HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 3rd February, 2012

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 3rd February, 2012, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Peter Sass**
Telephone: **01622 694002**

Tea/Coffee will be available from 9:45 am

Membership

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

Webcasting Notice

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

Item	Timings
1. Introduction/Webcasting	
2. Substitutes	

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

4. Minutes (Pages 1 - 6)

5. Overview of Health Scrutiny Regulations (Pages 7 - 12)

6. Reducing Accident and Emergency Admissions: Part 3: Mental Health Services (Pages 13 - 26) 10:00 – 11:00

7. East Kent Hospitals NHS University Foundation Trust Clinical Strategy (Pages 27 - 38) 11:00 – 12:00

8. East Kent Maternity Services Review: Written Update (Pages 39 - 44)

9. Mental Health Services Review (Pages 45 - 48)

10. Date of next programmed meeting – Friday 9 March 2012 @ 10:00 am

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
(01622) 694002

26 January 2012

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 6 January 2012.

PRESENT: Mr N J D Chard (Chairman), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr C P Smith, Mr K Smith, Mr R Tolputt, Mr A T Willicombe, Cllr J Burden, Cllr R Davison, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Mr L Christie and Cllr J Cunningham

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest.

Michael Lyons declared a person interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting of 25 November 2011 are correctly recorded and that they be signed by the Chairman. There were no matters arising.

4. NHS Emergency Resilience and Olympics Planning
(Item 5)

Meradin Peachey (Director of Public Health), Matthew Drinkwater (Head of Emergency Preparedness and Response, NHS Kent and Medway), Paul Mullane (Head of Emergency Planning, Response and Resilience, 2012 Olympics Lead, NHS Kent and Medway), Jon Amos (Contingency Planning and Resilience Manager, South East Coast Ambulance Service NHS Foundation Trust), and Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed and introduced the guests before explaining that the purpose of the meeting was for Members of the Committee to seek reassurances from the NHS on behalf of the people of Kent that the appropriate plans were in place relating to emergency resilience, and specifically to the Olympics and Paralympics Games.

(2) The Director of Public Health was invited to introduce the item and did so by explaining that she was the lead director for NHS Kent and Medway. The overall principle was to ensure there was one clear approach to mobilising emergency plans across all provider Trusts and the Primary Care Trusts in Kent and Medway. The call system operated 24-hours a day and the plans meant the whole resource of the NHS could be mobilised.

(3) The publicly available plans produced by the NHS were contained in the Strategic Major Incident Response Plan which each NHS Trust produced and refreshed each year. This ran alongside the Business Continuity Plans which all organisations produced annually. This was a practice mirrored across all the organisations which were Category 1 and 2 responders and so were part of the Kent Resilience Forum.

(4) There were a few key messages about NHS emergency resilience planning running through the information provided at the meeting. Representatives from the NHS were keen to stress that the emphasis was on developing capabilities rather than responses to specific scenarios as it was difficult to predict and plan for every possible event. This was complemented by the fact that plans could be scaled up across the local area, then regionally and nationally. What this meant in practice was that where necessary the NHS could call on the resources of any Trust, near or far, to provide resources and assistance, as well as call on the support of other organisations such as the police, fire and rescue service and the military.

(5) While there were limits to how much detail could be provided on the lessons learnt from actual incidents elsewhere, representatives of the local NHS explained that events in New York and Mumbai had been closely studied and there was sharing of good practice relating to other events around the world, such as in Norway and Belgium. The particular position of Kent and Medway, neighbouring London as it does and containing a number of transport hubs, was incorporated into the planning. For example, in response to a couple of specific concerns raised about Manston Airport, it was explained that yearly interagency exercises were carried out at the airport, with a live one taking place every 3-4 years; the last one took place last year.

(6) The Ambulance Service was key to the implementation of any plans. Most calls triggering an emergency response came through the ambulance service which coordinated NHS Gold Command. This in turn was able to allocate NHS resources across Trusts in case of need, with the Folkestone earthquake given as an example in recent years. The Trust reported that recent changes in the way the ambulance service was organised meant it could deliver a more flexible response. This included the availability of 60 Critical Care Paramedics and the introduction of the Make Ready Depots. The two Hazardous Area Response Teams (HART) at Ashford and Gatwick formed an important part of the resources the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) could deploy. These were specially trained teams of 42 staff, each on permanent standby and able to enter ‘hot zones’ in the event of chemical spills and similar events.

(7) Related to this, the Director of Public Health explained that there was a greater need now than 20 years ago to plan for biological and chemical incidents. She

was the lead STAC for Gold Command in the County. STAC stood for Science & Technical Advice Cell and meant that she had the responsibility for pulling together the best advice relating to poisons and poisonous substances. This system was designed to avoid the situation which occurred at the Buncefield oil disaster a few years ago when it took 3 days to pull together the proper advice. There were 12 public health consultants in Kent and Medway STAC trained when 3 from the Health Protection Agency were included. Continual STAC coverage for 3 days had been rehearsed.

(8) A number of Members raised a number of related concerns about the impact of the Olympic and Paralympic Games. The whole period of the Games would see a marked increase in the number of people travelling through Kent and Ebbsfleet Station was seen as a major pinch point. One Member felt that little had been done to warn the general public of the anticipated impact of the Games on the wider transport network. There would still be the regular amount of commuter traffic over this period and recent high winds had shown how quickly the traffic system could cease up. Alongside the impact on the continuity of daily life, Members also expressed concerns about the ability of the NHS to continue providing a regular level of service, as people would still require medical treatment over this time.

(9) In response, representatives from the ambulance service explained that the core assumption behind the plans was to keep the regular 999 service continuing as normal. Modelling from previous Games as well as modelling carried out by the London Ambulance Service and Office of National Statistics, meant that an increase in activity of between 1% and 7% was predicted as a result of the Games. While the service was lean, it was used to dealing with a flux in demand. The NHS was already used to dealing with extra demands over winter and was used to dealing with such occurrences as Operation Stack and Kent had recently hosted the Open Golf Tournament which saw an increase in the number of people travelling through the County. Leave restrictions and other measures such as a bank system had been brought in to make sure the appropriate capacity was available. A more coordinated response with police and other services was being brought in at control room level with weekly Gold level meetings during the Games. Specific funding for days when events were taking place had been requested by the ambulance service. In addition, SECAmb were in negotiation with commissioners over their 2012/13 contract around the anticipated 1-7% increase in activity. The Trust offered to report back to the Committee in April as to the outcome of this process.

(10) With regards the Olympic Park in London, there was a national scalable Department of Health plan which would enable appropriate resources to be brought in from the most appropriate source, including the military. This could involve calling on Trusts based in Kent and Medway, as when SECAmb provided assistance during the London riots in 2011. During the period of the Games, 28 staff from across the SECAmb area would move to assist covering the London area. While none of the Olympic lanes would be in Kent, patients in Kent and Medway did access London acute services and so there was a potential impact. SECAmb was working with Transport for London and the London Ambulance Service over the best ways to ensure continuity of service.

(11) In relation to the Paralympic cycling events to be held at Brands Hatch, SECAmb was working with St. Johns Ambulance and specialist Olympics and Paralympics medical staff on preparations. The regular ambulance fleet would be able to provide the necessary cover. In addition, there were three air ambulances across the SECAmb area, with the helicopters of the RAF Coastguard on standby. London and Essex were in a position to provide mutual aid.

(12) The Chairman thanked the guests for their valuable contributions and looked forward to receiving further information from SECAmb in April.

(13) AGREED that the Committee thank representatives of the local heath sector for their contribution to its review of this important subject, commends the work they have done in conjunction with other partners and wish them all every success for this Olympics year.

5. Reducing Accident and Emergency Admissions: Preliminary Findings
(Item 6)

(1) The Chairman introduced the item by explaining that the report in front of Members contained some preliminary findings and that the final report on reducing accident and emergency admissions would only be produced following the 3 February HOSC meeting at which the role that mental health services play would be considered.

