HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 31st January, 2014

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 31st January, 2014, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Denise Fitch**
Telephone: **01622 694269**

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 P Beresford, Councillor Mr M Lyons, Councillor S Spence, and Councillor C Woodward

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 - 14)

5.	Musculoskeletal Services (Pages 15 - 20)	10.00
6.	Child and Adolescent Mental Health Services (Pages 21 - 48)	10.05
7.	Kent and Medway Adult Mental Health Inpatients Review: Implementation Plan (Pages 49 - 60)	11.00
8.	Kent and Medway NHS and Social Care Partnership Trust: Update (Pages 61 - 78)	11.45
9.	Patient Transport Services: Written Update (Pages 79 - 86)	12.30
10.	Faversham Minor Injuries Unit: Written Update (Pages 87 - 94)	12.35
11.	Forward Work Programme (Pages 95 - 96)	12.40

12. Date of next programmed meeting – Friday 7 March 2013 @ 10:00 am

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
(01622) 694002

23 January 2014

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, 29 November 2013.

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

ALSO PRESENT: Cllr Mrs A Blackmore and Mr A H T Bowles

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

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest

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

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

3. Minutes
(Item 4)

(a) Ms Angela Harrison wished to pass on her thanks to the Chairman, committee staff and colleagues in the NHS for arranging a recent visit to Maidstone Hospital.

(b) The Chairman explained that the Vice-Chairman and he had recently met with representatives of Health Watch and explained that he hoped the Committee and Health Watch Kent would develop a close and productive working relationship. As a beginning, his suggestion was to invite two representatives of Health Watch Kent to attend future meetings of the Committee. This suggestion was agreed to by the Committee.

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

4. Quality Surveillance
(Item 5)

Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(a) The Chairman welcomed Sally Allum to the meeting and introduced the item, explaining that the Committee had received a presentation on quality issues in July and had asked for a further update on this specific area. The full Government response to the Francis Report had been published the previous week and this was a subject which would be returned to in due course, so the focus of this meeting would be on the Quality Surveillance Group (QSG).

(b) Sally Allum explained that she had attended the Committee in July with Dr Steve Beaumont and she was glad to hear that the visit to Maidstone Hospital had been a success. It was hoped this would be the beginning of a rolling programme. She then proceeded to talk to a presentation, a copy of which was included in the Agenda before Members. Following this, Members proceeded to ask questions and discuss areas of particular interest or concern.

(c) There are QSGs across England, one for each of NHS England's Local Area Teams, with four regional ones matching NHS England's regional offices. It was explained that one of the lessons of the Francis Report was the need to bring disparate information together. The QSGs were set up in April to do just this and work proactively to obtain soft and hard information on the quality of care. Through an early warning system by looking at a whole range of indicators, it would then be possible to react to issues early. While the QSG had no executive powers, it can make recommendations to commissioners and regulators. It did not duplicate the work of safeguarding boards, to which it could also make recommendations.

(d) It was explained that the membership of the Kent and Medway QSG included commissioners, regulators, Kent County Council and Medway Council, Health Watch and Health Education England. The regional tier also included professional regulators, clinical networks and senates, and the Ombudsman. In response to a question it was confirmed that the Director of Public health and the Director of Families and Social Care were the representatives from Kent County Council. As regards Clinical Commissioning Groups (CCGs), the NHS England Area Director insisted on senior accountable officers attending, and this made the QSG in Kent and Medway slightly different to others. It was explained that there had been full attendance at all meetings and that while good work had been done, the QSG was reviewing how it worked to see how it can improve further. Sally Allum reported that while Health Watch Medway was fully engaged and had added value to the work on Medway NHS Foundation Trust, the QSG did not have the right representation from Health Watch Kent. Mr Nick Chard offered to follow this up after the meeting.

(e) The QSG was supported by Sally Allum's team, which consisted of eight members of staff. No additional staff were required just for the QSG. Sub-groups were established where a particular issue required more time to discuss, such as ones on Medway NHS Foundation Trust and Child and Adolescent Mental Health Services (CAMHS).

(f) Bringing all these groups together enabled whole systems scrutiny. All areas of care were looked at, with work on primary care balancing out that one the acute sector. As the lead commissioner for health and justice provision across the south east, this area was something the Local Area Team for NHS England also looked to include in the work. The inclusion of Health Education England meant the perspective of students could be drawn upon and this was one which had been lacking in the past. Early benefits had been seen in the care home sector where pulling information together had brought providers onto the radar when they might not have been before. Here as in other areas, there was good challenge between the partners on the QSG as when the Care Quality Commission (CQC) reported positively on a care home, but where other partners had concerns. The involvement of both local authorities had been positive; both with regards care homes and children's issues.

(g) CAMHS made a good example of the kind of work the QSG did across the whole pathway. As a result of the piece of work carried out by the QSG, it began to be appreciated just how diverse the CAMHS provision was and it was not just a case of one main provider. It became clear that changing providers would make little difference unless the whole pathway was reviewed. It was explained that in the past there had been too much a focus on the provider of services, so in this example it would be part of the review to ask whether the commissioning of CAMHS was adequate, as well as the provision.

(h) The QSG was looking at how to apply the model of the recent Keogh reviews into fourteen acute hospitals more widely as this was seen as effective. Heat maps were produced taking into account the number of quality issues, level of risk and level of confidence in the provider. There was then a determination as to whether issues identified could be dealt with during routine business or whether further action was required. This further action could involve an inspection, and this could possibly involve the regulators, commissioners or HOSC. The ultimate step was to hold a risk summit with the provider concerned and all the relevant partners there to ensure action was taken.

(i) Comments were made by Members to the effect that over the years different organisations had been to HOSC and painted a particular picture, with a different picture emerging later. With the increased fragmentation of the health sector, Members questioned how things would be different in the future. Recent events at Medway NHS Foundation Trust were given as an example. It was explained that a number of issues had been known about at the Trust for ten years or more. What was new was a lack of tolerance of bad provision combined with a new regulatory system which could learn from the lessons of the Francis Report and look at a wide set of indicators. It was further explained that similar issues had been uncovered at Mid-Staffordshire as had been found at Maidstone and Tunbridge Wells and that for each of the fourteen Trusts reviewed by Keogh, there were likely to be as many facing similar problems. However, the work of QSGs around the county meant many of these were known to regulators and commissioners with action being taken. While it was still early days, this work would continue.

(j) The issue of quality of access was raised by Members and the response was given that while it was not explicitly included in the presentation, it was a key area which was being looked at and got to the heart of considering the whole

care pathway. A particular issue around problems accessing mental health services in West Kent was raised and Sally Allum undertook to feed this back to NHS West Kent CCG. Similarly, the issue of patients transferring from one organisation to another had long been recognised as an issue and that this was partly a cultural challenge with the need to avoid one organisation looking to blame another for any problems.

(k) In response to a specific question, it was explained that the NHS did keep regular records on individual staff members' performance and quality of care. The challenge now when there was a wider variety of providers was to ensure this was being done equitably.

(l) The relationship of HOSC and the QSG was also discussed, and the view was expressed that there had been a certain randomness to the reporting of quality issues to the Committee. The QSG had been asked to produce quarterly report to the HOSC and the Health and Wellbeing Board to assist decision making.

(m) The Chairman proposed the following recommendation:

- That the Committee thanks its guest for the information provided, recognises the importance of this issue and looks forward to receiving quarterly reports.

(n) AGREED that the Committee thanks its guest for the information provided, recognises the importance of this issue and looks forward to receiving quarterly reports.

