HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 27th April, 2018

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 27th April, 2018, at 10.00 am	Ask for:	**Lizzy Adam**
Council Chamber, Sessions House, County Hall, Maidstone	Telephone:	**03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (11):	Mrs S Chandler (Chair), Mr M J Angell, Mr P Bartlett, Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr N J Collor, Mrs L Game, Ms S Hamilton, Mr K Pugh and Mr I Thomas
Liberal Democrat (1)	Mr D S Daley
Labour (1):	Ms K Constantine
District/Borough Representatives (4):	Councillor L Hills, Councillor J Howes, Councillor M Lyons, and Councillor T Searles

Webcasting Notice

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UNRESTRICTED ITEMS

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

Item Timings*

1. Substitutes

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

3. Minutes (Pages 5 - 12)

4.	Kent and Medway Strategic Commissioner (Pages 13 - 18)	10:05
5.	Financial Recovery in East & North Kent (Pages 19 - 28)	10:30
6.	Transforming Health and Care in East Kent (Pages 29 - 36)	11:15
7.	East Kent Out of Hours GP Services and NHS 111 (Pages 37 - 42)	12:00

BREAK (12:30 - 13:30)

8.	SECAmb: Update (Pages 43 - 48)	13:30
9.	Patient Transport Service (Pages 49 - 66)	14:15
10.	Kent & Medway Integrated Urgent Care Service Procurement (Pages 67 - 72)	14:45

11. Date of next programmed meeting – Friday 8 June 2018

Proposed items:

- Acute Trusts: Update
- Review of Winter Performance 2017/18
- Children & Young People's Mental Health Services & All Age Eating Disorder

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)

**Timings are approximate*

Benjamin Watts
General Counsel
03000 416814

19 April 2018

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, 26 January 2018.

PRESENT: Mrs S Chandler (Chair), Mr M J Angell, Mr P Bartlett, Mrs P M Beresford, Mr M A C Balfour (Substitute) (Substitute for Mr N J D Chard), Mr N J Collor, Ms K Constantine, Mr D S Daley, Ms S Hamilton, Mr K Pugh, Mr I Thomas, Cllr L Hills and Cllr T Searles

IN ATTENDANCE: Ms L Adam (Scrutiny Research Officer)

UNRESTRICTED ITEMS

34. Membership
(Item 1)

The Chair informed Members that following Mr Whiting's appointment as Cabinet Member for Planning, Highways, Transport and Waste, he was no longer able to serve as a Member of the Health Overview and Scrutiny Committee.

35. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 3)

Mr Thomas declared an interest, in relation to any discussion regarding a new hospital in Canterbury, as a member of Canterbury City Council's Planning Committee.

36. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting held on 24 November 2017 are correctly recorded and that they be signed by the Chair.

37. Transforming Health and Care in East Kent
(Item 5)

Hazel Smith (Accountable Officer, NHS South Kent Coast and Thanet CCGs) and Michael Ridgwell (Programme Director, Kent and Medway STP) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Ms Smith began by explaining that whilst there had been no substantive change since the update in November, the papers provided additional information on local care which had been requested. She acknowledged that further work was required, to demonstrate the model for local care was the same across East Kent, with GPs working together to develop primary and community care to support their

local populations of 30,000 – 60,000. In terms of the potential Kent and Medway Medical School (KMMS), confirmation regarding the bid's success would be received on 31 March 2018. If successful, the new undergraduate programme would begin in September 2020 with first year students undertaking placements in community hubs. She noted that the public listening events that had taken place last year were broadly supportive of the proposed transformation in East Kent; areas to address included the need to develop local care; transport and access; and specialist centres.

(2) Members enquired about the local care model in Herne Bay; the potential third option, proposed by Paul Carter, Leader of Kent County Council, with A&E services being provided on three sites; and the commissioning of an impact assessment. Ms Smith explained that the model in the Herne Bay area was the same as the Encompass vanguard but was run by a separate organisation of GPs and reflected the needs of its local population. She explained that the East Kent CCGs had met with Paul Carter to discuss his proposal; she noted the importance of looking at all the viable options. She stated that following the meeting the medical directors across Kent & Medway had written to Mr Carter stating that the provision of A&E services on three sites was not clinically deliverable. Mr Ridgwell noted that there had not been A&E services on all three sites in East Kent for 13 years. Mr Ridgwell advised Members that public consultation would be undertaken before any decision was made. Ms Smith committed to circulating the letter from the medical directors to the Committee. In response to a question about the impact assessment, Mr Ridgwell explained that an integrated Impact Assessment was being undertaken by Mott MacDonald; the final report would be shared with the Committee. He suggested that a Deloitte report into social-economic impact, referenced by a Member, was a historic document and would seek further information about it.

(3) Following a reference to option 2, the offer to build a new hospital in Canterbury from a developer, as a 'super hospital', Ms Smith stated that it was not a term being used by the East Kent CCGs. She confirmed that the CCGs were not looking to commission a tertiary hospital; where specialist tertiary services were required, they would be continued to be purchased from the London hospitals. The Chair stated the importance of clear terminology in the public consultation.

(4) Members asked about the planning for population growth, training programmes and the merger of CCG management functions. Ms Smith confirmed that predicted population growth had been used in the planning and review of the long list of options. She noted that there were a number of primary care facilities in East Kent that required refurbishment or rebuilding; the CCGs were seeking for investment to facilitate this. Ms Smith informed the Committee that training programmes were in place to help develop and train staff, including the Health Navigator Programme. She committed to bringing back the comprehensive workforce plan with the Committee later in the year. Mr Ridgwell confirmed that discussions were being undertaken around shared CCG management functions; he committed to providing a paper on this to the Committee at its next meeting.

(5) In response to a question about stroke services, Mr Ridgwell stated that the national view, which had been upheld by the South East Coast Clinical

Senate, was that specialist stroke services should be co-located with other specialist services. The proposal for East Kent was the provision of one specialist stroke unit at the William Harvey Hospital. He stated that whilst NHS funding was a national challenge, the stroke review in Kent & Medway was driven by quality and workforce rather than finance. Evidence from stroke services which had already been reconfigured indicated improved outcomes for patients and a societal benefit as patients did not require as much support as part of their recovery. The Chair noted that the concerns about accessibility particularly in East Kent had been raised at the JHOSC and requested that the JHOSC minutes be shared with the Committee once available.

(6) Members commented about workforce, services in Thanet, sub-acute provision in South Kent Coast, and public transport. Ms Smith reported the importance of evidencing a deliverable workforce as part of the business case. She highlighted the work of the Acute Response Team in Thanet, a group of GPs who were implementing enhanced primary care services to reduce hospital admissions; it was anticipated that when the team was fully operational, it could reduce attendances by 25%. She noted that development of primary care hubs in Cliftonville and Westwood Cross; local discussions were taking place about which GP practices would look to relocate, provide core services or extend services. As part of the development of sub-acute provision, Ms Smith noted that from 1 April 2018 patients in South Kent Coast CCG area would be able to access emergency GP appointments from primary care hubs; this would enable GPs to spend more time with patients with complex needs. She explained that direct conversations with bus companies would be planned. She noted that as part of the reconfiguration of outpatient services in East Kent, bus services to hospitals were initially funded by the NHS but now attracted enough business to run sustainably without subsidy.

(7) In response to questions about the viability of option 2 and the timetable for the identification of a preferred option, Ms Smith explained that the CCGs were working with KCC to understand if option 2 could be taken forward by the end of February.

(8) RESOLVED that:

(a) the report on Transforming Health and Care in East Kent be noted;

(b) a full update be presented to the Committee at the earliest opportunity but no later than April;

(c) the Committee be provided with the rationale as to why the provision of A&E services on three sites is not clinically deliverable.

38. Financial Recovery in East Kent
(Item 6)

Hazel Smith (Accountable Officer, NHS South Kent Coast and Thanet CCGs) was in attendance for this item.

(1) The Committee received a report on the financial recovery plan for the East Kent CCGs which expanded upon the report considered by the Committee in

September 2017 on the financial recovery plans for Ashford and Canterbury CCGs.

(2) Members enquired about the under delivery of contract management savings and the potential £18 million deficit. Ms Smith explained that in some cases the CCGs' ability to achieve change within the timescales had been optimistic. She noted that the deliverability of some initiatives only became apparent once operational; additional cost pressure relating to increased drug costs and sepsis cases, workforce and a national change to clinical coding had also impacted on the CCGs' financial position. Ms Smith assured the Committee that a consistent financial recovery programme was being applied across the four CCGs via weekly joint management meetings. Ms Smith acknowledged that the £18m deficit was a risk and stated the importance of service transformation in restoring financial balance in East Kent. She explained that the NHS did not want to save money but reduce waste. She noted that initiatives under consideration including infertility treatment and gluten free prescriptions were small in terms of their financial impact in comparison to the acute trust costs.

(3) In response to concerns raised around the reduction of MRI scans, Ms Smith explained that national data showed that GPs in East Kent had greater access to MRI scans than elsewhere which was impacting on access for urgent cancer patients. Ms Smith advised the Committee that this initiative was being led by a group of GPs who were looking to establish a service whereby patients could be assessed by professionals in the community with enhanced skills to determine whether they required an MRI scan or a referral into the acute trust. A new clinical pathway programme had also been installed to enable clinicians to identify appropriate referrals. She acknowledged that cancer targets in East Kent were not being met; a Cancer Recovery Plan had been developed to improve cancer performance. She committed to sharing CCG cancer performance data with the Committee.

(4) In response to a question about increased drug costs, Ms Smith explained that there were two cost pressures. The first was the increased cost of drugs in the category M drug tariff; the cost of these drugs were nationally set following negotiations between government and pharmaceutical companies. The second cost pressure on drugs was the impact of Brexit.

(5) RESOLVED that the report on financial recovery in East Kent be noted, and the East Kent CCGs be requested to provide an update in March 2018.

39. East Kent Out of Hours GP Services and NHS 111
(Item 7)

Hazel Smith (Accountable Officer, NHS South Kent Coast and Thanet CCGs) and Sue Luff (Head of contract) were in attendance for this item.

