hopper service?

The promotion of the Health Hopper service was limited as it was intended that the Health Shuttle would replace it in the future. It was however, included on a dedicated NHS travel website. The website address was www.eastkentnhsgettingthere.nhs.uk.

# Inquiry Report Eleven

## Eastern and Coastal Kent Primary Care Trust
## East Kent Hospitals Trust

Lynne Selman (Director of Citizen Engagement and Communications, Eastern and Coastal Kent Primary Care Trust), Howard Jones (Director of Facilities, East Kent Hospital Trust), Sheila Pitt (Head of Practice Based Commissioning, Eastern and Coastal Kent Primary Care Trust), and Paul Mullane (Head of Legal Services and Emergency Planning and Response Manager, Eastern and Coastal Kent Primary Care Trust) were invited to the meeting held on 17 June 2008. The answers were provided to the committee in written format that has been incorporated into the Inquiry Report below. Supplementary questions asked by Members of the committee were prefixed with the letters 'SQ'.

Q1. How would the proposed new community hospital be an improvement on the current hospital at Buckland?

Unlike the current Buckland facility, a new healthcare facility would be 'fit for purpose' being designed for the particular healthcare services that the hospital Trust provided. It would improve on clinical adjacencies, circulation space and take into account the latest standards for room size and design. The EKHT would also be able to address designs that reduce Health Acquired Infections, improve Privacy and Dignity, and Security. The architects will ensure that each space is designed to enhance the patient journey and provide a welcoming and light environment that promotes good-quality care. In all these respects a new healthcare facility would be a vast improvement on a refurbishment project, which could never fully address new design standards.

Ms S Pitt stated that it was intended (as per PBC commissioning intentions) that an enhanced range of services and facilities could be provided, beyond those currently provided at Buckland.

SQ1. What provision is being made to ensure that the building is 'future proof'?

In response to Councillor A Friend's question, it was stated that potential future needs would be considered in any design. An example of this was at the KCH, where there was provision incorporated into the design to allow for the addition of an extra floor.

Q2. What are the qualities that you are looking for in any potential site for a new community hospital?

Accessibility for any potential new site was a major feature. The healthcare facility needed to be in a position that met the needs of the local population, which in this case was the Dover district. Ideally, co-location with existing community facilities would enhance the service by promoting cooperation between community and acute services. However, if necessary, the unit could stand-alone. Good public transport links and other facilities nearby would be the best solution.

Adequate, inexpensive car parking and drop off/pick up facilities would be required and public transport direct to/from the location was vital and should not involve long walks or multiple changes of service. Access issues were those most frequently raised by patients and the public and the most frequent source of complaints. GP commissioners had anecdotal feedback from patients that lack of transport or parking was denying some patients recommended care.

Q3. Can you guarantee that the provision of all locally based services will continue in the interim period between Buckland Hospital closing and the new community hospital opening?

It was stated that there was an absolute guarantee that all the current, locally based, services would continue. Clearly, the construction of a new unit away from the Buckland site would be the easiest way to achieve this as existing services could continue unaffected at Buckland whilst the new build went ahead. If the option for refurbishment of the existing premises were to go ahead, services would have to be decanted into vacant space, whilst improvement works were undertaken. In the event that any services were required to move, this should be with the full knowledge of, and consultation with, commissioners.

Q4. Will the new community hospital have provision for the reinstatement of endoscopy services?

A new facility, if commissioned, could have an Endoscopy Unit built within it to provide this service for the Dover community. This was a very clear commissioning intention by the PBC, together with other diagnostic services for Dover. This was based on clinical need

identified by GPs and based on strong patient demand for diagnostics closer to home. The above was strongly endorsed at a recent public PBC meeting held on 11 June 2008.

The EKHT and the PCT are planning a joint patient survey to gain more information on patient views on the provision of this service in Dover, including a greater understanding of why some patients from Dover choose to have endoscopies elsewhere, even when offered an appointment in Dover.

Q5. What will be the minimum services that the proposed new community hospital will provide?

The minimum services would be all those existing on the Buckland site. It was expected that an increased level of service would be offered, but this was subject to the work of the practice-based commissioning consortium which was due to be shared with the East Kent Hospital Trust in August 08. The outline intentions were shared at public meeting held on 11 June 2008.

Q6. What are the additional services, if any, under consideration for provision in a new community hospital?

