HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 29th November, 2013

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 29th November, 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 - 28)

5. Quality Surveillance (Pages 29 - 54) 10:00

6. NHS 111 (Pages 55 - 64) 10:45

7. Faversham MIU update and the development of the urgent care and long term conditions strategy (Pages 65 - 72) 11:45

8. Musculo-Skeletal Services (Pages 73 - 78) 12:25

9. Date of next programmed meeting – Friday 31 January 2014 @ 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

21 November 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 Council Chamber, Sessions House, County Hall, Maidstone on Friday, 11 October 2013.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mr L Burgess, 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, Cllr Chris Woodward, Mr P J Homewood, Mr R A Marsh and Mr M J Northey

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

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) The Vice-Chairman reported to the Committee that following a meeting with the relevant Cabinet Member, January was proposed as the date for the Committee to consider Child and Adolescent Mental Health Services (CAMHS).

(b) RESOLVED that the Minutes of the meeting of 6 September 2013 are correctly recorded and that they be signed by the Chairman.

4. Meeting Dates 2014
(Item 5)

AGREED that the meeting dates for 2014 be noted.

5. East Kent Outpatients Consultation: Written Update
(Item 6)

(a) The Chairman introduced the item and explained that it was a written follow-up to the discussion the Committee had on the East Kent Hospitals University NHS Foundation Trust's clinical strategy in June and that the intention was for the issue to return to HOSC following the public consultation.

(b) Comments were invited from Members. Several comments were made as to the importance of including information about travel to the 6 sites where services would be provided. One Member used the analogy of supermarkets, with the need for services to be where the demand was. On the topic of the number of sites, one Member referred to the discussion in June when NHS representatives mooted the possibility of a 7th site on Sheppey and hoped there would be clarification as to whether this was still the case.

(c) On the plans for public meetings, the report in front of Members stated that there were plans to hold one in either Hythe or Dymchurch. One Member requested a meeting be held in both towns.

(d) The Chairman drew attention to the part of the NHS report where a request was made for volunteers from HOSC to read and comment on the draft consultation document. The following Members of the Committee volunteered:

- Dr M Eddy
- Mr R Latchford, OBE
- Councillor Michael Lyons

(e) The Chairman proposed the following recommendation:

- That the Committee note the report, ask the NHS to take on board the comments and questions raised by the Committee and that a small group be formed to liaise with the NHS on the draft consultation document.

(f) AGREED that the Committee note the report, ask the NHS to take on board the comments and questions raised by the Committee and that a small group be formed to liaise with the NHS on the draft consultation document.

6. Patient Transport Services
(Item 7)

Ian Ayres (Chief Officer, NHS West Kent CCG), Helen Medlock (Associate Partner, KMCS), Deborah Tobin (Senior Associate, KMCS), Alastair Cooper (Managing Director, NSL Care Services), Paul Costello (Client Account Manager, NSL Care Services), Felicity Cox (Kent and Medway Area Director, NHS England), and Dr John Allingham (Medical Secretary, Kent LMC) were in attendance for this item.

(a) The Chairman introduced the item and asked the Committee's guest to explain the background and the current situation.

(b) It was explained that NSL Care Services took over the provision of Patient Transport Services (PTS) on 1 July 2013. This came at the end of a two year process. Previously there had been a patchwork of five providers, of which four were major providers. A decision had been reached by the old Primary Care Trust Board that a single provider was preferable. It was still the consensus now that one provider was preferable. The bid from NSL scored the best on value for money and quality.

(c) The transfer to the new provider was very complex given the number of different providers previously with different shift patterns, fleets, operating procedures, organisational cultures and so on. 100 staff needed to be transferred under TUPE to the new provider. It was openly admitted that the transfer had not gone to plan. It was explained that there were two parts to the service. The first part, that of whether appointments were able to be booked, was going to plan. However, the second part, that of whether patients were being picked up and taken to their appointments at the appropriate time, was not. NSL were currently achieving 60-65% regarding timeliness.

(d) Both the commissioner and provider apologised for this. It was explained that there was a recovery plan in place and things were improving. There were a number of performance indicators in the contract and Mr Ayres stated that he received updates on the 5-6 key ones daily, the top 8-9 ones weekly and the rest monthly. Performance data was being shared with the Acute Trusts and an independent expert was being brought in to review the measures being taken to improve the situation and this would report before the winter. NHS England was supportive of this approach.

(e) It was further explained that the PTS eligibility criteria had not changed from the previous arrangement and that the criteria in Kent and Medway was more generous than elsewhere. They had been applied inconsistently in the past. It was reported that press stories about people being refused transport were cases where someone was not eligible for PTS or had not requested the service. A request was made for the eligibility criteria to be made available to the Committee.

(f) One Member commented that subsequent to a recent news story, he had been contacted with a number of further examples. It was accepted that there was a problem around public confidence with the service.

(g) Representatives from NSL explained that they had underestimated the challenge of setting up the new service. One challenge was the shift system. Some staff were on 9-5 contracts but the service requires a 24/7 shift system. A consultation was underway with staff to enable this to be changed. This consultation ended soon and a new shift system would be able to be brought in on 4 November. The role of supervisors was seen as key. At pinch points were demand could not be met, sub-contractors were used. The activity was also different to that anticipated, with a greater need of the use of stretchers. It was explained that when further activity data was available, NSL might acquire further vehicles capable of accommodating stretchers.

(h) Members asked a series of questions and raised a number of points aiming at probing deeper into the reasons behind the problems with the transfer to a new provider. On being asked directly, the commissioners gave the judgment that the service was not as good as it was before the change, but that it would be better. The provider admitted to being surprised by the complexity of the challenge, but the point was also made that NSL successfully ran PTS contracts in other areas of the country and had a recent successful takeover of a contract in the South West of England. A Member made the counter point that this was not much comfort to patients in Kent.

(i) In terms of the commissioning, the Committee was informed that the specification for the contract was drawn up based on information collected in the past. One Member drew attention to the statistics presented on page 30 of the Agenda. This indicated that there were more stretcher patients than planned and the number of wheelchair patients was higher than planned but then went below. The question was posed as to whether the levels would settle down to that expected. However, the numbers of high dependency patients were negligible compared to the planned numbers. It was explained that while there was good information about the bills relating to PTS in the past, the details around the number and type of journeys was less reliable. The numbers in East Kent could be out by 30-40% either way. On high dependency patients, these journeys were undertaken by a sub-contractor but the type of journey was not recorded. The uncertainty about the accuracy of the figures extended to the period between the awarding of the contract and NSL taking it over. In hindsight, it was acknowledged that a shadow period where accurate information could be gathered would have been a sensible approach. Commissioners had looked to the market for a solution of the problem but had not explained fully what was required of the service. Lessons had been learnt and would be applied to future procurements. The priority now was to ensure a sustainable service was being delivered and then a full review of the process would be able to be carried out. A request was made for the findings of any internal review undertaken to be shared with the Committee. The point that Kent County Council (KCC) had a good track record on procurement was well taken and it was explained that there were a number of areas where KCC and the NHS could learn from each other and procurement was one area where the NHS could learn from KCC.

(j) The financial implications of the problems faced by the service were also explored by the Committee. It was explained that it was an activity based contract and even though NSL had been required to hire more staff and use sub-contractors, the commissioners would not be providing any more money. Only in cases where the activity was significantly above or below that specified in the contract would there need to be a conversation between commissioner and provider about the cost of the contract. There were clear performance indicators in the contract and it was possible that penalties would be imposed. Against this, the point was made that penalties were not enough on their own where there was an issue with the culture of a service or organisation.

(k) On the subject of the key performance indicators, it was explained that these were reviewed by a programme board consisting of NHS organisations and patient representatives. However, it was accepted that a point made by a Member of the Committee was valid and that some thought would be given to an appropriate place to receive these reports where they would be more openly available, such as possibly the NHS West Kent CCG Board.

(l) Of the 40% who did not undertake their journeys at the booked time, some were at their destinations much too early and some were late, but the exact figures for how many of each there were not available at the meeting. The Acute Trusts were being very supportive of the service and while the commissioners could ask for data on how many patients needed to have their appointments rescheduled, it was felt this would add an extra burden to the hospitals.

(m) A number of questions were asked about the fleet. It was explained that there was a disinfectant/cleaning regime and that this did mean vehicles were out of action during cleaning. Additional vehicles were sourced to cover these times. In Kent a standard business fleet was used, with the exact type of vehicle depending on the availability of servicing in the area. Members gave examples of places where pods where used, enabling a wider range of vehicle types to be made available as the chassis would be interchangeable between them. This was something which would be looked at. In response to a specific question, it was explained that while tacographs were not used, a similar system was and data suitable for analysis was gained this way. It was accepted that while there were significant differences between patients and parcels, there could be lessons to learn from the logistics industry.

(n) A series of specific questions were asked and responses received. It was accepted that better signposting to the service in GP surgeries would be appropriate. Volunteer drivers were used and they all had to undergo DBS checks. The service had six bases and these were at Dartford, Tonbridge, Larkfield, Ashford, Aylesham and Margate.

(o) Questions were also asked about regular users of the service. On this issue it was explained that renal patients made up around a third of all journeys and these were programmed ahead of time. There was a full-time person whose role it was to contact each of the renal units four times each day to ensure the service was delivering at an acceptable level. Although only 50-60% of renal patients were delivered within the 30 minute window required, feedback suggested the current levels of service were acceptable. Lessons were being learnt from this and would inform the oncology service when it was rolled out.

(p) There was a discussion on the recommendation and the Chairman, along with a number of Members, commenting positively on the honesty of both commissioner and provider.

(q) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their attendance and contributions today along with their answers to the Committee's questions, and asks for a written update report within 3 months and a return visit in 6 months.

(r) AGREED that the Committee thanks its guests for their attendance and contributions today along with their answers to the Committee's questions, and asks for a written update report within 3 months and a return visit in 6 months.

7. Health and Wellbeing Board: Update
(Item 8)

Roger Gough (Cabinet Member for Education and Health Reform), Felicity Cox (Kent and Medway Area Director, NHS England), and Dr John Allingham (Medical Secretary, Kent LMC) were in attendance for this item.

(a) The Chairman welcomed the Cabinet Member for Education and Health Reform and invited him to present an overview to the Committee. A copy of the PowerPoint is appended to these Minutes.

(b) It was explained that the creation of Health and Wellbeing Boards (HWBs) formed part of the Health and Social Care Act 2012. They have become one of the most accepted parts of what was, in other aspects, a strongly contested piece of legislation. They are viewed as part of the architecture that works. The Health Select Committee at the House of Commons was originally sceptical of HWBs but is now a strong supporter of them.

(c) Much of the membership of the Kent HWB follows the statutory requirement, but there are additions. There is more than one KCC Member on the Board and there are three representatives from the Borough/City/District Councils across Kent. It follows the principle that no group should have a majority and has a strong emphasis on consensus. There has not been a vote required thus far and it would in a sense be a failure if one was required.

(d) In terms of its role, it took over responsibility for the Joint Strategic Needs Assessment (JSNA). It is responsible for the production of the Pharmaceutical Needs Assessment. This is a technical document and work on it is due to begin at the next HWB meeting. The third document, the Joint Health and Wellbeing Strategy (JHWS) takes centre stage as it sets out the vision for health and social care across the county. Health and social care commissioning plans need to be aligned to it. During the passage of the Health and Social Care Act, the role of the HWB in promoting integration was strengthened and this is now a key part of its role.

(e) The Health and Wellbeing Board took on its statutory role on 1 April 2013 and its meetings have been webcast since this time. Before this, a shadow board was in existence from September 2011. During this time, GPs and local authorities have become increasingly used to working together.