5. NHS 111
(Item 6)

Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust), Helen Medlock (Associate Partner, KMCS), Patricia Davies (Accountable Officer, NHS Swale CCG), Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(a) The Chairman welcomed the Committee's guests and asked them to introduce the item. A number of Members of the Committee had had the opportunity to visit one of the 111 call centres in the region, and this experience was remarked on positively. The offer was made during the meeting to extend the opportunity to visit to other Members.

(b) Representatives from NHS Swale CCG explained that this organisation was the lead CCG for commissioning both 111 and 999 services across the South East area, covering 22 CCGs in total. On behalf on the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) it was explained that there were three key questions to answer. These were whether the service was improving, whether it was meeting the requirements of providing access to the service and how was the service going to be improved in the future. It was further explained that SECAmb was meeting the targets in terms of call

answering and responding to calls and was working to improve transfers between clinicians, or 'warm transfers' as they were referred to.

(c) Members of the Committee commented positively on the way the NHS had been honest about the problems the service had faced and the way it had dealt with them to improve the service. In response to questions arising from this it was explained that the 111 service was not perfect nationally or locally. It was a national service, tendered locally, and this had been carried out by the Primary Care Trusts which preceded Clinical Commissioning Groups. Locally, contract penalties had been applied and the rectification of the service had been successful. The SECAmb representative stated that discussions with the CCG had begun on contract variation.

(d) The broader point was raised that although the idea of commercial confidentiality was well understood, the Committee needed to think about how best to examine and scrutinise the use of public money. The Committee was informed that all the relevant financial information could be found in the SECAmb Board Papers and that these were publicly available on their website.

(e) There was a discussion on the need to effectively promote and communicate the existence of the 111 service. Although many measures were being taken, it was explained that there were restrictions on local areas advertising the service ahead of a national campaign which had yet to take place.

(f) The pressure on accident and emergency departments was raised. CCG representatives explained that Swale CCG and Dartford, Gravesham and Swanley CCG were working with the King's Fund on this topic. Data from north Kent suggested that attendances at accident and emergency departments were flat and that the real challenge was the rate of people attending who were subsequently admitted. It was added that winter was coming, and there would be a change in the case mix, with more children and the elderly presenting at accident and emergency departments.

(g) The role of technology was another area raised and discussed. The Ibis system used by SECAmb enabled GP systems to be connected with that of the ambulance service and that for calls relating to people with long term conditions or receiving end of life care, then the service would be able to view the appropriate information, including details of who should be contacted. The NHS Pathways programme, used by the 111 and 999 services for triage was also discussed. The representative from SECAmb explained that this system had been signed off by the Royal Colleges and expressed the hope that it could be used in accident and emergency departments as well to enhance consistency. More broadly, SECAmb wished to develop a single point of access service across the health economy. It was working with all 22 CCGs on how to access local urgent care boards and discuss the best ways of sharing information.

(h) Although it was not related to the 111 service, the issue of the police being called to deal with mental health crises was discussed. Work was being done on this in Kent and pilot schemes were underway where a mental health professional accompanied police men and women.

(i) On the topic of innovation and improving the service, it was explained that NHS 111 was a big national service and that there was the opportunity for different ideas to be piloted. One Member raised the idea of giving telephone access to 111 in accident and emergency departments and the response was given that a version of this was being trialled in Sussex. It was important to look at the processes carefully to avoid such situations as an ambulance being called and sent to a person already in an accident and emergency department. There was a pilot underway in Blackpool where the 111 system and accident and emergency department were closely connected.

(j) The Chairman proposed the following recommendation:

- That the Committee thanks its guests, notes the good progress made and looks forward to an update next year.

(k) AGREED that the Committee thanks its guests, notes the good progress made and looks forward to an update next year.

6. Faversham MIU update and the development of the urgent care and long term conditions strategy
(Item 7)

Dr Mark Jones (Chair, NHS Canterbury and Coastal CCG), Simon Perks (Accountable Officer, NHS Canterbury and Coastal CCG), Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England) and Dr John Allingham (Medical Secretary, Kent Local Medical Committee) were in attendance for this item.

(a) The Chairman welcomed the guests of the Committee and asked them to introduce the item. The representatives of NHS Canterbury and Coastal CCG began by setting out a short chronology. Three weeks prior to the Committee meeting, the CCG had considered the outcome of the tendering service for the Minor Injuries Unit at Faversham Cottage Hospital. There were no successful bidders and the decision was taken to serve notice and close the service. The request was made by the CCG to bring the topic to HOSC. Since the announcement two weeks before, there had been a lot of interest and concern expressed. Stakeholder meetings had been held and would continue to be held.

(b) The Chairman then asked Mr Andrew Bowles to speak as a guest of the Committee. Mr Bowles thanked the Chairman for the opportunity to address the Committee and also thanked the representatives of the CCG for including him in other meetings which had taken place and were due to take place. He read out a message from the local MP, Hugh Robertson. Mr Robertson expressed his concern at the closure of a valued local service as well as the impact of the longer journey times to the alternative sites and the congestion which could be caused at them.

(c) Mr Bowles added that part of the problem was that this proposal had not been known about in advance and so this had not allowed for any discussions with the Borough Council on possible solutions. Mr Bowles explained that he was Leader of Swale Borough Council and a former non-executive director of a

Primary Care Trust. In light of this experience, he thought that when a procurement exercise had begun with nineteen interested parties, which then resulted in eight attending a bidder event, and ultimately one bid which was found wanting, then the whole process should be looked at again. The Council had recently voted unanimously to write to the Secretary of State on this issue which was one of great concern locally and would impact on the 28,000 residents of Faversham. The request had been made to the CCG asking them to go back to stage one of the procurement and undertake it again, consulting the Borough Council and Kent County Council (KCC), particularly in light of KCC expertise in procurement. Mr Bowles added that Estuary View in Whitstable was a good service, but it was 5-6 miles away and there were inadequate public transport links. This meant people were more likely to travel to the Kent and Canterbury Hospital, adding to the pressures at that site.

(d) Mr Bowles also made reference to a statement issued by the local GPs in Faversham explaining that they were not in favour of the closure and had not been involved in the decision. CCG representatives explained that the local GPs had subsequently issued a new statement clarifying that they had been involved in discussions, but had not been involved in the confidential part of the tendering process.

(e) CCG representatives further explained that the tendering process was not a short one. The original contract was for a collection of services. The treatments rooms would be remaining. The tendering exercise was only for the Minor Injuries Unit (MIU). It was explained that 300 people each month used the MIU and that it would be better to improve access to GP services for these people. The original contract for the MIU had been extended over and over by the predecessor Primary Care Trust and could not legally be extended any further. There had been lots of discussions with GPs and patients and the public and an East Kent wide specification had been developed as to what an MIU should be so this service would then be consistent across the area. The tender was for a seven day service including an x-ray service. The one bid submitted involved bussing people to Sittingbourne and cost £100,000 more than the cost envelope. The cost of the tender was set by the national tariff.

(f) Members of the Committee then proceeded to ask a series of questions and make a number of comments. One Member observed that GP practices were also stretched and could not necessarily be asked to take on additional services. Reference was also made to correspondence sent to Members of the Committee by the Friends of Faversham Cottage Hospital and Community Health Centres. Clarification was sought as to the place of the £300,000 which the Friends had raised for an x-ray machine in the tendering. It was explained that this had been a core component of the tender. However, the building had been appraised and it was not suitable for an x-ray machine.