The outline commissioning plans presented at a public meeting held on 11 June 2008, expressed aspirations to retain, extend, and add services in Dover. This would include key areas such as diagnostics and outpatients.

Q7. Would you accept that an important component in providing effective outpatient and minor injury services in a single location is the provision of diagnostic services, such as x-ray or MRI, at the same site?

Radiology facilities would be provided in the new hospital, and an external pad would be provided which could be used for mobile MRI and/or CT diagnostic facilities.

SQ2. Is there the technical infrastructure in Dover to support diagnostic services?

In response to Councillor C E Kirby's question, it was stated that the East Kent Hospital Trust had installed its own digital communications infrastructure which was at N3 standard.

Q8. How guaranteed is the £11 million for the construction of a new community hospital?

The £11 million is an estimate but a public commitment to at least this level of funding has been made by the Chief Executive of the East Kent Hospitals Trust in discussing its plans for an application for Foundation Trust status. The actual outturn cost could only be calculated once greater details of the design are known and as with all NHS facilities would be subject to business case approval. The provision of land on which the unit sits would greatly enhance the business case, as it would be more affordable to the East Kent Hospitals Trust.

Q9. In developing plans for a new community hospital, have other providers and public bodies such as the Out of Hours service provided by South East Health Ltd, local primary care providers, and Dover District Council been consulted?

The Out of Hours service already exists within Buckland Hospital and therefore would be automatically transferred to the new unit, unless commissioning plans changed. The intention was that all key stakeholders would be involved in the planning process for the new facility. The PBC groups anticipated continuing public and other stakeholder participation in designing services and in site planning. The PCT had given a clear commitment to supporting this at public meeting held on 11 June 2008.

Q10. Under the 'Our health, Our care, Our community: Investing in the future of community hospitals and services' programme, the Government allocated £750 million for investment in new facilities over five years. Has any consideration been given to making a bid for funding under this scheme to supplement the existing funds allocated for the construction of a new community hospital?

The intention of East Kent Hospitals Trust is to construct this new unit as soon as possible and it has identified, in broad terms, capital within the EKHT existing capital programme to enable the unit to be constructed. This would ensure a much faster programme than would be available if the EKHT were dependent on external funding such as the £750 million referred to. An example of this was the recently agreed facility in Ashford that took 4 years for funding to be approved.

Q11. When would you expect the proposed new community hospital to be operational?

The intention of East Kent Hospitals Trust was to deliver a solution as soon as possible. The building of a unit in Dover was dependent on decisions made by Dover District Council, including planning permission, as the Trust did not own any land in this area. As soon as any suitable land was made available, the sooner detailed design and construction work could begin. As part of the initial considerations for a new community hospital, a calculation of the floor space required for the existing services had already been undertaken (approximately 534 square metres).

Q12. Will there be any change to the role and services provided at the Dover Health Centre if a new community hospital is constructed?

The commissioning plans of the PBC group would be looking at a wide range of services that would require a range of settings to deliver them (e.g. Dover Health Centre; community hospital, GP surgeries; intermediate care in residential, nursing and home settings, etc.).

Q13. Given the low level of car ownership in urban Dover, what will you be doing to ensure that there will be sufficient public transport services to any new community hospital?

A new facility in Dover having access to good public transport services, which could be adjacent to the unit, would be a key criterion for the site.

The EKHT is an active member of the Integrated Transport Working Group, led by the PCT, which includes members from Kent County Council, who have responsibility for transport services. As the principal objective of this group was to formulate a cohesive transport strategy for access to health, it was possible that further action could be taken to enhance any new facility placed in central Dover.

Transport and infrastructure has been a key focus in the PBC commissioning intentions and decisions on healthcare service provision would be inter-dependent on transport and infrastructure to ensure a holistic solution. A significant level of responsibility lay with partners in District and County Council's to ensure that access to healthcare was not denied through lack of transport infrastructure.

The Kent County Council Health Overview and Scrutiny Committee (HOSC) has agreed to set up a select committee to move transport issues forward. The PCT/EKHT/SECAM would be prepared to update a separate meeting of the Dover District Council Scrutiny (Community and Regeneration) Committee on improvements to patient and emergency transport provided by the NHS.

Q14. Do the proposals for a new community hospital contain any provision for a limited number of intermediate care beds?