(2) A number of Members supported the Chairman's impression that the NHS was becoming more a series of silos and less an integrated service. Several Members provided examples from their own experiences of the lack of communication between different NHS organisations.

(3) Members felt that there were a number of ways in which attending an accident and emergency department (A&E) was becoming the default response of many people. Where GP surgeries could not carry out minor procedures, or could not do so within a reasonable amount of time, then members of the public may feel attending A&E was the only option. This tendency would be reinforced where there were issues around accessing GP out-of-hours services and uncertainty around the services which minor injury units and pharmacies could or could not provide. There were also areas, like Maidstone, which had no community hospital. The Chairman undertook to write to the Chief Executive of Kent Community Health NHS Trust to request information about opening times and the availability of services at community hospitals, minor injury units, and walk-in-centres.

(4) On Member reported that a major report on this subject had come out the day after the last occasion the Committee had considered it. The Member felt that this would have changed the outcome of the debate if it had been known about and that the NHS may well have known it was about to be published and what it contained. It was felt that there was a need to take on board the findings of these report in order to develop a more accurate understanding of the realities of the health service.

(5) AGREED that the Committee note the report.

6. Forward Work Programme

(Item 7)

(1) The Chairman introduced the Forward Work Programme and highlighted some of the items proposed for future meetings. The Chairman requested that should any Member have any specific question relating to the 9 March item, *Partnership between Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust*, then they should be forwarded to the Committee Researcher by the end of Friday 13 January. In addition, the Chairman commented that the idea of an event around April time looking at 'One Year to Go' before the new NHS system is introduced on 1 April 2013 had been passed on to the Health and Wellbeing Board but no response had been received.

(2) On this subject, Members felt that it would be beneficial for them to receive information on the Health and Wellbeing Board and what it was considering because there was a possible role for the Committee in adding value to the development of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. The Researcher to the Committee undertook to ensure Members received information about future Health and Wellbeing Board Agendas.

(3) On the subject of the partnership between Darent Valley and Medway Maritime, one Member explained that the Governors of each Trust were visiting the other on 1 and 15 February and felt any interested Member would be able to take part in either or both and undertook to provide the relevant contact details to the Committee Researcher in case any Member wished to enquire further.

(4) A representative of the Kent LINk requested the opportunity to bring back a report on mental health issues in April and undertook to provide the necessary information to the Committee Researcher.

(5) A range of views were expressed on the development of locality boards and how they would fit in with health scrutiny. There had been a paper on this subject included in the Agenda for 14 October 2011 and since then there had been developments around the Committee structure at Kent County Council which may also have an impact on the way health scrutiny develops. The Chairman felt that while it was something of a chicken and egg situation, the Committee would be able to accommodate and respond appropriately to any issue which came through the locality boards.

(6) There were a number of broader points made about the role and effectiveness of the HOSC. One the one hand, the view was expressed that it was difficult to see what practical results the Committee was achieving in improving the local health service. On the other hand, the view was expressed that the Committee had created a major shift in the way the local NHS approached public consultation, with the recent work on maternity services in East Kent an example, and that this was a positive achievement.

(7) There was clear consensus around the fact that the development of the Health and Wellbeing Board and other changes in the health and local government sectors would mean a change to the way health scrutiny was carried out. One Member felt it would be of assistance to have a reminder of the statutory powers of the HOSC and the Chairman undertook to ensure there was a paper in the next Agenda.

(8) AGREED that the Committee approve the Forward Work Programme.

7. Date of next programmed meeting – Friday 3 February 2012 @ 10:00 am
(Item 8)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 February 2012

Subject: Overview of Health Scrutiny Regulations

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1. Summary

Box 1. Key Powers of HOSC:

Health Overview and Scrutiny Committees may:

- examine any matter relating to the health services within the local authority area;
- make reports and recommendations;
- request information and attendance at meetings from local NHS bodies;
- establish joint committees with other local authorities;
- delegate functions to other local authority committees;
- co-opt Borough/City/District Councillors onto the Committee;
- respond to formal referrals of issues from LINk; and
- refer matters relating to substantial variations of service to the Secretary of State on two grounds:
    - inadequate consultation; and/or
    - the Committee does not consider that the proposals are in the best interest of the local health service.

2. Background

(a) The current legal framework for health scrutiny in England was established through the *Health and Social Care Act 2001*[1] which put in place proposals contained in the *NHS Plan* of 2000.

[1] *Health and Social Care Act 2001,* http://www.legislation.gov.uk/ukpga/2001/15/part/1/crossheading/local-authority-scrutiny-of-health-service-provision

(b) Under the *Local Government Act 2000*[2], each upper-tier local authority is required to have a committee to carry out the health scrutiny function.

(c) The term HOSC is used in this paper for convenience and to fit the current usage of Kent County Council. Committees have different names in different local authorities and operate in a variety of ways.

(d) The Kent HOSC has considered a wide range of subjects relating to the health service in the County. This has included a number of substantial variations of service including trauma and orthopaedics services, women's and children's services at Maidstone and Tunbridge Wells NHS Trust and the current East Kent Maternity Services Review.

(e) As well as the regular meetings of the Committee, the HOSC forms part of the South East Health Scrutiny Network consisting of the Chairman and lead Officers of the equivalent Committees from Kent, Medway, Surrey, Brighton and Hove, East Sussex and West Sussex. As well as meeting with the Strategic Health Authority and discussing issues that affect the whole region, the Network provides an opportunity to share best practice and work of improving and refining health scrutiny. The Chairman and Committee Researcher also attend the regular Health Accountability Forum hosted by the Centre for Public Scrutiny.

3. *The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048)*[3]: Key Features

(a) The remit of HOSC is broad as it "may review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority."

(b) In the context of the regulations, 'NHS bodies' refers to Primary Care Trusts, Strategic Health Authorities and NHS provider Trusts (including Foundation Trusts) which are part of the local health economy.

(c) The HOSC may require information from NHS bodies, subject to certain exemptions. It may also require attendance by officers of local NHS bodies at its meetings, having given reasonable notice.

(d) The HOSC is able to make reports and recommendations to local NHS bodies and to its local authority on any matter which it has reviewed and scrutinised. Where a response has been requested from a local NHS body, it must do so within 28 days.

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[2] *Local Government Act 2000*, http://www.legislation.gov.uk/ukpga/2000/22/section/21

[3] *The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048)*, http://www.legislation.gov.uk/uksi/2002/3048/contents/made

(e) Local NHS bodies must consult the HOSC over any proposals "for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such services."

(f) There is an exception where there is a "risk to the safety or welfare of patients or staff," in which case the local NHS body must inform the HOSC as to why no consultation took place. In addition, the requirement to consult does not apply to pilot schemes and proposals to establish or dissolve a Trust, except where this involves a substantial variation of service.

(g) Where a HOSC feels that a consultation has been inadequate, that the reasons for not having a consultation were inadequate, or where they consider the proposals would "not be in the interests of the health service in the area of the committee's local authority," then the matter may be referred to the Secretary of State.

(h) The regulations allow for the co-option of district councillors onto the HOSC and for the delegation of its authority to an overview and scrutiny committee of another local authority.

(i) A joint Committee with another local authority may also be established which will exercise those HOSC functions the authorities deem appropriate. The subsequent *Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) 2003*[4] from the Department of Health stated that when an NHS body consulted two or more local authority health scrutiny committees a joint committee "shall" be established. It is only this joint committee which may exercise the health scrutiny powers over the specific issue being consulted on, including that of referral.

4. Further developments

(a) The *National Health Service Act 2006*[5] replaced various relevant sections of the *Health and Social Care Act 2001*. It included enabling sections for further regulations and updated the parts on exempt information as well as providing further regulations about joint overview and scrutiny committees. Section 242 placed a duty on NHS bodies to involve local people in decision making. The definition of "the health service" was extended to cover "health-related functions of a local authority" (i.e. those arrangements pursued under section 75 of the Act[6]).