(1) Ms Luff introduced the report and began by updating the Committee about the successful implementation of the new contract by Integrated Care 24 (IC24) to run the NHS 111 and GP Out of Hours (OOH) service in East Kent on 1 December 2017. Ms Luff noted that the Christmas period had been challenging for NHS 111 and GP OOH providers nationally, initial performance

in East Kent was positive. She reported that the CCGs were working with IC24 to fully develop the service which included working towards the national workforce competency through staff training; developing the clinical advice service and extending the working group to include patient representation. She confirmed that the Folkestone OOH base had reopened and the bases in Deal, Herne Bay and Romney would reopen by the end of February.

(2) Members enquired about the provider, OOH signage and due diligence process. Ms Luff explained that IC24 was a not-for-profit organisation who was an experienced provider of NHS 111 and GP OOH services. She stated that signage regarding OOH services should not contain information about the provider; Ms Luff stated that she would investigate the signage at the William Harvey Hospital. Ms Luff explained that due diligence had been undertaken on the previous provider, Primecare. She stated that the concerns identified by the CQC replicated those that the CCGs had already raised with Primecare; the CCGs had issued a contract performance notice following a quality visit to Primecare's HQ in Wales. She noted that an external audit of the procurement and termination of the Primecare contract had been undertaken to identify lessons learnt for future contracts. She noted that Primecare continued to operate as a healthcare provider but was subject to scrutiny by NHS England and the CQC who undertook monthly quality visits.

(3) In response to a question about staff training, Ms Luff explained that there was a rigorous training programme to ensure all 111 staff were suitably qualified, competent, skilled and experienced. Once trained, staff were subject to a period of supervision and their calls were audited monthly; if staff fell below the expected level, they were required to re-complete the training programme. If staff failed the training programme twice, their contracts were terminated. She stated that staff who transferred from Primecare to IC24 were treated as new starters and were required to complete the training programme.

(4) RESOLVED that the report be noted, and the East Kent CCGs be requested to provide a written update in March to confirm that the Deal, Herne Bay and Romney Marsh bases had been re-opened by the 28 February 2018.

40. Assistive Reproductive Technologies (ART) Policy Review
(Item 8)

Stuart Jeffrey (Chief Operating Officer, NHS Medway CCG) was in attendance for this item.

(1) Mr Jeffrey introduced the report and welcomed Members questions and comments in relation to the review of Assistive Reproductive Technologies (ART) policies in Kent and Medway.

(2) Members enquired about the funding of donated genetic material for same sex couples, interventions prior to IVF and public consultation. Mr Jeffrey confirmed that donated genetic material for same sex couples would be funded going forward and public consultation would not be undertaken on this aspect of the review. Mr Jeffrey advised Members that there would not be any change to early interventions that would have an impact prior to IVF, the focus of the review was on the number of funded IVF cycles. Mr Jeffrey stated that a 12-week public consultation was planned and would include a survey, public

meetings across Kent & Medway and engagement with interested groups such as Fertility Fairness and Healthwatch Kent to target hard-to-reach groups. The launch of the public consultation was subject to sign-off by NHS England's assurance process.

(3) Members commented about the emotional impact on affected patients and gene screening. Mr Jeffrey stated that whilst the driver for the review was financial, he acknowledged that it was a sensitive subject and the consultation would seek to gather qualitative information around this to help the CCG better understand the emotional impact and ensure it could be taken into account. Mr Jeffrey committed to providing further information about the commissioning of gene screening.

(4) RESOLVED that:

(a) the Committee deems the proposed policy changes to be a substantial variation of service;

(b) a joint HOSC be established with Medway Council.

41. Kent and Medway Integrated Urgent Care Service Programme (Written Briefing)
(Item 9)

(1) The Committee considered a report about the procurement of the NHS 111 and Clinical Assessment Service telephony services across Kent and Medway and the procurement of face-to-face services in North Kent including out-of-hour services and urgent treatment centres.

(2) RESOLVED that the report be noted and Adam Wickings, Senior Responsible Officer for Kent and Medway Integrated Urgent Care Service Programme, be invited to provide a verbal update to the Committee on 2 March 2018.

42. Kent and Medway Emergency Care Performance (Written Briefing)
(Item 10)

(1) The Committee considered an interim update on NHS winter performance which focused on the emergency care performance over the Christmas and New Year period.

(2) The Chair noted the Committee's concerns about the interim performance data and requested that a review of winter performance be brought forward from the June to April meeting with clearer performance data.

(3) RESOLVED that:

(a) the report on emergency care performance over the Christmas and New Year period be noted;

(b) the NHS be requested to note the Committee's concerns about the interim performance data;

(c) the NHS be requested to provide a review of the 2017/18 winter plans and clear performance data to the Committee in April 2018.

43. SECAmb Regional Sub-Group (Written Briefing)
(Item 11)

(1) The Committee considered the notes of the SECAmb Regional Scrutiny Sub-Group held on 22 October 2017. The Chair invited Mr Angell to provide an overview of the meeting which included a presentation on the new Ambulance Response Programme and a tour of the Emergency Operations Centre at the Trust's HQ.

(2) Members requested that the following points to be raised at the next meeting of the Sub-Group:

- the difficulties in ambulances accessing new build sites or narrow roads
- an update on the fire service co-responding with the ambulance service.
- an update on the turnover of paramedic practitioners who go onto work in primary or secondary care
- an update on the Trust's public education programme to promote resuscitation and access to defibrillators.

(3) RESOLVED that the notes of the SECAmb Regional Scrutiny Sub-Group on 22 October 2017 be noted.

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Item 4: Kent and Medway Strategic Commissioner

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 27 April 2018

Subject: Kent and Medway Strategic Commissioner

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Kent & Medway STP.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 26 January 2018 during the Transforming Health and Care in East Kent agenda item, Michael Ridgwell (Programme Director, Kent and Medway STP) confirmed that discussions were being undertaken around the shared CCG management functions in Kent & Medway; he committed to providing a paper on this to the Committee at the March meeting.

(b) The Committee was due to consider this item on 2 March 2018; the meeting was cancelled due to the adverse weather conditions.

(c) A written report on the development of a strategic commissioner function in Kent & Medway is attached for information.

2. Recommendation

RECOMMENDED that the report on the Kent and Medway Strategic Commissioner be noted and the Kent & Medway STP be requested to provide an update at the appropriate time.

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (26/01/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7639&Ver=4

Contact Details

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NHS

Kent and Medway Strategic Commissioner – HOSC Update

April 2018

The Clinical Commissioning Groups (CCGs) across Kent and Medway are developing a strategic commissioner function to work across multiple CCGs. The aim is to strengthen how the CCGs work together, where doing so can drive service improvements that our patients need and expect.

Making strategic commissioning decisions across multiple CCGs is good because it provides consistency and reduces duplication; both for ourselves and the hospital, community and mental health services we work with. It will help improve services for patients by reducing variation in quality and access to care and will drive up standards across all providers.

Following discussions within the individual CCGs in January and February 2018 seven of the eight CCGs have committed to establishing the strategic commissioner and sharing a single senior management team with one accountable officer (chief executive). An announcement covering six of the eight CCGs was made on 12 March, confirming Glenn Douglas as the new accountable officer. Thanet CCG joined shortly after on 19 March. South Kent Coast CCG is having further discussions with its GP member practices and is expected to make a decision on 19 April (verbal update to follow at meeting).

As well as working strategically across all areas, the CCGs will also work in two groups on more local matters. These groupings are:

- **Medway, North and West Kent:** covering the CCGs of Medway; Dartford, Gravesham and Swanley; Swale; and West Kent.
- **East Kent:** covering the CCGs of Ashford; Canterbury and Coastal and Thanet (South Kent Coast if confirmed at later date).

This means that the responsibilities of CCGs will be delivered at three levels:

- Kent and Medway wide
- Locality groups of four CCGs
- Individual CCGs

The CCGs across Kent and Medway have already been working informally in this way for several years.

Co-design of the future model

The work to establish the strategic commissioner function is underway but is still in the design stage. In March we held two design workshops and a final session is taking place in early May. These sessions are looking at which commissioning responsibilities should stay with individual CCGs and which should be done either once across all CCGs or within the

locality groups. We are also considering if any current NHS England functions might sit more appropriately with a strategic commissioner.

A core part of this design work is looking at how we ensure the local voice of clinicians and patients is heard at the strategic level, and how we ensure that commissioning decisions are still taken locally where this is most appropriate. We are working with staff, member practices, lay-members of the CCGs and patient and public representatives to develop the new model.

The strategic commissioner will operate in a shadow form through 2018/19 during which time we will review progress and develop proposals for a permanent model.

Single management team roles

Glenn Douglas has taken up the accountable officer responsibilities with immediate effect from 12 March. He also retains his role as chief executive of the Kent and Medway Sustainability and Transformation Partnership.

As part of establishing the new arrangements the previous CCG accountable officers have taken on the following roles:

	Shared management team role	**Previously accountable officer for**
Ian Ayres	Medway, North and West Kent Managing Director	West Kent CCG
Patricia Davies	Director of Acute Strategy	Dartford, Gravesham and Swanley CCG, Swale CCG
Simon Perks	Medway, North and West Kent Deputy Managing Director	Ashford CCG, Canterbury and Coastal CCG
Caroline Selkirk	East Kent Managing Director	Medway CCG
Hazel Smith	Director of Partnerships	South Kent Coast CCG, Thanet CCG

Does this mean the CCGs have merged?

No, the creation of a strategic commissioner is about the CCGs working together. However, each CCG remains a statutory organisation with its own Governing Body and remains responsible for the commissioning of healthcare in its area.

The strategic commissioner will operate as a joint committee of the eight CCGs. It will have some delegated powers to make decisions on work that covers all CCG areas. The detail of its membership and governance is currently being developed.

A formal merger of CCGs is one potential option for the longer-term. We will be discussing this in the coming months, but it is not the only option and no decisions have been made at this stage. A proposal to merge would require all the CCGs involved to engage and seek the views of their membership practices and other stakeholders, and NHS England would also have to approve a proposal to merge. Nationally there are some CCG mergers happening this year and other groups of CCGs are looking to merger in 2019/2020.

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Item 5: Financial Recovery in East & North Kent

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 27 April 2018

Subject: Financial Recovery in East & North Kent

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the East & North Kent CCGs.

It provides additional background information which may prove useful to Members.

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1. East Kent

(a) On 20 September 2017 the Committee initially considered a report about the financial recovery plans for Ashford and Canterbury CCGs.