The current capacity of the intermediate care scheme is adequate (running at about 90% capacity), although the PBC groups would like to commission flexible bed capacity (from a suitable facility, not necessarily in a hospital) to deal with any peaks in activity. They also plan to ensure there is enhanced medical cover when required to deal with patients with more-complex needs.

Q15. Is the current level of provision of intermediate care beds in Dover sufficient to meet demand?

Please see the answer to Q14.

Q16. How advanced are the proposed Models of Care being developed from the Dover Project?

The PBC plans are broader and more detailed than the 11 areas in the original Dover Project. However, the outcomes of that project have been incorporated into the draft commissioning intentions (with the exception of Pharmacy proposals). The services and the estate and finance required would be determined by the end of August 2008, as agreed with Kent County Council HOSC.

The pharmacy proposals had been changed after discussions with local General Practitioners and Pharmacists who had expressed concerns about expanding the pharmacy provision in the district. As a consequence, the new model of care was that no change to existing provision would be made.

Q17. How involved have the local Practice Based Commissioning groups been in the development of the new Models of Care emerging from the Dover Project?

As the local commissioners for Dover, the Dover and Aylesham PBC group has been fundamental in developing further the models of care from the Dover Project. However, some, such as intermediate care, have already had considerable investment and are fully operational now.

Q18. Have there been any changes in the proposed models of care since the last meeting with the Committee in Autumn 2007?

The response to this question was partially covered by Q16. However, generally the PBC aspirations are wider than the 11 areas in the Dover project. In addition EKHT sub-groups in some topic areas had continued to meet (e.g. outpatients; minor injuries/illness; birthing unit; child health) to map out internal service improvements.

Q19. The Dover Project consultation contained proposals for day and community-based children's services. Has any consideration been given to the provision of a small number of local intermediary care beds for children in the District?

It was under discussion by the PBC group, although no firm plans have been developed for it at present. It would first be necessary to ensure all the appropriate clinical safety and other considerations were viable and in place.

Q20. In hindsight, is there anything that you would change about the consultation process for the Dover Project?

Although it would not have been possible to foresee the perfect time to undertake the consultation, the timing of the Dover Project consultation was not ideal as it overlapped with significant changes in the PCT's structure and the introduction of practice-based commissioning, both of which have inevitably meant some delay in planning and implementation.

Recently, the PBC group has been given considerable additional commissioning and patient and public engagement support from the PCT in order to speed up the drafting of, and consultation on, commissioning intentions.

Q21. In recent months a series of high profile public events have been organised that highlight the concerns of local people over the future of Buckland Hospital. How do you intend to convince local people that the proposals for a new community hospital will result in tangible improvements to the quality of health service provision they receive in the future?

The PCT has to ensure that it has a robust communication strategy, including information for the public available via multiple media sources (web sites, newsletters, etc.) and to involve community leaders and opinion formers in the development of plans both for services and buildings.

The current project underway to gather the views of both primary care and PCT commissioners, informed by the public, service users and other agencies is an indication of the commitment to ensure appropriate services are available in Dover and that there will be "transparent" stakeholder involvement in the process (e.g. meeting held on 11 June 2008; the setting up of a "lay" advisory group to the PBC consortium; and a further open meeting to be held on estates options.)

Q22. There is some concern over the provision of health services in Dover in the event of a major incident either at the Port of Dover or on the A20. Can you relate to this concern and how would you seek to reassure elected members that sufficient arrangements are in place to deal with such an incident?

Any declared Major Incident at the Port of Dover, on the A20 or within any part of the Dover District in respect of the provision of Healthcare, is the responsibility of the South East Coast Ambulance NHS Trust; East Kent Hospitals NHS Trust; and the Eastern and Coastal Kent Primary Care Trust.

The Ambulance Trust has responsibility for the designation of the 'Receiving' Hospital, which is either the William Harvey Hospital, Ashford, or the Queen Elizabeth The Queen Mother Hospital, Margate. The Ambulance Trust is also responsible for the deployment of Paramedic Teams to the scene, whose role is to triage and to start life saving treatment immediately, and for arranging for the urgent transfer of patient's to specialist centres such as the Burns Unit at East Grinstead.

NHS Community Services, which is the 'Provider Arm' of the Eastern and Coastal Kent Primary Care Trust, has plans in place for Community Clinical Response Teams to respond to Rest Centres/Survivor Reception Centres. There is also provision to treat the 'Walking Wounded' at the Minor Injuries Unit in Dover. The Port of Dover has a 'Survivor Reception Plan', which deals with the response to Marine incidents. The Ambulance Trust and the Eastern and Coastal Kent Primary Care Trust form part of that plan.