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[4] *Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) 2003*, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4066609.pdf

[5] *National Health Service Act 2006*, http://www.legislation.gov.uk/ukpga/2006/41/section/244

[6] Ibid., http://www.legislation.gov.uk/ukpga/2006/41/section/75

(b) The *Local Government and Public Involvement in Health Act 2007*[7] established Local Involvement Networks (LINks) and subsequent regulations updated the 2002 regulations around the HOSC needing to take into account information from a "Patients' Forum." The LINks have the ability to refer matters to the relevant overview and scrutiny committee (on health or social care issues) and receive an acknowledgment within 20 days and be kept informed of any action taken by the Committee[8].

(c) There is also a requirement for certain provider Trusts to send a copy of their annual Quality Account to their local HOSC by 30 April each year. HOSCs have 30 days to provide a statement of no more than 1000 words for inclusion in the final published version. The guidance states this is a voluntary role for HOSCs, depending on resources, capacity and priorities[9].

5. Joint Health Scrutiny Committee with Medway Council

(a) Pursuant to the 2001 Act, a Joint Committee with Medway Council was established at the meeting of the County Council of 25 March 2004. The arrangements were updated at County Council on 14 September 2006[10].

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

6. *Health and Social Care Bill*: Health Scrutiny in the Future

(a) Subject to Parliamentary approval and subsequent guidance, the *Health and Social Care Bill*[11] contains changes to the health scrutiny legislation as follows:

i. From April 2013, the functions of the current Health Overview and Scrutiny Committee will be conferred on the local authority directly. The exercise of this function could be through a specific health scrutiny committee or through a different arrangement. The scrutiny function will not be able to be exercised by the Health and Wellbeing Board or the local authority executive.

ii. The powers of health scrutiny will expand to include any local NHS funded provider and any local NHS commissioner. As

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[7] *Local Government and Public Involvement in Health Act 2007,* http://www.legislation.gov.uk/ukpga/2007/28/section/226

[8] *The Local Involvement Network Regulations 2008 (S.I. 2008/528*), http://www.legislation.gov.uk/uksi/2008/528/contents/made

[9] Department of Health, *Quality Accounts: a Guide for Overview and Scrutiny Committees*, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125167.pdf

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

[11] *Health and Social Care Bill*, http://services.parliament.uk/bills/2010-11/healthandsocialcare.html

things stand, the NHS Commissioning Board, being a Special Health Authority, will not be subject to local authority health scrutiny, but it is likely reports and recommendations will be able to be made to it.

iii. The ability to challenge substantial service change will remain, though it is possible that the decision to refer will require a vote of the full Council. As is the case currently, the details around health scrutiny will be contained in official guidance and Statutory Instruments. There is likely to be a consultation specifically on health scrutiny regulations at a later date.

7. Recommendation

That the Committee note the report.

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Item 6: Reducing Accident and Emergency Admissions: Part 3: Mental Health Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 February 2012

Subject: Reducing Accident and Emergency Admissions: Part 3: Mental Health Services

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1. Background

(a) This is the third meeting considering this subject, the other meetings being 14 October and 25 November 2011. In addition, preliminary findings were noted at the meeting of 6 January 2012.

2. Questions

(a) The strategic questions which this review will seek to answer are:

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

- How can levels of attendance best be reduced?

(b) The specific questions submitted to the Trusts attending today's meeting are appended to this report.

2. Recommendation

That the Committee consider and note the report.

Appendix – Questions from the Committee

1. Do the current levels of attendance at accident and emergency departments pose any particular challenge for the commissioning and provision of mental health services?

2. What is the role of mental health services in reducing attendances at accident and emergency departments?

3. What is the place of urgent and emergency care in your organisation's QIPP programme?

4. From the perspective of the mental health service, what are the main challenges to reducing attendance at accident and emergency departments?

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

To: Health Overview and Scrutiny Committee, 3 February 2012

Subject: Reducing Accident and Emergency Admissions: Mental Health Services: Background Note

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1. Accident and Emergency (A&E) Departments

(a) There are three types of A&E department[1]:

Type 1 = A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients

Type 2 = A consultant led single specialty accident and emergency service (e.g. dental).

Type 3 = Other type of A&E/minor injury units (MIUs)/Walk-in Centres, primarily designed for the receiving of accident and emergency patients. An appointment based service (for example an outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example most out of hours services), or a dedicated primary care service (such as GP practice or GP-led health centre) is not a type 3 A&E service even though it may treat a number of patients with minor illness or injury.

(b) Selected key trends for A&E across England:

- Attendances at Type 1 A&E departments are the main source of emergency admissions to hospital[2].
- Emergency admissions rose by 11.8% equalling 1.35 million additional admissions from 2004/05 to 2008/09[3].
- The number of attendances at Type 1 departments grew by 1.2% and the proportion admitted as emergencies grew by 14.3% from 2004/05 to 2008/09[4].

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[1] The Department of Health, *Quarterly Monitoring of Accident and Emergency (QMAE), Guidances, FAQs and Simple form,* p.3, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_129783.doc

[2] The Nuffield Trust, *Trends in emergency admissions in England 2004-2009: is greater efficiency breeding inefficiency?*, p.1, http://www.nuffieldtrust.org.uk/publications/trends-emergency-admissions-england-2004-2009.

[3] Ibid., p.1.

[4] Ibid., p.1.

- Across all three types of A&E, there was a 10% increase in attendance from 2004/05 to 2008/09 with the majority of the additional attendances being at Types 2 and 3[5].

- More than 70 per cent of hospital bed days are occupied by emergency admissions[6].

- The majority of attendances at A&E are self-referrals (65.5% in 2009/10) with referrals from GPs and the emergency services at 6.4% and 9.3% respectively (also for 2009/10). Around 25% arrive by ambulance or helicopter[7].

(c) *The NHS Operating Framework 2012/13* stated the clinical quality indicators introduced in 2011/12 would remain in place for local use with the operational standard of 95% of patients being seen within 4 hours used to judge performance nationally[8].

(d) These clinical quality indicators are:

- Unplanned re-attendance
- Left without being seen rate
- Total time spent in A&E department
- Time to initial assessment
- Time to treatment
- Ambulatory care
- Service experience
- Consultant sign-off

2. Mental Health Services

(a) An estimated 5% of those attending A&E have a primary diagnosis of mental ill health. The largest groups within this are substance abuse and deliberate self-harm.

(b) A further 20-30% of attendees have coexisting physical and psychological problems.

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[5] Ibid. pp.6-7.
[6] The Kings Fund, *Emergency bed use: what the numbers tell us*, December 2011, p.1, http://www.kingsfund.org.uk/publications/emergency_bed_use.html
[7] NHS Information Centre, *Accident and Emergency Attendances in England (Experimental Statistics) 2009*-10, January 2011, p.15, http://www.ic.nhs.uk/webfiles/publications/004_Hospital_Care/HES/aandeattendance0910/AE_Attendances_in_England_Experimental_statistics_2009-10__v2.pdf
[8] Department of Health, *The Operating Framework for the NHS in England 2012/13*, 24 November 2011, p.19, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf.

(c) Overall, it has been estimated that around 35% of A&E attendances are alcohol related (including violent assaults, road traffic accidents, mental health emergencies and deliberate self-harm)[9].

(d) There is a range of health services involved in urgent and emergency care for people with mental health problems – including crisis resolution home treatment teams (CRHT) and liaison psychiatry services.

(e) CRHT provide treatment at home for those who are acutely unwell but do not require A&E admission[10].

(f) Liaison psychiatry provides psychiatric treatment to patients attending general hospitals, whether they attend out-patient clinics, accident & emergency departments or are admitted to in-patient wards[11].

3. QIPP

(a) The QIPP (Quality, Innovation, Productivity and Prevention) is a series of 12 workstreams aimed at making efficiency savings to be reinvested in services. Across the NHS in England as a whole, the QIPP target is to find £20 billion in efficiency saving by the end of 2014/15[12].