(b) On 26 January 2018 the Committee considered a report on the financial recovery plan for the whole of East Kent which expanded upon the September report. The Committee agreed the following recommendation:

- *RESOLVED that the report on financial recovery in East Kent be noted, and the East Kent CCGs be requested to provide an update in March 2018.*

(c) The Chair agreed to a request from the East Kent CCGs to postpone the item until the April meeting.

2. North Kent

(a) On 20 September 2017 the Committee also considered the annual CCG ratings. NHS Dartford, Gravesham and Swanley CCG were invited to present to the Committee at this meeting following it being rated as inadequate and placed in financial special measures by NHS England.

(b) As part of its recommendation, the Committee requested NHS Dartford, Gravesham & Swanley CCG to provide an update on its financial recovery plan at the appropriate time.

(c) The Chair has therefore requested an update on financial recovery in North Kent, in addition to East Kent, be presented to the Committee at its April meeting.

The East & North Kent CCGs have prepared the attached reports to be presented to the Committee.

East Kent CCGs pages 21 - 24
North Kent CCGs pages 25 - 28

3. Recommendation

RECOMMENDED that the report be noted and the East & North Kent CCGs be requested to provide an update in November.

Background Documents

Kent County Council (2017) *'Health Overview and Scrutiny Committee (20/09/2017)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7788&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (26/01/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7639&Ver=4

Contact Details

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Briefing note for Kent County Council

Health Overview and Scrutiny Committee (HOSC)

Financial Recovery in east Kent 2017/18

Introduction

The four CCGs in east Kent have been working to contain expenditure over the year. As the year end progressed a key issue has been an "external determination process" which has sought to identify the correct payment to East Kent Hospitals University NHS Foundation Trust based on the activity for the year. The CCGs have now prepared their initial draft of the final accounts for this year. These accounts include the result of the determination process.

Whilst the specific contracting and accounting issues for the year have been important the health system as a whole has been working on plans for the future. These plans have been rooted in the Sustainability and Transformation Plan process and have concentrated on better ways of providing care out of hospital. Overall these plans have identified savings of approximately £55m across the four CCGs. The phasing of these savings depends on the work done in each CCG. A significant proportion of these savings are expected to be made by 2019/20.

Draft Accounts for 2017/18

The accounts prepared reflect the outcome of the external determination process. The process showed that improvement was needed in the way activity was recorded in the east Kent health system and set out arrangements for this to be done. The determination stated that the CCGs should be paying an additional £14m for 2017/18. This outcome so close to the year-end has had a significant impact on the financial position of the CCGs and the draft accounts show figures with an aggregate deficit for the four CCGs of £29m.

Savings achieved in 2017/18

The four CCGs have worked hard to successfully achieve savings in the year. The main areas of success have been:

- Drug spending
- Continuing Health Care
- Non-acute contracts

As set out above there has been substantial work on the development of care outside of hospital. Detailed plans for implementation have been a key element of the workload in the current year and will continue to be at the centre of work in 2018/19. External research work has

demonstrated that the Encompass model of local care in the Canterbury and Coastal area has delivered significant reductions in hospital usage.

Recovery Plan

The CCGs will pull together a recovery plan for 2018/19. This plan will have three key components:

1. **QIPP stretch targets** – this addresses the forecast under-performance in the current QIPP programme by supporting and challenging the project leads in the existing schemes to produce a higher financial return from the original agreed projections.

2. **Reduction in expenditure run rate** – this addresses the CCGs forecast commissioning and running costs with a focus on those areas that the CCG can control and affect by agreed management action.

3. **Commissioning spend reduction** – these address the remaining gap by looking at the full range of contractual levers in all sectors.

CCG governance to deliver savings

The four east Kent CCGs have commissioned a review of their governance structures to ensure that they can deliver financial recovery. This plan will ensure that staff resources are appropriately prioritised across QIPP and financial recovery projects.

Update on initiatives under consideration

The four east Kent CCGs are currently considering implementing a small group of savings schemes based on a Kent and Medway analysis of a list of initiatives that have been introduced elsewhere in the NHS.

They include:

Prescribing guidance for gluten free foods - Following the outcome of the national consultation on the availability of gluten free foods on prescription in primary care, the east Kent CCGs have confirmed their commitment to support the recommendation which is to retain a limited range of bread and mix products on prescription. This means that the following gluten free foods will no longer be available for prescribing: biscuits, cereals, cooking aids, grains/flours and pasta.

In vitro fertilisation (IVF) – The CCGs across Kent and Medway are currently working together to review provision of Assisted Reproductive Technologies, including IVF, for effectiveness, quality and equity of access as well as the impact of potential changes in line with national guidance and clinical evidence. This will be undertaken in the context of local priorities and limited resources. At present Kent and Medway provide up to two full cycles of IVF whereas the majority of CCGs now commission one cycle. A pre-consultation public engagement plan is currently being

developed. NHS South Kent Coast CCG has still to agree to the review and this will be considered by the governing body.

Direct Access Magnetic resonance imaging (MRI) – Direct GP Access to MRI scans for orthopaedic conditions is being reviewed as part of the work to redesign musculoskeletal conditions (MSK) pathways in east Kent. This review has been clinically driven and will set clear diagnostic pathways for MSK related conditions.

Conclusion

The east Kent CCGs have prepared financial plans for 2018/19 which are currently with NHS England. The achievement of these plans will be challenging. The main emphasis of the recover process is based on the implementation of local care in line with the Kent and Medway Sustainability and Transformation Plan (STP).

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NHS

Briefing note for Kent County Council HOSC

NHS Dartford Gravesham and Swanley CCG and NHS Swale CCG: Financial Recovery Report for 2017/18

Dartford, Gravesham and Swanley CCG challenges

Dartford, Gravesham and Swanley CCG was facing an over spend of £13.5m in 2017/18 in addition to the £7.3m deficit planned at the start of the year. The agreed deficit plan in part recognises the shortfall in allocation growth from Ebbsfleet and other local housing developments. In total the £20.8m potential variance from break-even represented 4% of the CCG's turnover.

The key driver behind the financial recovery programme was a change of approach, attitude and culture where it is unacceptable to over-spend coupled with a continuous programme of added value review and scrutiny to address the financial gap.

We also needed to change the culture and relationship with have with the CCG's providers so that we can control and manage the financial value of contracts. We aim to do this in part through the development of the Integrated Care System proposition with DVH, which will move us to a greater system approach with one control total and plan. The first stage of this process has focused on the establishment of the joint PMO with DVH and both the Trust and CCG have aligned staff to support this endeavour.

In addition, the CCG and Trust have commissioned GE Healthcare Finnamore to complete a longer term financial model looking at how the system can achieve financial balance and sustainability over a 3-5 year period, factoring growth and efficiency gains through joint working. However, this significant piece of programme work will require regulator support and facilitation both in terms of resource, nominal investment and agreement to manage the system as a system rather than as separate control total parts. However, the financial recovery plan for 2017/18 was not predicated on the delivery of the Integrated Care model.

The main reasons for the £13.5m challenge are as follows:

- QIPP shortfall (£4.0m) –The CCG has a £12.8m QIPP Programme in 2017/18. However, at month 5 the CCG was forecasting £8.8m delivery, which was a £4m shortfall.
- MSK pathway - a slippage £0.6m on the assumed benefits
- Contract Management projected over performance - the assumption was £6m over spend projection on acute contracts
- Re-admissions – the assumption is of a gain £1.0m from the readmissions clinical audit is not materialising.
- CHC – with more regular placement reviews a further £0.4m gain was assumed.

Swale CCG: the challenges

Swale CCG was facing a challenge of £9.7m in 2017/18. The agreed plan for the CCG was break-even. This financial challenge of £9.7m represents 6% of the CCG's turnover.

It should be noted that to achieve the agreed control balance, the CCG planned a QIPP programme of £5.8m, which contained several demand management and cost reduction projects, although £2.8m was "unidentified" at the start of the year.

As with DGS CCG the key drive behind the recovery programme, is a change of approach, attitude and culture where it is unacceptable to over-spend and there is a continuous programme of added value review and scrutiny to address the financial gap.

The development of the FRP was based on efficiencies the CCG have identified through benchmarked data, evidence of effectiveness from other CCGs and indeed successes of our own and moving these harder and faster, for example medicines management. However, these gains will get us so far. Longer term efficiencies and sustainably can only be achieved at a system level and further work is required to create the potential for system gain.

The main reasons for the £9.7m challenge are as follows:

- QIPP shortfall (£3m) –The CCG has a £5.8m QIPP Programme in 2017/18. However, at month 6 the CCG was forecasting £2.8m delivery, which is a £3m shortfall.
- Projected acute contract over-performance of £6m
- Running costs over spending projections of £500k
- Medicines management – initial projected lower delivery shortfall of £400k

The Recovery Plan

The recovery plan in both CCGs consisted of three elements:

1. **QIPP stretch targets** – this addresses the forecast under-performance in the current QIPP programme by supporting and challenging the project leads in the existing schemes to produce a higher financial return from the original agreed projections.
2. **Reduction in expenditure run rate** – this addresses the CCG's forecast commissioning and running costs with a focus on those areas that the CCG can control and affect by agreed management action.
3. **Commissioning spend reduction** – these address the remaining gap by looking at the full range of contractual levers in all sectors. By their very nature some of these actions only delivered savings in quarter 4.

The detail in each of these areas was generated using various tools available for benchmarking and self - assessment within the NHS commissioning environment:

- Clinical Variation – using Right Care data, the Atlas of Variation and STP opportunities to identify areas of clinical variation in planned care. The Commissioning structure had recently been re-aligned to focus on the FRP schemes; within this a lead had been assigned for each area of clinical variation. A GP clinical lead had also been appointed to champion this programme. The CCGs identified size of opportunity for each GP practice.

- Menu of Opportunities – national best practice examples across all commissioning areas. This was a long list of opportunities and the CCGs all self - scored where they were on taking ideas forward.

- VFM disinvestment - some overlap with Menu of Opportunities and COO list; Items under disinvestment will fall under the CCG value for money review and areas where activity is high should be picked up by the clinical variation.

Recovery Plan Governance and Delivery

The CCGs also changed their focus and governance structure so that financial recovery is an integral part of the CCGs decision making process. This ensures that staff resources are appropriately prioritised across QIPP and financial recovery projects. The Programme Delivery Steering Group, which supports the financial recovery is currently meeting weekly to embed the process. The process is overseen by a Programme Management Office (PMO) which is led by Company Secretary and Assistant AO.