(g) Observations were made about the length of time the CCG as an organisation had been operating and whether this had made an impact on the success of the procurement. CCG representatives explained that the staff supporting the procurement were experienced and had carried out procurements for Primary Care Trusts in the past. It was also explained that the tendering process had been looked at and no issues had been found and that the original specification had been drawn up in consultation with local GPs, public and

patients. It therefore did reflect local need. CCG representatives explained that it was difficult to see where the process could have been stopped due to the numbers expressing an interest and it was judged that the one bid submitted was worthy of serious consideration. The process had failed only in the sense that a suitable provider had not been found. The only option would be to tender at a lower service specification.

(h) Concern was expressed about other changes being proposed in other areas, such as at Deal Hospital, and whether the closure of the MIU at Faversham was possibly the thin edge of the wedge leaving East Kent ultimately only with three large acute hospital sites. CCG representatives explained that the broader shift was to move services out of acute hospital sites and that the CCG was a partner in East Kent Hospitals' outpatient services consultation as they felt it was important to listen to the views of the public. The view was expressed that it was important to look at what services would be required in the future, not what had been provided in the past.

(i) A Member of the Committee drew a comparison to Edenbridge Community Hospital where the MIU had been revamped and that this served a smaller population. In response to the points raised, it was explained that the CCG could not provide the service in house under the current rules and that the service was also not suitable for Any Qualified Provider.

(j) Discussion also included the nature of the Faversham Hospital estate. It was explained that it was owned by NHS Property Services Limited and there were no planning applications on it. It was believed that Estuary View was privately owned by the relevant GP practice. The MIU at Faversham took up 3% of the floor space of the hospital, or two and a half rooms. There were also 2 GP practices on the site so there was no danger to the future of the hospital. This was questioned by a local Member who believed that while the GP practices were adjacent to the hospital, and linked to it, they were not part of the hospital estate as such. In response to a question, it was explained that no interest in provided services in the areas currently occupied by the MIU had been expressed.

(k) Mr Nick Chard proposed the following recommendation:

- That this Committee asks that the decision to close the service on 31 March 2014 is set aside. This will allow a new procurement exercise to be undertaken after taking advice and with full consultation with the people of Faversham and their democratically elected representatives.

(l) This was seconded by Ms Angela Harrison.

(m) This recommendation was discussed by the Committee and the view was expressed that this did constitute a substantial variation of service. The possibility of referring the issue to the Secretary of State was raised. The Researcher to the Committee explained the regulations underpinning a formal referral along with the requirements of the KCC constitution. Although it would not be a formal referral, the Committee requested that the Chairman write to the Secretary of State on this matter which the Chairman undertook to do.

(n) AGREED that this Committee asks that the decision to close the service on 31 March 2014 is set aside. This will allow a new procurement exercise to be undertaken after taking advice and with full consultation with the people of Faversham and their democratically elected representatives.

7. Musculo-Skeletal Services
(Item 8)

Due to the amount of time taken to discuss other items on the Agenda, the Chairman determined to postpone consideration of this item until the next meeting.

8. Member Updates

(a) As mentioned earlier in the meeting, two Members of the Committee had had the opportunity to visit Maidstone Hospital with the Chief Nurse of NHS West Kent CCG and speak to staff and patients. As one of the Members to attend, the Vice-Chairman was invited to provide feedback to the Committee on this visit.

(b) The Vice-Chairman explained that they had received a very warm welcome at the Hospital and the visit began with the opportunity to speak to the Chief Nurse at the Hospital as well as other senior members of staff. There was then the opportunity to visit a couple of wards and then discuss what had been seen at the end. A wide range of quality issues were covered and discussed. The Hospital appeared exceptionally clean and well organised with infection control a particular strength. Patients spoke highly of their treatment.

(c) The positive comments of the Vice-Chairman were echoed by Ms Angela Harrison who also took part in the visit. She explained that they had the opportunity to speak with staff at all levels of the organisation as well as patients. It was explained that what came through particularly strongly was the enthusiasm of both staff and patients.

(d) Both wished to put on the record their thanks to Dr Steve Beaumont and the other NHS colleagues involved in the visits. The Chairman offered to write a letter of thanks on their behalf and explained that it was hoped that further visits to this and other sites would be arranged in the future.

(e) A local Member explained that he was glad to hear these positive comments and spoke of the different ways the Hospital was developing a variety of specialised services for the future. He hoped more Members took the opportunity to visit.

(f) The Chairman wished everyone a Merry Christmas and a Happy New Year.

9. Date of next programmed meeting – Friday 31 January 2014 @ 10:00 am
(Item 9)

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 31 January 2014

Subject: Musculoskeletal Services

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on musculoskeletal 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 East Kent Federation of Clinical Commissioning Groups (CCGs) has asked that the attached report be presented to the Committee. The East Kent Federation brings together the following four CCGs:

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

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

(c) This item was on the Agenda for the meeting of 29 November 2013. Consideration of the item was postponed due to the length of time devoted to other items on the Agenda.

2. Recommendation

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

Background Documents

None.

Contact Details

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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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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 31 January 2014

Subject: Child and Adolescent Mental Health Services (CAMHS)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on Child and Adolescent Mental Health Services (CAMHS)

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

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1. Introduction

(a) There are a number of items on today's Agenda related to mental health services. General information on mental health services is included in the covering report to this item as the first of these. This will be useful background for all the mental health items.

(b) Mental health and mental health services are both terms with a very wide scope:

1. Nearly 11% of England's annual secondary care health budget is spent on mental health.

2. More than £2 billion is spent annually on social care for people with mental health problems.

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

4. The wider economic costs of mental illness have been estimated at around £105 billion a year.[2]

(c) Mental health problems have traditionally been divided in several ways, but are not necessarily mutually exclusive where an individual person is concerned:

1. Organic (identifiable brain malfunction) or functional (not due to structural abnormalities of the brain) illness.

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[1] HM Government, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, February 2011, pp.8, 10,* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

[2] NHS Choices, http://www.nhs.uk/nhsengland/nsf/pages/mentalhealth.aspx

2. Neurosis (severe forms of normal experiences such a low mood, anxiety) or psychosis (severe distortion of a person's perception of reality).[3]

2. Mental Health Services – Overview[4]

(a) Historically, there has been a relatively clear-cut divide between 'front-line' mental health services delivered by professionals such as GPs and community mental health nurses and the more 'specialised' services delivered by professionals such as psychiatrists and clinical psychiatrists, largely working out of psychiatric units. More recent developments in mental health services have emphasised a shift to providing specialised services in community settings.

(b) GPs treat many patients, and usually refer where appropriate directly to community mental health teams (CMHTs) or psychiatric outpatient clinics. CMHTs are the main source of specialist help for mental health problems. These teams can include social workers, community psychiatric nurses, doctors, psychologists, occupational therapists and support workers.

(c) Some of the ways in which mental health services have been developed in the community include:[5]

1. Early intervention teams which aim to treat psychotic illness during its early onset.

2. Assertive outreach teams to provide intensive support for those difficult to engage in traditional services.

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

(e) CRHT teams provide treatment at home for those who are acutely unwell but do not require A&E admission.[6]

(f) Liaison psychiatry provides psychiatric treatment to patients attending general hospitals, whether they attend out-patient clinics, accident & emergency departments or are admitted to in-patient wards.[7]

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[3] Adapted from definitions produced by the London Health Observatory (LHO), http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/MentalHealth.aspx

[4] Information in this section mainly adapted from *The NHS Handbook* and http://www.nhs.uk/NHSEngland/AboutNHSservices/mentalhealthservices/Pages/Availableservices.aspx

[5] NB: The names given to services can vary between areas of the country.