(f) Five priorities were set out in the first iteration of the JHWS earlier this year. These are: young people, prevention of ill health, long term conditions, mental health, and dementia. Thus far, each meeting of the HWB has concentrated on one of these priorities. At the next meeting, the focus will be on mental health.

(g) In the days before the HWB took on its statutory role, the operating plans of all seven Clinical Commissioning Groups (CCGs) across Kent were considered in terms of how far they shared a common view. The additional point was made that more needed to be done on bringing the plans of social care, NHS England's direct commissioning and public health to share with the HWB, though some work had already been done by public health.

(h) The observation was made that the Health and Social Care Act was drawn up with compact urban councils in mind where a single local authority and one or two CCGs would be able to work together directly. One of the slides in the PowerPoint presented to the Committee contained a map designed to show the numerous overlaps. Across Kent there were three health economies, twelve Borough/City/District Councils, and seven CCGs. Only one of the latter

was coterminous with the boundaries of a Borough/City/District Council. One of the challenges this posed for the HWB was how to effectively drill down into local concerns while retaining the focus of CCGs from other areas of the County. In September 2012 it was decided formally to establish seven sub-committees of the HWB aligned with CCG boundaries. This model built on something Dover and Shepway had worked on before. The HWB, which itself is a Committee of Kent County Council, is there to look at issues wider than one CCG. This includes large scale reconfigurations, data sharing, and performance across the patch. It also picked up on national policies and initiatives and saw they were taken up locally. The CCG level Boards were there to do the 'heavy lifting' in making integration work locally. Members were also informed that due to their local nature, the priority of each CCG level HWB was different. There was also a 'mixed economy' as to who chaired them. Some were chaired by representatives from the Borough/City/District Council, others by a CCG representative. Mr Gough explained that he was Chairman of the Dartford, Gravesham and Swanley CCG level HWB along with being Chairman of the Kent level HWB.

(i) The overall aim of the HWB was to explore new ways of working to ensure the financial sustainability of both the NHS and local authorities. This involved moving care upstream with greater emphasis on prevention, self care, integration between the sectors, and looking to ensure there were no unnecessary admissions into acute or residential care. A slide with numerous examples of the work going on was presented to Members. Amongst these examples were the integrated health and social care teams in Dover and Shepway and work on year of care tariffs which looked to obviate the perverse incentives which currently existed. There was much good work going on and part of the challenge was to consider how it could be scaled up.

(j) Mr Gough drew attention to two national schemes that were of particular interest. The first was the Integration Pioneer Programme. This was launched earlier this year with bids invited for pioneer status to receive Department of Health support related to the work they were doing on integration. The Kent bid has made it past the first stage and it will become known this month whether it has been successful. When the bid was approved by the HWB, it was agreed to continue with the work set out in it regardless of whether the bid was successful or not. Among the areas being looked at as part of this programme is that of workforce planning.

(k) The second policy was the Integration Transformation Fund. This was discussed at the September meeting of the HWB. Overall, it sets a faster pace for integration. Rather than new money, different funding streams are brought together to the sum of £3.8 billion nationally. This is for the creation of a pooled budget where the NHS and local authorities will be equal partners and where the responsibility will rest with the HWB. The ultimate aim is to have a fully integrated system by 2018. £1 billion of this money is at risk in that local systems have to deliver integration or lose the funding. Progress will be assessed in two tranches, one at the beginning of the 2015/16 financial year and the other at the end of the same year. This will necessarily reflect work done in 2014/15, the start of which is not far away. There is a need to progress with plans quickly, and the idea is to take this work forward through the group which had been established to produce the pioneer bid. The ultimate aim is to

move activity currently carried out in the acute sector to the community sector. It was important to work with providers as it was necessary to avoid destabilising them. This could mean reconfiguration of acute services and this could be controversial. It was accepted there was a tension between local plans and Kent-wide ones, but it was hoped this would be a dynamic tension.

(l) Following the presentation, there were a number of areas of questioning and discussion. On the topic of possible future reconfiguration in the acute sector, it was further explained that there was a decades' long debate in the health sector over the need for centres of excellence where medical specialists were able to see sufficient numbers of patients to maintain and improve their skills against the need for patients to be able to access healthcare closer to home. These were arguments that the Committee were familiar with.

(m) There is a separate argument around the shift of resources from the acute sector to the community and primary care sectors and what this means for the acute sector. The NHS West Kent CCG 'Mapping the Future' Programme was part of this discussion around moving activity to community and primary care settings along with enhanced self-care. This was considered by the Committee at its September meeting.

(n) This connected with the 'NHS A Call to Action' and 'Improving General Practice A Call to Action' programmes. In the latter, the future shape of general practice was also under discussion. Connected with this, it was important to know that NHS England commissioned primary care and CCGs could not commission themselves.

(o) With the year of care tariff, the price paid for treatment is separated out so some goes to the community sector. This could be a risk for the acute sector as it reduces their income. However, the costs of acute trusts could be reduced alongside the reduction in income. Acute trusts could also deliver some work in the community. The shift to community care needed to be managed to avoid the risk of destabilising acute trusts, which would be a particular problem in East Kent where there was no obvious alternative.

(p) The point was made that unless there were services in the community and sufficient GPs, people would still go to acute hospitals. Services did need to be in the right place delivering the right care and Professor Chris Bentley had worked with Kent looking at areas of deprivation and whether they were able to access the right services.

(q) Questions were asked about the relationship of KCC with Kent Community Health NHS Trust (KCHT) and Kent and Medway NHS and Social Care Partnership Trust (KMPT). It was explained that there was a continuing and developing partnership with KCHT on joint working, but it was explained that there was a tension for KCC with its dual role of commissioner and provider. Similarly with KMPT, there was lots of joint working and the example of the Live it Well programme was given. It was also pointed out that there were a number of providers of mental health services apart from KMPT.

(r) There were a number of questions about children's services. In response to a specific question about the location of Sheppey children's centre, it was

explained that this was for historical reasons but that there were moves to more closely integrate CCGs and children's centres. On the question of Children's Trusts, it was explained that their work had moved to the HWB and there was currently a discussion about whether it was better to have a sub-committee of the Board focusing on children's issues or to have children's issues as a regular item on the CCG level HWB agendas.

(s) On the broader topic of wellbeing, a couple of Members raised the issue of what measures KCC could take around licensing laws and dealing with the impact of gambling. Mr Gough offered to continue this particular discussion outside the meeting. The observation was made that wellbeing was a broad concept which could mean the HWB could look at so many things it could risk losing focus.

(t) Mr Gough also expressed a willingness to discuss further the report that a CCG level HWB had a rule excluding Councillors who were not on the Board from asking questions as a member of the public. This rule was not part of the Terms of Reference for the HWB.

(u) There was a discussion about the care that KCC delivered in people's homes. It was explained that Kent had always done well on the time allowed for care visits, but there was less information on the quality of care. Kent social services were part of the NHS England hosted Kent Quality Surveillance Group which did a lot of good work looking at quality issues across the County. This was not an area which the HWB had looked closely at, but it could in the future.

(v) There was a discussion on the future relationship between the Committee and the HWB. Mr Gough explained that he had been to the Committee a number of times during the period of the shadow HWB, and was more than happy to attend in the future. It was for the Committee to determine its own work programme, but the integration agenda and JHWS along with others were all areas that the Committee could legitimately consider.

(w) The Chairman proposed the following recommendation:

- That the Committee thank Mr Gough for his attendance and contributions to the meeting and requests that the Committee continue to be informed of the work of the Health and Wellbeing Board.

(x) AGREED that the Committee thank Mr Gough for his attendance and contributions to the meeting and requests that the Committee continue to be informed of the work of the Health and Wellbeing Board.

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

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The Kent Health and Wellbeing Board

Roger Gough

Cabinet Member for Education & Health Reform

HOSC 11 October 2013

Kent County Council kent.gov.uk

Kent HWB Membership

- The Leader of Kent County Council or his nominee
- Corporate Director for Families and Social Services
- Director of Public Health
- Cabinet Member for Adult Social Care & Public Health
- Cabinet Member for Education and Health Reform
- Cabinet Member for Specialist Children's Services
- Clinical Commissioning Group representation: up to a maximum of two representatives from each consortium (e.g. Chair of CCG Board
- and Accountable Officer)
- A representative of the Local HealthWatch
- A representative of the NHS Commissioning Board Local Area Team
- Three elected Members representing the District/Borough/City Councils (Swale BC, Tunbridge Wells BC and Dover DC nominated through the Kent Leaders)

Kent County Council kent.gov.uk

Responsibilities of the HWB

- Joint Strategic Needs Assessment (JSNA)
- Pharmaceutical Needs Assessment (PNA)
- Kent Health and Wellbeing Strategy
- Ensuring the commissioning plans of the CCGs, Public Health and Adult and Childrens' Social Care reflect the priorities of the JSNA and the Health and Wellbeing Strategy
- Promoting integration and partnership and joined up commissioning plans across the NHS, social care and public health

Achievements so far

- Work over last 3 years building on GP and Council relationships
- “Members and GPs working together”
- Kent HWB meeting in shadow form since September 2011. Formal committee of KCC since April 2013
- All CCGs represented on the Board and 3 District reps
- JSNA published – district & CCG chapters
- Health & Wellbeing Strategy published. Developing Strategy for 2014-2017
- HWB’s priorities linked to the 5 outcomes in HWBS: Young people, prevention of ill health, LTC, mental health and dementia
- March 2013 - Endorsement of the 7 CCG operating plans
- Established 7 locally-focused HWBs that align with the CCG structure. Now sub-committees of Kent HWB
- Pioneer Bid submitted summer 2013
- Integration Transformation Fund – increased sense of urgency!