The CCGs has also made changes to its meetings and the CCG now has meetings held at the same time for each CCG for Governing Body, Quality Finance and Performance and Audit Committee. This reduces the time in meetings for senior staff, including those with joint roles and gives strength in knowledge and experience from the lay members.

The Director of Commissioning and Performance post which has been vacant was filled in July 2017 and the new post holder brought additional drive and challenge to the financial recovery plan.

The CCG has also restructured its contracting and performance teams to provide more direct support to DGS and Swale CCGs and to integrate the teams into the commissioning and finance teams.

The financial results achieved in 2017/18

The financial performance results quoted are those submitted to each CCG Governing Board and NHSE, and prior to annual accounts audit.

DGS CCG against its original financial plan target of £7.3m deficit has achieved a deficit of £9.1m.

It should be noted however that the variation from target was driven by a national issue related to the supply and cost of generic drugs which accounted for £1.4m of the £1.8m gap. The remaining £400k was driven by increased activity in the acute sector.

Swale CCG against its original financial plan target of break-even has achieved a deficit of £3m

The key drivers of the deficit includes the generic drugs issue (noted above), increased activity within the acute contract and slippage in the QiPP programme.

Whilst both CCGs have not achieved their financial plan target, it should be noted that the results are substantial improved from the 2017/18 mid -year forecasts.

Conclusion

Looking forward, both CCGs have committed to the NHSE control limit in 2018/19 of break-even. Despite the gains made in the under lying run rate and the culture of both CCGs, the achievement of these control totals will be very challenging without the radical change to the systems cost base as presented within the Kent and Medway STP.

END.

Item 6: Transforming Health and Care in East Kent

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 27 April 2018

Subject: Transforming Health and Care in East Kent

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the East Kent CCGs.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 24 November 2017 the Committee considered a report regarding the potential medium list options for urgent and emergency care and acute medicine and elective inpatient orthopaedics in East Kent.

(b) On 26 January 2018 the Committee considered an update report on the transformation of acute and local care services in East Kent. The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the report on Transforming Health and Care in East Kent be noted;

  (b) a full update be presented to the Committee at the earliest opportunity but no later than April;

  (c) the Committee be provided with the rationale as to why the provision of A&E services on three sites is not clinically deliverable.

2. Recommendation

RECOMMENDED that the report be noted and the East Kent CCGs be requested to provide an update at the appropriate time.

Background Documents

Kent County Council (2017) *'Health Overview and Scrutiny Committee (24/11/2017)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7533&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (26/01/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7639&Ver=4

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Transformation of Health care in east Kent

Update report to HOSC

27 April 2018

Introduction

This paper provides HOSC with progress on east Kent health and care transformation. Success will require multiple dependencies to be managed that include:

- Commissioners and providers developing and delivering a shared vision for health and care services across east Kent
- Development of robust local care
- Management of existing operational challenges across the system, for example workforce
- Delivery of national initiatives such as primary care at scale and urgent treatment centres.

In January 2018, the HOSC received an update on the development of local care that included:

- The development of 17 primary care hubs to increase range of services available locally
- The adoption of the "Dorothy" model to deliver multi disciplinary care
- Increased access to GPs
- Increasing use of Minor Injury Units and the range of services offered at these locations.

The east Kent transformation programme is complex and on a scale that requires a whole system response

Since January we have been working to:

- Develop a new level of detail in the **local care plans** for each CCG
- Demonstrate the **impact** that proposed plans for local care will have at a CCG and east Kent level
- Understand how services will operate **locally** to support the resident population for both options
- Shift the focus of modelling service changes from individual organisations to localities and an **east Kent system level** so we understand how they will impact patients
- Model data on patient pathways, travel times, and workforce in current state, to ensure we can **engage with local people** and apply the agreed criteria to evaluate options ahead of consultation
- Build on existing public and stakeholder engagement to **inform and test proposals** before formal public consultation. On 22 March a system wide "Design by Dialogue" event was held in Canterbury. Further events are planned in each locality.
- Further develop **pre-consultation engagement** to explore models of care and ensure they can meet local needs
- Secure additional support to assist in the development of a **robust and comprehensive pre consultation business case** (PCBC in readiness for subsequent NHS E assurance tests.

Local Care: What will out of hospital care look like?

- More **care provided through GPs** and in **community settings**

Detailed modelling at a locality level for each CCG on the types of services that could be delivered within each locality. This has helped to quantify the intended impact of changes and address the different geographical needs.

- GP practices working **together at scale** delivering **more services**

A total of 17 hubs are proposed across the 4 CCGs. The ability to work at scale supports the effective deployment of resources and creates opportunities to extend the range of services offered.

- Care **based on population need** not organisations

Development of local plans that share an east Kent identity whilst reflecting the specific needs of local people, priorities and access.

- **Teams of different health and care professionals working together** focusing on the patient

Multi disciplinary working improves the co-ordination of care, patient experience and outcomes as well as reducing hospital attendances and admissions.

- Focus on **long term conditions** and **prevention**

The importance of prevention is a key theme emerging from both public and stakeholder engagement and is a key part of local care development.

NHS England Guidance (March 2018): Planning, assuring and delivering service change for patients

In March 2018, NHS England (NHSE) published it's updated guidance for those considering and involved in substantial service change.

Key points to note include:

- A provider can satisfy its duties to consult through a **commissioner led consultation**
- The need for full and **consistent engagement** with stakeholders and neighbouring STPs in line with the "four tests"
- If hospital bed closures are proposed, **supplementary tests apply** and include the need to satisfy that sufficient alternative provision, reduction of admissions and plans to improve performance must be met
- If capital funding is required NHSE/ NHS Improvement will assess **sustainability** and **affordability**
- Commissioners should seek a comprehensive range of perspectives for the **case for change** and build their proposal by identifying the range of service change options that could improve outcomes within available resources
- Commissioners should progress to the "four test" assessment by NHSE once it is content that the **options are viable**.

What are the practical next steps in progressing the transformation of health and care services in east Kent?

- **Development of a robust and comprehensive pre consultation business case (PCBC)**

The PCBC represents the first full presentation of the collated evidence, plans and proposed implementation that will be tested against the NHSE assurance tests for service reconfiguration. This case needs to be comprehensive and compelling and will need to take into account the amended NHSE guidance that sets out the level of detail expected.

- **EK financial and activity modelling – a system wide view**

Developing an east Kent wide financial plan underpinned by detailed activity and capacity modelling at a system level and by organisation. This will need to provide assurance against the delivery of changes to models of care both in and out of hospital.

- **Evaluation of the "medium list" of options**

Option 1 – a three site hospital model providing a major emergency centre at WHH, emergency centre at Queen Elizabeth The Queen Mother Hospital in Margate (QEQM) and a GP led facility at Kent and Canterbury Hospital (K&C) supported by enhanced local care development including urgent treatment centres, extended GP surgery hours, local hubs providing an enhanced range of services.

Option 2 – a single site option centralising hospital services in a new estate adjacent to the current K&C Hospital whilst supporting the delivery of most frequently accessed and used services locally.

- **Ongoing public and stakeholder engagement to develop the option(s) and in preparation for formal public consultation**

An initial system wide event was held on 22 March and further dates are planned to engage the local population in the development of plans and to use their views to inform and shape the look of future services.

Item 7: East Kent Out of Hours GP Services and NHS 111

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 27 April 2018

Subject: East Kent Out of Hours GP Services and NHS 111

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the East Kent CCGs.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 3 June 2016 the Committee received a report from the East Kent CCGs which provided an update about the outcome of the East Kent integrated urgent care service procurement combining NHS 111, GP Out-of-Hours and new care navigation service.

(b) On 25 November 2016 the Committee considered an update about the implementation of the new East Kent integrated urgent care service contract provided by Nestor Primecare Limited.

(c) On 20 September 2017 the Committee was provided with an update following Primecare being rated as Inadequate and being placed into Special Measures by the Care Quality Commission (CQC) on 3 August 2017.

(d) On 24 October 2017 the Committee was notified that Primecare had opted to exercise its right to serve an accelerated notice period of three months on Friday 29 September 2017. On 14 November the Committee was formally notified that Integrated Care 24 (IC24) would take over the contract from the beginning of December.

(e) On 26 January 2018 the Committee received an update about the implementation of the new contract by IC24. The Committee agreed the following recommendation:

- *RECOMMENDED that the report be noted, and the East Kent CCGs be requested to provide a written update in March to confirm that the Deal, Herne Bay and Romney Marsh bases had been re-opened by the 28 February 2018.*

(f) The Committee was due to consider this item on 2 March 2018; the meeting was cancelled due to the adverse weather conditions.

2. Recommendation

RECOMMENDED that the report on the East Kent Out of Hours GP Services and NHS 111 be noted.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (03/06/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6259&Ver=4

Kent County Council (2016) *'Health Overview and Scrutiny Committee (25/11/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6263&Ver=4

Kent County Council (2017) *'Health Overview and Scrutiny Committee (20/09/2017)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7788&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (26/01/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7639&Ver=4

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NHS

Health Overview and Scrutiny Committee Briefing

East Kent NHS 111 and GP out of hour's services

April 2018

Author: Sue Luff, Head of Contracts

Sponsor: Caroline Selkirk – Managing Director East Kent

Background

Integrated Care 24 Limited (IC24) took over the provision of the Integrated 111 and Out of Hours Service (OOH) on 1 December 2017. This was as a result of the previous provider exercising its right to serve an accelerated notice period.

IC24 is a not for profit social enterprise and has more than 25 years' experience providing healthcare services, including GP OOH care and NHS 111 services across the east and south of England.

The mobilisation period of the contract was reduced due to the circumstances therefore the original out of hours bases provided by the previous provider were not utilised.

The Clinical Commissioning Groups within East Kent were challenged by HOSC to open all bases.

The table below documents the bases which did not open at the start of the contract in December 2017.

Base	Weekday Opening Mon-Fri	Weekend Opening Sat-Sun	Bank Holiday Opening	Grade of staff delivering service
Canterbury and Coastal – Herne Bay QVMH	None	08:00 – 18:00 Sat 09:00 – 18:00 Sun	09:00 – 18:00	GP
Deal	None	09:00 – 14:00 Sat and Sun	09:00 – 14:00	GP
Romney Marsh	None	09:00 – 16:00 Sat and Sun	None	Nurse Practitioner

Current situation

Following the last update to the HOSC where the committee was assured that there would be OOH presence in all localities the CCG has worked with the provider to support the ability to provide access to the bases across east Kent.