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

[7] Royal College of Psychiatrists, Faculty of Liaison Psychiatry,

(g) Recent years have also seen the development of the Improving Access to Psychological Therapies (IAPT) programme aimed at extending 'talking therapies' and encouraging provision outside hospitals.

(h) In the acute sector, acute admission wards provide inpatient care with intensive support for patients in periods of acute psychiatric illness. Inpatient Assessment Units assess functional and organic type illness in older adults, and take referrals from Community Mental Health Teams for Older People, GPs and Consultant Psychiatrists.

(i) Other mental health inpatient services aim to provide rehabilitation services and provide care to people with an enduring mental illness and for whom a residential placement in the community has been judged to be unsuitable.

(j) Patients who are in an acutely disturbed phase of a serious mental health disorder are detained in Psychiatric Intensive Care Unit (PICU) facilities.

(k) Forensic mental health services are there to deal with patients whose behaviour is beyond the scope of general psychiatric services and who may require a degree of physical security. Patients in secure care will be detained under the Mental Health Act; some may have committed an offence.[8] These services fall into three categories:

1. Low-security services, often near general psychiatric wards in NHS hospitals.

2. Medium secure services operating regionally with locked wards.

3. High-security services provided by the three specialist hospitals of Ashworth, Broadmoor and Rampton.

(l) CAMHS services are arranged in four linked tiers:

- **"Tier 1** - provides treatment for less severe mental health conditions, such as mild depression, while also offering an assessment service for children and young people who would benefit from referral to more specialist services. Services at this level are not just provided by mental health professionals, but also by GPs, health visitors, school nurses, teachers, social workers, youth justice workers, and voluntary agencies.

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http://www.rcpsych.ac.uk/specialties/faculties/liaison.aspx

[8] NHS Confederation, *Defining mental health services. Promoting effective commissioning and supporting QIPP*, January 2012, p. 11, http://www.nhsconfed.org/Publications/reports/Pages/Defining-mental-health-services-QIPP.aspx

- **Tier 2** - provides assessment and interventions for children and young people with more severe or complex health care needs, such as severe depression. Services at this level are provided by community mental health nurses, psychologists, and counsellors.

- **Tier 3** - provides services for children and young people with severe, complex and persistent mental health conditions, such as obsessive compulsive disorder (OCD), bipolar disorder, and schizophrenia. Services at this level are provided by a team of different professionals working together (a multi-disciplinary team), such as a psychiatrist, social worker, educational psychologist, and occupational therapist.

- **Tier 4** - provides specialist services for children and young people with the most serious problems, such as violent behaviour, a serious and life-threatening eating disorder, or a history of physical and/or sexual abuse. Tier four services are usually provided in specialist units, which can either be day units (where a patient can visit during the day), or in-patient units (where a patient will need to stay.) Depending on the nature of the condition this could be a stay of several days to several months."[9]

3. Mental Health and Payment by Results[10]

(a) The year 2012/13 saw the beginnings of a major shift in the way mental health services are funded, from block contracts towards Payment by Results (PbR) currencies relating directly to individual service users accessing services. It was the introductory year for mental health care clusters to be introduced with local prices.

(b) The clusters cover most mental health services for working age adults and older people.[11] Pilot work is taking place with CAMHS providers currently to develop a suitable approach for PbR for CAMHS.

(c) The care clusters as a unit of currency are based primarily on the characteristics of a service user, rather than on their diagnosis alone. There are 21 clusters in use.

(d) A distinction is made between currencies and tariffs in NHS finances. A currency is the unit of healthcare for which a payment is made and the tariff is the price paid for that unit of healthcare.

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[9] NHS Choices, *Mental health Services Available*, http://www.nhs.uk/NHSEngland/AboutNHSservices/mentalhealthservices/Pages/Availableservices.aspx

[10] Information for this section sourced from: NHS England and Monitor, *Draft guidance on mental health currencies and payment*, http://www.monitor-nhsft.gov.uk/sites/default/files/publications/Draft%20guidance%20on%20mental%20health%20currencies%20and%20payment.pdf

[11] A list of exclusions can be found: Ibid., Annex A.

(e) Work by NHS England and Monitor is continuing on the development of a long-term payment system for mental health services.

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the reports on Child and Adolescent Mental Health Services (CAMHS).

Background Documents

None.

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NHS
West Kent
Clinical Commissioning Group

Strategic Commissioning Direction for

Children and Young People's Mental

Patient focused

KENT HEALTH AND OVERVIEW SCRUTINY COMMITTEE

FRIDAY 31 JANUARY 2014

STRATEGIC COMMISSIONING DIRECTION FOR CHILDREN AND YOUNG PEOPLES MENTAL HEALTH AND WELLBEING IN KENT

SUMMARY

This draft report provides an overview of progress in the development of an integrated commissioning approach to children and young people's mental health provision in Kent.

RECOMMENDATIONS

The Committee is asked to:

Note the report and endorse the integrated commissioning proposal

1. STRATEGIC CONTEXT

The need to improve children and young people's mental health provision is a key challenge for health commissioners and stakeholders. One in ten children aged five to 16 has a clinically significant mental health problem and this burden is rising, Kent mirrors the national picture. Early intervention and a range of high quality services will improve efficiency and patient outcomes. The Kent JSNA 2010 and an updated CAMHS needs assessment 2011, states that at any time in Kent there are approximately 17,000 children aged between five and fifteen who have a diagnosable mental health disorder.

The overarching strategic context for the delivery of children's mental health in Kent is linked to five key strategies

- DoH The NHS Outcomes Framework
- DoH No Health Without Mental Health
- Kent Health and Wellbeing strategy
- KCC Every Day Matters
- Draft Kent and Medway Emotional Wellbeing and CAMHS Strategy 2012

The Kent Health and Wellbeing strategy 2012 outcomes, one and four, set key objectives for children's mental health mental health. The Health and Wellbeing strategy commits to meeting objectives through an integrated commissioning approach and through the delivery of integrated provision and person centred care, essentially the delivery of seamless services for the public. The outcomes are:

Outcome One - Every child has the best start in life

Outcome Four – People with mental health issues are supported to live well

KCC Every Day Matters sets a clear vision for children's services. This is underpinned by 4 broad outcomes and five priorities. The key vision within Every day Matters is:

"Every child and young person in Kent achieves their full potential in life, whatever their background".

The four outcomes at the heart of Kent County Councils integrated children's services are:

- Keep all children and young people safe
- Promote the health and wellbeing of all children and young people
- Raise the educational achievement of all children and young people
- Equip all young people to take a positive role in their community.

Kent County Council, Kent and Medway NHS and key partners developed the Draft Kent and Medway Emotional Wellbeing and CAMHS Strategy 2012 using a multi-agency approach to improve emotional wellbeing and mental health of children and young people in Kent and Medway. This draft strategy has influenced the aim of improving services by strengthening strategic relationships across the system, provide direction and direct the development of commissioned services.

2. KENT INTEGRATED COMMISSIONING PROPOSAL

Current arrangements

In September 2012 NHS Kent & Medway and Kent County Council agreed to align funding in order to jointly commission new Emotional Well-being and Mental Health Services for children and young people. Sussex Partnership NHS Foundation Trust (SPFT) commenced delivery of Community Children and Young People's Mental Health Services (CAMHS), with Kent and Medway NHS acting as the lead commissioner. The total value of the contract is £15m. KCC contributes £1m for the children in care (CIC) element of the service.

It was agreed that the new services would take the form of an Emotional Well-being Service delivering support within universal settings (Tier 1 - 2), alongside a 'Community CAMHS' model comprising targeted (Tier 2) and specialist (Tier 3) mental health

services. Within this contract is the specialist service for children in Care, funded by KCC. Tier 4 CAMHS Specialised mental health is commissioned through NHS England. There are currently two years remaining of the contract to April 2016.