(b) The QIPP workstream on urgent care:

i. "aims to maximise the number of instances when the right care is given by the right person at the right place and right time for patients. The workstream starts from a perspective that rather than 'educating' patients about where it is appropriate for them to go, we should focus on designing a simple system that guides them to where they should go;" and

ii. "aims to achieve a 10 percent reduction in the number of patients attending Accident and Emergency with associated reductions in ambulance journeys and admissions."[13]

(c) The Department of Health broadly defines urgent and emergency care as "the range of healthcare services available to people who need

[9] Department of Health, *Checklist Improving the management of patients with mental ill health in emergency care* settings, September 2004, p.3 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4089197.pdf

[10] Royal College of Psychiatrists, *Acute mental health care: briefing note*, November 2009, p.5, http://www.rcpsych.ac.uk/Docs/Acute%20mental%20health%20care%20briefing%20final%2097-03%20version.doc

[11] Royal College of Psychiatrists, *Faculty of Liaison Psychiatry*, http://www.rcpsych.ac.uk/specialties/faculties/liaison.aspx

[12] The Department of Health, *Quality Innovation, Productivity and Prevention,* http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm

[13] The Department of Health, *Urgent care,* http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115468

medical advice, diagnosis and/or treatment quickly and unexpectedly."[14]

(d) In relation to QIPP and mental health, the following indicators are monitored nationally:

- the number of new cases of psychosis served by early intervention teams;
- the percentage of inpatient admissions that have been gatekept by Crisis Resolution/Home Treatment Teams; and
- the proportion of people under adult mental illness specialties on the Care Programme Approach (CPA) who were followed up within seven days of discharge from psychiatric inpatient care[15].

(e) The RAID (Rapid Assessment Interface and Discharge) 24/7 psychiatric liaison service in Birmingham has been listed in *The NHS Operating Framework* as an example of QIPP good practice[16].

Appendix: 111 Update

(a) The procurement for a 111 service across Kent, Medway, Brighton and Hove, East Sussex, West Sussex and Surrey was launched on 30 November 2011 by South East Coast Strategic Health Authority[17]. The contract award will take place in June and NHS 111 operating across these 6 local authority areas by 1 April 2013 at the latest.

[14] The Department of Health, *Urgent and emergency care,* http://www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/index.htm
[15] Department of Health, *The Operating Framework for the NHS in England 2012/13*, 24 November 2011, p.17, *http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf*
[16] Ibid., p.22, *http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf*. See also: The NHS Confederation, *With money in mind. The benefits of liaison psychiatry*, November 2011, http://www.nhsconfed.org/Publications/briefings/Pages/With-money-in-mind.aspx
[17] NHS Supply2Health*, Procurement of NHS 111 Service in NHS Kent & Medway, NHS Surrey and NHS Sussex*, http://www.supply2health.nhs.uk/Q37/Lists/Advertisements/DispForm.aspx?ID=43

Reducing A&E Attendances and Admissions: The Role of Mental Health Services

At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time. [1]

1 Introduction

This paper sets out information requested by the Health Overview and Scrutiny Committee (HOSC) for the meeting to be held on 3 February 2012. This meeting is the third part of a review looking at the impact of current attendance at A&E on the sustainability of health services across Kent and Medway and how levels of attendance can best be reduced.

To inform the review, the Committee has asked for the following:

- Do the current levels of attendance at A&E pose any particular challenge for the commissioning and provision of mental health services?
- What is the role of mental health services in reducing attendances at A&E?
- What is the place of urgent and emergency care in the QIPP programme?
- From the perspective of the mental health service what are the main challenges to reducing attendance at A&E?

Information to answer these questions is set out in the sections below.

2 The challenge of current levels of attendance at A&E for mental health services

The context of a mental health response to A&E is the service currently in place to provide urgent and emergency care for people in a mental health crisis.

This service is provided by the Crisis Resolution and Home Treatment (CRHT) teams, offering acute mental health care for people living in the community and experiencing a severe crisis requiring emergency treatment.

[1] *(McManus s, Meltzer h, Brugha T et al. (2009) Adult Psychiatric Morbidity in England, 2007: Results of a household survey. Leeds: NHS Information centre for health and social care)*

Previously, such treatment could only have been provided by admitting the person to an acute inpatient mental health service.

The introduction of CRHT services was a key element in the 1999 National Service Framework for Mental Health; the NHS Plan (2000) made the provision of CRHT services a national priority; and the Department of Health's 2002 Public Service Agreement included targets for numbers of teams and people treated by them.

The main aim is to provide people in a mental health crisis with the most appropriate and beneficial treatment at home. CRHT was also intended to reduce admissions to acute inpatient adult mental health wards and bed occupancy, support earlier discharge from those wards and reduce out-of-area treatments. The service is available around the clock, every day of the year; and provides immediate assessment and treatment for people who are experiencing a major mental health crisis, and support to their relatives, carers and social systems to resolve the crisis.

Referrals to the CRHT teams come from a number of sources. These include:

- Ambulance service
- GPs
- Kent Police
- NHS Direct
- Mental Health Matters Helpline
- A&E departments
- Secondary care community mental health teams
- Self referral by people known to secondary care mental health services

In Kent and Medway last year (2010/11), 2,646 people were seen by the CRHT teams, resulting in the provision of 3,387 episodes of home treatment and facilitation of 1,615 admissions to acute inpatient adult mental health beds.

Within this context the challenges for mental health services to respond to demand from A&E are as follows:

- CRHT teams are receiving referrals from a range of sources, with A&E only one among them. The teams have finite resources and need to prioritise who they respond to. This might mean that they may be unable to prioritise someone who is in A&E (and therefore in a place of safety) above someone who is in a mental health crisis at home, in the street or in a police station.
- KMPT and mental health commissioners recognised that this service model is making best use of resources within the mental health system but possibly not helping the use of resources within the general hospitals / acute trusts.
- According to the SHA Quality Observatory's ranked opportunity listings 2011 for each of Kent and Medway's four Acute Trusts, self harm is the

third (west Kent and Medway) and sixth (east Kent) highest reason for attending A&E.

- A fully functioning liaison psychiatry service is in place in eastern and coastal Kent, located in EKHUFT A&E departments and wards
- From April 2011 in west Kent, some parts of the secondary care mental health services were separated off, attached to the local A&E departments and called liaison psychiatry Services. These services are now embedded in the A&E departments and able to respond to acute trust priorities.
- These west Kent liaison psychiatry staff currently operate from 9 am to 5pm daily and respond to urgent or emergency calls from A&E; assessing need, managing difficult behaviours, linking up with primary and secondary care mental health services and facilitating patient transfers. (This includes facilitating a Mental Health Act assessment if needed.)
- Response times are good (majority under 2 hours) when the liaison psychiatry staff are in place, and the service works well. Feedback form acute trust staff and patients suggests that the service has been very helpful, improving patient experience and contributing to reducing A&E attendances and re-attendances.
- We know from analysis of attendance data that there are two peaks in attendance at A&E by people with a primary diagnosis of mental health needs. One is in the morning when the liaison team can respond and one is in the evening. During the evening, the referrals return to the CRHT team and response times can be longer for reasons described above. Increasing west Kent liaison psychiatry resources to enable them to cover A&E from 5 pm to midnight as well, and the wards, will improve response times and should enhance the acute trusts' efficiency.

3 The role of mental health services in reducing attendances at A&E

A number of reports published over the last few years set out the case for developing better links between mental and physical health services and the establishment of liaison psychiatry services. These include:

- Case for change – mental health liaison service for dementia care in hospitals (Department of Health 2011)
- No Health Without Mental Health: The supporting evidence (Academy of Medical Royal Colleges 2010)
- NICE 2010 (CG90) The treatment and management of depression in adults and social care
- NICE 2010 (CG103) Delirium: diagnosis, prevention and management
- Healthy mind, healthy body (NHS Confederation 2009)
- No Health Without Mental Health: The ALERT Summary Report (Academy of Royal Medical Colleges 2009)

- Managing urgent mental health needs in the acute trust (Academy of Medical Royal Colleges 2008)
- NICE/SCIE 2006 (amended 2011) (CG42) Supporting people with dementia and their carers in health and social care
- Who Cares Wins: Guidelines for the development of Liaison Mental Health Services for older people (Royal College of Psychiatrists 2005)

These highlight a number of ways that mental health services can work with people with mental health needs in acute hospitals to ensure that they get timely access to appropriate services and reduce inappropriate attendance at A&E.