The following bases are now operational:

- William Harvey Hospital - Ashford
- Kent & Canterbury Hospital – Canterbury
- Queen Elizabeth the Queen Mother Hospital – Margate
- Queen Victoria Memorial Hospital - Herne Bay
- Buckland Hospital - Dover
- Royal Victoria Hospital - Folkestone

It has not been possible at this at this stage to open the Romney Marsh and Deal bases. This is primarily due to lack of available GPs to ensure there is consistent and robust cover across all areas.

Within Romney Marsh the provision of the service was previously delivered by a nurse practitioner. Therefore the site was only utilised at 25 per cent as patients that needed review from a GP travelled to another base. To support the ability for timely access for a GP review, IC24 have increased their ability to provide mobile access for GPs for home visits for review patients within their own homes where they have the greatest care needs as an alternative. This will ensure that this cohort of patients does not need to travel where unnecessary.

Within Deal, the GP Federation is working towards additional GP access through the national strategy to extend access for patients to primary care outside normal working hours. To support this IC24 will work with the local GP practices to ensure that they are able to share the cover required for the respective services. In the interim the local MIUs will be able to support access for patients out of hours for assessment for minor illness with support from IC24 where a GP review is required.

Future Development

There are several national and local drivers which require the need for additional GPs support to deliver access to care for patients within the traditional out of hour's period. This has led to the development of the following local services to date:

Provider	Service Delivered
Invicta Health Care	GP within Accident and Emergency within William Harvey Hospital GP within Kent and Canterbury Hospital
Channel Health Alliance (South Kent Coast GPs)	Extended Hours across locality hubs including Deal, Dover Folkestone Hythe and Romney Marsh Increased home visiting service
Acute Response Team – (Thanet GPs)	GP within Accident and Emergency in Queen Elizabeth the Queen mother Hospital
Herne Bay Integrated Care LTD (Herne Bay GPs)	New MIU/Minor Illness service within Queen Victoria Memorial Hospital(QVMH)

There will be further development of services designed to support patient access to urgent care assessment.

One of the impacts of the development of the additional services means that the primary care workforce is needed to support delivery of the services which can lead to services all trying to secure workforce from the same pool of staff.

Whilst the competing services all require support from general practice it is recognised that there are opportunities for all providers to work in partnership to ensure that as a collective group they are able to provide a consistent and equitable service for all patients whilst meeting the required needs of the various strategies. This will also support the ability to ensure that the GP workforce across east Kent is supported to deliver the competing demands.

To support the services CCG leads have met with the providers to discuss the principle for shared working which in turn will ensure that the primary care workforce is supported to deliver the service needs.

It has been agreed that a workshop will be held in early May to map the patient needs across each locality and agree ways in which the respective services required can be delivered using a partnership approach. Invitees will include patient representatives, Healthwatch Kent and HOSC.

The CCG will report the outcome of this workshop to the HOSC for assurance.

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Item 8: SECAmb: Update

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 27 April 2018

Subject: SECAmb: Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided about the SECAmb Regional Scrutiny Sub-Group.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) In November 2016 the SECAmb Regional Scrutiny Sub-Group was established, comprising of representatives from the six health scrutiny committees in the South East, to scrutinise South East Coast Ambulance Service NHS Foundation Trust's (SECAmb) response to the findings of the Care Quality Commission inspections and the Trust's wider recovery plan.

(b) The Sub-Group last met on 19 March 2017; the notes from the meeting were not available at the time of publication and will be circulated to the Committee in due course. At the meeting, it was agreed to revert to individual scrutiny of the Trust by each health scrutiny committee going forward.

(c) Subsequently the Chair has invited SECAmb to this meeting of the Committee to provide an overview of the new Ambulance Response Programme (ARP) and Trust's performance data for Kent in comparison to the whole of the SECAmb area.

2. Recommendation

RECOMMENDED that the report be noted and SECAmb be requested to provide an update at the appropriate time.

Background Documents

None

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Ambulance Response Programme

The Ambulance Response Programme (ARP) is a change to the way in which ambulance services (in England) receive and respond to emergency calls.

This programme followed the 2013 NHS England review into urgent and emergency care of which the ambulance services in England were an integral part. Early on, recognition that ambulance service response standards had not been reviewed since the mid 1970's, despite the service experiencing a yearly increase in demand, as well as a reduced effectiveness in responding to the most serious of 999 calls.

In 2015, NHS England commissioned Sheffield University to undertake a study into ambulance responses, therefore between October 2015 and April 2016 trials took place in three ambulance services that involved the study of approx. 10 million patients.

Prior to the introduction of ARP, ambulance services were required to dispatch a resource to the most serious of 999 calls within 60 seconds of the call transferred from the BT switchboard to the receiving ambulance service. This approach often resulted in:

- Dispatching a resource before the problem was known
- Sending ineffective resources to stop the clock
- Sending multiple vehicles to the same incident
- Having to stand down vehicles and retarget them towards other calls
- If a car was sent then long waits could be experienced in waiting for a transporting ambulance to arrive
- Lower priority calls could experience long waits for a response

The Ambulance Response Programme's aim of increasing operational efficiency whilst maintaining a clear focus on the clinical needs of patients, enables the service, through the re categorisation of 'call priorities' (Table 1), the opportunity to send 'the right response, the first time, in time'. This is achieved through call handlers having more time to assess the call in the first instance. Previously, for Red 1 and Red 2 (immediately life threatening) calls a 60 second target was set. However, ARP Category 1 (unconscious or not breathing) calls have a 30-second target and Category 2 calls (life threatening), the target is 240 seconds, giving the call taker greater opportunity to establish the nature of the problem and allocate the most appropriate resource. ARP can also result in a 'no' resource sent where appropriate (following appropriate triage).

Another key aim of the ARP is to ensure that all patient response times are measured. This is achieved through the introduction of a ‘mean’ response time target along with a 90th percentile for C1 & C2 responses along with a 90th percentile for C3 & C4.

It is worth noting that calls classed as C2 make up approx. half of all calls received (see table 1 for definitions).

The ARP will:

- Ensure the resource dispatched is the right resource to match the patients clinical needs
- Increase the opportunity to treat patients either over the phone (Hear & Treat) or in the home environment (See & Treat)
- Increase early recognition of cardiac arrest and other life threatening conditions
- Reduce lengthy waits for less urgent calls
- Improve resource availability and efficiency

Post implementation of the ARP, there will be ongoing reviews to understand the impact of the programme on the current structure of the service. Some of the key changes required in line with the intention of the programme are:

- An increase in the ratio of ambulances v’s response cars, to support the ‘right response first time
  - One of the key metrics for ARP is sending transport capable resources i.e. an ambulance
- A review of the clinical grades of staff to support the change in ratio vehicle type

Performance

There is minimal variance between SECAmb’s performance for both Kent and the wider region (Kent, Surrey, Sussex). It is however, recognised that the Trust is particularly challenged in meeting its C3 & C4 targets (table 2) for 17/18.

C1 performance for ambulance services in England during March 2018 was 8 minutes and 22 seconds (mean) with SECAmb achieving 8 minutes and 14 seconds (mean). This places the Trust 5th (out of a total of 10 Trusts) nationally.

C2 performance in England for March was 27 minutes and 7 seconds (mean) with SECAmb achieving 19 minutes and 37 seconds and placed 2nd nationally.
SECAmb’s performance for both C3 and C4, (mean target) saw the Trust in 9th position for both categories.

Demand and Capacity Review

Commissioners and SECAmb have identified a gap in funding, to deliver its existing model and achieve all performance targets. The identification of this 'gap' is supported by NHSE and as a consequence of this, a joint review into the existing and potential future operating models was jointly commissioned by Commissioners and SECAmb, and supported by Deloitte and ORH.

The focus of the review is on two operating models: 1) Paramedic Led Ambulance Model and 2) The Targeted Dispatch Model. Both models have identified a requirement to increase not only the number of front line staff but also the fleet resource. Both models have been defined through a clinical sub group consisting of Commissioners and SECAmb colleagues.

Initial findings have been made available to both SECAmb and Commissioners and have resulted in the selection of the 'targeted dispatch model' with a requirement to conduct a more detailed analysis together with an evaluation of a trajectory for delivering compliance with ARP standards. An update slide deck is included to convey the detail to associate commissioners in the past weeks. The work has not stopped here insofar that the next steps will involve an in depth analysis of delivery profile taking into account the constraints faced by the system and SECAmb.

This is important insofar that the targeted dispatch model builds on our work with you and the wider system to enable and facilitate alternatives to conveyance to an Emergency Department. That is, increase 'hear and treat' and 'see and treat' or refer into jointly developed and clear care pathways to deliver continued benefit to patients and the system. As we move forward the opportunity to collaborate on what experience and skill sets are deployed in the pre hospital and out of hospital settings of care is truly exciting.

