HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 11th October, 2013

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 11th October, 2013, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Tristan Godfrey**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
UKIP (3):	Mr L Burgess, Mr J Elenor and Mr R A Latchford, OBE
Labour (2):	Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor C Woodward, Councillor Mr M Lyons, and Councillor S Spence (one vacancy)

Webcasting Notice

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UNRESTRICTED ITEMS

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

Item	Timings
1. Introduction/Webcasting	

2. Substitutes

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

4. Minutes (Pages 5 - 12)

5. Meeting Dates 2014

   The Committee is asked to Note the following dates for meetings in 2014:

   Fri, 31 January
   Fri, 7 March
   Fri, 11 April
   Fri, 6 June
   Fri, 18 July
   Fri, 5 September
   Fri, 10 October
   Fri, 28 November

6. East Kent Outpatients Consultation: Written Update (Pages 13 - 20) 10:00

7. Patient Transport Services (Pages 21 - 34) 10:05

8. Health and Wellbeing Board: Update (Pages 35 - 36) 11:15

9. Date of next programmed meeting – Friday 29 November 2013 @ 10:00 am

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
(01622) 694002

3 October 2013

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 Darent Room, Sessions House, County Hall, Maidstone on Friday, 6 September 2013.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr L Burgess, Mr N J D Chard, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr A J King, MBE, Mr R A Latchford, OBE, Mr G Lymer, Cllr M Lyons and Cllr Chris Woodward

ALSO PRESENT: Cllr Mrs A Blackmore and Cllr R Davison

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest

(a) Mr Nick Chard declared a personal interest in the Agenda as a Non-Executive Director of Health Watch Kent.

(b) Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes
(Item 4)

(a) It was highlighted that page 1 of the Minutes Section 3(a) should read 'one of the issues.'

(b) RESOLVED that, subject to this amendment, the Minutes of the meeting of 19 July 2013 are correctly recorded and that they be signed by the Chairman.

4. Forward Work Programme
(Item 5)

Felicity Cox (Kent and Medway Area Director, NHS England) was in attendance for this item.

(a) Approval was expressed of the idea of visiting the Deal Hospital site as it had been the subject of a recent public meeting. It was suggested that a visit to the Buckland Hospital site could also be included. The Chairman undertook to look into what could be arranged.

(b) The subject of winter planning by acute hospitals was raised. Felicity Cox explained that through the Urgent Care Board, she would be able to make available to the Committee the winter plans once they had been signed off.

(c) Clarification was sought about the Adult Mental Health Inpatient Services Action Plan suggested for January 2014. It was explained that this was a specific report arising from the work of the Kent and Medway NHS Joint Overview and Scrutiny Committee and did not preclude the Committee considering other mental health issues. The topic of Child and Adolescent Mental Health Services (CAMHS) was mentioned. It was explained that the Corporate Parenting Panel received quarterly updates on this topic. The Vice-Chairman explained that CAMHS was a complex subject and it would be a question of the most appropriate time to consider the subject given that there was a relatively new provider. The Chairman and he were to meet with Mrs Whittle soon and a suggested date would be brought to the next meeting of the Committee.

(d) The request was made for the Committee to have the opportunity to hear from the CCGs across Kent, perhaps in geographical clusters, as soon as possible and the Chairman explained that this was being actively pursued.

(e) AGREED that the Health Overview and Scrutiny Committee note the report.

5. Medway NHS Foundation Trust: The Keogh Review
(Item 6)

Mark Devlin (Chief Executive, Medway NHS Foundation Trust) and Felicity Cox (Kent and Medway Area Director, NHS England) were in attendance for this item.

(a) The Chairman of the Committee welcomed the Chief Executive of Medway NHS Foundation Trust (MFT) who then proceeded to introduce the item. Mr Devlin explained that following the publication of the Francis Report, 14 Hospital Trusts across England were selected on the basis of having been outliers for 2 years in one of 2 mortality statistical measures – Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). Sir Bruce Keogh was asked to investigate why the statistics were as they were and to ensure that the hospitals were improving. The Trust was visited by a 25 strong group involving active clinicians, regulators and local Clinical Commissioning Group (CCG) representatives. There was an announced visit followed by a second unannounced visit. Public meetings were held in Chatham and Sheppey. MFT was one of only 2 Trusts out of the 14 which had no issues escalated to regulatory bodies. The review concluded that there was good practice at the Trust, but that it was inconsistent; Mr Devlin agreed this was fair comment. Some of the improvements to be made could be undertaken solely by the Trust but some would involve the assistance of other bodies.

(b) It was further explained that most of the recommendations made by the review were in progress anyway. An example was given of the mortality working party set up by the end of 2012. This was chaired by the Medway Director of Public Health and involved Trusts with a good record around mortality. There were 50 points in the action plan and there were 6 areas where improvements were to

be focused and these were set out in the Agenda on pages 38-40. HSMR and SHMI were useful as a 'smoke alarm' but did not tell the whole story of what as happening in a hospital. The SHMI at MFT was now at the lowest it had ever been and while the HSMR was still at 12, this was an improvement on the previous year.

(c) MFT was the busiest hospital in Kent and getting the right skill mix was central to being able to deliver 24/7 care. A review of the nursing and midwifery establishment was underway. More acute physicians were being recruited and there was a clear correlation between their numbers and safety. 25 consultants were being sought and 16 had already been recruited, all high calibre candidates. In response to a question, it was acknowledged that staffing levels were lower at weekends and at holidays and that this was being looked at. On the other hand, in response to being asked whether MFT would have responded as well as it had to the previous day's major traffic accident on the Sheppey Crossing if the accident had occurred on a Sunday, Mr Devlin explained that it would. He was proud of the way the hospital had dealt with the Sheppey Crossing accident and the MFT accident and emergency department was resilient. Consultants were always available on call and the hospital was set up as a trauma unit.