Some examples are:

3.1 Working with ambulance services

Ambulance crews attend to people with a wide range of mental health problems. Mental health commissioners supported KMPT to introduce a protocol with SECAmb in January 2011 that enables crews to refer to mental health services rather then convey to A&E those people who do not require a medical or physical intervention by A&E. An ambulance paramedic practitioner or paramedic attending an incident in Kent and Medway can contact the local mental health service for advice or directly to refer a person aged 18 and over at risk as a consequence of anxiety/panic attacks; depression, psychosis or mania; reaction to severe distress (maybe related to unemployment, bereavement, isolation, loneliness, physical disability or significant illness); eating disorder; self harming behaviour or expression of a wish to self harm or end their life.

3.2 Developing new pathways

KMPT and commissioners are working in partnership, preparing for the introduction of the 111 number supplied by NHS Pathways and the Directory of Services. This will ensure that people with mental health problems who have an urgent need which is not so severe as to call 999 or go to A&E, can be directed to appropriate mental health services or their GP. Also work is underway to develop the emergency ambulatory care pathway and KMPT is in support, with a particular focus on self harm, offering advice on best practices to support key clinical quality components to be included in a self harm pathway.

3.3 Robust care planning for those known to mental health services

For people who are known to mental health services, robust care plans with clear information about how individuals can access urgent help from mental health services will contribute to A&E attendance avoidance.

3.4 Timely diagnosis

For people who are not known to mental health services and presenting at A&E, the A&E role is to ensure that mental illness is diagnosed at attendance and these people are linked in with mental health services as appropriate. This group includes those whose mental illness has brought them to A&E and also those who present with physical illness that has been stimulated by mental illness e.g. despair leading to self harm or illness induced through substance misuse. Among people with a physical illness or injury serious enough to require admission, a high proportion have a mental health problem that is frequently masked or overlooked, which can impact on recovery. This includes people with a cognitive impairment or dementia.

3.5 Improving physical health care for those with mental illness

There is another area too that mental health services can address positively to affect attendance at A&E and this is in the area of being more proactive in meeting the physical health needs of those who are in their care. We know that people with a long term mental health condition have reduced life expectancy and are more likely to have poor physical health, including serious conditions such as respiratory and cardiovascular diseases, diabetes, cancer and epilepsy. The Care Quality Commission recently highlighted that inpatients in acute mental health services currently have limited access to general hospital services, other than access via A&E.

Local work is underway to address these needs in better ways, in particular through a new joint protocol between KMPT and Kent and Medway's four acute trusts to facilitate access to urgent physical health care or opinion for patients admitted to mental health units. This is supported by an increased awareness of physical health and checks by acute inpatient mental health ward teams for earlier detection of physical health deterioration.

3.6 Early intervention for those with long term physical health conditions

We know that having a long term physical health condition brings significant psychological challenges. For example, there are high levels of depression present in people with a range of long term physical health conditions and the level is associated with higher general hospital use. The evidence is summarised in *No Health Without Mental Health: The supporting evidence.* For example, people with depression are twice as likely to use A&E services as those without it[2]. People with chronic obstructive pulmonary disease who are also depressed have longer hospital stays. Addressing co-morbidities by developing better links between physical and mental health services can lead to reduced attendances and re-attendances at A&E as well as reduced general hospital admissions and referrals to outpatient services.

[2] *(Mykletun A, Bjerkeset O et al (2007) Anxiety, Depression and cause-specific mortality: the Hunt study. Psychosomatic Medicine)*

3.7 Develop liaison psychiatry services

One clear recommendation in the reports is that each general hospital should have a dedicated liaison psychiatry or mental health service, embedded to provide mental health care throughout the entire hospital to adults of all ages and including people with dementia. The principle is that patients with mental health problems in general hospitals should have the same level of access to a consultant psychiatrist as they would from a consultant specialising in physical health problems.

The overall aim of a liaison service is for mental health to be assimilated into the routine care of people attending or admitted to a general hospital. It requires a proactive approach, not limited to direct patient contact. The core functions are to:

- raise awareness of the importance of mental health in a general hospital;
- facilitate the general hospital staff's acquisition of basic skills of assessment and treatment of people with mental ill health; and
- represent the cause of people with mental health problems who are under the care of a general hospital.

4 The place of urgent and emergency care in the QIPP programme

The QIPP Programme includes action to integrate the delivery of mental and physical health services, informing 2012/13 PCT contracts with KMPT and acute trusts to include financial incentives for improved performance in relation to:

- reducing attendance and reattendance at A&E by KMPT service users with no physical presentation who are held on open mental health pathways;
- improving the identification and management of people with mental health needs presenting at A&E or as inpatients in general hospital beds, leading to timely access to mental health pathways and less practice variation across Kent and Medway (especially in A&E responses to people who present with self harm);
- improving the diagnosis of dementia in general hospitals; and
- reducing the use of antipsychotic medication among people with dementia in both mental health and general hospital services.

Additionally, KMPT acute mental health services will be:

- working more closely with the mental health helpline provider in order to ensure appropriate referrals of people to CRHT rather than A&E;
- increasing the capacity for CRHT assessments at home for people and home treatment interventions; and
- evaluating the SECAmb to mental health services pathway.

5 The main challenges to reducing attendance at A&E from a mental health perspective

The main challenges to reducing A&E attendances from a mental health perspective are to:

- continue to work on ensuring that robust care plans are in place for people known to the mental health system;
- develop the capacity in emergency and urgent care mental health services to enable the development of Liaison Psychiatry from 5 pm to midnight in Dartford and Gravesham and Maidstone and Tunbridge Wells Trusts' A&E departments and during office hours for wards; and
- improve early intervention for those with long term physical health conditions by further developing access to primary care psychological therapy services.

6 Conclusion

The provision of mental health services that can respond to emergency and urgent mental health needs wherever they present is a core part of the mental health services. A&E departments are one area where people present with emergency needs and developing liaison psychiatry services will increase responsiveness. KMPT and commissioners are committed to continuing work on ways to develop these services and as part of whole systems with health and social care partners through the Urgent Care Boards and Whole Systems Boards.

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Item 6: East Kent Hospitals NHS University Foundation Trust Clinical Strategy Review.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 February 2012

Subject: East Kent Hospitals NHS University Foundation Trust Clinical Strategy Review.

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1. Background

The Chief Executive of East Kent Hospitals NHS University Foundation Trust has requested the opportunity for the Trust to attend a meeting of the Committee to present and discuss the initial work being undertaken in the development of its clinical strategy.

2. Recommendation

That the Committee note the report.

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

To: Health Overview and Scrutiny Committee: 3 February 2012

Subject: Emergency Surgery

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1. Introduction.

(a) In February 2011, the Royal College of Surgeons of England produced the document *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*[1]. This had the aim of providing information and standards on emergency surgical service provision for both adult and paediatric patients.

(b) The following provides a summary of the report.

2. What is emergency surgery?

(a) The report explains that an emergency surgical service is not one that simply operates out of hours. Instead, six elements are outlined.

Box 1. Elements of emergency surgical provision[2]:

- Undertaking emergency operations at any time, day or night.
- The provision of ongoing clinical care to post-operative patients and other inpatients being managed non-operatively, including emergency patients and elective patients who develop complications.
- Undertaking further operations for patients who have recently undergone surgery (i.e. either planned procedures or unplanned 'returns to theatre').
- The provision of assessment and advice for patients referred from other areas of the hospital (including the emergency department) and from general practitioners. For regional services this may include supporting other hospitals in the network.
- Early, effective and continuous acute pain management.
- Communication with patients and their supporters.

(b) For most surgical specialties, providing emergency surgical care works out to around 40-50% of the workload. This varies according to the speciality; for example, in neurosurgery over half the admissions are non-elective and account for 70-80% of the workload.