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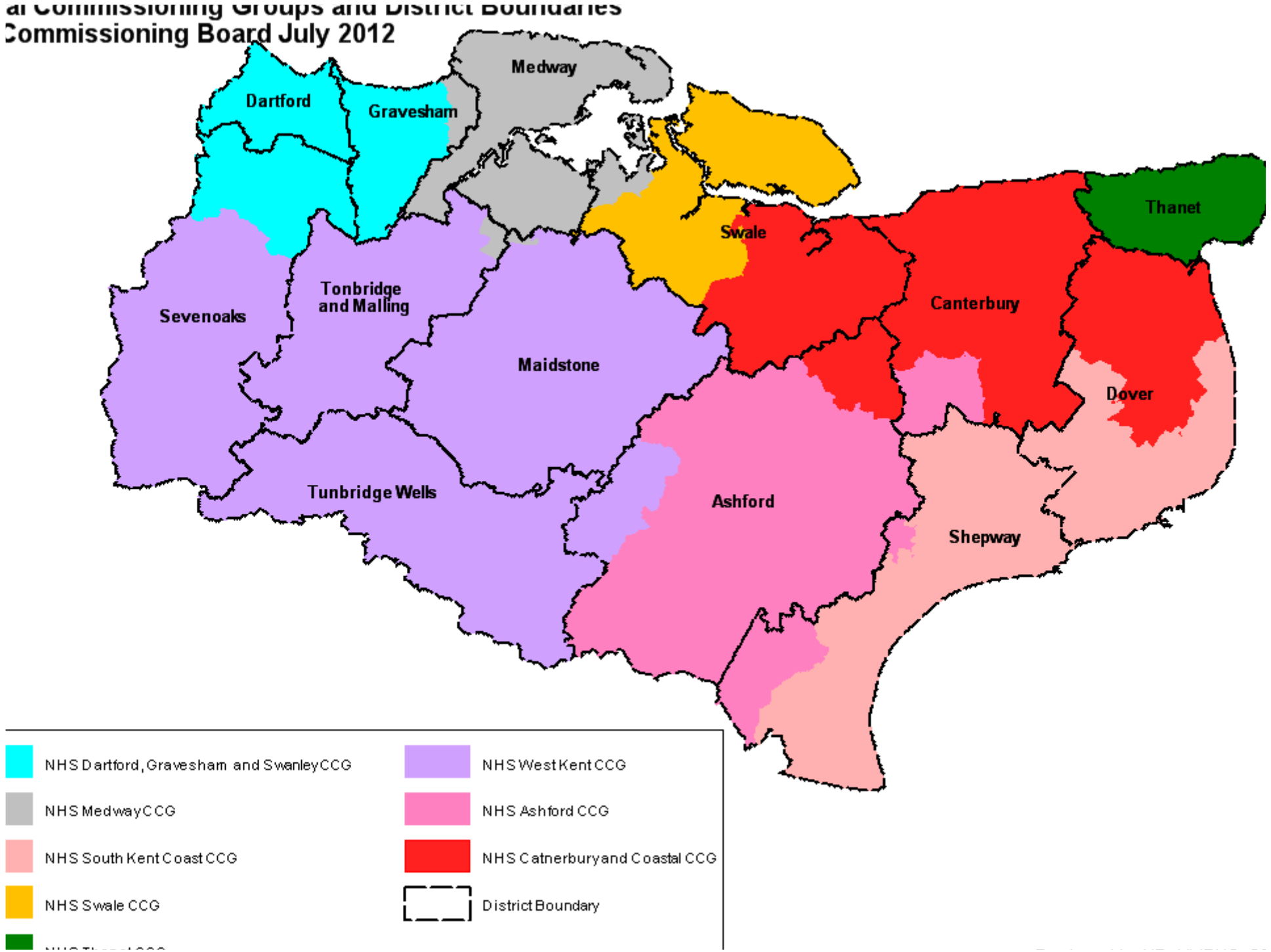
al Commissioning Groups and District Boundaries
Commissioning Board July 2012
Medway
Dartford
Gravesham
Swale
Thanet
Sevenoaks
Tonbridge and Malling
Maidstone
Canterbury
Dover
Tunbridge Wells
Ashford
Shepway
NHS Dartford, Gravesham and Swanley CCG
NHS Medway CCG
NHS South Kent Coast CCG
NHS Swale CCG
NHS West Kent CCG
NHS Ashford CCG
NHS Canterbury and Coastal CCG
District Boundary

Division of Labour between the local and Kent HWB

- The Kent HWB Board will add value by:
  - Tackling big strategic issues which cut across geographies e.g reconfiguration across CCG boundaries
  - Using the JSNA and HWBS to identify gaps across Kent which need addressing
  - Diffusing best practice across Kent
  - Broader Kent-wide thinking where appropriate

CCG based HWBs

- Size and complexity of Kent
- Local Boards: district or CCG based?
- Dover and Shepway experience
- CCG option agreed at last September's HWB. Key areas of focus include:
  - CCG level Integrated Commissioning Strategy & Plan
  - Ensuring effective local engagement
  - Endorse and secure joint arrangements e.g pooled budgets for commissioning, partnership arrangements for service integration
  - Local monitoring of outcomes
- Informal meetings have been set up and "show and tell" sessions have

  Identified key issues and gaps

CCG level HWBs

- Membership includes:
  - Local Government:
    - District Council(s) senior Member representative(s) and Officer reps
    - At least one KCC Member (Cabinet Member or nominee)
    - KCC Social Care Director & Commissioning Manager
    - Public Health representative
    - Children's link to be identified
  - CCG - At least one GP and a Senior CCG Officer
  - Healthwatch and /or other public engagement forum representative
- Programme of support from NHS Leadership Academy from Jan 2013
- Integrated commissioning plans are in place
- Each local HWB is looking at sub-architecture e.g Integrated Commissioning Groups, Children's Groups to replace LCTBs

CCG level HWBs

CCG Level HWB	Chair	Priorities	Initial Meetings
Ashford	Cllr Michael Claughton	LTC and Young people	24.7.13 & 23.10.13 Future dates being set
South Kent Coast	Cllr Paul Watkins	LTC, community pharmacy, intermediate care services, linked to Troubled Families	Meetings held bi-monthly
Canterbury & Coastal	Dr Mark Jones	Urgent care review, LTC	9.7.13 Future dates being set
West Kent	Dr Bob Bowes	Mapping the future, health inequalities, LTC	Bi-monthly meetings in place
Thanet	Dr Tony Martin	Health inequalities and LTC	30.5.13 & 29.7.13 Future dates being set
DGS	Roger Gough	Health inequalities and LTC	Bi-monthy meetings set up
Swale	Andrew Bowles	LTC and integrated commissioning plan with DGS	24.7.13 Future dates being set

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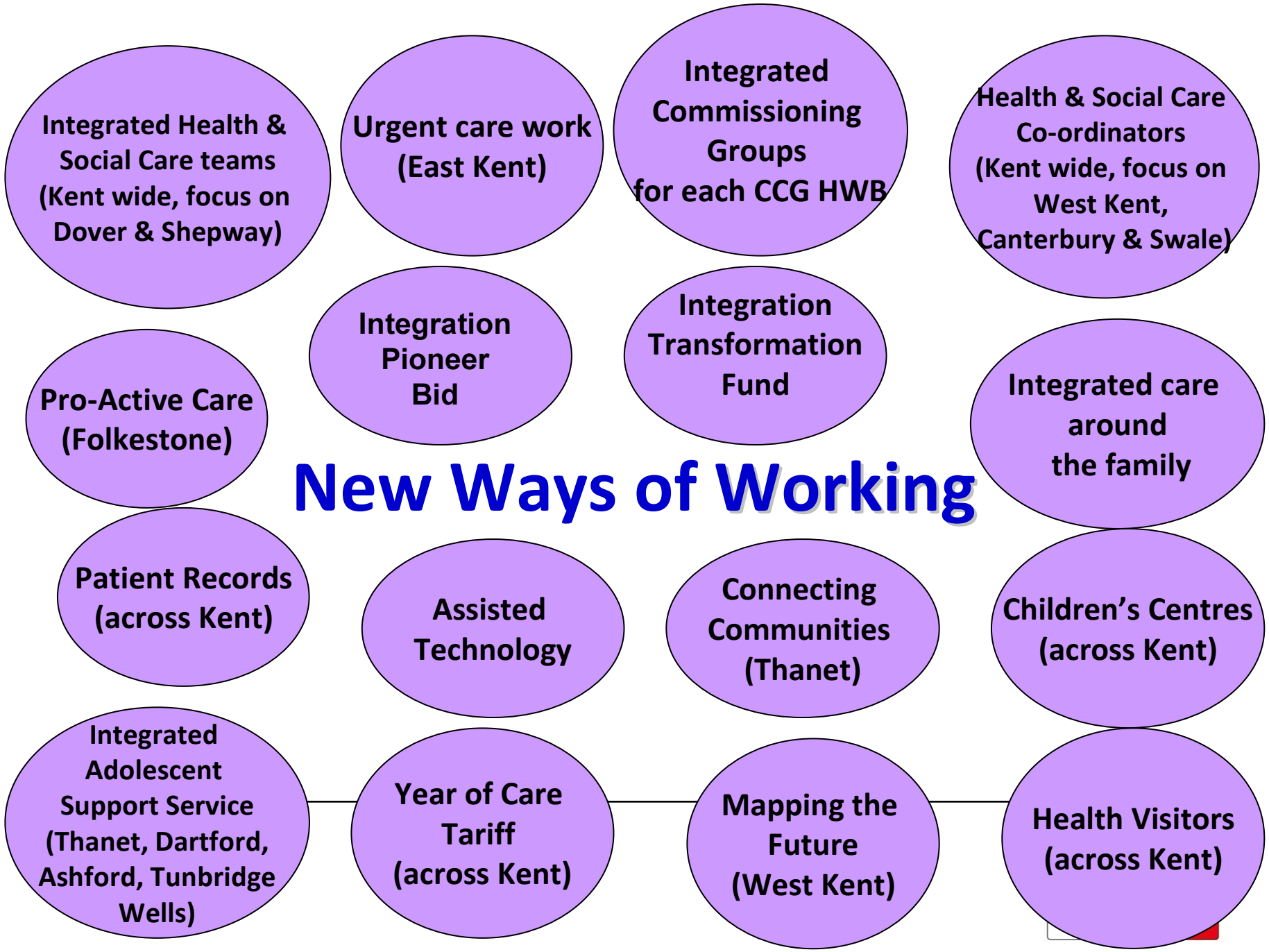
Integrated Health & Social Care teams (Kent wide, focus on Dover & Shepway)
Urgent care work (East Kent)
Integrated Commissioning Groups for each CCG HWB
Health & Social Care Co-ordinators (Kent wide, focus on West Kent, Canterbury & Swale)
Integration Pioneer Bid
Integration Transformation Fund
Pro-Active Care (Folkestone)
Integrated care around the family
New Ways of Working
Patient Records (across Kent)
Assisted Technology
Connecting Communities (Thanet)
Children's Centres (across Kent)
Integrated Adolescent Support Service (Thanet, Dartford, Ashford, Tunbridge Wells)
Year of Care Tariff (across Kent)
Mapping the Future (West Kent)
Health Visitors (across Kent)

Integration Pioneer Programme

What we will achieve in 5 years:

Integrated Commissioning:

- Design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that means the avoidance of hospital and care home admissions.
- The Health and Wellbeing Board will be an established systems leader.
- Clinical Design partnerships between the local authority and CCGs with strong links to innovation, evaluation and research networks.
- Year of Care tariff financial model and risk stratification will be tested and adopted at scale.
- Integrated budget arrangements as the norm alongside Integrated Personal Budgets.
- Outcomes based contracts supported by new procurement models will be in place that incentivise providers to work together.

Kent County Council kent.gov.uk

Integration Pioneer Programme

What we will achieve in 5 years:

Integrated Provision:

- Good person centred integrated care will be evidenced through use of the Narrative Proactive models of 24/7 community based care, with fully integrated multi-disciplinary teams. The community / primary / secondary care interfaces will become integrated.
- A new workforce with skills to deliver integrated care.
- Leadership of the integrated workforce with a commitment to 'place'.
- Integrated IT systems to improve patient / service user care, underpinned by personal health records that can be accessed by the individual
- We will systematise self care so that people with long term conditions can do more to manage their own health and social care needs to prevent deterioration and overreliance on services.
- New kinds of services that bridge current silos of working where health and social care staff can "follow" the citizen, providing the right care in the right place.

Target: Full Integration by 2018

- Integration Transformation Fund - £3.8 bn
- Pooled budget – LA and NHS equal partners
- Fully integrated system in place by 2018
- Plan in place for delivery March 2014
- Pioneer Programme - the vehicle for delivery?
- £1bn “at risk” funding split over 15/16 financial year
- Will only work if services are redesigned to move activity from acute sector to the community and primary care
- Involvement of providers is critical
- Implementation of plans may lead to significant hospital reconfiguration

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 November 2013

Subject: Quality Surveillance

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on Quality Surveillance in Kent and Medway.

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

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1. Introduction

(a) At its meeting of 19 July 2013, the Committee received an update on the Francis Report from Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England) and Dr Steve Beaumont (Chief Nurse, NHS West Kent CCG). The Committee agreed the following recommendation:

- 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 a further update in November, in particular in relation to quality surveillance aspects.

(b) The Minutes from this discussion are appended to this report for reference.

(c) During the meeting, Dr Beaumont offered to take small groups of Members around local acute hospital sites. The first visit took place on 18 November when Mr Mike Angell and Ms Angela Harrison visited Maidstone Hospital.