(d) There was however a need to redesign the accident and emergency department, which saw 90,000 patients a year and had limited floor space. There was also a need to ensure staff were properly supported and to improve patient flows to the community. The local Urgent Care Board would be essential in steering this. Further information was given by Felicity Cox, representing NHS England. There were good reasons for thinking that MFT would be able to access significant funds from the money announced by the Department of Health to assist emergency care. In addition, there had been discussions about Swale CCG's 2% transition funding being available for the accident and emergency department at MFT. More generally, the Trust faced the challenge of an old estate.

(e) In response to a specific question about the action plan, it was explained that there was a mechanism to regularly review the governance mechanisms at the hospital and so this would have been done anyway. The action plan was a live document, one which had originally been endorsed by the Board in June. The HOSC Agenda pack contained version 9 and the Trust were now on version 11. 90% of the actions would be completed within 6 months, with the date of the latest set for June 2014. MFT had a legal undertaking with Monitor to achieve the action plan and there was a recovery plan with the Kent and Medway Quality Surveillance Group as well. There was 3,700 staff at MFT and the improvement methodology would first be spread to the top 50-60 clinical leaders before being spread to the rest of the workforce. This shared improvement methodology would ensure consistency.

(f) In response to another question about the action plan, it was explained that a refresh of the executive team was underway and had been for the last 6-9 months. There were the same number of directors, but the job titles had changed in some instances. This was done to emphasise the need to change some deeper rooted cultural challenges at the Trust. In response to a specific

request, the offer was made to supply the Committee with an organogram of the hospital.

(g) On the need to improve the public reputation of the Trust, it was acknowledged that this was a challenge and that this had got harder because of the Keogh Review. The Committee were asked for any thoughts and comments. It was explained that the most recent Annual General Meeting had been held in the form of a listening exercise. The Chief Executive explained that he did often spend time talking to patients, sitting with them in outpatients or helping on a meal round and he wanted more senior staff to do the same.

(h) In response to a specific question, it was explained that in the action plan short term meant up to 3 months, medium term meant 3-6 months and longer terms meant longer than that. It was also confirmed that the action plan had also been to the equivalent Committee at Medway Council.

(i) Further questions were asked about the mortality statistics. The impact of the relatively higher level of deprivation in Medway was asked about and it was explained that both mortality indicators should take this into account. The Trust was able to drill down into the data, which was very useful. One area highlighted was the number of patients at the end of their lives who were admitted to MFT. This was partly because there was not a hospice for adults in the area. It was not always appropriate to send an elderly patient by emergency ambulance to hospital when they required end of life care. More needed to be done to ensure people's wishes about end of life were taken into account and acted on. Several Members agreed this should be a priority area to develop.

(j) The Committee proceeded to discuss possible recommendations. In addition to the recommendation, it was suggested that the Chairman write a letter to Mr Devlin expressing the Committee's gratitude to him and the staff of MFT for the way they responded to the previous day's accident on the Sheppey Crossing. The Chairman thought this was a good idea and undertook to do this.

(k) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their attendance and contributions today, asks that they take on board the comments made by Members during the meeting particularly with regards end of life care and looks forward to receiving further updates in the future at the appropriate time within the next twelve months.

(l) AGREED that the Committee thanks its guests for their attendance and contributions today, asks that they take on board the comments made by Members during the meeting particularly with regards end of life care and looks forward to receiving further updates in the future at the appropriate time within the next twelve months.

6. West Kent CCG: Mapping the Future
(Item 7)

Ian Ayres (Chief Officer, NHS West Kent CCG), Dr Bob Bowes (Chair, NHS West Kent CCG), Felicity Cox (Kent and Medway Area Director, NHS England) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(a) The Chairman introduced the item and welcomed representatives of NHS West Kent CCG as the first CCG to bring their strategic plans to the Committee.

(b) Dr Bowes presented an overview and began by explaining that the Mapping the Future programme was a long term project aimed at dealing with the funding shortfalls of £20 million each year. With an ageing population and long terms conditions on the rise, if no changes were made there would be a £62 million shortfall in the next five years. In the past, old style management consultant exercises had been carried out to identify efficiencies. These had gone nowhere as providers had not been involved. The Mapping the Future programme involved them, commissioners, and the public in the redesign, with 4 different clinical scenarios used to develop ideas. Seeking the views of HOSC was a core part of this engagement exercise. There was a diagram on page 73 of the Agenda which set out how the relationship between the sectors of the health economy could be redone.

(c) All of this was underpinned by a tremendous data challenge and the Department of Health was working with GPs to work out the best way to use data effectively and be able to share it across organisations.

(d) A question was posed about how Mapping the Future was being publicised and communicated. The offer was made to send the Committee a written report setting this out in more detail.

(e) A question was posed about the structure of the health service and whether this meant organisations were more in silos than in the past. It was conceded that there were more autonomous organisations but now that 5-6 years of expanding budgets had ended, there was more of an emphasis on collaboration. CCG representatives explained that 3 key ideas had come out of Mapping the Future workshops. First, it was recognised that continuing to do the same things, but working harder and faster, would buy a little bit of time but there was rather a need to do something fundamentally different. Second, there was a recognition that all sectors were impacted and needed to respond and act. Third, there was increasing acceptance of the idea of 'the Kent Pound.' This phrase was used as shorthand for the recognition that there was only one finite sum of money for health and care across Kent and health and social services needed to work together, if debt was not to be just moved around the system.