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[1] The Royal College of Surgeons of England, *Emergency Surgery. Standards for unscheduled surgical care. Guidance for providers, commissioners and service planners*, February 2011, http://www.rcseng.ac.uk/publications/docs/emergency-surgery-standards-for-unscheduled-care

[2] Ibid., p.7.

3. The case for change and common issues:

(a) A number of reasons for changing the way emergency surgical care is delivered are given.

Box 2. Drivers of change[3].

- Patients requiring emergency surgery are among the sickest treated in the NHS.
- Outcome measurement in emergency surgery is currently poor and needs to be developed further.
- Current data show significant cause for concern – morbidity and mortality rates for England and Wales compare unfavourably with international results.
- It is estimated that around 80% of surgical mortality arises from unplanned/emergency surgical intervention.
- The NHS has to reduce its costs significantly over the coming years – savings can only be delivered sustainably through the provision of high quality and efficient services. The higher complication rate and poorly defined care pathways in emergency surgery (when compared to elective surgery) offer much greater scope for improvement in care and associated cost savings.
- The reduction in working hours for doctors and the focus on elective surgical care has changed the level of experience and expertise of trainees when dealing with acutely ill surgical patients.
- Patients expect consultants to be involved in their care throughout the patient pathway.
- Evidence from a survey of general surgeons indicated that only 55% felt that they were able to care well for their emergency patients.
- At least 40% of consultant general surgeons report poor access to theatre for emergency cases.

(b) A number of common issues to be addressed are outlined in the report[4]:

- Priority and timeliness of surgery
- Understanding quality and outcome issues
- Teamworking
- Organisation of staff
- Organisation of facilities
- Clinical interdependencies
- Communication with patients and supporters

4. Models of care.

(a) Within the clinical interdependencies which exist, a number of models of care are outlined in the report[5]:

[3] Ibid., p.13.
[4] Ibid,. pp.8-12.

- Consultant-based care
- Separating elective and emergency care
- Surgical assessment units
- Clinical networks
- Extending the working day
- Outcomes and quality indicators

(b) The report is not prescriptive as to which model of care should be adopted, and the bulk of the report consists of describing the standards underpinning unscheduled surgical care applying to both paediatric and adult patients.

[5] Ibid., pp.13-16.

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East Kent Hospitals University NHS
NHS Foundation Trust

CINICAL STRATEGY REVIEW
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BRIEFING

1. Introduction

East Kent Hospitals University NHS Foundation Trust (EKHUFT) has an ambition to deliver services which are:

- safe;
- clinically effective; and
- sustainable

The Trust has a strong reputation as a high performing organisation with some of the best outcome measures in the country – a low mortality rate, very low infection rates, an award winning stroke service and other specialist services like cardiac care, vascular surgery and interventional radiology that are recognised nationally.

These high quality services have been developed and sustained because the Trust is constantly looking at clinical evidence and questioning whether there are better ways of delivering services that offer improved clinical outcomes for patients and provide a better patient experience.

New medicines, technologies and surgical techniques are constantly being developed and the Trust want to keep you abreast of our latest thinking so that we can deliver the best possible service to your communities.

2. Purpose of the Report

The purpose of this report is to provide you with background to the clinical strategy review and the latest update on the joint forward work programme. This includes the:

- background to the clinical strategy review and the drivers for change;
- emerging key themes and aspirations for the future;
- next steps and the governance framework that will be put in place across the local health economy to manage discussions; and
- proposed timescales for taking the work forward

3. Background to the Clinical Strategy Review

The Clinical Strategy review, which is driven by clinicians, commenced in October 2010. At an early stage, as part of this process, the Trust outlined its commitment to delivering the following:

- working together and “putting patients first”;
- implementing service changes leading to improvement in quality of care;
- ensuring local access to emergency care;
- delivering sustainable services able to develop for the future; and
- ensuring any service changes are clinically led

On 27 October 2011 EKHUFT launched the initial stage of the engagement and communications process to support the key issues, emerging themes and drivers for change from the clinical strategy review.

This involved director-led internal staff briefings across the Trust, followed by attendance at a joint workshop which involved the Trust and the East Kent Commissioning Federation (a joint commissioning body set up by the East Kent Clinical Commissioning Groups) to share current thinking on the strategic direction for EKHUFT over the next five years.

As part of the engagement and communication strategy to support this initial phase, telephone briefings and written correspondence to other key stakeholders across the wider health and social care economy have been undertaken. The Health Overview and Scrutiny Committee (HOSC) were informed at that point and this briefing paper has been drafted to inform the HOSC of progress.

Also, more recently, the CEO was invited to attend the Thanet District Council meeting to provide a briefing on the emerging themes from the Trust's Clinical Strategy, as part of the engagement process.

3.1 Key Drivers for Change

There are a number of clear drivers for change these are:

- Emergency surgery standards - recent publications from both the Association of Surgeons for Great Britain and Ireland (ASGBI) *"Emergency General Surgery: The Future"* and the guidelines from the Royal College of Surgeons (RCS) on *"Standards for Emergency Surgical Care".* Both these reports outline that outcomes for patients who need "out of hours" surgery – i.e. at night and at weekends, are relatively poor, as opposed to those treated during "normal" working hours on weekdays;

- Level 2 Trauma Unit priority site. The South East Coast Trauma Network has made a decision for the William Harvey Hospital, Ashford, to be a priority site for a Level 2 Trauma Unit. The publication *"The Regional Trauma System - Interim Guidance for Commissioners"* reflected similar points and standards as that in the guidance and recommendations made by the ASGBI and the RCS. There is evidence at national and indeed international level, that outcomes for patients suffering multiple / complex trauma (i.e. very severe injury) are better when they are treated promptly in specialist centres;

- The development of models of Ambulatory Care that provide pathways of care avoiding unnecessary hospital admissions;

- A national drive for the integration of services and therefore need to work with partner agencies to inform health services;

- The availability and skilled workforce that can offer appropriate specialist skills and services;

- The need to provide sustainable service across the health and social care economy.

4. Emerging Key Themes and Aspiration for the Future

4.1 Key Themes

Overall the key themes that emerged from the Trust's initial clinical strategy review were:

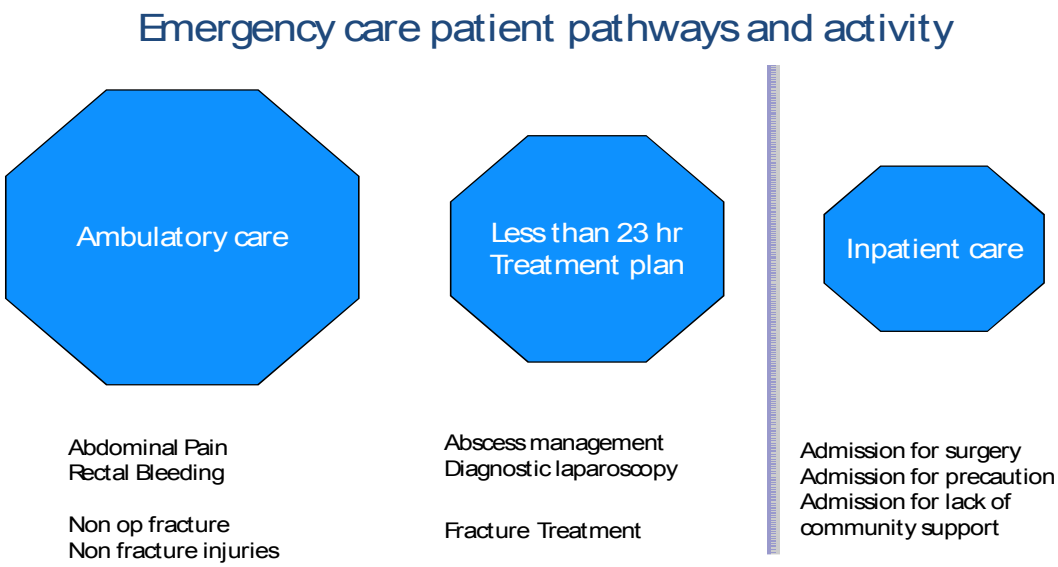
- clarity of the core services it should provide;
- a focus on improving quality of care / patient safety;
- the need to work with partners including primary care; community services in health and social care; voluntary and independent sector to provide end to end pathways of care;
- the need to address future funding issues; and
- the aspiration to locate "care closer to home" (where possible).