Ambulance Integration Programme

The ambulance integration programme (AIP), established by NHSE, has a number of key elements, one of which is the ARP. Some of the other key elements are:

- NHSE/NHS Improvement (NHSI) Hospital Handover guidance produced
    - In response to the continued high number of hours being lost with ambulance crews waiting to handover patients in emergency departments to receiving hospital clinicians
- Agreement to fund the transition of Paramedics from band 5 to band 6 in line with Agenda for Change
- ARP impact assessment published
- Winter pressure oversight assurance with funding

- Ambulance Trusts engaged in the emerging urgent & emergency care delivery arrangements

Table 1:

Category	Types of Calls	Response Standard	Likely % of Workload	Response Details
Category 1 (Life-threatening event)	Previous Red 1 calls and some Red 2s including • Cardiac Arrests • Choking • Unconscious • Continuous Fitting • Not alert after a fall or trauma • Allergic Reaction with breathing problems	7 Minute response (mean response time) 15 Minutes 9 out of 10 times (90th Centile)	Approx. 100 incidents a day (8%)	Response time measured with arrival of first emergency responder Will be attended by single responder and ambulance crews
Category 2 (Emergency, potentially serious incident)	Previous Red 2 calls and some previous G2s including • Stroke Patients • Fainting, Not Alert • Chest Pains • RTCs • Major Burns • Sepsis	18 minute response (mean response time) 40 minute response (90th centile)	(48%)	Response time measured with arrival of transporting vehicle (or first emergency responder if patient does not need to be conveyed)
Category 3 (Urgent Problem)	• Falls • Fainting Now Alert • Diabetic Problems • Isolated Limb Fractures • Abdominal Pain	Maximum of 120 minutes (120 minutes 90th centile response time)	(34%)	Response time measured with arrival of transporting vehicle
Category 4 (Less Urgent Problem)	• Diarrhoea • Vomiting • Non traumatic back pain	Maximum of 180 minutes (180 minutes 90th centile response time)	(10%)	May be managed through hear and treat Response time measured with arrival of transporting vehicle

Table 2:

SECAmb ARP Performance between 22nd November and 31st March 2018									
	Cat 1 Mean Response Time (07:00)	Cat 1 90th Centile (15:00)	Cat 1T Mean Response Time (19:00)	Cat 1T 90th Centile (30:00)	Cat 2 Mean Response Time (18:00)	Cat 2 90th Centile (40:00)	Cat 3 90th Centile (02:00)	Cat 4 Mean Respons e Time	Cat 4 90th Centile (03:00)
Kent	00:08:13	00:14:50	00:11:33	00:21:09	00:18:10	00:33:47	03:11:28	02:15:27	05:32:30
SECAmb	**00:08:15**	**00:14:51**	**00:11:19**	**00:20:39**	**00:17:59**	**00:33:42**	**03:19:26**	**02:11:15**	**05:12:29**

Item 9: Patient Transport Service

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 27 April 2018

Subject: Patient Transport Service

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by West Kent CCG.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 20 September 2017 the Committee considered an update on the contract performance relating to Non-Emergency Patient Transport Service as provided by G4S on behalf on West Kent CCG as lead commissioner. The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the report on Patient Transport Services be noted;

  (b) NHS West Kent CCG be requested to provide an update in six months with:

  (i) qualitative and quantitative data including the details about patient experience and areas of underperformance;

  (ii) feedback from the action plan regarding complaints.

(b) The Committee was due to consider this item on 2 March 2018; the meeting was cancelled due to the adverse weather conditions.

(c) West Kent CCG have prepared the attached reports to be presented to the Committee.

Original Paper - CCG (2 March) pages 51 - 58
Update Paper - CCG (27 April) pages 59 - 64
Key Performance Indicators – G4S pages 65 - 66

2. Recommendation

RECOMMENDED that the reports be noted and NHS West Kent CCG be requested to provide an update at the appropriate time.

Background Documents
Kent County Council (2017) *'Health Overview and Scrutiny Committee (20/09/17)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=45835

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G4S Non-Emergency Patient Transport

Performance Summary Kent and Medway

Executive summary

The Non-Emergency Patient Transport Service (NEPTS) is provided by G4S.
This report gives an overview of contract performance relating to Non-Emergency Patient Transport Service (NEPTS) contracts as provided by G4S on behalf on West Kent CCG as lead commissioner.

- Contract Lot 1 (Kent and Medway patient journeys excluding transports to Dartford and Gravesham hospital trust site and renal transports)
- Contract Lot 2 (Renal dialysis patient journeys only)

It should be noted that due to the transfer of commissioning support services from NEL CSU to Optum, December data is currently unavailable.

Contract Overview

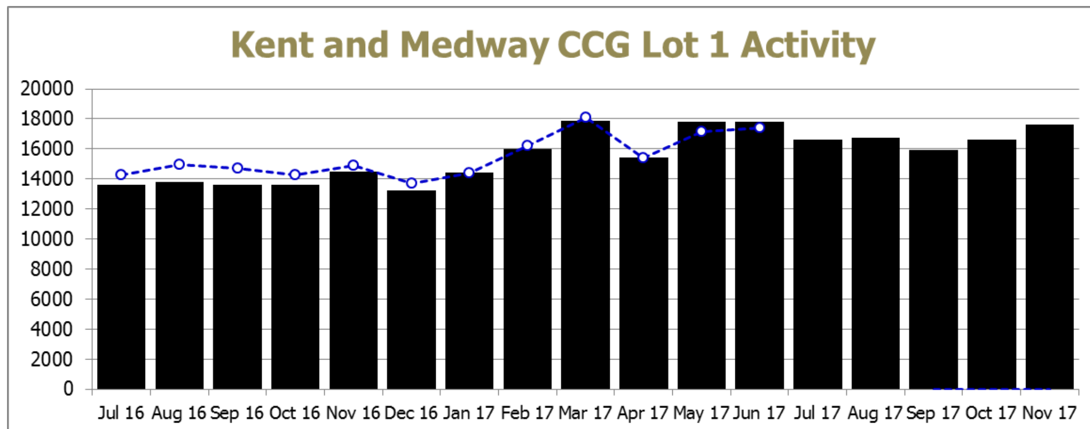
Activity under the contract has been lower than originally anticipated however there has been a greater demand for higher mobility and longer distance journeys. There has also been increased escort numbers which has impacted on the patient loading factor. Due to the vehicle and staffing pressures on the service G4S have been below many of their contractual KPIs but have maintained a low level of formal complaints. They have also made significant progress in their training compliance for staff and have been further developing their relationship and communications with local provider trusts.

Lot 1 Contract Performance Review

Activity Performance

The graph on the next page provides snapshot of activity volumes by plan and by actual activity for all non-urgent patient transport journeys provided by G4S (excluding transports to Dartford and Gravesham hospital site and renal transports) for both all Kent and Medway CCGs to the end of November 17.

Activity overall has increased from February 2017 following the mobilisation of further journeys to and from Kings and Guys and St Thomas' sites (estimated at around 32,000 journeys for Kent and Medway patients.



Please note that due to the rebasing of contract levels ("True-up") and the phased removal of London journeys (exc Kings and Guys) from the service, it was agreed to remove the monitoring of G4S activity against plan values.

Activity post February mobilisation for Lot 1 is now closer to expected levels than it was in the first few months of the contract. The type of activity and acuity level of patients is different to that included in the original plan, which was based on the data that was available prior to the tender. This means that the vehicle and personnel resources available are not always sufficient to meet the level demand. Additionally the journey mileage has also seen an increase from the commissioned levels.

KPI Performance

Performance against the core KPIs is running at 71 per cent of planned outpatients arriving within the expected time slot. Performance against planned discharges looks low however G4S have stated that a high proportion of this is due to patients not ready and the pick-up time being amended on the day. G4S are currently looking to resubmit a more accurate picture based on a new agreement that any booking changed by more than 60 minutes would be reclassified as an on the day booking.

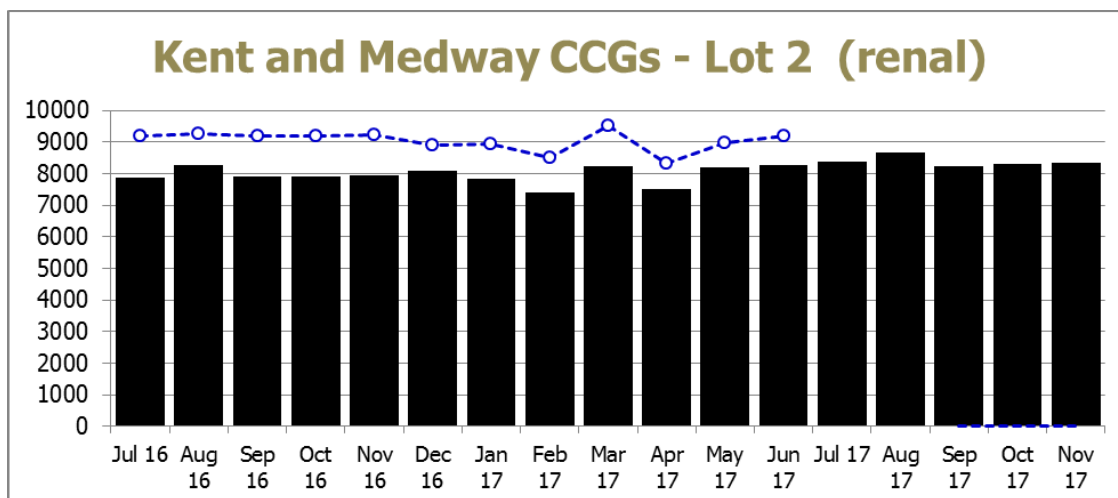
Due to the increased pressure from the variance from plan, G4S have found it challenging to improve performance to meet their contractual KPIs. Commissioners and CSU colleagues have met with G4S to discuss the additional resource needed in order to deliver the contractual KPIs with the new activity demands and discussions remain ongoing. Due to this there has been some discussion about the KPI regime and tailoring this to ensure that patient experience and safety can be at an acceptable and reasonable level. This work is expected to be concluded in late February 2018.

Reference and journey type	Required standard	Performance Threshold	Sep-17	Oct-17	Nov-17	Dec-17
1a - Journey booked in advance - outpatient arrival.	Patients to arrive on time and no more than 75 minutes prior to their appointment time OR no more than 60 minutes if it is the first appointment of the day for that clinic.	95%	78%	77%	74%	71%
1g - Outpatient return journey - all bookings.	Return journey patients to be collected within 60 minutes of the identified booked-ready time	85%	77%	80%	77%	78%
2a - Journey booked in advance - discharge.	Patients to be transported within 60 minutes of the identified booked-ready time	95%	33%	36%	36%	47%
2b - Journey booked on the day - discharges.	Patients to be transported within 120 minutes of the identified booked-ready time	90%	65%	65%	65%	64%
3a - Journey booked in advance - transfer of care.	Patients to be transported within 60 minutes of the identified booked ready time	90%	41%	43%	30%	52%
4 - Aborted/ cancelled journeys.	Journeys aborted/cancelled as a result of the PTS provider	0%	1%	1%	1%	0%
5a - Travel time (up to 10 miles)	Patients travelling up to 10 miles to / from their destination should not spend longer than 60 minutes on either an inward or outward journey	90%	81%	81%	79%	82%
5b - Travel time (more than 10 miles and less than 35 miles	Patients travelling between 10 to 35 miles to / from their destination should not spend longer than 90 minutes on either an inward or outward	90%	71%	74%	73%	76%
5c - Travel time	Patients travelling from 35 to 50 miles to / from their destination should not spend longer than 120 minutes on either an inward or outward journey	90%	59%	55%	48%	55%

Lot 2 Contract Performance Review

Activity

The graphs on the next page show a snapshot of transport activity volumes by plan and actual activity for patients receiving renal dialysis.



Please note that due to the rebasing of contract levels ("True-up") it was agreed to remove the monitoring of G4S activity against plan values.