(f) A number of specific questions were asked about the financial structure of the new NHS, some of which were more generic than specifically about West Kent. On behalf of NHS England, Felicity Cox undertook to provide the Committee with a breakdown of how the funding flowed down the NHS structure. CCG representatives explained that CCG's provided no services but were the commissioners of the majority of health services in Kent and so held contracts with the various providers. West Kent CCG received approximately

£1,000 per head of population, with a fixed £25 per head for administration. This funding was lower than for other areas of Kent and it was explained that it was not a straightforward capitation funding system. There was a complex funding formula which had been in use for a number of years and this gave a heavy weighting to deprivation but less to age. As a consequence, West Kent also received a smaller amount per head of population than other areas in the days of Primary Care Trusts. The Department of Health and NHS England were looking at future models of funding. On a capitation model, West Kent CCG would receive an additional £40 million annually.

(g) It was also explained that CCGs commissioned healthcare for all people in their geographical area and this included the responsibility for funding the healthcare of people resident in the area who fell ill and/or received treatment in different CCG areas. There was a discussion with Members about the size of CCGs with the view being expressed that West Kent CCG was too big to respond to local concerns. In response it was explained that West Kent CCG mapped the area broadly covered by Maidstone and Tunbridge Wells NHS Trust and that CCGs needed to be a certain size to be effective and that this did not mean the local dimension was lost.

(h) There was also a discussion on the possible tension between putting patients first and balancing budgets. CCG representatives explained that fiscal responsibility was the best means to ensuring patients needs were met. If a service was not sustainable and ceased to function, this would not be in anyone's interest. The view was expressed that the balance was too much in favour of the hospital sector historically. It was not that hospitals hung onto patients in order to make money but rather there was a need to share skills and responsibilities in order to enable patients to be transferred. Another challenge was that the tariff for services did not always match the real costs.

(i) In response to a specific question, it was accepted that Borough/District Councils should be listed in the Mapping the Future document as stakeholders.

(j) The value of pharmacies was raised and acknowledged. However, there was discussion of some oddities in the pharmacy system. There were a number of drugs where the cost of them was much less than the prescription charges but they were not available without a prescription and a charge being made. In response to a specific example being described, it was explained that there were occasions when paracetamol was prescribed. There was a limit to 32 of the number of paracetamol which could be purchased over the counter. Some people required a larger amount and a prescription was issued, though this would normally only be to patients who received free prescriptions anyway. If paracetamol was prescribed to someone who needed to pay, this was most likely an oversight.

(k) In response to another specific example, it was explained that the GP contract meant the practice should be available in some form between 8.00 am and 6.30 pm, Monday to Friday, even if the surgery was physically closed. The surgery should not close at lunchtime and just provide a telephone message asking people to call 111. If this was the case, Felicity Cox as the

representative of NHS England, which held GP contracts, requested the name of the practice.

(l) On the topic of GP opening hours, the question of their being inconsistent across Kent was raised by Members. It was explained that practices had a choice between cutting costs and expanding services and this tension was not new. The view was expressed by Members that GPs could work longer hours to assist with access and reducing attendances at accident and emergency departments. Both GPs in attendance countered that they were both working longer hours than in the past and this was not practical.

(m) The Mapping the Future programme would continue to develop and more detail as to how the ideas in it would be progressed would be forthcoming in the future. It was also explained that the Mapping the future programme involved a wide range of clinicians and these had experience of good practice both nationally and internationally.

(n) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their attendance and contributions today, asks that they take on board the comments made by Members during the meeting and looks forward to receiving further updates in the future.

(o) AGREED that the Committee thanks its guests for their attendance and contributions today, asks that they take on board the comments made by Members during the meeting and looks forward to receiving further updates in the future.

7. Date of next programmed meeting – Friday 11 October 2013 @ 10:00 am
(Item 8)

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 October 2013

Subject: East Kent Outpatients Consultation: Written Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the East Kent Outpatients Consultation.

It is a written update only and no guests will be present to speak on this item.

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

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1. Introduction

(a) Representatives from East Kent Hospitals University NHS Foundation Trust attended the meeting of this Committee on 7 June to discuss the Trust's developing clinical strategy.

(b) The outpatients' strategy was one of the areas of particular focus during this meeting. The recommendation agreed by the Committee on 7 June was the following:

- AGREED that the Committee thanks its guests for their attendance and contributions today, agrees that the proposed changes to outpatient services and breast surgery services do represent a substantial variation of service and look forward to receiving further updates in the future; and also requests that East Kent Hospitals NHS University Foundation Trust take on board the Committee's comments regarding public consultation before the Trust takes any final decision on wider consultation.

(c) Further information is contained in the attached report from East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group.

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to note the report.

Background Documents

Agenda, Health Overview and Scrutiny Committee, 7 June 2013,
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5073&Ver=4

Minutes, Health Overview and Scrutiny Committee, 7 June 2013,
https://democracy.kent.gov.uk/documents/s41448/Minutes%2007062013%20Health%20Overview%20and%20Scrutiny%20Committee.pdf

Appendix to Minutes, Health Overview and Scrutiny Committee, 7 June 2013,
https://democracy.kent.gov.uk/documents/s40889/Appendix%20to%20Minutes%20-%207%20June%202013.pdf

Contact Details

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Outpatients Consultation: An update

1. Introduction

1.1 As part of East Kent Hospitals University Foundation Trust clinical strategy the Trust has been examining how it can improve outpatient services for the residents of east Kent. In surveys, patients have indicated that they want improvements in accessibility to outpatient services and to see a reduction in the number of visits they have to make to agree their treatment plan.

1.2 The aim of the review is therefore to improve both the quality of the Trust's outpatient services and make the service more accessible for patients, thus reducing the number of journeys they have to make to receive their treatment plan.

1.3 In June the East Kent Hospitals University Foundation Trust briefed the Health Overview and Scrutiny Committee on its progress and plans for taking forward the clinical strategy and the plans around improving outpatient services.