(d) The National Quality Board (NQB) was established by the Department of Health in 2009 following the NHS Next Stage Review and the publication of *High Quality Care for All.* It brought together the national organisations across the health system responsible for quality including the Care Quality Commission, Monitor, the NHS Trust Development Authority, NICE, the General Medial Council, the Nursing and Midwifery Council, the NHS Commissioning Board, Public Health England and the Department of Health

(e) In January 2013, the NQB published the report *Quality in the new health system - maintaining and improving quality from April 2013*. This had been published in draft form in August 2012. This report set out plans for the creation of Quality Surveillance Groups (QSGs) which

would match NHS England's local and regional structures. The following definition was provided:

- "The QSG will act as a virtual team across a health and care economy, bringing together organisations and their respective information and intelligence gathered through performance management, commissioning, and regulatory activities to maintain quality in the system by routinely and methodically sharing information and intelligence."[1]

(f) In October 2013, a *Keogh Quality Note* was published jointly by NHS England, the Care Quality Commission, Monitor, NHS Trust Development Authority and NHS Health Education England. This "sets out the roles, responsibilities and accountability of each of the organisations that are expected to play a part in enabling improvements in the hospitals involved in the Keogh Review."[2] This included discussion of QSGs: "The role of Quality Surveillance Groups is principally about alignment, not accountability."[3]

(g) The role of QSGs was also highlighted in the full Government response to the Francis report which was published on 19 November 2013:

- "The Quality Surveillance Groups will focus on the following questions:
  - What does the data and the soft intelligence tell us about where there might be concerns about the quality of care?
  - Where are we most worried about the quality of services?
  - Do we need to do more to address concerns or gather intelligence?

  Once concerns are identified, action can be taken swiftly by the relevant organisation." [4]

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the reports presented on the Quality Surveillance Group.

[1] Department of Health, *Quality in the new health system – maintaining and improving quality from April 2013*, January 2013, p.52, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213304/Final-NQB-report-v4-160113.pdf

[2] NHS England, the Care Quality Commission, Monitor, NHS Trust Development Authority and NHS Health Education England, *Keogh Quality Note*, October 2013, p.4 http://www.england.nhs.uk/wp-content/uploads/2013/10/keogh-qual-ltr.pdf

[3] Ibid., p.7.

[4] Department of Health, *Hard Truths. The Journey to Putting the Patient First*, 19 November 2013, Volume 1, p.67, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259648/34658_Cm_8754_Vol_1_accessible.pdf

Appendices

Appendix - Extract from HOSC Minutes, 19 July 2013, https://democracy.kent.gov.uk/mgAi.aspx?ID=25454

Background Documents

Department of Health, *Quality in the new health system – maintaining and improving quality from April 2013*, January 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213304/Final-NQB-report-v4-160113.pdf

NHS England, the Care Quality Commission, Monitor, NHS Trust Development Authority and NHS Health Education England, *Keogh Quality Note*, October 2013, http://www.england.nhs.uk/wp-content/uploads/2013/10/keogh-qual-ltr.pdf

Department of Health, *Hard Truths. The Journey to Putting the Patient First*, 19 November 2013, Two Volumes, https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response

Contact Details

Tristan Godfrey
Research Officer for the Health Overview and Scrutiny Committee
tristan.godfrey@kent.gov.uk
Internal: 4196
External: 01622 694196

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Appendix – Extract from Minutes of Health Overview and Scrutiny Committee meeting, 19 July 2013.

Item 4: The Francis Report: Update

Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England), and Dr Steve Beaumont (Chief Nurse, NHS West Kent CCG) were in attendance for this item.

(a) The Chairman welcomed the Committee's guests and they introduced themselves and provided an overview of the topic with the aid of a PowerPoint which was shown in the meeting and also made available in advance of the meeting and contained in the Agenda pack Members had before them.

(b) Dr Beaumont explained that in his previous career in the military, he had sent staff to Mid-Staffordshire Hospital and feedback mirrored the comments in the Francis Report about the hospital's 'unhealthy, dangerous culture'. However, it was also stressed that underneath there was still good nursing care provided. He went on to explain that along with the other Chief Nurses at Clinical Commissioning Groups (CCGs) across Kent, his priority was to address issues around quality of care. The Francis Report contained 290 recommendations and promoted a 'board to ward' approach to implementation. In the new NHS landscape, this was the equivalent to saying 'CCG to provider'. Dr Beaumont explained that he would be visiting all providers, starting with the main Acute Trust in his CCG area (NHS West Kent CCG), Maidstone and Tunbridge Wells NHS Trust, and moving on to all others, including independent providers.

(c) His CCG held their board meetings in public and there were PPGs (Patient Participation Groups), lay member involvement and patient satisfaction data on which to draw. There was a new complaints system in the NHS and information was available direct from providers as well as that which went direct to CCGs. In addition, the NHS Constitution underpinned everything which was done in the NHS. This covered actions by staff and patients as it was in effect a concordat. The NHS had to deliver safe care, but patients had a responsibility to turn up to appointments.

(d) One particular area of data was highlighted, that around serious incidents and 'Never Events.' Members asked for some examples of what came under these terms and it was explained that the context defined what or was not a serious incident. An example was given of an incident where the patient was satisfied with the outcome of the treatment received, but which was still reported and classified as a serious incident. In this particular case a simple change was possible, reducing the chance of it recurring. The key aim was to get people to regard serious incidents as an opportunity for learning rather than to pinpoint somebody to blame. In places where there has been a

defensive culture, events might be downgraded to avoid reporting. This was something which needed to change. Staff involved in a serious incident were debriefed. The other side of this was the importance of spreading best practice. These points were relevant to health and social care, with each sector able to learn from the other. The outcomes of the Berwick review were awaited and were expected later in July. Professor Don Berwick was an international safety expert, and had particular experience of the USA, which had a different culture in its health services and which would mean the results of the report would need careful consideration.

(e) In response to a specific question it was explained that attitudes to whistle-blowing were changing and becoming more positive. It was suggested that the defence ombudsman model could be something the NHS could consider. In addition, each CCG had a Chef Nurse who was outside of the chain of command and they were all a source of support for nursing staff.

(f) Tackling issues of safety and quality of care involved looking at the education and training of staff. NHS representatives brought the Cavendish Report to the attention of the Committee. This looked at the training received by Health Care Assistants (HCAs). The report found this to be variable, with some training consisting of nothing more than the viewing of a DVD. This had an impact as registered nurses were still responsible for the quality of any care delegated to a HCA. It was unclear how this worked in the community setting. Against this variability, there was a need for a clear career progression for HCAs. The debate on whether there was a need to register HCAs was also raised. Although no definitive answer on one side or the other was given by NHS representatives, the point was made that it was currently perhaps too easy for a HCA who had been sacked in one area to move to another and find a new job.

(g) There were also wider issues around recruitment and training to consider. The importance of recruiting people with the right values was discussed. This included medics and values based assessment was being introduced across the NHS. Members brought up the suggestion that the idea of nursing being a vocation had been lost when nursing became a graduate career. It was explained that this had been introduced in part to ensure nurses had parity of esteem with other professions within the NHS. However, work was currently ongoing locally with Canterbury Christ Church and Greenwich University to make nurses education more practical. Work was also being done to address the fact that there were minimum standards for midwifery and intensive care nursing, but not for nursing on general wards. The Chief Nursing Officer for England introduced the 6 Cs last year and these were being relaunched with the idea of covering all caring staff, including those in social care. These 6 Cs are Care, Compassion, Competence, Communication, Courage and Commitment.

(h) At the national level, Health Education England was a new organisation charged with providing leadership for the new education and training system. The improvement of training around end of life care was a priority. More broadly it was recognised that there was a need to avoid a system where a trainee's energy and enthusiasm was reduced.

(i) Members also raised concerns about the barriers to putting quality at the heart of care due to the apparent tendency for NHS organisations to work in silos, both within an organisation and between organisations. NHS representatives replied that there was a genuine opportunity to make positive changes in this area now. There had been a series of major reports which required a response. Locally, there was the Keogh report into Medway Hospital, and this report raised questions for all hospitals to consider, not just Medway. The point was also raised as to why it needed a major report to be published before action was taken. It was acknowledged that there was a need to tap into knowledge of local issues and react before this stage. CCGs were visiting local providers and leading clinicians in CCGs were working shifts at local providers to see the situation at the ground level and data was being used to identify the key areas to investigate further. NHS representatives also pointed out that the experiences of students needed to be tapped into as they saw a range of places and services and were in a good position to make comparisons between good and bad practice.

(j) Part of the issue was the difficulty in defining quality and there was a need to get beneath a service being simply labelled as 'green' or 'red'. This was where the Quality Surveillance Groups (QSG), hosted by NHS England local teams, were so valuable. For the first time there was a formal way to bring soft and hard intelligence on the quality of health and care provision together. Commissioners, local authorities, regulators and Health Watch were all represented on the local QSG. There was a QSG for Kent and Medway. In the transition from Primary Care Trusts to CCGs, there had been a quality handover as well of the kinds of information which would be of value to the new commissioners. The question was asked about the role of the public on the QSG. It was explained that there was a need to ensure public access to the relevant records. It was suggested the role of Health Watch might also need to be strengthened.

(k) There were also changes to the regulatory system reported to the Committee. There was a Burdens review underway with the aim of reducing regulations and paperwork by a third. There were acknowledged issues at the CQC and this was one area where the system was being simplified. This would include ratings for providers and a 'well run' test. The current system was too complex to enable members of the public to properly judge the quality of a service. Separate Chief Inspectors for hospitals, social care and primary care had either been already appointed, or would be appointed. Opinions on these were split between seeing them as a positive way forward or an

additional layer of bureaucracy. It was explained that the Chief Inspector of hospitals would be available to go into hospitals which had been placed in special measures. More broadly there was an accountability review looking at three levels – individual, organisational, and system failure.

(l) The 'friends and family' test was being rolled out across a number of health sectors, including for prisoners. This would provide a useful source of data and information.

(m) The hope was expressed that the measures being taken would improve public confidence in the NHS. Members of the Committee and NHS representatives discussed the difficulty in getting good practice and success stories a higher profile in the media, who were more interested in negative stories. NHS representatives explained that the media reaction to stories also differed across the sector with the Keogh report into Medway getting a higher profile in the local papers than on the radio. The point was also made in discussion that public confidence was more than just a matter of reporting in the media, with nursing and other staff travelling to and from work in uniforms given an example of the negative impression which could be given.

(n) The impact of the Francis Report was also discussed. A Member indicated that there were 290 recommendations, which was a large number to consider. Some of the recommendations dealt directly with scrutiny. One of them was for the need for health scrutiny to have the appropriate support and this meant that Members needed to know enough to be able to ask the right questions when presentations were delivered at HOSC. NHS representatives explained that they were more than happy to have more involvement by HOSC Members in the day to day business of the health sector, including taking part in visits or shadowing. On the number of recommendations, it was indicated that it would not be possible to come up with a response to all 290 locally and there was a need to be aware of and link into work being led nationally by the Department of Health and others. The request was made that a paper be prepared on how HOSC, the Health and Wellbeing Board, and Health Watch all fitted together.

(o) A series of questions on specific services were asked during the meeting. It was explained that the Deputy Chief Nurse had a special interest in working with the police on mental health issues and work was being done with Kent and Medway NHS and Social Care Partnership Trust around custody suites and that this should show some benefits. On the levels on attendance at accident and emergency departments, it was explained that there were 17,000 care home beds across Kent and Medway and it was necessary to ensure better care was being delivered here to reduce attendance at accident and emergency departments. More broadly, there a need to ensure appropriate community health services were in place. For example, the current model of district nursing needed to be considered to see if it

was the best way of delivering services, particularly as many district nurses were nearing the age of retirement.

(p) 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 a further update in November, in particular in relation to quality surveillance aspects.

(q) 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 a further update in November, in particular in relation to quality surveillance aspects.