The Health and Social Care Act 2012 provided a new structure for commissioning of mental health in England in the main commissioning transferred from the Primary Care Trusts to Clinical Commissioning Groups (CCGs). Since April 2013 following organisational re-structures as part of the Health and Social Care Act reforms, West Kent CCG has been the coordinating commissioner across Kent for the CAMHS (Tier 2 and 3) contract.

At the time of taking over the contract, SPFT inherited significant waiting lists from the previous provider of the service, particularly in West Kent for specialist (Tier 3) and targeted services (Tier 2), which they have been working to reduce. An action plan was put in place to reduce waiting times for first appointment to 4-6 weeks, this was achieved by September 2013, but waits have started to increase in Quarter 3.

At present, West Kent CCG is the co-ordinating commissioner on behalf of Kent & Medway CCG's and is taking a robust approach to managing the performance of the provider against the contract requirements. As a consequence of targets that were missed, the CCG initially formally wrote to Sussex Partnership Trust outlining its concerns and seeking re-assurance through an action plan to address the shortfall in service delivery. Board to board discussions to further improve performance monitoring data is now in place in order to provide confidence in the performance regime and quality of service delivery. Contractual levers such as penalties have been considered and if performance does not improve these can be implemented.

Some improvements have been made, the service is prioritising those young people who need urgent support and there have been no breaches in urgent referrals. The introduction of the Choice and Partnership approach is helping caseload management. Care pathways and referral routes have improved. A workforce development plan has been implemented and the service is still recruiting to reach a full complement of staff. Temporary staffing solutions (agency) are being used to support this area particularly the Dartford area, to address this backlog.

The CCG will continue to monitor and work with the provider to ensure that the service is working to full capacity and will continue to use all necessary contract levers to ensure this is adhered to. West Kent CCG will continue to co-ordinate monthly performance meeting with SPFT to review progress.

Strategic Integrated Commissioning Proposal

Since April 2013 through the current coordinating commissioner contract monitoring arrangements it is becoming apparent that the CAMHS provision is not correctly

imbedded within the wider context of vulnerable children and young people pathways and the wider context of current and future C&YP commissioning plans.

Recent drivers from central government particularly the Children and Families Bill is pushing towards a more integrated and partnership approach in developing children and young people services. Kent CCG's believe this is a good opportunity, during this contract refresh round to consider developing a Section 75 Pooled Budget Agreement with KCC bringing all the appropriate investment into an agreed strategic arrangement.

A Section 75 agreement will provide the structure for integrated commissioning arrangements leading to greater opportunities to create a more seamless patient care pathway journey. This will provide greater opportunity for Health Commissioners to ensure that Health financial investment and health outcomes of children and young people pathways is more integrated within the preventative and recovery pathway that currently sits within the remit of KCC.

Through this arrangement, there is the opportunity to develop with KCC joined planning and investment to support the Emotional Well-being and Mental Health Services for children and young people and CAMHS provision through the patient journey. An agreed approach to the integration of The Common Assessment Framework (CAF) coordinators and the KIASS will support CAMHS referral processes ensuring children are correctly assessed by the best service to meet needs. Agreed strategic planning of provision will promote access into the KCC preventative agenda (including Public Health), education services, targeted prevention & early intervention services (which will include young offenders, Healthy Young Minds Provision), Troubled Families Agenda and Aim Higher agenda (disabilities - transition).

Through the establishment of Section 75 Pooled Budget Agreement, there may be a requirement for 3 agreements either sitting underneath an overarching Section 75 or three separate Section 75 agreements to reflect the emerging North Kent, East Kent and West Kent health economies. This arrangement mirrors the agreed NHS Adult mental health commissioning arrangements from April 2014.

To prevent any possible dilution of Health Investment within this arrangement, the Section 75 Pooled Budget Agreements will become the mechanisms for CCG's to monitor KCC in their function as Commissioners on Health's behalf; and as there could be three arrangements within the overarching Section 75, CCG's and KCC will have greater input, control and flexibility of how their investment is being used to meet local populations needs.

In addition to CAMHS the arrangements for wider children's emotional wellbeing commissioning frameworks can also be considered going forward.

If agreed, the initial milestone is for an 'in principle' agreement with key stakeholders by April 2014. Following agreement, an options analysis will be completed. Once the details of the transfer have been agreed , West Kent CCG on behalf of Associate CCG Commissioners will novate the current CAMHS contract as a whole across to KCC for them to act as commissioners for the contract on behalf of Health. The proposal has been raised with colleagues across the health economy and with KCC and although there is a positive response to this proposal.

3. GOVERNANCE ARRANGEMENTS

A refresh of the JNSA and the draft Kent and Medway Emotional Wellbeing and CAMHS Strategy will be required going forward, to act as the strategic vehicle to deliver service transformation and improve outcomes for children and young people. Clarity regarding governance and the role of the Health and Wellbeing Board, Joint Commissioning Board and Health DMT will need to be considered. CCG's reporting mechanisms will need to be defined .Future plans could include an integrated children's mental health and wellbeing board who will oversee the delivery and performance manage the emotional and wellbeing strategy, this board could report into relevant organisation boards and report to the Health and wellbeing board.

4. FINANCE

The overall expenditure for Kent CCGs, KCC and Medway Council on tier 1,2 and 3 children's mental health provision is circa £15m this is allocated in the following areas:

CCGs/ Local Authorities	**Total (£)**
NHS Ashford CCG	1,203,028.10
NHS Canterbury and Coastal CCG	2,192,839.41
NHS Dartford, Gravesham and Swanley CCG	1,729,550.25
NHS Medway CCG	1,124,075.04
NHS South Kent Coast CCG	2,333,250.47
NHS Swale CCG	1,157,091.15
NHS Thanet CCG	1,781,140.31
NHS West Kent CCG	3,007,645.73
Kent County Council	1,000,000
Medway Council	144,269
Total	**15,672,889.45**

The value of the South London and Maudsley (SLAM) contract for Kent and Medway Tier 4 provision at the point of transfer to NHS England was £4.8m.

5. NEXT STEPS

Kent CCG's will need to work collaboratively with Kent County Council and continue to build the partnership arrangements with the voluntary sector, patients and carers in order to implement the proposal to drive transformational change in the way children's

mental health services are commissioned, provided and purchased in line with key guidance. A refresh of the Joint Strategic Needs Assessment (JSNA) and the specific children's element of the Mental Health Assessment (MHA) will provide further evidence based information to support the commissioning intentions and commissioning governance framework.

Kent CCG's will be focusing on key transformational commissioning intentions aimed at driving significant economy and efficiency within the local health and social care environment. Commissioners in West Kent for example will demand a quicker and more responsive service for children and young people that need access to Mental Health services.

Contractual details linked to agreed baselines, risk, due diligence, performance monitoring in addition to any emerging PbR tariff, further efficiency programs and outcome focused KPI's will need to be clarified. Governance arrangements will need to confirmed. Where innovation has been successful it will be mainstreamed into the new Section 75 contract arrangements and innovation programs will continue to be a key contractual tool to transform, integrate and re design services to children and young people with mental health issues.

Once an 'in principle' agreement is reached more detailed work will commence to facilitate a Section 75 arrangement in 2014/15. Further details will need to be examined and an option analysis paper with more detailed thinking will be presented at a future Health and Wellbeing board.