The three NHS Trusts all have well established Emergency Response Plans in place to respond to a declared major incident in the Dover area. In addition, as part of the Civil Contingency Act 2004 there was a requirement for multi-agency training to be undertaken.

SQ3. What is the composition of the emergency clinical response?

In response to Councillor Mrs J F Tranter's question, it was stated that the Community Clinical Response (CCR) teams consisted of six nurses and a pharmacist. During the Folkestone earthquake, the CCR team provided support at the rest centre. Although the majority of major incidents occur out of normal hours, a team can be assembled within 45 minutes and there are arrangements with the police to provide transportation into Dover for the CCR team if required. There was also the option to utilise locally based staff if there were problems in assembling the team. In addition, there was also access to off road vehicles ensuring that in emergencies the roads were not the only method of reaching an incident.

# Section Seven

# Recommendations

***Summary of the recommendations of the Scrutiny (Community & Regeneration) Committee to Council***

# Recommendations

7.1 In undertaking this review, it should be acknowledged the committee has sympathy for the strong local feeling in favour of restoring the hospital provision in Dover to acute status. However, it was felt that the most effective approach available to the committee was to use the opportunity to work with the Eastern and Coastal Kent Primary Care Trust, the East Kent Hospitals Trust and other providers in an attempt to influence the development of proposals for a new community hospital so that the best outcome could be achieved for the local community.

7.2 The Scrutiny (Community and Regeneration) Committee at its meeting held on 20 May 2008 (Minute No. 34) made a recommendation to the Cabinet that was adopted as CAB24 as follows:

That the Cabinet work closely with the Eastern and Coastal Kent Primary Care Trust and the East Kent Hospitals Trust to locate a central and accessible site in Dover for Community Hospital Services for the population of Dover and the surrounding areas.

7.3 Following the Review of Future Health Service Provision in the Dover District by the Scrutiny (Community and Regeneration) Committee, the recommendations that are made are as follows:

That it be recommended to (Cabinet and) Council:

(a) That the Cabinet be urged to lobby Kent Police and the Highways Agency in the strongest terms to find a solution to the unacceptable problem of lorries on the A20 occupying both lanes, particularly during the times of heavy traffic volumes or congestion, and as a consequence restricting or blocking the access of emergency services to Dover.

(b) That the committee welcomes the assurances given by the Eastern and Coastal Kent Primary Care Trust in support of its firm conviction that the existing locally provided health services must be maintained and requests

that the committee be updated on any developments in health service provision.

(c) That an invitation be extended to the Eastern and Coastal Kent Primary Care Trust and the East Kent Hospitals Trust to attend the meeting of the Scrutiny (Community and Regeneration) Committee to be held on 16 September 2008 to inform the committee of the final decision on the replacement of Buckland Hospital and the services to be provided at the new community hospital.

(d) That the Council express its disappointment to Kent County Council over the gap in provision between the end of the Patient and Public Involvement Forum's and the start of the new Local Involvement Networks (LINks).

(e) That the Eastern and Coastal Kent Primary Care Trust, the East Kent Hospitals Trust, South East Health Ltd and local General Practitioners be urged to work together to reduce administrative burdens on staff and to develop compatible computer systems for a single patient record system.

(f) That the Eastern and Coastal Kent Primary Care Trust, the East Kent Hospitals Trust and the two Practice Based Commissioning groups be urged to provide as many new high quality local health services as possible in both the new community hospital and in the community.

(g) That the committee recognises the concerns expressed by the local community in relation to access and waiting times for health services and it requests that the East Kent Hospital Trust and Eastern and Coastal Kent Primary Care Trust continue to work with it in monitoring these matters.

(h) That while the committee welcomes the promising efforts being made to improve Patient Transport Services by the East Kent Hospital Trust, it urges that measures be considered to address the burden being placed on families having to travel regularly from the Dover District to visit patients at either of the two acute hospitals.

(i) That concern be expressed over the cost of hospital car parking and that the East Kent Hospitals Trust be urged to introduce free or reduced charges for

parking at the new community hospital in Dover and the network of East Kent hospitals generally.

(j) That in considering the network of intermediate care beds in the Dover District the Eastern and Coastal Kent Primary Care Trust be urged to make a small provision of intermediate care beds for children.