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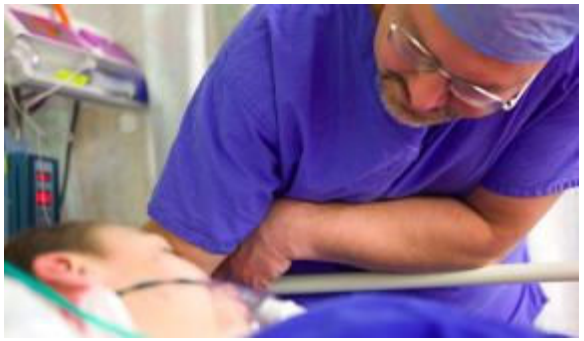
Quality Surveillance Groups (QSGs)



Sally Allum

Director of Nursing and Quality

29 November 2013

THE NHS CONSTITUTION

the NHS belongs to us all

Background

- ***Quality in the new health system – Maintaining and improving quality from April 2013*** sets out the distinct roles and responsibilities across the system for quality and how the system should work together:
  - **Proactively** – to share information and intelligence on quality and to spot potential quality problems early. A network of Quality Surveillance Groups (QSGs) should be established to make this happen locally and regionally
  - **Reactively** – to identify potential or actual serious failures and to take corrective action, working collaboratively to secure improvement and protect service users.
- Key messages from **Francis** and **Berwick**

Role of QSG

The role of QSGs

•QSGs bring together different parts of the health and care economy to routinely and methodically share information and intelligence about quality.

•This information is gathered through performance management, commissioning and regulatory activities.

•QSGs do not have executive powers

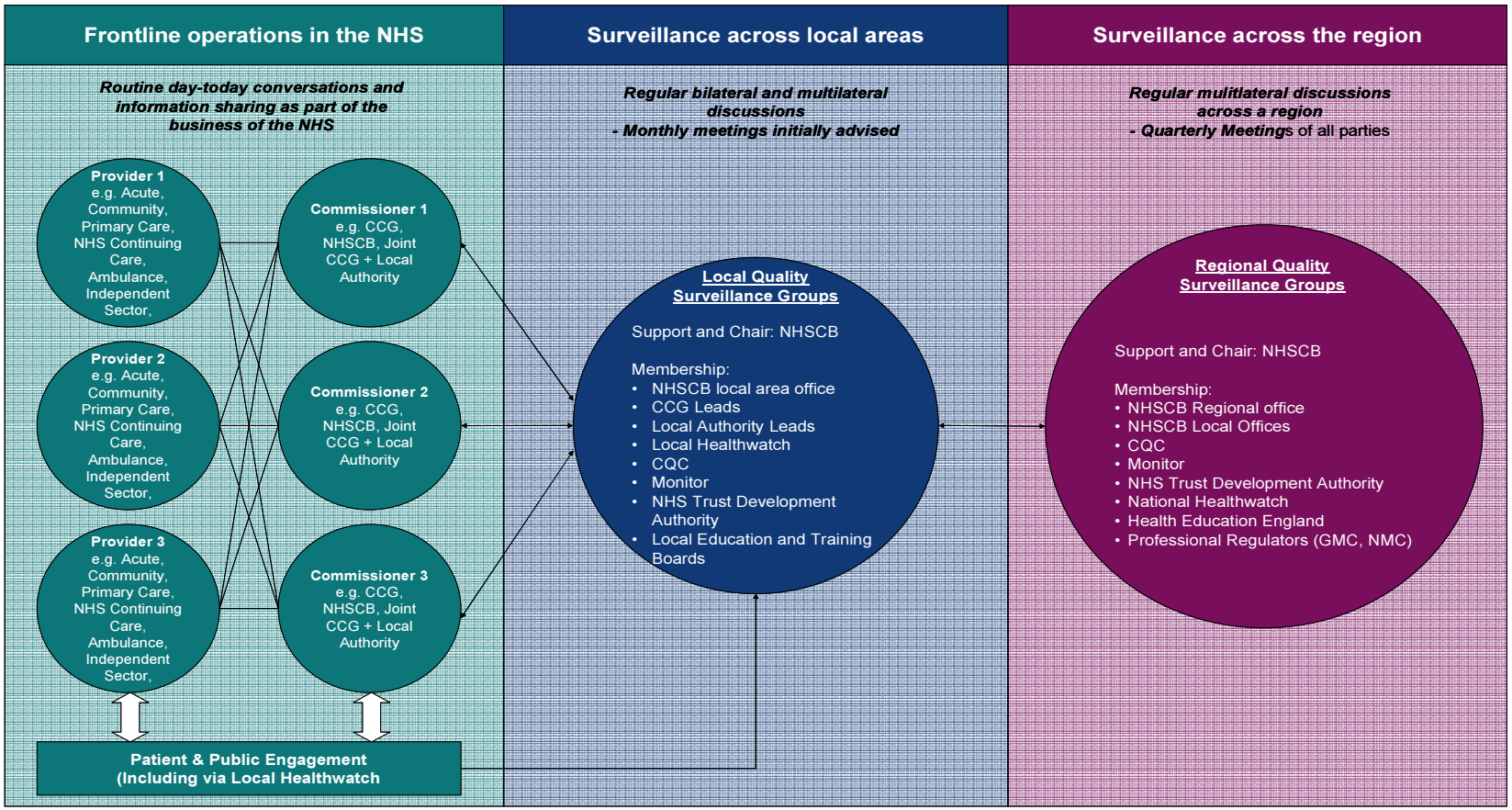
Operating model

•QSGs will operate at 2 levels:

1. Locally, on the footprint of the NHS England's 27 local area teams

2. Regionally, on the footprint of the NHS England's four regional teams.

Whole System Cooperation



4 QSG Roles and Responsibilities

Chair & Membership

- The chair is Felicity Cox the Area Director NHS England Kent and Medway.
- The QSG for Kent and Medway is well attended by the Accountable Officers and Chief nurses of the CCGs.
- Directors of Children and Social care services of both Kent and Medway Councils
- Directors of Public health for Kent and Medway councils
- Regional manager of Monitor

Membership

- Regional and Area Compliance Manager for CQC
- Associate Director for Governance and Quality Trust Development Agency
- Director of Education and Quality Health Education England Surrey and Sussex, Kent and Medway
- Public Health England (invited)
- Healthwatch
- Medical Director and Director of Nursing NHS England Area team and Members of their team

Membership

- **Local QSG Membership**
  - All local commissioners in the area (NHS England, CCGs)
  - Representatives from the NHS Trust Development Authority (where there are NHS Trusts in the area)
  - Health Education England
  - Public Health England
  - Local Authority
  - Local Health Watch
  - Representatives from the regulators, Monitor and the Care Quality Commission

Membership

- **Regional QSG**
  - Professional regulators
  - Ombudsman
  - Networks/senates

Areas of care reviewed

- This includes any NHS funded care in Kent and Medway.
- Care homes and nursing homes
- Mental health
- Ambulance services
- CAMHS work with national and regional pathway assessing need and requirements
- Primary Care
- Large Provider Trusts
- Health and Justice provision

Role of NHS England

- NHS England role involves:
  - proactively ensuring that all parties who need to be involved, are involved;
  - facilitating sharing of information if needed;
  - ensuring that there is a clear understanding as to how the QSG will consider all providers and system wide issues over time;
  - chairing meetings where a chair is required by the group;
  - co-ordinating communications where there is a need to do so; and
  - providing a record of the discussions and agreed actions.

- The QSG model is evolving over time. We are reviewing the effectiveness of QSG in November /December.

QSG Example

- NHS England responsible for co-ordination of the response of all parties to the Keogh review (Medway Foundation Trust)
- Sub group of the QSG has been leading in this and work with Trust Board to ensure action plan and Key Performance Indicators are delivered.
- Responsibility of monitoring progress is with Monitor as the regulator in this case.
- Sub group has meant that all parties concerned are able to provide support and not duplicate.
- Reports to QSG

Methodology of Surveillance

The level of surveillance of providers is determined by the Heat Map Framework. The following factors are considered:

- Number of quality issues
- Level of risk
- Level of confidence in the provider

Working with councils

- KCC and Medway Council actively discuss concerns at the QSG and indicate areas of concern that they want to be joint working with and aware of.

- CQC and Health work with the councils together to ensure that standards of care are correct for vulnerable people.

QSG connect

- Through regional QSG
- Through Clinical senates
- Through Allied Scientific and Clinical Networks

Links with HOSC and Health and wellbeing board

- Through Directors of Children and health and social care (members of QSG)
- Through Healthwatch
- Links with the commissioning teams
- Area Team Directors reporting quarterly to HOSC and HWBB; covering quality to support decision-making.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 November 2013

Subject: NHS 111

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the commissioners and providers of the NHS 111 services in Kent.

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

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1. Introduction

(a) NHS 111 is a national telephone service which has the aim of enabling better access to healthcare services when people need them fast, but where the situation is not life threatening. The service is divided into 44 areas across England. There are different providers around the country and it is commissioned locally.

(b) South East Coast Ambulance Service NHS Foundation Trust (SECAmb), in partnership with Harmoni, provides the service across Kent, Surrey, and Sussex. Across this area, there are two NHS 111 call centres. The Chairman, Mr Robert Brookbank, visited the call centre in Dorking in July 2013. Five Members of the Committee visited the call centre in Ashford in September 2013. These Members were: Mr Mike Angell, Mr Nick Chard, Dr Mike Eddy, Mr Jeff Elenor and Mr Geoff Lymer.

(c) The Committee has not had NHS 111 on its Agenda as an Agenda item in its own right. However, it has been discussed on a number of occasions when SECAmb was present (for example, 4 January 2013[1]). Discussion of NHS 111 formed part of the March 2012 report produced by the Committee, *"Not the Default Option" A Review into the Levels of Attendance at Accident and Emergency Departments."*

(d) Local commissioners are responsible for performance management of NHS 111 services, and set their own performance targets for services. There are two national Key Performance Indicators for NHS 111:

1. over 95% calls answered in under 60 seconds; and
2. under 5% abandoned after 30 seconds.[2]

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[1] Item 7, 4 January 2013, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5068&Ver=4

[2] House of Commons Hansard, 23 October 2013, Written Answers, PQ171701, Col.213-4W, http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131023/text/131023w0002.htm

(e) Based on data from 39 sites, the following figures for the service across England for August 2013 are available:

1. In September, there were 585,302 calls to the NHS 111 service, with 94.5% of these calls from people directly dialling 111. Scaled up, this would represent 8.1 million calls per year across England to the NHS 111 service.
2. In September, 97.1% of answered calls made to NHS 111 were answered within 60 seconds. Of all calls offered 0.7% were abandoned after waiting longer than 30 seconds.
3. Average episode length of a call in September was 15 minutes 0 seconds.
4. For answered calls 85.2% received triage.
5. Of all answered calls 7.1% were offered a call back, of those offered a call back 37.1% were called back within 10 minutes.
6. On average 24.0% of call time was handled by clinical staff for all calls in September. Eleven sites are currently able to submit this data, due to the data being classed as commercially sensitive by some providers. [3]

(f) On 8 October, Dr Daniel Poulter MP, Parliamentary-Under Secretary of State for Health made the following statement on NHS 111:

"NHS 111 is now available across more than 90% of England. Latest published performance data (8 September 2013) shows that over 580,000 patients used NHS 111 in July 2013. In addition, over 96% of calls were answered within 60 seconds, above the 95% target.

"NHS England is undertaking a full review of the NHS 111 service to ensure it is fit for the future and is collecting data to monitor impact on emergency service demand. In addition, the Urgent and Emergency Care Review, being led by Sir Bruce Keogh, will look in depth at the system of emergency care and how we ensure that it provides the care patients need, from the right people, in the right place. This will include piloting opportunities for NHS 111 clinicians to have access to patient records, to enable a more integrated service for patients.