List of Background Documents

DoH NHS Outcomes Framework

No Health Without Mental Health 2011

Draft Kent and Medway Emotional Wellbeing and CAMHS Strategy 2012

Kent Health and Wellbeing Strategy 2012

Health and Social Care Act. 2012

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Update Child and Adolescent Mental Health Services

SUMMARY

Since September 2012 Sussex Partnership Foundation Trust (SPFT) has been providing targeted and specialist community children and young people's services (CHYPs) mental health support across Kent. The lead commissioner is West Kent CCG. This report provides an update of progress to date.

RECOMMENDATIONS

The Committee is asked to:

Note the report and comment on progress

Background

Sussex Partnership NHS Foundation Trust (SPFT) began managing children and young people tier 2 (targeted) and tier 3 (specialist) mental health services from September 2012. We inherited waiting lists for both tier 2 and tier 3 services in west Kent where young people and families were waiting an average of 18 months and as long as 3 years for routine assessments.

SPFT immediately put measures in place so that no young person would wait for an emergency or urgent appointment and there have been no breaches[1] regarding these referrals. An action plan was put in place to address the historic waiting times for routine referrals with a trajectory to reduce the waiting time for all first appointments to a target of 6 weeks by end of September 2013 and this has been a key focus of our work over the last year whilst re-designing the service to introduce a new model.

It has been a year of challenges and change. When we took over the inherited service the legacy was as described a combination of long waiting times and large numbers of young people who had been seeing services for a very long time, often only for an annual review. The staffing resource to deliver the children and young people's services (ChYPs) in Kent, (also inherited), are all committed to the common goal of improving the lives of children. On 1st September 2012, 274 staff transferred into SPFT via TUPE arrangements. Services across Kent were previously provided by 7 different organisations each with a differing culture and varying expectations of

[1] Definition of breach: Emergency referral standard is that young person should be seen within 24 hours and urgent referral within 10 days therefore a breach are those seen beyond these targets.

staff; all delivering different levels of services reflecting historic commissioning decisions and investment levels. A 3 year contract is a challenging time frame to deliver and consolidate whole system change and so from day one we embarked on an ambitious change programme to improve the service, reduce the waiting times and deliver an equitable service offering across Kent, based on the lessons learned from running services in Sussex and Hampshire. The aim is to bring care closer to young people and their families and to ensure services are easily accessible and maximise choice.

Overview of the CAMHs services across Kent and outline of the differences between services at tiers 1 – 4

Universal services (tier 1) includes those services whose primary function is not to provide specialist mental health care, but which have a general role in meeting the emotional well-being and mental health needs of children and young people. This includes services provided through GP's; health visitors and school nurses as well as the early intervention services commissioned through Kent County Council which can be accessed via the Common Assessment Framework (CAF) i.e. the Young Healthy Minds service.

Since September 2012 SPFT has been providing [2]targeted and specialist community children and young people's services (CHYPs) for Kent, - lead commissioner West Kent CCG - defined as:

Targeted services (tier 2) are for those young people with emerging emotional difficulties and mental health problems, and are offered when the needs of the referred young person can be met by a single clinician providing a short term intervention. Our Targeted ChYPS service will provide an assessment and intervention (6 to 8 sessions – with the option to review).

Specialist services (tier 3) provide specialist assessment and treatment of moderate to severe mental health difficulties and associated risks in all young people under 18 years. Our Specialist ChYPS is delivered by a multi-disciplinary team. They work together to identify and meet the needs of children and young people with highly complex mental health presentations.

Tier 4 services are the inpatient beds and a small number of highly specialist out-patient services which are provided by the South London & Maudsley NHS foundation Trust (SLAM) for Kent and are commissioned by the London local area team (LAT) of NHS England.

[2] Note SPFT is not the only provider of targeted (tier 2) services in Kent, both Young Healthy minds and Kent CC provide a mix of tier 1 & tier 2 all of which are accessed via CAF

A young person's journey may involve movement through the tiers / levels of service in a stepped care approach, as their condition is recognised as more complex or as and when conditions are ameliorated. However some children and young people will receive services from more than one of the tiers at the same time.

Referral routes to CAMHs services

The emotional well-being services which are delivered at tier 1 as part of the universal provision can only be accessed via CAF.

The targeted and specialist community services provided by SPFT (tier 2&3) can be directly referred into by GPs, other health professionals (Paediatricians, School Nurses and Health Workers), Social Workers, schools and other professionals who work with young people preferably via the completion of a referral form, although urgent / emergency referrals can be made via telephone.

The tier 4 services are accessed by referral from the specialist community services (tier 3).