As you can see from the chart below there has been underperformance in terms of number of journeys for patients requiring renal dialysis. In line with Lot 1, there has also been a material shift in the types of mobility for transport that is requested. There are also additional changes around the further development of twilight sessions that mean a change in working for G4S and further pressure on patients with a clinical need to travel alone which has reduced the utilisation rate of vehicles.

KPI Performance

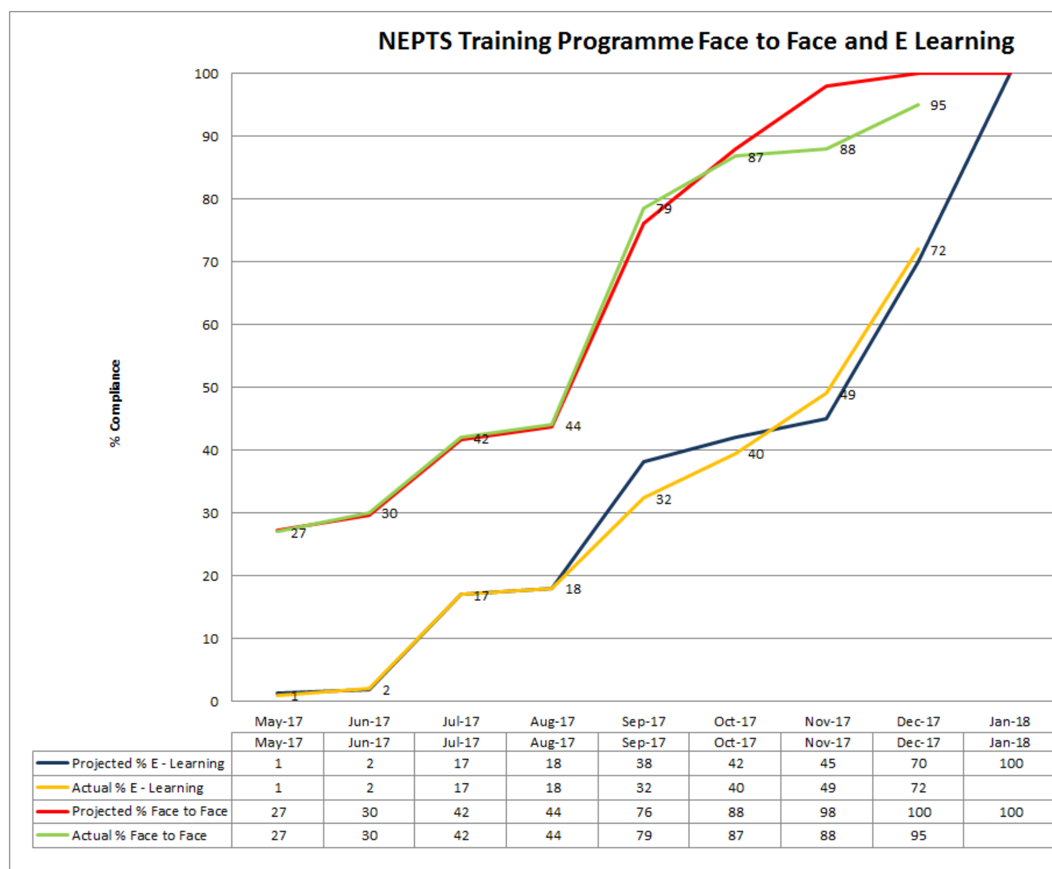
In line with Lot 1, KPI performance has been below expected levels since the mobilisation of the contract and commissioners and G4S have had an agreed rectification plan with trajectories in place for some time. Due to the challenges in levels and mix of activity it is understood that full achievement is not achievable with the current level of resource.

Reference and journey type	Required standard	Performance reporting threshold	Sep-17	Oct-17	Nov-17	Dec-17
1a - Arrival time	Patients to arrive on time and no more than 15 minutes prior to or later than their scheduled appointment	95%	84.21%	87%	86%	85%
1b - Return Journey	Return journey patients to be collected within 30 minutes of the identified booked-ready time.	95%	83.90%	82%	77%	76%
4 - Aborted/ cancelled journeys.	Journeys aborted/cancelled as a result of the PTS provider	0%	0.03%	0.01%	0%	0%

Service Quality Review

Training

G4S had identified that training records for staff previously subject to TUPE were not complete as they had not been provided by the previous contractor. Therefore the decision was taken to retrain everyone to ensure consistency and provide assurance about both the level and delivery of training. This was shared with the CQC and levels of training have improved and are now fully compliant in February 2018.



	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Projected % E - Learning	1	2	17	18	38	42	45	70	100
Actual % E - Learning	1	2	17	18	32	40	49	72	
Projected % Face to Face	27	30	42	44	76	88	98	100	100
Actual % Face to Face	27	30	42	44	79	87	88	95	

Complaints

The challenges experienced by G4S in the delivery of the service resulted in an increase in critical feedback from both patients and stakeholders. There were previous concerns raised by commissioners via a Contract Query Notice (CQN) around the complaints process operational in G4S. G4S have since provided a comprehensive action plan and additional assurances around their processes and commissioners are in the process of reviewing this information with a view to close the CQN.

The total number of formal complaints received in December was 61 of 25,425 journeys. Most complaints are regarding timeliness of journeys for outpatient appointments.

G4S are currently working on a complaints trend analysis and providing feedback to providers and commissioners on lessons learnt.

Type	Jul	Aug	Sep	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Complaint	18	9	8	18	9	8	10	14	10	17	42	56	17	30	41	29	38	64	69	76	61	601
Concern	111	77	31	111	77	31	23	50	66	62	113	90	41	47	34	3	8	4	8	16	10	794
Service to Service/Datix	103	54	69	103	54	69	50	26	46	44	60	41	20	64	71	73	74	72	62	53	39	1021
Grand Total	232	140	108	232	140	108	83	90	122	123	215	187	78	141	146	105	120	140	139	139	100	2416

Patient engagement, communication and satisfaction survey December 2017

There were a total of 620 responses on the patient satisfaction for December (2.4 per cent of journeys). G4S acknowledges that the number of responses is lower than it could be and are working to increase their feedback rate. Analysis of the current feedback received across the contract is detailed in the table below and feels to be predominantly positive or neutral.

Question	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
We would like you to think about your recent experiences of our service. How likely you are to be to recommend our service to friends and family if they needed to use a similar service?	408	141	54	9	6	2	620

Question	Strongly Agree	Agree	Neither agree or disagree	Disagree	Don't know	Total
When you booked the transport, your call was answered quickly and you were given a clear explanation of the eligibility process?	390	0	226	41	15	672
You were contacted prior to your appointment to confirm the transport?	473	0	140	14	8	635
You arrived at your appointment on time?	488	0	171	10	5	674
If not, someone informed you that your transport was running late?	90	0	83	5	7	185
The ambulance you travelled in was clean and tidy?	533	0	162	4	0	699
The member of staff driving you to your appointment was polite and courteous at all times, offering assistance where needed?	596	0	114	2	0	712
You felt safe and comfortable throughout your journey?	592	0	121	1	1	715

CQC Inspection

In October G4S was the subject of a full CQC inspection which had positive findings and is publically available. It comments on positive, caring staff and fleet procedures while recognising the work being undertaken to improve on training compliance. A link to this report can be found below.

http://www.cqc.org.uk/location/1-2921123651/inspection-summary#transport

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West Kent
Clinical Commissioning Group

G4S Non Emergency Patient Transport – Kent and Medway

Kent HOSC – 27/04/2018

Ian Ayres – Accountable Officer – NHS West Kent CCG

What have been the challenges?

Change in patient activity

Reduction in demand for cars of c. 14%

Increase in escort demands by c. 9%

Increase in ambulances by c. 4%

Increase in length of patient journey mileage

Urgent Care pressures in healthcare services

Increased bed pressures

Rising demand for on the day bookings/discharges

Extreme weather conditions

Late cancellations of appointments

Staffing challenges (Hospitals and PTS)

Road conditions = increased journey time and amended routes

Increased patient concern=increased call volumes in call centre

What have we done?

- Developed remedial action plans to address complaints CCG/G4S
- Development of remedial action plan to address the level staffing at acute sites CCG/G4S
- Employed a dedicated relationship manager to work with providers on challenges and issues G4S
- Worked with local acute providers to address working relationships and communication G4S
- Shared effective discharge processes active in East Kent across other local providers G4S
- Funding third party transport costs during the activity and cost deep dive/"True up" CCG

What has improved?

- Reviewed complaints process and improvement transparency for patients and providers on the process.
- Significant improvement in mandatory training
- Positive CQC report and evidenced progress around associated action plan
- Engagement with local acute providers has increased through the G4S relationship manager
- More active G4S participation in provider internal meetings and boards.
- Maintenance of performance through the use of Third Party transport following the Kings and Guys mobilisation
- Improved Quality reporting from G4S

What next?