2. Context

2.1 Currently outpatient services are provided from 22 sites across Kent. The ways in which the clinics are currently organised is not providing the best service to our patients. Many of the facilities could be modernised and they offer only a limited number of clinical support services such as diagnostics. Although there are a large number of geographical sites where outpatient clinics are held, some of these are very small and infrequent. There is also an inconsistency about what is offered where and there are still a number of patients travelling further than they need to for their clinical outpatient appointment. In addition, patients are often required to make visits and attend multiple sites for their full assessment and treatment.

2.2 The Trust proposes providing a wider range of services across six sites, which will allow a significant improvement in the number of patients able to access outpatient services within a 20 minute drive time. On these six sites there will be a better range of diagnostic and treatment facilities that will allow the Trust to develop a "one stop clinic" approach. The Trust also aims to improve access by rearranging clinic times so that clinics are available for longer hours, including early evening clinics, as well as clinics on a Saturday morning, which will better meet the needs of our population.

2.3 The Eastern and Coastal Kent Primary Care Trust previously consulted the public on "The Dover Project – Your Say" and the affect it would have on services provided in Dover, Deal and the surrounding areas. As a result the Trust is investing £23m to rebuild the facilities at Dover to provide up-to-date, modern facilities for the south Kent coast population. It will, over the next few years, also improve the outpatient facilities at its four other sites. The Trust will also be looking to consolidate and improve its outpatient services on one site on the North Kent coast, making the sixth outpatient clinical hub.

2.4 The Trust also aims to improve patients' experience by streamlining arrangements for making appointments, increasing car parking and investing in public transport to all six sites.

2.5 Innovations such as telehealth and telemedicine may also mean further improvement by reducing the number of appointments needed to monitor patients' progress. This technology could also allow hospital teams to communicate with GPs and patients directly preventing, where appropriate, a further appointment for a hospital visit.

3 Public Consultation

3.1 As agreed with the HOSC in June, the Trust will discuss this more widely with the public to make sure that we listen to and consider the views of the communities we serve, taking care to involve staff groups who will potentially be asked to work differently.

3.2 NHS Canterbury and Coastal Clinical Commissioning Group confirmed that it wishes to undertake this consultation in partnership within its locality, to understand the views of local patients, staff and residents. This paper sets out the consultation plans for the HOSC, as requested.

3.3 The objectives of the Public Consultation process are therefore to:

- raise awareness of the proposals for outpatient services with all stakeholder groups;
- provide information so that people can respond effectively; and
- listen to the overall response from stakeholders, staff, patients and the public concerning the proposed changes to outpatient services.

3.4 As part of the formal consultation process, we will ensure there are various means for people to contribute their views:

- There will be a dedicated page on both the Trust and CCGs website with all the pertinent information and an online survey and dedicated email address.
- Printed copies of the main consultation document and summary document will be widely available on hospital sites and at current outpatient clinics, in GP practices, leisure centres and community centres.
- There will be 10 public meetings held over the 13 week consultation process to enable anyone who wishes to attend and discuss their views first hand with staff and clinicians. These will be held at various times and in a wide range of venues to ensure accessibility.
- All stakeholder organisations will be offered the opportunity to invite staff to attend a meeting and provide information about the plans and record their views.

- There will be a series of focus groups with those individuals or communities who are unlikely to contribute their views through the usual routes.

4 Proposed process and target audience

4.1 The approach to public meetings proposed for the Outpatients consultation is a round the table workshop and interactive activity, to capture stakeholders' feedback. The workshop style approach should ensure that people are able to discuss how to improve outpatient services. Each table top discussion will enable attendees to contribute their views on how to improve services, discuss the options for the north Kent coast and ask questions about the practical impact of these plans.

4.2.1 There will be a visual display and written information available (including the consultation document and detailed information on issues which affect the plans, such as the improvements to car parking and public transport which the Trust has underway). Copies of the consultation summary documents will also be available for attendees can take away with them.

4.2.2 An animation film has been produced, which explains how the proposed outpatient one-stop service works. It should also be possible to pre-record interviews with key staff and patients, which then can be played during the events for those who prefer visual and audio presentations. These could also be put on *YouTube*, linked via the web page and promoted through social media.

4.3 There will also be provision to manage those attending raising individual issues directly with support staff or through messages on a graffiti wall for free comments.

4.4 It is proposed that a minimum of 10 public events are held in different parts of the county each lasting up to three hours. These events will be heavily promoted through local press, voluntary sector communications, on community notice boards etc. The proposed locations are:

- Margate;
- Canterbury;
- Whitstable;
- Herne Bay;
- Faversham;
- Deal;
- Dover;
- Folkestone;
- Hythe or Dymchurch; and
- Ashford.

4.5 The round table approach will aim to diffuse any confrontational attitudes, enabling people to find out about the proposals in a non-threatening environment and focussing them on the areas that most interest them. It also provides an

opportunity to capture quantitative and qualitative feedback from a wide range of people.

5 Target audience

Patients, carers and the public
EKHUFT staff
Council of Governors
GPs
Clinical Commissioning Groups
Local authorities and Borough councils
Kent Community NHS Trust
Mental Health Trusts
Social Services
NHS Property Company
South East Coast Ambulance Trust
Kent hospital trusts
Kent Health Overview and Scrutiny Committee
Kent Healthwatch
MPs
Unions, staff communication and professional bodies
EKHUFT members
Patient user groups
Volunteers, League of Friends
Voluntary and community organisations
LMCs, royal colleges, professional bodies etc.
NHS and independent community providers

6. Timescales

6.1 The detailed preparations for consultation are underway at the moment and the documents are being drafted.

6.2 It is proposed therefore that the formal public consultation will commence in mid-December 2013 (final date subject to Boards' approvals and printing timescales) and will run through to mid-March 2014.