In order to support the key drivers for change, the Trust confirmed that its priority is to address the issues facing emergency surgical care, which in doing so means that the issues for a level 2 trauma unit also needs to be addressed at the same time.

4.2 Aspiration

In striving to address all of the above, the key message is that the priority of the clinical strategy is for a quality sustainable emergency surgical service, which will locally build on day surgery and 23 hour surgery provision. In addition, it would support enhanced outpatient services with a one-stop clinic approach.

The diagram below begins to tease out how services might change in the future and shows a growth in the number of patients that can be seen in an ambulatory pathway or within a 23 hour day surgery unit, all of which can still be delivered from local sites.



4.2.1 Urgent Care and Long Term Conditions

The vision for urgent care (accident and emergency) and long term conditions (LTC) fully supports, and is in line with, the vision for emergency surgical services.

In essence, the emergency care model states that:

- all 'medical' patients should be seen by general medicine;
- there should be faster access to expert assessment by having on-call physicians at the "front door" and by providing telephone access;

This in turn will:

- reduce delays, duplication, unnecessary tests and inappropriate admission;
- increase the uptake of ambulatory care pathways; and
- overall, result in better outcomes.

This model is the preferred model recommended by the Royal College of Physicians and also means that direct access to paediatrics and gynaecology must be available.

The model also proposes other innovative practices for the management of fractured neck of femur patients, which tend to be a vulnerable patient group with co-morbidities. The proposal is that this patient group would be managed locally by ortho-geriatricians whilst the surgical treatment would continue to be undertaken by the trauma and orthopaedic surgeons. This pathway would be consultant led, resulting in better outcomes.

4.2.2 Specialist Services

For Specialist Services, the Trust is currently out to consultation on a maternity review which is due to end in January 2012. Whilst the result of this is not yet known, other than those proposals outlined in the review, the Trust is not considering changing the number of sites from which maternity and paediatric services are provided from.

However, similarly to Surgery and Medicine there will be fundamental workforce changes with the need for these specialties to support services at "the front door" to ensure that triage occurs effectively and patients are quickly sign-posted to appropriate services in the hospital.

4.2.3 Support Services

For support services it is important that early diagnostics can be provided to aid and support the decision-making process for senior consultants at the "front door". In addition, it is important that a range of diagnostics is provided "closer to home" and that the Trust re-focuses on emergency services and admission avoidance.

In relation to enhanced outpatient and ambulatory care services the Trust proposes that it examines:

- 'one-stop' clinic approach with co-located diagnostics;
- extended working days including weekends;
- provision of urgent consultations / telephone advice; and
- the wider use of telemedicine.

The Trust currently offers outpatient services from over 20 sites. However, it does not provide a comprehensive range of services from these sites. They have often grown up historically. The Trust would wish to offer a more comprehensive range of local services however, it needs to ensure it does this in a sustainable and affordable way. To achieve this, it is likely outpatient services would need to be offered from a reduced number of sites. Currently the Trust is modelling delivering services from six sites, but this is something it is seeking views and comments on.

5. Next Steps and Governance Framework

The Trust recognises that whilst there is a strong foundation for change, further discussion and partnership working is needed with the East Kent Commissioning Federation to jointly develop and agree the future shape of hospital services in East Kent. The Trust also acknowledges the need to carry out a full assessment of the impact of any service change on local populations and access to services. Clearly any major service reconfiguration would need to be subject to future public consultation.

A governance framework has been produced by Commissioners in East Kent which outlines a number of Whole System Boards and enabling groups which will facilitate any discussions from providers relating to their clinical strategies from a whole system perspective.

In addition, within the Trust there will be an internal mechanism comprising of working groups which will feed into the whole system governance framework.

Through the Clinical Commissioning Groups, GP representation will be sought in order to ensure that both a primary and secondary care perspective is given so that a joint agreement on the proposed way forward is made.

6. Proposed Timescales

Timelines will need to be agreed with the CCGs, however it is important that the Trust drives the timescales as it needs to address some important clinical issues, particularly in emergency surgery. Within the Trust, a date for the inaugural meeting of the Clinical Strategy Implementation Board has been identified The Trust is therefore proposing for discussion with the CCGs the following timescales:

Milestones	**Timescales**
Trust internal follow up engagement and communication led by the Divisional Directors	November to December 2011
External follow up engagement and communication with the CCG localities	November to December 2011
First meetings of Clinical Boards and enabling groups	January 2012
Pathways to be developed by the Clinical Boards	Spring 2012

7. Conclusion

It is requested that the Health Overview and Scrutiny Committee note the drivers for change and the emerging key themes from the clinical strategy review and also note the future work programme during this initial engagement and communication stage.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 February 2012

Subject: East Kent Maternity Services Review: Written Update.

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1. Background

(a) The Health Overview and Scrutiny Committee received written updates on the East Kent Maternity Services Review at the meetings of 4 February 2011 and 10 June 2011.

(b) Members heard from NHS representatives at the meeting of 22 July 2011. At this meeting the Committee agreed to examine this issue in more depth at a later meeting and that a small working group of Committee Members be established to further investigate and prepare a report for HOSC. The Members of this informal HOSC Liaison Group were Mr Nigel Collor, Mr Dan Daley, Cllr Michael Lyons and Mr Roland Tolputt.

(c) Members of this informal HOSC Liaison Group reported back to the Committee when it further considered this subject on 9 September 2011. It was also decided that Mrs Elizabeth Green should join this Group, which would continue to liaise with the NHS on the subject.

(d) Representatives of the NHS were last invited to discuss this topic at the meeting of 14 October 2011. Members were provided with copies of the consultation document at this meeting as the consultation was launched that same day.

(e) The consultation ran until 20 January 2012.

2. Recommendation

That the Committee note the report.

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Progress report – maternity review in east Kent.

Background

In January 2011 the PCT and East Kent Hospitals University NHS Foundation Trust (EKHUFT) instigated a maternity review to ensure east Kent would continue to deliver safe, equitable maternity services. The review was triggered by the increasing birth rate and changes to the pattern of patient choice leading to more than 50 per cent of all babies being delivered in 2009/10 at the William Harvey Hospital in Ashford. To alleviate the pressure on services at Ashford there was a temporary cessation of births at Dover midwife led centre which re-opened in January, when Canterbury Midwife Led Unit was temporarily suspended for births and some of the experienced midwives transferred to Ashford. To prevent further confusion and risk to parents the suspension of births at Canterbury continues until the end of the review.

The joint Maternity Review steering group is chaired by Dr Sarah Montgomery (clinical lead and GP from Ashford Clinical Commissioning Group). One of the main objectives of the steering group has been to:

- Enable a robust two-way dialogue between the partner organisations and their staff, patients, GPs, stakeholders and the local population, ensuring a transparent and well informed debate about the issues faced. It is important that any decisions taken are informed by both local opinion and clinical evidence that meets the requirements of sections 242 and 244 of the Health Act.

Engagement in the planning and development of the maternity review

From April to August 2011 there was extensive engagement with stakeholders to ensure their views were able to influence the review. GP clinical leads were part of the review steering group and cascaded information to their colleagues. GPs have also received ongoing briefings and progress reports through the east Kent commissioning group, the federation of east Kent CCG leads, and the Local Medical Committee. Each east Kent Clinical Commissioning Group gave its approval to the final three options consulted upon, and their support for option one as the stated preferred option. Other interested stakeholders such as MPS, the Kent Health Overview and Scrutiny Committee and local district councils have also been regularly informed of the review: its purpose, progress and ultimate consultation.