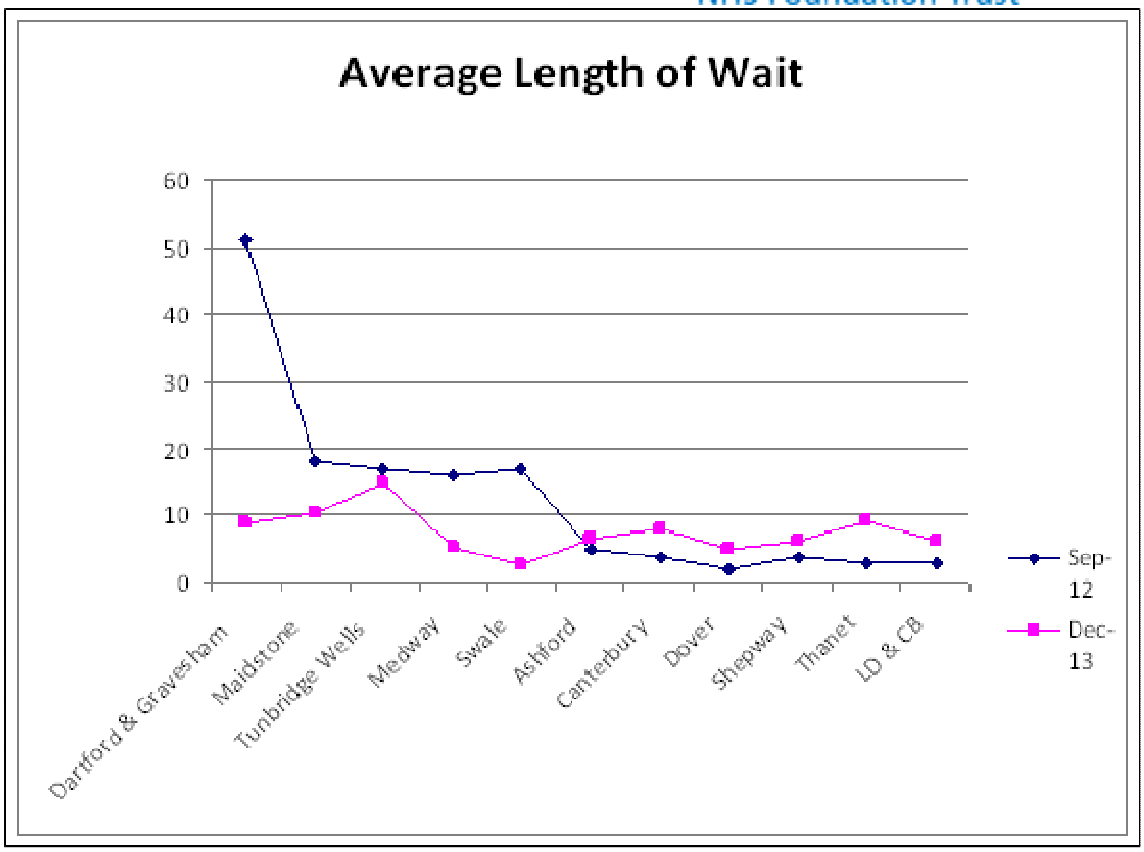
Current position

Performance - Waits

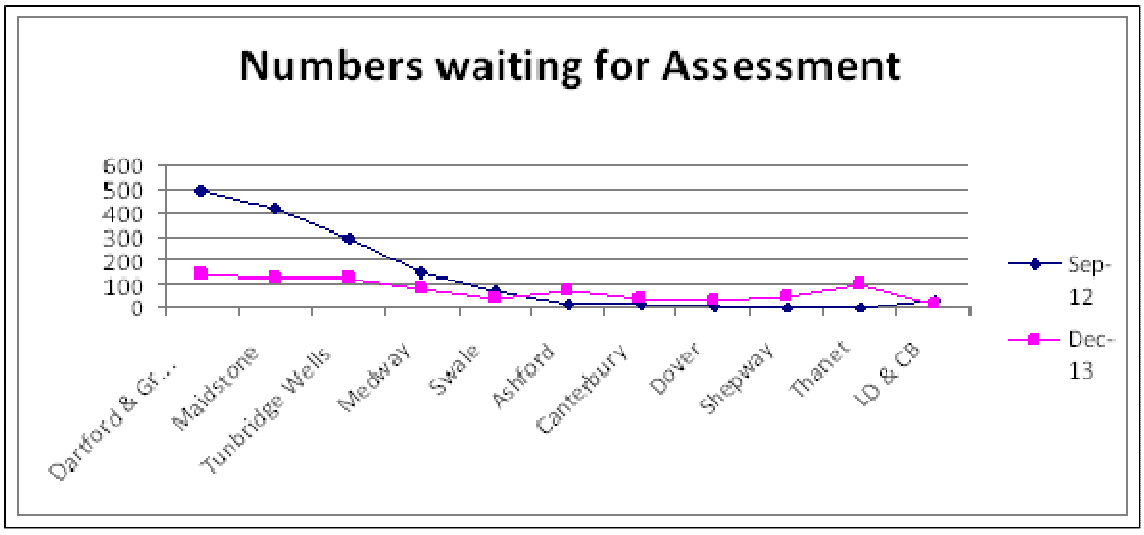
Young people do not wait if they require an emergency or urgent response, we have put in place an equitable out of hours service across the county that not only provides robust assessment regarding young people detained on a section 136, but also supports young people presenting at A&E in crisis and the A&E teams themselves. This means that the service now provides a 24 hour response for those young people presenting in crisis; during the routine working hours of the service (9-5 Monday to Friday) this response is provided by the hub duty teams. There have been no breaches with regards to young people needing a response within 24 hours of presentation and this cohort accounts for approximately 10% of the services activity. The service is also prioritising those young people needing urgent support who are seen within 10 days on average 20% of appropriate referrals are assessed and begin treatment within four weeks of receipt of referral and 36% within 10 weeks.

Routine referrals

As described above we inherited variable performance across the county with the longest waits in the West



In the year since September 2012 services have focused on addressing the large numbers of young people waiting for assessment. Legacy waits have now all been cleared and there are no young people referred before April 2013 still waiting to be seen.



As described above a key priority for services has been the external waiting-list. To tackle the large numbers we instigated a waiting-list initiative in the west of Kent drafting in additional capacity from across our services to ensure that all young

people were assessed; by the end of September 2013 the inherited waiting lists for those families waiting for routine appointments were cleared. The services have been unable to maintain this progress with referrals received since May 2013, because of an increase in demand on the service both in terms of numbers and severity, the impact of increasing numbers of urgent referrals is more young people with serious mental health problems presenting to the service for help this has led to delays on the routine waiting-list.

As a consequence the service has waiting times of beyond 6 weeks in some areas. In addition the waiting-list initiative to target the inherited waiting-list has led to a longer than ideal internal waiting-list for treatment (those who have been assessed), which the service is developing a capacity plan to address. The service has made good progress in their recruitment drive and are now in the process of making arrangements for the new cohort to start in post. We have been successful in recruiting a good calibre of staff and this is evidenced from feedback from teams. Vacancies remain in the specialist children in care team and creative solutions are being sought. In the interim temporary staffing solutions (agency) are being used to support particularly the Dartford area, to begin to address the internal waits.

The current average waiting times for a specialist first assessment appointment (in weeks) at the end of December 2013 were as follows:

Area	Average length of wait (weeks)	
	Sept 2012	**Dec 2013**
Dartford & Gravesham	51	9
Maidstone	18	10.5
Tunbridge Wells	17	15
Medway	16	5.38
Swale	17	2.8
Ashford	5	6.5
Canterbury	4	8
Dover	2	5
Shepway	4	6.2
Thanet	3	9.2
LD & CB	3	6.2

The contract standard is 4-6 weeks from referral to assessment and 8-10 weeks from referral to the commencement of treatment. As a comparator in Sussex the waiting time for assessment is a maximum of 4 weeks from referral and treatment 18 weeks. In Hampshire 95.8% of young people have started their treatment within 18 weeks of referral.

At the end of December 2013 the numbers of young people assessed and waiting for treatment to begin were as follows:

CCG	Numbers waiting to begin treatment
Dartford Gravesham & Swanley	495
Swale	103
Thanet	14
West Kent	343

The introduction of the Choice and Partnership approach which best manages demand and capacity, is enabling the service to develop a demand and capacity plan. As part of this work the service is conducting a caseload audit to confirm this active caseload. Currently the open caseload stands at 10,077, however this includes a significant number of young people inherited by the service who have been historically held perhaps being reviewed annually. The "Right from the Start" service model which is being implemented is designed to identify and treat the presenting problem and then discharge rather than hold. The service is sharing with the CCG the detail of the capacity plan that is being developed and close scrutiny will be in place regarding delivery and any sustained increase in demand on the service and this will be discussed with CCGs through the monthly performance meetings, which are co-ordinated by the west Kent CCG's on behalf of Kent and Medway CCG's.

As can be seen from the above the internal wait for treatment is mainly an issue for the West hub (including Dartford Gravesham and Swanley). This reflects the historic picture of services.

The service prioritises in accordance to presenting need it is therefore the routine referrals that can have a protracted wait as the service is prioritising in terms of urgency those requiring an immediate response. Review of the Dartford and Gravesham internal waiting-list show that the longest waits are for either a psychiatry appointment or a specific therapeutic intervention such as family therapy.

ADHD/ASD

There are some particular pressures in South Kent in accessing specialist assessments particularly for Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Conditions (ASD) and there are a number of young people waiting for these assessments.

With regards to ADHD, CCG's are considering the future commissioning of the ADHD pathway. In the South there is currently a deficit regarding paediatric support.

A similar situation is evident for ASD assessments though this is a more multi-disciplinary assessment that can also require a speech and language input. Further work is being undertaken on the pathway through a clinically led NICE (National Institute of Clinical Excellence) guidance group and CCG's are also reviewing future options for commissioning this pathway.

Commissioning performance framework

At present West Kent CCG is the co-ordinating commissioner on behalf of Kent & Medway CCG's and they are taking a robust approach to managing the performance of our services against the contract requirements. The commissioner has recognised that Improvements have been made, the service is prioritising those young people who need urgent support and there have been no breaches in urgent referrals, waits for treatment (measured from referral to treatment) have improved and are considerably less than the average before we took over the contract however the length of wait between assessment and treatment has increased and this is a concern. The introduction of the Choice and Partnership approach is helping caseload management and a further more detailed demand and capacity plan is being developed. Care pathways and referral routes have improved. A workforce development plan has been implemented and the service has been successfully recruiting a high calibre of staff to reach a full staffing complement - there are on-going concerns in recruitment delays. Some of the difficulty has been the volume of staff needing to be recruited to and the specialist nature of posts. Temporary staffing solutions (agency) are being used to support this area particularly for the Dartford area to address the backlog.