6.3 The analysis of responses will be conducted by an independent University research team during March and early April, so that the two organisations are able to consider the responses received in late April / May.

7. **Consultation activity plan**.

Activity	Timeframe
People have enough information about the proposals to form a view	
Produce written consultation document and supporting materials	Final draft document 29.11.2013
Produce video presentations and pre-recorded interviews for use at events and for website	October

Develop on-line / web information	Web info complete by w/c 1 Nov, maintained throughout
Work with media to ensure accuracy of public information	Mid-November then throughout Consultation
Raise awareness of the consultation among local population including targeted information to the EKHUFT/C&C membership etc.	Materials ready first week in Dec in time for launch mid-December.
People have opportunities to respond to the consultation, ask questions and propose alternatives	
Identify all stakeholders including those impacted by the proposals and identify method of engagement	Complete by w/c 18.10.2013
Establish means to receive feedback - email, freepost, text, phone,	In place by 11.10.2013
Develop an electronic feedback mechanism	In place first week in Nov
Utilise and monitor social media (Facebook / twitter etc)	To go live in Dec then maintained throughout
Hold a minimum of 10 open public workshop events across the county to provide local people the opportunity to find out more, ask questions and share their views	Events spread across Dec to Feb 2014
Hold series of events to ensure membership, governors and staff are well briefed and able to contribute their views	Early Jan, Feb, Mar
Offer presentations and discussion at externally hosted meetings, forums and networks	Attendance at foras throughout consultation
Hold a series of focus groups targeted at those identified via the Equality Impact Assessment process as potentially being specifically impacted by the proposals	Dec to Feb
Hold meetings with all district / borough councils and MPs	Dec to Feb
Place adverts in local papers, seek editorial coverage to supplement attendance, adverts in shopping arcades	Dec to Feb
Governance	
Establish and maintain process logs - risk register, lessons learned log, audit trail	In place by w/c 20 Sep
Establish Consultation working group	18.9.2013
Arrange independent analysis of consultation feedback	Commission by 4.10.2013 survey by 18.10. sign off 25.10.
Arrange independent analysis of consultation	

process	
Hold stakeholder feedback event following consultation	April feedback to main stakeholders, Board decision end of May

8. For information

This progress report is for the committee to note. If two or three HOSC members would like to volunteer to read and comment on the draft consultation document to assist us in ensuring it is written in a clear and accessible style,we would be happy to share the next confidential iteration of the document with those volunteers.

We anticipate that the next report to the HOSC will be after the consultation responses have been received and analysed by an independent university research team in April of next year.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 October 2013

Subject: Patient Transport Services

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

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

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1. Introduction

(a) The following is a definition of Patient Transport Services from the Department of Health:

- *Non-emergency patient transport services, known as PTS, are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients' medical needs.*[1]

(b) The Health Overview and Scrutiny Committee most recently considered the subject of PTS on 1 February 2013. This followed information provided by NHS Kent and Medway that following a procurement process, NSL Care Services had been chosen as the preferred provider on non-emergency PTS. The minutes of this part of the 1 February meeting are appended to this report.

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the reports from West Kent CCG and NSL Care Services.

Appendices

Extract from HOSC Minutes 1 February 2013.

[1] Department of Health, *Eligibility Criteria for Patient Transport Services (PTS)*, 23 August 2007, p.7, http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_078372.pdf

Background Documents

Department of Health, Eligibility Criteria for Patient Transport Services (PTS), 23 August 2007,
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_078372.pdf

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Appendix – Extract from HOSC Minutes 1 February 2013.

4. Patient Transport Services
(Item 5)

Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway), Deborah Tobin (Senior Project Manager – Patient Transport, NHS Kent and Medway), Alastair Cooper (Managing Director - Care Services and Passenger Transport, NSL Care Services), Felicity Cox (Chief Executive, NHS Kent and Medway), and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(a) Members were reminded that this was a topic the Committee had looked at previously and were aware that the Patient Transport Service (PTS) was being tendered. There were two lots to the tender. The first was to run a single call centre, and the second was to run the PTS itself. NHS representatives explained that NSL Care Services had been awarded both lots. This company's bid was ranked top on quality. It was also competitive on price, but was not the cheapest.

(b) NSL Care Services ran other PTS services and the call centre for all these services was in Shrewsbury. It was explained that this call centre would receive the calls for PTS in Kent and book the journey, but the actual planning would be undertaken locally in Kent. A series of questions were asked about how local knowledge was factored in. The example was given of the existence of three towns or villages named Newington in Kent. NSL Care Services explained that the script used in the call centre got bookings pinpointed to a specific address, house number and street, and this made up for those occasions when no postcode was known by the caller. It was explained that the 999 services did not always have postcode information either. In addition, there was liaison with the locally based service planners.

(c) A number of Members expressed concerns about situations where patients were discharged from hospital late at night and anecdotal evidence was provided of people being left outside their homes unable to get in following discharge. NHS representatives explained that late night discharge did happen on occasion, but it should be avoided where possible. It was also commented that patients attending accident and emergency departments who were then not admitted to hospital may be discharged at night as well. The duty of care was transferred to the PTS provider and NSL Care Services explained that it was part of their training of staff to ensure people were not abandoned. Where a home could not be accessed, or was uninhabitable, alternatives would be sought and this might involve returning them to hospital. No person would be simply abandoned.

(d) In response to a specific question, NSL Care Services explained that volunteer drivers were used in some of its other areas, such as Lincolnshire. Volunteer drivers were checked out in the same way as

permanent or bank staff. Volunteer drivers were often preferred due to their local knowledge, particularly in rural areas.