"As part of the £250 million of support for emergency care this winter announced by the Secretary of State for Health, my right hon. Friend the Member for South West Surrey (Mr Hunt), on 10 September 2013, Official Report, columns 45-48WS, we have set aside £15 million towards securing a reliable NHS 111 service throughout the winter period. This will pay for up to an additional 200 call handlers and 60 clinicians, who would be able to handle an extra 20,000 calls to the service each week.

[3] Taken from: NHS England, *NHS 111 Statistics – September 2013*, http://www.england.nhs.uk/statistics/2013/11/08/nhs-111-statistics-september-2013/

"There is widespread consensus that NHS 111 is in principle a good idea. For many patients, accessing the National Health Service by telephone is often the quickest and easiest way to get advice and speak to a doctor or nurse when needed, and we remain committed to ensuring the best possible service for patients."[4]

(g) On 13 November 2013, Sir Bruce Keogh published a report on the first stage of the Urgent and Emergency Care Review referred to in the Written Answer above. This report set out five proposals 'for improving urgent and emergency care services in England':

1. Supporting self-care.
2. Helping people with urgent care needs to get the right advice or treatment in the right place, first time.
3. Providing a highly responsive urgent care service outside of hospital so people no longer choose to queue in A&E.
4. Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery.
5. Connecting the whole urgent and emergency care system together through networks.[5]

(h) In the section of the report giving details on proposal 2 above, a number of suggestions for enhancing the NHS 111 service were put forward. Under the Next Steps section of the report, work will be progressed over the next 6 months on completing a "new NHS 111 service specification so that the new service (which will go live during 2015/16) can meet the aspirations of this review."[6]

(i) The report summarises the changes put forward as follows:

"We will greatly enhance the NHS 111 service so that it becomes the smart call to make, creating a 24 hour, personalised priority contact service. This enhanced service will have knowledge about people's medical problems, and allow them to speak directly to a nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need. It will also be able to directly book a call back from, or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem."[7]

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[4] House of Commons Hansard, 8 October 2013, Written Answers, PQ169027, Col.106W, http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131008/text/131008w0004.htm#13100917000044

[5] Sir Bruce Keogh, *Transforming Urgent and Emergency Care Services in England, End of Phase 1 Report,* pp.22-27, NHS Choices website: http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

[6] Ibid., p.28.

[7] Ibid., pp.7-8.

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the reports from the commissioners and providers of the NHS 111 services in Kent.

Background Documents

Health Overview and Scrutiny Committee, Kent County Council, March 2012, *"Not the Default Option." A Review into Levels of Attendance at Accident and Emergency Departments."*
https://democracy.kent.gov.uk/documents/s42660/Not%20the%20Default%20Option%20March%202012.pdf

Sir Bruce Keogh, *Transforming Urgent and Emergency Care Services in England, End of Phase 1 Report,* NHS Choices website: http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

Contact Details

Tristan Godfrey
Research Officer for the Health Overview and Scrutiny Committee
tristan.godfrey@kent.gov.uk
Internal: 4196
External: 01622 694196

South East Coast Ambulance Service NHS Foundation Trust

Swale Clinical Commissioning Group

South East Coast Ambulance Service NHS Foundation Trust and NHS Swale Clinical Commissioning Group

Kent Health Overview and Security Committee

29 November 2013

Introduction

Following a visit to Ashford NHS 111 contact centre by HOSC members and a visit to the Dorking NHS 111 contact centre by the Chairman of the HOSC, SECAmb and commissioners have been asked a series of questions in order to prepare for a follow up discussion with the HOSC on 29 November 2013.

Each of the questions features in the narrative that follows with an answer provided by either SECAmb, commissioners or a combination of both.

Question 1

Can you please provide a summary of the NHS 111 service in Kent along with a timeline of key landmarks in the development and operation of the service?

The NHS 111 service has been introduced to provide a single point of access for people needing urgent NHS healthcare, when it is not an emergency. One of the aims of NHS 111 is to alleviate the inappropriate use of services such as 999 and local A&E departments, so they can focus on life-threatening emergencies.

The NHS 111 service has replaced NHS Direct as the single number to call for urgent care advice in Kent, Medway, Sussex and Surrey (KMSS). Calls to the existing out-of-hours services in Surrey, Sussex and Kent have been diverted to the new 111 number and information about the number is now being promoted to the wider public.

NHS 111 is staffed by a team of fully trained advisers, supported by experienced clinicians, who ask callers questions to assess symptoms, give healthcare advice and direct to the right local service as quickly as possible. This can include a local GP, GP out-of-hours service, urgent care centre, community nurses, emergency dentist or late-opening pharmacy.

Call handlers undergo an extensive training and induction programme. This includes six weeks' training to use NHS Pathways, plus additional training and coaching as part of their induction. On average, there is one clinician to every four call handlers in KMSS.

When someone calls NHS 111, they are assessed straight away using the nationally clinically validated NHS Pathways assessment tool . If it is an emergency, an ambulance is despatched immediately without the need for any further assessment. For any other health

problems, the NHS 111 call advisers are able to direct callers to the service that is best able to meet their needs. Between 15 and 20% of calls are transferred to a clinician within the NHS 111 service and 10% are advised by a GP within the service.

The inclusion of GPs within the NHS 111 service was agreed locally in KMSS, and goes beyond the national specification although this is being reviewed locally and nationally.
NHS 111 is staffed 24 hours, 365 days a year. Calls from landlines and mobile phones are free although, due to a national quirk in the system, 'pay as you' go mobile phone users must have 1p credit in order to use the service.

The key timelines for the service are provided below:

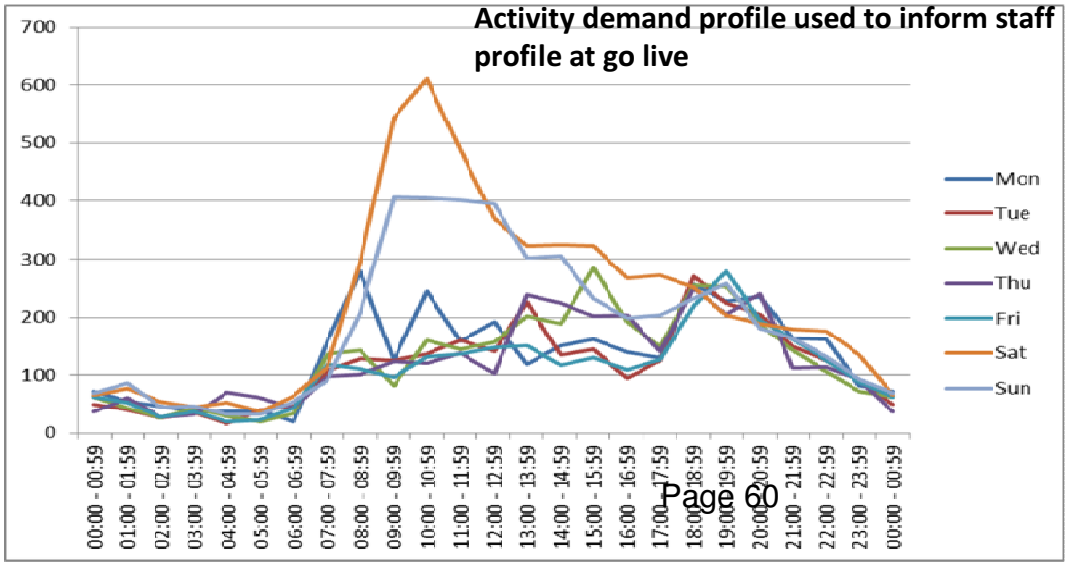
Service commencement for management of GP Out of Hours calls in Kent and parts of Sussex	13 March 2013
Performance notice served and rectification period start	17 April 2013
NHS Direct service switched off and calls managed by NHS 111	30 July 2013
Rectification period ends	1 August 2013
Public launch (awareness raising of the service)	13 August 2013

To raise awareness of the service following public launch, NHS 111 materials, including wallet cards, leaflets, easy-read leaflets and posters were sent to libraries, children's centres, Gateways, GP surgeries, pharmacies, hospitals, community services, mental health services and other outlets in Kent and Medway.

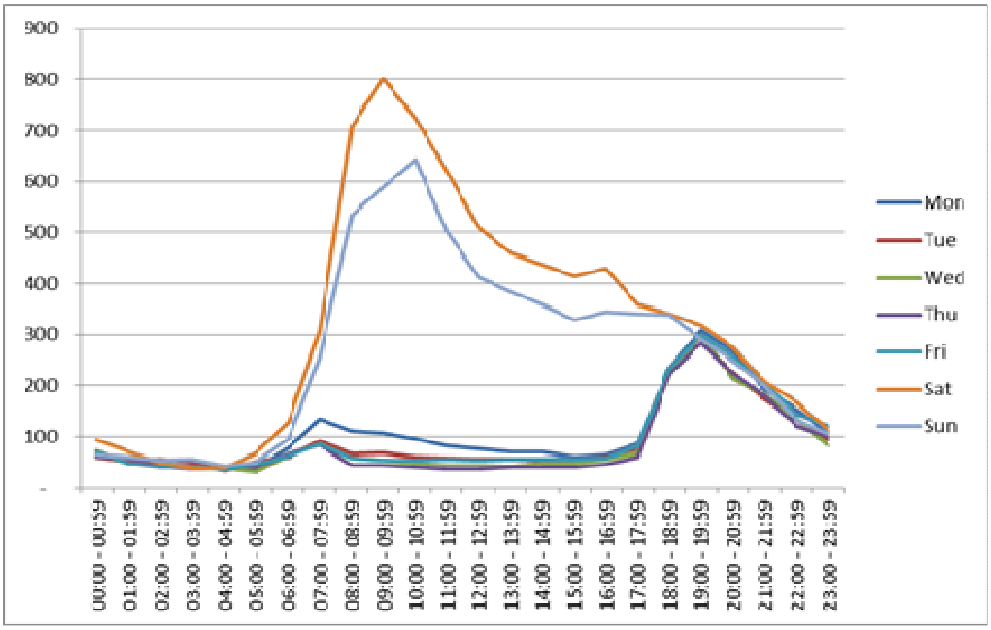
Question 2

There were acknowledged problems with the service in the early stage of operation. Can you please provide a summary of the nature of these problems, what analysis has been done into the reason for these problems and what has been done to rectify them?

The service planned its staffing profile against a call volume profile from other NHS 111 services and the DH NHS 111 profile and was considered to be appropriate for the service go live. This call profile is presented below and presents a week's activity with the expectation that there is moderate levels of activity through the week.



Shortly after go live it was clear that the service was unable to cope with peak call volume at the weekend. In-week performance was positive but weekend challenges led to a review of the historic call volume and profiles from incumbent providers. The commissioners generated these data and provided a revised profile which is below:



There was a lead-in time in order to re-profile the staffing complement and increase the workforce to cope with higher call volume during weekend mornings. As soon as the staff rota fill reflected the need of the revised activity profile, performance for the service was good and Key Performance Indicators related to access were consistently over-achieved.

In addition to access issues in the early days following go live, there were some technical faults which lead to a complete IT systems resilience review; there was a snowball effect related to feedback and complaints from system providers which increased the need for teams to manage feedback and there was a need to undertake additional stakeholder engagement in order to ensure good working relationships for the future.

Question 3

What have been the financial consequences of the initial problems and the measures required to overcome them?

Due to the commercially sensitive nature of NHS 111 contracts, it is not possible to detail the financial impact of the above issues. In order to get the service to where it needed to be for patients, SECAmb and Harmoni focussed on service quality; financial balance was not a priority at this time. As the service has now stabilised, providers will be reviewing the financial situation with commissioners.