Throughout the review the NHS has worked closely with the local Maternity Services Liaison Committee relying on its feedback to shape the engagement and consultation process, and its support in encouraging parents across east Kent to become involved and respond through their networks of ante natal classes, mother and baby groups and their Facebook page.

The NHS has also worked closely with contacts in children's centres and Sure Start centres or Young Active Parents groups, to ensure conversations are had with parents in settings where they are comfortable. From April to May 2011 NHS staff

interviewed 94 parents and held a focus group with teenage parents about their recent experience of maternity services, asking where they felt the service could be improved and what their priorities were for maternity care were. This helped focus the review and the final consultation on changes to services for birth only, leaving the majority of antenatal and postnatal care as it is currently delivered by teams of community midwives across east Kent including at Dover and Canterbury.

Staff and parents using maternity services were also surveyed for their views,

- 231 parents completed a patient experience survey based upon the national Care Quality Commission survey
- Staff held regular discussions with senior staff in the early stages of the review and 94 staff from a range of clinical roles completed an online survey.

Community midwife	24
Midwife at acute trust	42
Consultant	5
GP	1
Maternity Care Assistant	9

Both the PCT cluster and EKHUFT have used their established contact with Foundation Trust members and governors, the Health Matters Reference Group, Kent LINk and other voluntary and community sector organisations to inform and involve people in the review, by:

- running an online survey,
- holding a series of community roadshows
- visiting a host of family friendly events in the summer of 2011 to canvas views on which priorities should influence the decision on maternity services.

Throughout the review the NHS has taken care to reach those communities of need who have expressed an interest in the review including young adults, learning disability groups, fathers' groups, community centres with many eastern European parents, and Nepalese parents. These were communities who had expressed an interest in being actively involved when we contacted them initially. The PCT has offered to meet all specific communications needs and attend any meetings where it was felt that a face to face discussion would assist their involvement in the process.

The review has also been featured in several issues of 'Your Health' magazine 30,000 copies of which are distributed through GP practices, hospital waiting areas, supermarkets, libraries and community centres, as well as in hairdressers etc to ensure the wider community was aware of and able to comment on the maternity review.

The local media have also been regularly updated with press releases and news statements, and both the broadcasting media and local newspapers have featured the review. The Kent Messenger ran a campaign in its Canterbury papers and through an online survey to oppose the cessation of births at Canterbury birth centre. Their online petition with 450 names was presented to the PCT on 19 October 2011. From 9 June 2011 – 13 Oct 2011 there were 68 stories in the papers including 20 letters.
Over 25 of the stories appeared in more than 1 paper and the majority or the letters were printed in more than one paper as well. Most of the coverage was in the Kentish

Gazette series which includes Kentish Gazette Canterbury and district, Whitstable Gazette, Herne Bay Gazette and Faversham news.

Across these differing means of engagement approximately 1,000 people have been directly involved in the early development of the maternity review. They have influenced the plans, the review's focus and the options developed, as well as the criteria for the final decisions being made.

The Strategic Health Authority and the National Clinical Audit Team have also reviewed the evidence and provided strategic assurance on the plans, as have both Boards of the Trust and PCT.

Finally, in August a working group from Kent HOSC worked with the PCT and EKHUFT to advise on a suitable consultation plan. The formal 14-week consultation on three options for the future of maternity services in east Kent ran from 14 October 2011 to 20 January 2012.

Consultation on maternity review

During the consultation a range of methods have been used to promote the consultation process:

- advertisements in KM messenger newspaper across east Kent,
- radio advertisements on Heart FM
- interviews on BBC Radio Kent
- news items on BBC South East and Meridian
- updates in the Kent LINk bulletin and newsletter
- 1,684 emails and 278 postal copies of the consultation document were sent to a range of local organizations from GP practices through to the voluntary and community sectors and the PCT's virtual panel.
- Posters and documents in GP surgeries, libraries, children's centres and Sure Start buildings and shopping centres.
- Online information being available at: http://www.easternandcoastalkent.nhs.uk/get-involved/consultations-and-surveys/maternity-services-review/ with suitable links on the Trust's website and through social media i.e. Facebook and Twitter.
- 2,000 full consultation documents and 10,000 summary documents were distributed to GP practices, hospital waiting areas, libraries, community centres, children's centres, Sure Start centres and various parent classes and groups running across east Kent.
- Your Health magazine had a double page spread featuring the review and consultation and 30,000 copies have been distributed across east Kent.
- The citizen engagement team has personally visited more than 45 parents groups including baby massage, breastfeeding, parent and toddlers, messy play, dads' groups etc being run at children's centres, community venues or in Sure Start centres to raise awareness, provide information, answer any questions and encourage parents and organisations to respond to the consultation.
- An online email address and telephone number have also been given so that people could request additional information, ask questions or request copies of the consultation document.

- The consultation documents have been available in various formats including: easy read, large print, Polish, and Nepalese. Translators have assisted at community groups where the participants did not speak English as a first language.

There has also been a series of 10 public meetings held at times recommended by parents during the early engagement These were advertised as part of the whole consultation as detailed above.

At these two-hour public roadshows a panel of clinicians and commissioners has presented information on the review, the reasons why it was necessary, the outcome expected of the review, the steps taken during the review, the options arrived at and what would happen following the review. There has then been an hour of open question and answer session sometimes followed by round table discussions depending on the numbers present. The numbers attending these events has not been very high, partly due to consultation fatigue, and partly due to the proactive engagement and outreach programme to parent groups across east Kent that meant many people have felt able to contribute directly both before and during the review without specifically attending the public meetings.

As expected the attendance has been highest in the four events in Canterbury and Dover where a mixed audience of councillors, campaigners, parents and interested citizens have had constructive discussions about the proposed options and also heard parents' experience of the service, their praise and their concerns.

Next steps

The responses have all been logged during the review, from phone calls and email enquiries for further information, to briefings provided to Dover and Canterbury Overview and Scrutiny Committees and the visits to children's centres. 251 online surveys have been submitted, 205 paper surveys have been received and several stakeholders have sent in written submissions.

These have all been sent to independent researchers from Greenwich University who will collate and analyse all the information and report to the joint Maternity Review Steering Group in March. The Group will consider this alongside all the evidence gathered during the review and make a final recommendation to the Boards of EKHUFT and the PCT in late March.

The Boards will then take the final decision whether to accept their recommendations, and these outcomes will be reported to Kent HOSC in April.

Item 9: Mental Health Services Review.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 February 2012

Subject: Mental Health Services Review

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1. Background

(a) The Committee received a report from NHS Kent and Medway at the meeting of 25 November 2011. This paper explained that further information on work being planned on services for people with mental health needs would be brought to the Committee this year. An update from NHS Kent and Medway is attached.

(b) As outlined in the Forward Work Programme discussed at the Committee meeting of 6 January 2012, this subject may require the establishment of a formal Joint HOSC with Medway Council.

2. Recommendation

That the Committee note the report.

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Kent and Medway

Mental Health Services review

Early notification of an options appraisal workshop for acute mental health services Friday 24 February – 2pm to 7pm - Cavalier Suite, King Charles Hotel, Brompton Road, Gillingham, Kent ME 7 5QT.

As Members are aware Kent and Medway NHS and Social Care Partnership Trust is working with mental health commissioners at NHS Kent and Medway to develop a long-term clinical strategy for adults in an acute phase of mental illness. This is in conjunction with improvements to the management by primary care of people with mental health needs

To deliver the best possible inpatient care for people in an acute phase of mental illness, it is proposed to explore moving to a model of **centres of excellence** in Kent and Medway. Each based in modern, purpose-built, accommodation, with a critical mass of staff to provide the best quality of care for patients.

This model would improve safety and promote recovery, which is better for service users, better for staff, and represents a better use of NHS resources.

We would like to invite Members to a stakeholder options appraisal workshop to review all viable options regarding the potential centres of excellence for Kent and Medway.

This workshop will be from 2-7pm on Friday 24 February Cavalier Suite, King Charles Hotel, Brompton Road, Gillingham, Kent ME 7 5QT. Full details of the event will be sent to all Members shortly.

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