(e) Developing this theme, it was explained that part of the service specification involved the requirement to refer callers who were not eligible for PTS to other services which may be able to help, such as volunteer driver services. These alternatives were not run by the NHS, but their value as a supplement was readily acknowledged. A directory of locally available services was being pulled together to enable accurate assistance to be given. The large provider Trusts in Kent were providing information on the transport services they knew about and this work would continue. No service in the country was able to list all the available services, but it would expand and develop over time.

(f) Specifically relating to PTS for patients with mental health needs, a Member of the Committee commented that this was an area where dissatisfaction with the service had been expressed in the past. It was added that the eligibility criteria may or may not apply to individuals as their condition changed over time. In response it was explained that work was being done with Kent and Medway NHS and Social Care Partnership Trust on linking directly with user groups to target them specifically.

(g) The Committee were informed that clinicians could book PTS directly, either by phone or by logging on electronically. The same questions were asked of the clinician booking and so the same eligibility criteria applied; there was no question of a clinicians' judgment being second-guessed. In response to a specific follow-up, the Committee were informed that patients were eligible from the time of their GP referring them to a consultant and it did not need to wait for a diagnosis to be confirmed.

(h) PTS was a service free to the user. It was explained that there was a separate Healthcare Travel Costs Scheme (HTCS) available through hospitals. Some patients would be able to claim reimbursements for travelling to access healthcare.

(i) A specific question about accessing services was asked giving the example of an elderly person needing to have tests done regularly due to being prescribed Warfarin. The answer was given that PTS did not cover accessing primary care services. However, in the case of Warfarin, there was a domiciliary service available through GP practices. A nurse should be able to visit the particular patient, negating the need to travel.

(j) On the topic of escorts accompanying the patient, it was explained that clinical escorts were covered by the eligibility criteria, and other escorts might be; this was an area where there was a need for consistency.

(k) It was reported that the eligibility criteria used in Kent and Medway was slightly more generous than the national requirements for PTS. There was a debate around whether more people should or should not be covered by the eligibility criteria. Part of this discussion involved questions about what proportion of patient journeys were undertaken by PTS. The view was expressed by NHS representatives that this was not an especially useful figure to look at as health needs changed; the important point was for 100% of those eligible to be transported. Information would be provided to Clinical Commissioning Groups (CCGs) about PTS usage. This would help identify any gaps in the service. The eligibility criteria may be reviewed in the future. A CCG representative explained that there were difficult choices to be made in commissioning. Including more people in the eligibility criteria meant less money for other services. There was an element of regret in any choice.

(l) Members and health sector representatives agreed on the need to publicise the PTS service effectively and a communications plan had been developed.

(m) In response to a specific question about where the vehicles would be based, it was explained that NSL Care Services were seeking five bases in Kent and Medway. Along with admin facilities to enable planning, these would need to be secure compounds for the parking of both PTS vehicles and cars belonging to staff.

(n) The Chairman proposed the following recommendation:

- The Committee thanks its guests for their contribution, notes the report and looks forward to further updates in the future.

(o) AGREED that the Committee thanks its guests for their contribution, notes the report and looks forward to further updates in the future.

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Report to Kent County Council Health Overview and Scrutiny Committee

11 October 2013

Patient Transport Services

Background

NHS Kent and Medway agreed to tender the non emergency patient transport services in July 2011, following concerns raised by the Kent and Medway LiNK in 2010. A report describing the procurement process was brought to the Health Overview and Scrutiny Committee in March 2012. Following award of contract, a report on mobilisation was brought to the Committee in February 2013.

This paper summarises the process to put the new service in place, describes the key elements of the service and outlines the process by which commissioners are managing the implementation since the service went live on 1 July 2013.

Procurement and Implementation process

The previous services were delivered in a variety of ways from in house provision by acute providers, the emergency ambulance service and a range of ad hoc and private contracted arrangements. There was no means of assuring the services provided and the LiNK report identified a number of issues including a lack of consistency in eligibility and issues with booking arrangements.

A project board, led by commissioners managed the process and continues to meet through implementation. The board includes patient representatives and senior managers from the Trusts and the Provider. This project was scoped and services were discussed at length with existing Kent and Medway providers and providers/commissioners from other parts of the country.

Specifications were then developed for the Patient Transport Service Centre who handle the bookings and for the transport service itself. Both specifications were developed with PTS Commissioners, patients, carers and staff/managers at each of the Trusts and in line with successful services in other areas.

Prior to a two stage procurement process, the criterion for evaluation was agreed by the Board. A significant number of patients, commissioners, staff and senior managers at the Trusts evaluated both stages of the tender process.

After shortlisting through a Pre-Qualifying Questionnaire, six organisations were invited to tender and five submitted bids. The bids were then evaluated by a team of existing service managers, patients and commissioners with subject matter experts (including clinical quality, information governance, finance, human resources, emergency planning and others). The scores were then anonymised outside of that immediate group of evaluators.

The bids were scored based on 60% Quality and 40% price. NSL Care Services were selected as the preferred provider with the highest scores for quality in both the service centre and the transport service. Commercially, their price was within the

amount identified in the tender, although it was not the lowest for the transport service.

Prior to award of contract, a team of commissioners and Trust managers visited the NSL service and spoke to other commissioners and hospital staff in other parts of the Country to provide further assurance on the quality of service provided in those areas. The team came back confident that the contract should be awarded to NSL.

Key elements of the service

The contract covers 285,000 journeys for all patients who are the responsibility of the Kent and Medway CCGs, (plus those patients in Greenwich, Bexley and Bromley who use our providers). All types of patient mobility are included.

Some of the key features of the service include:

- The Service Centre is open from 7am – 9pm Monday to Saturday, with access by telephone or by web based routes;
- Eligibility screening is provided, with an appeals process and advice to those not eligible;
- Liaison with healthcare organisations;
- Transport provision is available 24/7, and includes on the day bookings for urgent requirements;
- Key Performance Indicators including timeliness of call handling and travel times;
- Quality standards for the service, as set by the standard NHS contract;
- Minimum dataset and reporting of patient level data to support service improvement;
- Incentive scheme (CQUIN) included to encourage improving standards.