Question 4

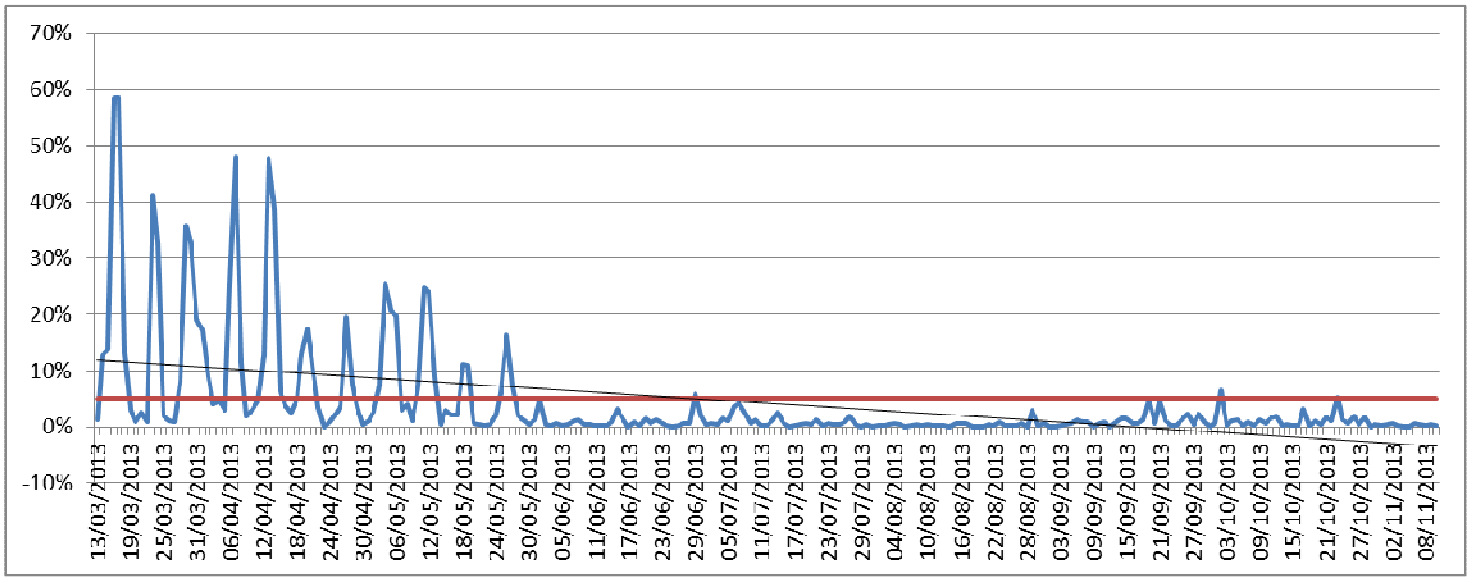
How is the service currently performing?

The service is performing well and has been since the end of rectification in August. The number of calls answered within 60seconds has been consistently above 95 per cent, and the rate of aborted calls is below 5 per cent every month.

There was a slight dip in performance shortly after the Medway Out of Hours call volume was fully introduced to the service, as this resulted in higher activity volumes than were expected. This impacted on Saturday performance against one of the access targets. However, staff levels have now been increased and the service has stabilised again. It is likely that ,in common with other elements of urgent and out of hours care across the NHS, there will be some challenges through the winter although rigorous planning has been undertaken to ensure that we make the best use of all available information to plan adequately.

Clinical Key Performance Indicators, which reflect the numbers of calls transferred immediately, or within 10 minutes, to a clinician, continue to be a challenge but significant improvements are being achieved month on month.

Call abandonment levels are demonstrated for each day since 1st April 2013. This demonstrates the challenges in April and May and shows clear performance improvement which has been maintained.



Question 5

What wider improvements to the health service are intended as a result of the 111 service?

NHS 111 is intended to provide patients with a simple means of navigating through a complex health system, to be able to receive the most appropriate service for their needs.

Patients can be certain that, when they are advised to attend a particular service, it is open and has the staffing suitable for their symptoms. In some cases, patients are directly booked into an appointment, although this feature is still to be developed widely. Kent HOSC previously identified concerns about the complexity of the health system and particularly access to minor injury units and walk in centres. By calling NHS 111, the patient is advised specifically about a service which will meet their needs

Another advantage of the system is for patients with long term conditions, or those nearing the end of their life who have particular care needs. Where patients have a known, often complex condition, their GP can identify any specific requirements for treatment and this 'special patient note' is available to the NHS 111 service to help inform care. This has been used by the out of hours GP services for some time, and is being further developed as part of the enhanced summary care record. This will help to support patients with agreed care plans to be managed in a way which they and their GP (or care manager) have agreed is most appropriate.

Access to community and mental health services have historically been via the GP out of hours service or for patients already known to the service who have been given a specific phone number because of their condition. NHS 111 can direct patients directly into the appropriate community service, if that service is able to accept them. As services are developed to received such calls, this will be an increasing feature and will enable direct access to the most appropriate professional.

Now that NHS 111 is running effectively, commissioners are working with providers in their area to identify when direct access is appropriate and how it is managed. An example is the single referral into community services which is being developed with Kent Community Healthcare Trust.

Another useful feature of the NHS 111 service is the ability to identify when services are requested but not available. This will help to inform commissioners' plans for the future as well as providing information on current provision. An example was a walk in centre which, although commissioned to be open until 8pm, was actually not taking patients after 6pm in case it became too busy to close at 8pm. The information allowed a discussion between the commissioner and provider to ensure a consistent message for patients. The data are beginning to be available but this facility is still at an early stage.

By enabling patients to be advised about the most appropriate service, including a wide range of alternatives to A&E, it is expected that this will support a much more diverse model of provision tailored to the known patient need. This will provide a much better experience for the patient as well as reducing duplication of health services and patients unnecessarily accessing multiple services at any point in time.

Question 6

What plans are there to develop the service in the future?

As described above, many of the features and benefits of the NHS 111 service are at an early stage of development. Some of the key areas for improvement are dependent on the national system and governance arrangements. The priorities for further development include:

- Further development of the special patient notes and End of Life register information.
- Improvements in some local protocols, for example for accessing repeat prescriptions
- Improvements in the way the information is provided back to the patient's own GP
- Review and development of the mechanisms for direct appointment booking and direct transfer of information to a wider range of providers
- Development of the service to meet the needs of more mental health patients.
- Information about the service to be available more readily to the public. (The challenges of delivery of NHS 111 in some areas elsewhere in the country has meant the national publicity has not been provided.)

Clinical commissioning groups in Kent and Medway are currently developing a phone and web app, with input from NHS 111 clinicians, GPs, hospital consultants and other health professionals, to help make it easier for people to find the most appropriate service for their needs. This app signposts people to NHS 111 as appropriate.

A significant publicity campaign is planned for the app.

As part of their winter communications, the CCGs are also undertaking a wide piece of communications with different audiences and have prepared a flyer for each CCG area, which signposts people to NHS 111 services as appropriate, as well as helping them to understand their other options. This is being sent to schools, children's centres, day nurseries, businesses, voluntary organisations and health and social care organisations, for dissemination to the public.

The CCGs are grateful for the support of KCC in this work.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 November 2013

Subject: Faversham MIU update and the development of the urgent care and long term conditions strategy

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Canterbury and Coastal CCG.

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

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1. Introduction

(a) NHS Canterbury and Coastal CCG requested the opportunity to bring the attached report to the attention of this Committee.

(b) For reference, there are 3 types of accident and emergency department:

- Type 1: a consultant-led 24 hour service with full resuscitation facilities;
- Type 2: a consultant -led single specialty accident and emergency service (e.g. ophthalmology, dental); and
- Type 3: other types of urgent care centre, such as minor injuries units or walk-in centres. A type 3 department may be doctor-led or nurse-led. It may be co-located with a major A&E or sited in the community.[1]

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the reports from NHS Canterbury and Coastal CCG.

Background Documents

None.

[1] Department of Health, *Guidance for the NHS in Delivering A&E Services*, 12 July 2011, http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/DH_113803

Contact Details

Tristan Godfrey
Research Officer for the Health Overview and Scrutiny Committee
tristan.godfrey@kent.gov.uk
Internal: 4196
External: 01622 694196

NHS Canterbury and Coastal Clinical Commissioning Group

NHS Canterbury and Coastal Clinical Commissioning Group

Health Overview and Scrutiny Committee

29 November 2013

HOSC update on the outcome of the procurement process for Faversham Minor Injuries Unit and the development of the urgent care and long term conditions strategy

Background

1.1 In January 2013 a review of Minor Injuries Units undertaken by NHS Eastern and Coastal Kent highlighted numerous differences between the Minor Injuries Units operating within east Kent. These differences included variation in service specifications, opening times, contract terms, access to x-ray, the datasets used by providers to capture activity and the processes to measure patients' experience of using these services. These differences are indicative of the fact that the Minor Injuries Units in east Kent were commissioned by different organisations at different times.

1.2 The review highlighted that Faversham Minor Injuries Unit had no x-ray facilities, (compare to all the other Minor Injuries Units in east Kent which had x-ray facilities available between 40%-100% of opening times), included an unusual additional service (a *Treatment Room Service* - an *Enhanced Service* normally provided by General Practice but which was incorporated into the minor injuries service as one of the General Practices within Faversham Health Centre declined to offer this service), and was paid on a *Block Contract* in excess of the applicable national tariff.

2.0 In April 2013 NHS Canterbury and Coastal Clinical Commissioning Group (CCG) replaced NHS Eastern and Coastal Kent as the statutory body for commissioning specified healthcare services for it's local population.

2.1 The CCGs Strategic framework aim is to provide viable alternative pathways to hospital admission for patients and better access to local treatment. This will improve treatment outcomes for patients, reduce pressure on local Hospitals and provide local care in the community for patients. There are a number of projects that have been brought together to make a strategic fit in terms of providing rapid access to urgent care.

2.2 The Urgent Care / Long Term Conditions Strategy for 2013/14 was devised against complex population and geographical challenges that impact on urgent care service providers:

- National context: - Urgent Care services have seen a demonstrable increase in demand in the past 12 months. Across the south of England, acute providers identified a noticeable shift towards activity presentations later in the day and out of hours. It has been identified that there are several reasons for the national increase in pressure in the NHS, including "a confusing and inconsistent array of services outside of hospital and high public trust in the A&E brand". *Sir Bruce Keogh (Medical Director, NHS England, 2013)*

- Local context: - East Kent Hospitals University Foundation Trust has highlighted the change in attendance patterns to the East Kent Integrated Urgent Care board throughout 2013. East Kent CCGs have successfully implemented a number of local schemes to reducing unnecessary re-attendances. Indications are that these initiatives have helped to reverse the national trend of significantly increased attendances to A&E.

2.3 The strategic goal of the CCG is to develop the integration of Urgent Care and Long term conditions strategies to improve local services to provide better options for patients to access care in their local community. Key deliverables are:
- Providing more care in patients' homes
- Reducing unnecessary attendances to hospital
- Reducing unnecessary hospital admissions

2.4 In it's Commissioning Intentions for 2013-14 the CCG committed to commissioning Minor Injuries Units to a consistent specification, including x-ray facilities, and in line with the national tariff (£58 per attendance for non-24 hour Minor Injuries Units).

2.7 A number of local initiatives have been introduced in east Kent to underpin these changes:
- Professional standards for urgent care – GPs within the Canterbury and Coastal CCG believe that minor illness is better seen and treated within a primary care setting. To enable this, the CCG has subscribed to professional standards, allowing patients to be seen on the same day or next day following an initial telephone triage.
- Support for ambulance services – dedicated professional lines have been established. These enable paramedics to seek advice before deciding to convey a patient.
- Neighbourhood care teams – provide social and community care in are in place locally. These provide outreach services within the community to support patients with long term conditions, providing a community service to ensure that they retain independence.