- Further monitoring of complaints remedial action plan CCG/G4S
- Call centre relocation to support a more resilient and responsive call answering service G4S
- Joint working with providers on better management of patient flow – G4S/Local providers
- Patient forum engagement meetings – G4S
- Scoping of anticipated activity changes and early horizon scanning for PTS transport changes G4S
- Greater focus on reducing long waits G4S/CCG
- Outcome of “True up” to be agreed CCG

QUESTIONS

Kent and Medway KPI Results September 2017 - February 2018

Lot 1 & 3

Reference and journey type	Required standard	Performance reporting threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	
1a - Journey booked in advance - outpatient arrival.	Patients to arrive on time and no more than 75 minutes prior to their appointment time OR no more than 60 minutes if it is the first appointment of the day for that clinic.	95%	78.0%	77.0%	74.0%	71.0%	76.0%	77.0%	
1g - Outpatient return journey - all bookings.	Return journey patients to be collected within 60 minutes of the identified booked-ready time	85%	77.0%	80.0%	77.0%	78.0%	76.0%	78.0%	
2a - Journey booked in advance - discharge.	Patients to be transported within 60 minutes of the identified booked-ready time	95%	33.00%	36%	36%	47.0%	45.0%	41.00%	Performance was affected due to the severe weather within Kent and Medway. The primary focus during the adverse weather was Renal patients, this affected pre booked and on the day discharges
2b - Journey booked on the day - discharges.	Patients to be transported within 120 minutes of the identified booked-ready time	90%	65.00%	65.00%	65.0%	64.0%	70.0%	69.0%	Performance was affected due to the severe weather within Kent and Medway. The primary focus during the adverse weather was Renal patients, this affected pre booked and on the day discharges
3a - Journey booked in advance - transfer of care.	Patients to be transported within 60 minutes of the identified booked ready time	90%	41.00%	43.00%	30.00%	52.0%	57.0%	54.0%	Performance was affected due to the severe weather within Kent and Medway. The primary focus during the adverse weather was Renal patients, this affected pre booked and on the day discharges
4 - Aborted/ cancelled journeys.	Journeys aborted/cancelled as a result of the PTS provider	0%	0.00%	1.00%	1.00%	1.00%	0.00%	1.00%	
5a - Travel time (up to 10 miles)	Patients travelling up to 10 miles to / from their destination should not spend longer than 60 minutes on either an inward or outward journey	90%	81.00%	81.0%	79.0%	82.0%	83.0%	89.00%	
5b - Travel time (more than 10 miles and less than 35 miles)	Patients travelling between 10 to 35 miles to / from their destination should not spend longer than 90 minutes on either an inward or outward	90%	71.00%	74.0%	73.0%	76.0%	76.0%	83.00%	
5c - Travel time	Patients travelling from 35 to 50 miles to / from their destination should not spend longer than 120 minutes on either an inward or outward journey	90%	59.00%	55.0%	48.0%	55.0%	59.0%	62.00%	

Renal Transport

Reference and journey type	Required standard	Performance reporting threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
1a - Arrival time	Patients to arrive on time and no more than 15 minutes prior to or later than their scheduled appointment	95%	84.2%	87.0%	85.6%	85.0%	82.6%	79.75%
1b - Return Journey	Return journey patients to be collected within 30 minutes of the identified booked-ready time.	95%	83.9%	81.7%	77.0%	75.8%	78.9%	76.79%
1c - On the day bookings and transfers	Patients to be collected within 15 minutes of booked-ready time (requires two hours' notice of booked-ready time)	95%	76.2%	27.0%	66.0%	69.0%	86.7%	68.57%
4 - Aborted/ cancelled journeys.	Journeys aborted/cancelled as a result of the PTS provider	0%	0.0%	0.0%	0.0%	0.0%	0%	0.05%

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Item 10: Kent and Medway Integrated Urgent Care Service Procurement

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 27 April 2018

Subject: Kent and Medway Integrated Urgent Care Service Procurement

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway CCGs.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) On 20 September 2017 the Committee was provided with an update regarding East Kent Out of Hours GP Services and NHS 111. As part of the Committee's deliberations, it agreed the following recommendation:

- *the Committee receives a report about the joint procurement of the Kent & Medway 111 service at its January meeting.*

(b) On 26 January 2018 the Committee considered a written report about the procurement of Lot 1 (NHS 111 and Clinical Assessment Service telephony services across Kent and Medway) and Lot 2 (face-to-face services in North Kent including out-of-hour services and urgent treatment centres). The Committee agreed the following recommendation:

- *RESOLVED that the report be noted and Adam Wickings, Senior Responsible Officer for Kent and Medway Integrated Urgent Care Service Programme, be invited to provide a verbal update to the Committee on 2 March 2018.*

(c) The Committee considered the changes to face-to-face services in North Kent (Lot 2) at its meeting on 14 July 2017.

(d) The Committee was due to consider this item on 2 March 2018; the meeting was cancelled due to the adverse weather conditions.

2. Recommendation

RECOMMENDED that the report on the Kent and Medway Integrated Urgent Care Service Procurement be noted and an update be provided to the Committee at the conclusion of the procurement.

Background Documents

Kent County Council (2017) *'Health Overview and Scrutiny Committee (14/08/2017)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=44860

Kent County Council (2017) *'Health Overview and Scrutiny Committee (20/09/2017)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7788&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (26/01/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7639&Ver=4

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Update Report to Kent Health Overview and Scrutiny Committee

Kent and Medway Integrated Urgent Care Service Procurement

Briefing for the meeting on 2 March 2018

From Adam Wickings, Chief Operating Officer, West Kent CCG, Procurement SRO, on behalf of all Kent and Medway CCGs

Background

The HOSC has received a number of reports about various aspects of Integrated Urgent Care Service (IUCS) during 2017 and received an update in January 2018 with specific regard to the planned procurement across Kent and Medway. This nationally mandated procurement is for enhancing the current 111 service on the basis of a national service specification, with increased focus on integration of the 111 service with local urgent care in and out of hours.

Before January the HOSC received a number of briefings about more local urgent care programmes which included reference to this planned procurement.

- The previous reports included the 'Case for Change' from Swale CCG and Dartford Gravesham and Swanley CCGs about their urgent care programme in July 2017. This included the local face to face urgent treatment services and the telephony (NHS 111 and clinical assessment service).
- West Kent CCG described their future vision for IUCS in September.
- The East Kent CCGs joined into the programme for the telephony services and this was verbally reported to the September HOSC meeting and included within the report on East Kent OOH and NHS 111 in November HOSC.

The CCGs are jointly procuring the telephony element of an IUCS in line with the national specification. A considerable amount of engagement with the public about the planning for an IUCS has been taken in local health economies across Kent and Medway: a report of this can be provided on request.

This briefing is to update members on the IUCS procurement across Kent and Medway.

Service overview

The new integrated urgent care service brings together the current service fragmentation and aims to reduce confusion for patients. Our aim is to provide care closer to people's homes

and help tackle the rising pressures on all urgent care services (primary and hospital) and emergency admissions.

Our preferred choice of access to urgent care services is via the improved NHS 111 service, which will be enhanced with a Clinical Assessment Service (CAS). The CAS will include a wide range of clinicians, including GP's Nurses, Paramedics, and Pharmacists.

Locally within Kent and Medway, and nationally mandated, we will also see the establishment of Primary Care led Urgent Treatment Centres (UTCs), based at the front doors of Emergency Departments (EDs).

These two developments locally, supported by the national specifications, aims to drive a higher level of clinical intervention and thus a reduction in unnecessary ED attendances and hospital admissions.

There will be joint clinical governance arrangements across the services and an active collaboration with the developing GP cluster/federations and the more specialist providers such as mental health and local care closer to home.

The service overall will cover all 9 elements of the national IUCS specification: https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf

The face to face element will also meet the national Urgent Treatment Centre specification:

https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf

Procurement process update

Kent and Medway are working together to procure the IUCS. A programme board has been established, including clinical leads, CCG executive leads and Healthwatch colleagues. This board is steering the procurement programme, with the decision making remaining with individual CCG governing bodies. Since the January HOSC meeting, a business case has been approved at 6 of the 8 CCG governing body meetings and is due for consideration at the last two on 22 February. Procurement is due to commence immediately after the CCG governing body approvals are completed. Due to the commercial sensitivity of procurement, the case is being considered in Part 2 of the private GB meeting.

The service is being procured in two lots, the first being the current NHS 111 services, with an increased level of clinical support and across the Kent and Medway footprint. The second is for face to face UTCs and out of hours primary care services for Dartford, Gravesend and Swanley, Swale and Medway CCG areas. The specification closely follows the national requirements.

<table>
<tr><td>Telephony Services</td><td colspan="6"><u>LOT 1</u>

<u>KENT & MEDWAY CCGs:</u>
NHS 111 / ICAS – Commencing 1 April 2019</td></tr>
<tr><td></td><td colspan="6"></td></tr>
<tr><td rowspan="5">Face-to-Face Services</td><td colspan="6"><u>LOT 2</u>
<u>DGS/Swale/Medway CCGs:</u></td></tr>
<tr><td colspan="2"><u>DGS CCG:</u></td><td colspan="2"><u>SWALE CCG:</u></td><td colspan="2"><u>MEDWAY CCG:</u></td></tr>
<tr><td colspan="2">Urgent Treatment Centre at Gravesham Community Hospital</td><td colspan="2">Two Urgent Treatment Centres (+ mobile facility) at Sheppey Memorial Hospital and Sheppey Community Hospital</td><td colspan="2">Urgent Treatment Centre at MFT</td></tr>
<tr><td colspan="6">P-led-out-of-hours (base site and home visits)</td></tr>
<tr><td colspan="3">Phased mobilisation:
GP-led OOH – 1 April 2019
UTC – 1 July 2019</td><td colspan="3">Commencing
1 April 2019</td></tr>
</table>

Existing contracts for the relevant services are coming to an end in March 2019 and therefore the procurement is on a timeline to commence the redesigned services by 1 April 2019, with a phased implementation for the urgent treatment centres in Dartford, Gravesham and Swanley and in Swale.

Benefits of the Integrated Service model:

The Integrated Urgent Care service will simplify the system for patients. It will provide greater access to clinical advice, will allow direct booking for face to face appointments where required – in urgent treatment centres or with a local GP. It will reduce the current duplication and fragmentation between different parts of the system.

The combination of procuring a telephony provider (including clinical assessment) across the whole area, and having the local face to face services embedded within each community are significant:

- Economy of scale for telephony & CAS with resilience.
- Local integration for face to face services – front door of Emergency Departments (where possible), linking Primary Care Services and Urgent Treatment Centres, enabling booked appointments and 'walk in' urgent care.
- Able to work closely with developing primary care organisations
- Collaboration between providers through integrated governance
- Opportunities for formal provider partnerships and/or bids for several lots

There are challenges, not least the workforce and digital infrastructure to support the model. The potential providers will be asked to provide innovative solutions to the challenges and to demonstrate how they will respond to local needs.

Timescale and next steps

The specifications for the two lots have been developed over recent months with a wide range of engagement on the model with clinicians, local providers, patients and public. The specifications follow closely the national requirements for Integrated Urgent Care and for Urgent Treatment Centres with the emphasis on relationships and collaboration between the different parts of the system. The final CCGs are considering whether to approve the procurement on the 22nd of February with the intention of then initiating the procurement process in late February 2018.

The expectation is for evaluation of the providers and approval of preferred bidders by August 2018 to allow for almost eight months of mobilisation prior to going live April 2019.

Healthwatch, clinicians and the relevant specialists are working with the commissioners on the evaluation criteria and participating in the evaluation process.

Once the preferred bidder is identified and the contract awarded, a detailed mobilisation plan will be agreed and implemented, working with a wide range of partners in the system.

We will be happy to come back to HOSC to provide further updates in due course.