The service also provides for patients who may not be formally eligible for transport under the criteria but require transport for humanitarian reasons or have been historically provided by the acute hospitals. This will be monitored by the new service and information provided to commissioners.

Eligibility for the service

As discussed in some detail at the February HOSC meeting, there has been no change to the Eligibility Criteria as a result of implementing this new service. The criteria used in Kent and Medway are slightly more generous than the national criteria and are continuing to be used. There have been a few occasions reported where patients have been told they are no longer eligible but these have been mistakes during implementation where staff have not understood that the Kent criteria are wider than the national.

Challenges during implementation

It became apparent very quickly from day one that there were problems and daily conference calls began with the commissioners and Trust colleagues. NSL identified the main issues and have been supported in resolving them. The paper from NSL Care Services provides more detail on the issues they have faced during the implementation of the new service. In addition to the operational provider

challenges, some of the problems are linked to the changes in the whole system -- in particular, the change in culture required for many of the hospital providers who had previously been used to an in-house service (such as we no longer transport equipment alone without a patient, we do not transfer staff to work and there is no an immediate on call service). Although the total number of journeys remains approximately the same as outlined in the tender, the makeup of those journeys is inconsistent with data previously provided and set out in that tender. For example, the higher percentage of wheelchair and stretcher journeys puts significant strain on the system as those patients cannot be easily allocated to non-wheelchair/stretcher vehicles unlike walking patients (see Attachment 1). Once activity data has been analysed in detail over several months, the configuration of the types of vehicles needed may need to be adjusted.

The chart in Attachment 1 shows the different level of activity thus far on each mobility category and on the day bookings

Although too early to give a definitive result at the moment, there also appear to be some anomalies across the patch in the number of out of hours transport, on the day discharges, transfers and admissions in relation to the data previously provided. Again, once we have more data in the upcoming months, this can be analysed in detail and addressed by the Board if any changes to the service needs to be made. There could be several explanations for this such as large numbers of attendances at A&E, previous activity being conducted by private providers and not recorded or any other number of reasons. Commissioners and Trust colleagues will work together to resolve any issues that arise in the upcoming months.

Although we are still receiving some complaints, the number of complaints is reducing as there have been improvements in the service and it is expected that the number of complaints will diminish month on month. The Communications Team at KMCS and the Head of Communications at NSL are working together to track and address each complaint individually.

The lead commissioner is continuing to monitor the situation very closely with daily calls and weekly reports to ensure that the service achieves the key performance indicators prior to the busy winter period.

Attachment 1

Annual Baseline	Annual Baseline	Monthly Baseline	July	% of plan	August	% of plan	Sept.	% of plan
Walking patient unassisted	124327	10361	6339	61%	6563	63%	6003	58%
Walking patient assisted by 1 staff	36500	3042	1800	59%	2207	73%	2075	68%
Walking patient assisted by 2 staff	56343	4695	5901	126%	6600	141%	7249	154%
Wheelchair patient	48525	4044	5758	142%	4000	99%	3637	90%
Stretcher patient	12925	1077	1450	135%	1344	125%	1305	121%
Bariatric patient	6237	520	275	53%	247	48%	206	40%
High Dependency Patient	2849	237	8	3%	34	14%	29	12%
Total	**287706**	**23975**	**21531**	90%	**20995**	88%	**20504**	86%
On the day Activity	42729	3561	3912	110%	3512	99%	3277	92%
Out of Hour Activity (5%)	14243	1187	278	23%	284	24%	291	25%

NHS KENT AND MEDWAY PATIENT TRANSPORT SERVICE

Early Days Service Overview

The new Patient Transport Service went live on 1 July 2013. The transition was not smooth and there were several factors that caused significant issues in the early period:

- Colleagues transferred from five different organisations into NSL
- NSL inherited shift patterns that did not support the new service specification
- Different activity volumes than those anticipated
- Higher levels of staff absence and sickness than expected
- Higher levels of reliance on contractors than expected

This is essentially a new patient transport service that was Kent focussed, rather than Trust based.

Summary of Rectification Actions

Communications

Call volumes in week 1 reached a peak in volume and whilst we planned for higher volumes these were surpassed by 3 times and as a result many callers experienced significant delays in accessing the system. This was broadly under control by the end of week 1 and call volumes started to fall in the second week. There was an increase in phone answering performance in line with the reduction in call volumes and the percentage of calls answered has remained above 90% since the first week of the contract. There is still some work to be done to reduce the time taken for patients to reach a call taker and this is a focus area.

KPI Description	Jul-13	Aug-13	1st - 29th Sept-13
Calls answered within 30 seconds.	58%	74%	70%
Calls answered within 60 seconds.	64%	80%	76%
Calls answered	83%	93%	91%

Table 1

Daily meetings were held with the Commissioners and Trusts throughout the first two weeks, so that issues could be raised and resolved. Additional NSL on site management support was provided and an NSL presence in the form of floor walkers was introduced at each major site. This presence has remained in place as the service beds in. These key colleagues have dedicated mobile phones and provide an on-site escalation service, supported by the Kent control room. We continue to work closely with Commissioners and Trusts whilst we make the necessary improvements to service delivery standards.

Planning and IT

There were some issues with data transfer where a small number of planned journeys did not come across into the new system. These volumes were not high, but caused major 'on the day' issues as NSL was only made aware when a point of care or a patient called in to enquire about their transport. Depending on the mobility type of the patient this could lead to significant delays in transport. Where this occurred we apologised to the patients affected and rearranged their transport. These data transfer issues were generally resolved during the first four weeks due to the dynamic nature of the service.