2.0 As part of the CCG strategy a new minor injuries service specification was designed for all MIUs in east Kent. This was put to tender in Faversham as part of an exercise aimed at standardising the minor injuries units across the region to give patients more certainty around the services they can expect. The specification stated that the service:
    - had to be within the ME13 8 postcode
    - had to include x-ray facilities

- had to re-direct patients with minor illnesses to primary care (this service is already funded by NHS England)
- would be paid the national tariff of £58 per attendance for patients presenting with minor injuries and a £10 local tariff to assess and re-direct patients with minor illnesses to primary care.

2.1 The tender process included staff from the CCG meeting with Faversham town patient and clinical representatives. The objective was to review the specification, making potential bidders aware of an offer from the Friends of the Faversham Cottage Hospital and Community Health Centres to fund the purchase of an x-ray machine (subject to agreement).

2.2 A patient representative was included on the tender panel and bidder interview. Bidder interviews were used to make patients aware of the numbers of Faversham patients that attended other Minor Injuries Units, providing a breakdown of potential demand for Faversham Minor Injuries Unit and highlighting that there was a 12% increase in attendances since period reviewed at part of the review referenced in 1.0.

Progress

3.0 The tender process resulted in nineteen expressions of interest. Eight organisations attended the bidder event. Following this, one bid was submitted. The sole bid proposed transporting patients requiring an x-ray to another location and payment under a block contract arrangement. As the bid did not meet the CCG's specification or financial criteria, the CCG determined that they could not support the award of the contract and regrettably that the Minor Injuries Unit in Faversham would close.

Next Steps

4.0 The CCG has reached an agreement with the current provider to continue the current service until the end of March 2014 to allow patients time to adjust, and for the CCG to make them aware of suitable alternatives. Those who, in the past, used the minor injuries service for treatment of minor illnesses will be able to access such care locally through their own General Practice. It is also the intention of the CCG to have alternative arrangements in place by this date for patients who currently use the *Treatment Room Service* at the Minor Injuries Unit.

5.0 Faversham patients requiring a minor injuries service after March 2014 will be able to attend the Minor Injuries Units at Sittingbourne Memorial Hospital and Estuary View, Whitstable as well as the Emergency Care Centre at the Kent and Canterbury Hospital. There is overlap between the services a minor injuries service can provide and those available at GP practices and pharmacies. Pharmacists can also provide health advice and guidance on common illnesses such as colds, flu, vomiting, and diarrhoea. In addition, all 22 GP practices across the Canterbury, Faversham, Herne Bay, Whitstable, Sandwich and Ash areas are signed up to the 'Professional Standards for Urgent Care'. This means that patients requiring urgent attention should always be offered the most appropriate type of appointment with a doctor or nurse, either face-to-face, over the phone or at home.

6.0 A number of comments in the media have linked the impending closure of Faversham Minor Injuries Unit with concerns regarding the future of Faversham Cottage Hospital. Whilst the CCG can understand the concerns of Faversham patients it wishes to make it clear that neither the Hospital nor other services provided at the hospital are affected by the closure of the Minor Injuries Unit. To put this into the context of the wider hospital, the Minor Injuries Unit utilises has a footprint of 33.45m2 (46.54m2 if you include its allocated share of communal areas) which accounts for 1.57% of the Hospital and Health Centre floor space and 3.2% of the Hospital-only floor space.

7.0 Members are also advised that the CCG is in discussion with its Patient Reference Group, local GPs, people and organisations, including trustees of The Friends of the Faversham Cottage Hospital and Community Health Centre, the MP, Faversham Town Council and Swale Borough Council to hear their concerns and discuss what is being done to lessen the potential impact of the service closing in March 2014.

Next steps in urgent care

8.0 A number of initiatives are planned across Canterbury and Coastal CCG. The current schemes that will be introduced this year (13/14) are:

- Community Geriatricians – This service provides a Care of The Elderly Consultant working within the local community area to support frail patients who are at risk of falling. This is currently being developed in partnership with EKHUFT. This service provides geriatric support to patients within the local community under a shared care service plan.
- Streamlining discharge processes to improve Care Home and Residential Home discharge pathways to hospital at weekends.
- Primary Care Hubs in A&E – These are currently in place in William Harvey Hospital and Kent and Canterbury Hospital. These provide primary care expertise to support patients arriving in A&E with primary care sensitive conditions. It is planned that these will be introduced at QEQM from December.
- New approach to health economy systems pressure management. Providers use data analysis to forecasting local pressure hotspots and plan to mitigate service pressure.

9.0 Projects for delivery next year:

- Integrated Urgent Care Centres: – It is the CCG's intention to commission integrated teams across urgent care to provide a more seamless service for patients. These will be centred within the A&E and local community. The teams will improve emergency services responsiveness across the local health economy. The aim is to produce a hub that can rapidly deploy resources to support patients in their own homes and ensure that delays within acute care are minimised.
- Review and enhancement of the GP out of hours contract: – this will provide a comprehensive review of the out of hours service to provide a seamless 24/7 service, integrating with multiple providers to enhance support offered to Care/residential homes and local resident with minor illness/primary care conditions out of hours. It will improve service responsiveness and reduce delays to provide better outcomes for patients.

- Investment and development in ambulatory care – this will ensure that patients are seen and treated in an effective local environment. We expect this will improve the quality of care and patent experience.

10.0 Members of the Health Overview and Scrutiny Committee are asked to note and comment on the contents of this briefing paper.

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Item 8: Musculo-Skeletal Services.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 November 2013

Subject: Musculo-Skeletal Services

Summary: This report invites the Health Overview and Scrutiny Committee to note the information provided on musculo-skeletal services

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) The following Clinical Commissioning Groups (CCGs) have asked that the attached report be presented to the Committee:

- Ashford;
- Canterbury and Coastal;
- South Kent Coast; and
- Thanet.

(b) The intention is for this item to return at the appropriate time in 2014.

2. Recommendation

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

Background Documents

None.

Contact Details

Tristan Godfrey
Research Officer for the Health Overview and Scrutiny Committee
tristan.godfrey@kent.gov.uk
Internal: 4196
External: 01622 694196

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NHS
Thanet Clinical Commissioning Group

NHS
Canterbury and Coastal
Clinical Commissioning Group

NHS
South Kent Coast
Clinical Commissioning Group

NHS
Ashford Clinical Commissioning Group

Health Overview and Scrutiny Committee

29 November 2013

Musculoskeletal and Orthopaedic Care Pathways.

Introduction

This report is an update for this committee regarding the work currently being undertaken by Ashford, Canterbury and Coastal, South Kent Coast and Thanet Clinical Commissioning Groups (CCGs) to re-design the Musculoskeletal (MSK) and Orthopaedic Care Pathways, the CCGs future plans for these pathways, and the rationale for the current re-design work and their future plans.

1. MSK Care Pathways is the term used by CCGs to describe the management of patients with conditions involving the musculoskeletal system in primary and community care settings.

2. Orthopaedics is the term used by East Kent Hospitals University Foundation Trust (EKHUFT) to describe the branch of surgery concerned with conditions involving the musculoskeletal system. However, it should be noted orthopaedic surgeons use both surgical and non-surgical interventions to treat musculoskeletal conditions.

3. Historically, healthcare commissioners have prioritised review, investment and re-design of MSK and Orthopaedic Care Pathways due to concerns that the level of demand for these services could not be met by the services commissioned but also believing that increased investment and expansion of services was not likely to be either appropriate or sustainable.

4. Ashford, Canterbury and Coastal, South Kent Coast and Thanet CCGs, having replaced the local Primary Care Trust (PCT) as the statutory body for commissioning specified healthcare services for their local populations as from April 2013, agreed a collaborative project to review and re-design their MSK and Orthopaedic Care Pathways on the grounds of the high number of patients using these services, their collective spend as a proportion of their allocated budgets and a shared provider base.

5. For 2013-14 the content of the CCGs collaborative project described above was based on a handover from the PCT. Thus three elements of the project were to (a) review and re-design the pathway for treating patients with low back pain with injections, (b) review of the *Community Orthopaedics* service provided by Kent

Community Health NHS Trust (KCHT) and (c) improve primary care referral management.

6. The first element of the project was predicated on the disparity between the east Kent CCGs and other Kent and Medway CCGs regarding the rate of pain injections per 1000 patients. East Kent CCGs have therefore implemented a process that ensures that patients with low back pain who may require more than one injection per year are jointly reviewed by the referring GP, the hospital consultant and each CCG's Planned Care Clinical Lead (also a GP). In the year to date (as of August) the rate of injections for low back pain per 1000 patients in east Kent CCGs has moved closer to the rate in other Kent and Medway CCGs.

7. The second element of the project was predicated on the view that the *Community Orthopaedics* service, though in itself believed to be a high-quality service, did not, in its current format, contribute to managing patient flows in an effective or sustainable manner. The formal review has concluded that, in its current format, this service inhibits the achievement of the 18 Weeks Referral-To-Treatment standard for patients on an Orthopaedic Pathway; attracts and assesses a high volume of patients at a high cost, many of whom are discharged or referred onto services which should more appropriately be available via GP direct access; results in a lower conversion to surgery rate in secondary care compared to patients referred directly by their GPs to secondary care; and doesn't reduce secondary care usage (the top 10 GP users of *Community Orthopaedics* have higher average referrals to secondary care than the bottom 10).

8. The east Kent CCGs have given formal notice to decommission *Community Orthopaedics* as from April 2014 and are in negotiations with KCHT as to the individual elements of this service that the CCGs will wish to commission via a GP direct access route as from April 2014.

9. The third element of the project was predicated on the view that improved primary care referral management remained critical to CCGs achieving a sustainable position in terms of the balancing the demand for MSK and Orthopaedic services with the capacity within the services commissioned. Consequently all east Kent CCGs, with the exception of Canterbury and Coastal CCG whose referral levels already matched their lowest year, committed to reducing referral levels to EKHUFT Orthopaedics to the lowest year for their CCG by working with their GP members to reduce referral variations. In the year to date (as of September) east Kent CCGs primary care referrals to EKHUFT Orthopaedics were 3.2% under plan.

10. Other elements of the project include review of hip replacement revision rates, diagnostic arthroscopy rates (the examination of a joint by inserting a specifically designed illuminated device into the joint through a small incision), review of the Shoulder Surgery Pathway, and an 18 Week Referral-To-Treatment Backlog Reduction Plan. Currently these elements are insufficiently advanced for an update to be given at this time.

11. Cognisant of the fact that re-designing MSK and Orthopaedic Care Pathways is a complex undertaking, that elements of these pathways will always need some form of re-design, that there is ever increasing demand for these services, that

the approach to commissioning which seeks to review and re-design pathways hails from a time when commissioners were greater in number and could develop pathway expertise and knowledge, and the fact that nationally mandated payment mechanisms may counter CCGs managing patient flows in an effective or sustainable manner, east Kent CCGs committed to investigating a different approach for 2014-15.

12. In simple terms, the east Kent CCGs are committed to developing a full business case for going out to tender for a lead provider for MSK and Orthopaedic Care Pathways in 2014-15. Within this, the intention is for the lead provider to be contracted to manage the entirety of east Kent MSK and Orthopaedic Care Pathways and to achieve set outcomes within an agreed financial value. Furthermore, the intention is for the contract to be underpinned by a formal financial risk share agreement between the CCGs and the lead provider, including a ratchet mechanism which will determine the percentage share of the financial risk based on the provider's performance against the outcomes specified.

13. Members of the Health Overview and Scrutiny Committee are asked to note the contents of this briefing paper and the commitment of the east Kent CCGs to return to the Health Overview and Scrutiny Committee in March 2014 with a further update.

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