In order for the service to be delivered to the standard required in the contract specification and expected by patients in Kent, the planning for the whole of Kent needed to be merged and delivered from one location. Some colleagues who transferred into NSL had very limited knowledge beyond their own areas of control and some were unable to work from the Larkfield site, where Planning and Control is based. This led to some instances of poor logistical planning in the early weeks and it is taking some time for other colleagues to learn the new areas and become proficient in the use of our planning and control systems. We have deployed experienced planners from elsewhere in NSL and have also recruited additional planning staff to resolve this issues more quickly.

In order to manage and control the ambulance crews efficiently they are issued with handhelds that provide a real time link to the booking system. This allows controllers to assign work to them dynamically, contact them using push to talk, and monitor progress during the day since they enter pick up and drop off times in real time. There was limited opportunity to train the transferring colleagues prior to go-live which meant that the system was not being used fully across the contract until week four. This caused delays in improving the service delivery and had a negative impact on patient experience.

HR

Several transferring colleagues found themselves working in areas they had not previously served, particularly in the West of the county, and it took some time for them to get used to this. NSL has also experienced high volumes of sickness and absence in the workforce which is being managed in line with the Terms of Conditions in place for the transferred colleagues. Shifts patterns (including start time, finish time and weekend working) are different across the County, and generally not in line with those required to deliver to the contract specification. A new shift pattern is currently being consulted on and is expected to be in place by early December. This mismatch between shift times and service requirement means that there is a shortfall in resources at specific times of the day. Until the consultation is completed this is being managed using a combination of volunteers (who are willing to work the shift pattern now), sub-contractor crews and bank staff. We have also recruited an additional twenty five colleagues on NSL terms and conditions since go live and intend to recruit a further twenty four within the next six weeks.

Patient Experience

Though the service and therefore patient experience has improved over the past three months we have received a significant number of complaints, mainly related to the timeliness of the service. All of these patients have received a letter of apology addressing their specific complaint, together with assurance of our commitment to improving the service. In addition, NSL managers have visited several patients to deliver an apology in person. We have also maintained an open channel with local media in order to issue apologies, statements and information as appropriate. The following table shows the number of complaints we have received in the last three months.

Month	July	August	September	Total
Complaints	52	53	37	142
Journeys	21,541	20,999	20,506	63,046
% Complaints	0.24%	0.25%	0.18%	0.23%

Table 2 Complaints

Summary of Current Performance Levels

Contract performance in July was poor and caused significant issues for both patients and Trusts. We have worked closely with our NHS colleagues to address the key issues and our performance has improved steadily over these three months. Table 3 shows our performance against the key indicators. Though there is clearly a lot more for us to do it does demonstrate that there has been a steady and sustained improvement in performance.

KPI	Description	Jul-13	Aug-13	1st - 29th Sept-13
Arrival Time - pre planned	Patients arriving 60 minutes prior to their appointment	49%	63%	67%
Arrival Time - pre planned	Patients arriving 30 minutes prior to their appointment	31%	46%	49%
Arrival Time - renal	Renal Patients arriving 30 mins prior to their appointment	29%	53%	57%
Return journeys (excluding renal or 'on the day requests')	Patients collected within 60 minutes	76%	80%	83%
Return journeys - renal (excluding 'on the day requests')	Renal patients collected within 30 minutes	46%	57%	67%
Discharged/Transfer patients	Booked 'on the day' collected within 3 hours	86%	80%	89%
Discharged/Transfer patients	Booked 'on the day' collected within 2 hours	70%	66%	78%

Table 3

An action plan has been developed and implemented to address how we will improve our performance levels and we expect these standards to continue to improve and the team is focussed on meeting the contract KPI's fully by the end of October 2013.

Summary

We are deeply sorry for any distress that has been caused to our patients and have apologised to the people we have let down. We are very disappointed that the

contract did not make a more seamless transition but we are satisfied that we did all we could to manage the issues we encountered. Many of the problems could not have been addressed during the implementation phase but we should have identified and communicated them more effectively as risks. We should not have been caught by surprise. We have conducted an internal lessons learnt exercise which we will incorporate into any future implementations.

We are currently working closely with Commissioners and Trusts to ensure that we are prepared for the expected surges in activity associated with winter pressures.

We remain fully committed to making this a flagship service for the people of Kent and Medway.

Alastair J Cooper
Managing Director - NSL Care Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 October 2013

Subject: Health and Wellbeing Board: Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the Health and Wellbeing Board.

There will be a presentation on this item.

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

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1. Introduction

(a) Each upper tier and unitary authority has a statutory Health and Wellbeing Board. The Health and Social Care Act identifies the statutory membership of the HWB as:

- At least one councillor of the upper tier local authority – Leader of the Council and/or their nominee;
- Representative of each relevant Clinical Commissioning Group (one person may represent more than one CCG with the agreement of the HWB);
- Director of Adult Social Services;
- Director of Children's Services;
- Director of Public Health;
- Representative of the Local Healthwatch Organisation;
- Such other persons or representatives as the local authority thinks appropriate; and
- NHS England (for the JSNA, HWB Strategy and matters relating to the commissioning functions of NHS England).

(b) The HWB is responsible for producing a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS). JSNAs are assessments of current and future health and social care needs in a particular area alongside an identification of the assets the local community has to meet the identified need. The JHWS set out how the needs will be met, in the context of identified priorities, as well as enabling the HWB to encourage integrated working between health, public health and social care commissioners. Both documents are to inform local authority and NHS commissioning plans.

(c) It is also responsible for the production of the Pharmaceutical Needs Assessment (PNA).

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report.

Background Documents

Health and Social Care Act 2013,
http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

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