As a consequence of targets that were missed, the CCG initially formally wrote to the Trust outlining its concerns and seeking re-assurance through an action plan to address the shortfall in service delivery. Board to board discussions to further improve performance monitoring data are now in place in order to provide confidence in the performance regime and quality of service delivery. The Trust is aware that contractual levers such as penalties have been considered and if performance does not improve these can be implemented.

The CCGs will continue to monitor and work with the Trust to ensure that the service is working to full capacity and will continue to use all necessary contract levers to ensure this is adhered to. West Kent CCG will continue to co-ordinate monthly performance meeting with us to review progress.

Key Challenges and Development Plans

The common assessment framework (CAF)

The CAF process is currently not cohesive across the whole system and work needs to be undertaken to improve care pathways and referral routes. The current system restricts access to universal services as a result the impact is that referral into our community services is easier than to refer into the appropriate universal (tier 1) support. This creates work for our services as all referrals received are triaged by our Multi-Disciplinary Teams (MDT) and approximately 23% of referrals received are sign-posted to these services. The system recognises the concerns and Kent CC are in the process of reviewing the use of CAF particularly for accessing health services.

Out of hours and inpatient admissions

We are in the process of implementing a crisis resolution/home treatment team to support those complex young people in the community who otherwise may be admitted to hospital. It is planned that following successful recruitment this will begin at the end of January 2014.

The increase described in the performance section above of unscheduled care referrals (emergency and urgents) and the increased severity of those presenting has meant that there has been an increase in the number of Kent young people admitted to inpatient beds over the last 6-9 months, which mirrors a national trend that has seen increased mental health admissions for both young people and adults. This has led to a shortage of beds available and some young people having to be placed in beds significant distances from home. The delays in finding a suitable bed has also meant that on some occasions the acute hospitals in Kent are being asked to admit young people into their beds with support from the community services until a CAMHs bed becomes available. This impacts on the capacity of both the acute trusts and our community services.

CCG's no longer commission inpatient mental health beds for young people as this has been passed to NHS England. A regular meeting has been established between South London and Maudsley NHS Foundation Trust (SLaM), SPFT and NHS England to look at the pathway and issues arising from it.

Alongside this we have established a meeting with the local acute providers to outline the service offer particularly out of hours and the roles and responsibilities of providers in securing an inpatient admission. NHS England are in the process of conducting a national review of inpatient beds.

Transition from children and young peoples services into adult services

Transition from our services into adult services should be a seamless journey, the majority of young people in CHYPs services do not need referral into adult services and therefore their transition is to return to the care of their GP.

Where young people are planned to continue into adult services ideally joint work / planning should start at least 6 months ahead of the young person's 18th birthday - the transfer process should be prepared for and not be adversely affected by Tier 4 admission - so that if the young person is in hospital when they turn 18 there is a seamless transfer to adult in-patients. Currently there is inconsistency in the trasition pathway with the main adult provider KMPT.

Commissioners are aware of this issue and making plans to work with all providers to support developing clear transition pathways.

Section 136

Our services are working hard with Kent Police to respond and assess young people who are detained under Section 136 of the mental health act in Kent where possible using A&E. Where there are significant concerns and it is inappropriate to assess someone in A&E currently young people are assessed at SLaM's Bethlem hospital in Beckenham as there is not a place of safety in Kent. The numbers of young people are small but usually this occurs 'out of hours' and there have been some difficulties in terms of communication and co-ordination regarding the pathway.

A Strategic Partnership group has been set up with the police that includes mental health providers and is co-chaired between a senior police officer and the west Kent CCG co-ordinating commissioner to look at strategic and operational issues, including the pathway. The Co-ordinating Commissioner is also liaising with NHS England regarding contract arrangements around the provision of a local dedicated Section 136 place of safety for young people. NHS England now has responsibility for the contract provided by SLaM.

Conclusion

In conclusion our services have made a good start, significant improvements have been seen in the provision of mental health support to the children and young people of Kent through the reduction in waiting times for assessment and the provision of a crisis and out of hours service. Work is well underway to implement the service model which includes the development of a fully complimented staffing establishment of specialist staff with appropriate competencies. Recruitment has been largely successful and new staff are commencing over the next few months. There is further work to do and the Trust is working closely with commissioners on delivery plans. We are aiming, if plans fall into place, in 6 months' time to have addressed the routine treatment wait and for the majority of young people to begin treatment within 10 weeks of referral.

Jo Scott, Programme Director,
Kent and Medway Children and Young People Services

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Children and Young Peoples; Overview of Partnership Summit

December 2013

Background

At any one time about 10% of all 5 to 16 year olds will be suffering from a clinically diagnosable mental health problem. Symptoms of these problems may be significantly exacerbated between the ages of 18 and 25 when young people are making the transition to adult services from children's services. Young people with mental health needs are more than likely to display dangerous behaviours in terms of their physical health, with rates of smoking, drinking alcohol and substance misuse higher than in their peers. Some focused work has already happened in Kent to address the needs of children and young people with mental health needs. The SHA commissioned a project in 2012 -The Kent Youth Mental Health Project was set up to assess the views of Kent's youth population, age 12/14-25, on youth mental health services in Kent. Report Written by: Yasmin Ishaq- Project Lead for Kent Early Intervention in Psychosis and Roxie Parkins Assistant Psychologist Early Intervention in Psychosis Kent and Medway NHS & Social Care Partnership Trust

To deliver the aim of the project three objectives were identified:

1. To build resources in local communities to support young peoples' mental well-being. They held a youth mental health first aid course. Where participants felt more confident in identifying early signs of mental health difficulties; gave them a greater understanding of signs and symptoms of mental distress;
2. To hear from young people in Kent and Medway about what helps and what hinders their mental health. A mixed-analysis exploratory design was employed. Focus groups and an online questionnaire were used and covered many aspects of the young people's lives.
3. Options for commissioning a youth mental health service. Repeatedly, the participants said that they wanted advice that would be accessible, both from people who have experienced mental health challenges and from professionals, so that they could choose the support that best helped them at the time that they needed it most. The participants said that they would like an umbrella service that encompassed a wide variety of support services.

Key Recommendations

A collaborative partnership via a consortia model would bridge the gaps between;

- Primary health care and specialist services.
- National and local initiatives.
- Adult and child and adolescent systems.
- Mental health and substance misuse services.
- Community and forensic services.
- Government and non-government organisations.
- Early intervention and early help seeking.

Partnership Summit

Key Challenges

Building on what has already taken place, in December 2013 the Area Teams for Kent & Medway and Surrey & Sussex convene a 'CAHMS Partnership Summit' that brought together the multiple commissioners, providers, third sector and other relevant organisation in order to integrate thinking and come to a common understanding of pathways and practices and future approaches to improving services.

There are a number of key challenges across Kent that will need to be addressed:

- Gaps in the north and west of the county.
- The need for an honest answer of when young people will be assessed.
- To develop an appropriate workforce, the failure to recruit and the need to look at alternative models for recruitment models.
- Clinical outcomes: need to look at better quality indicators.
- The Common Assessment Framework (CAF) is a major challenge, as it can be used to delay access to treatment.
- Section 136 which allows the police to take people to a place of safety from a public place if they think you have a mental illness and are in need of care for up to 72 hours, is a key challenge.

Going Forward

There are examples of national evidence based innovation. These can be examined through the review process and key areas are:

- children in care
- young healthy minds
- targeted prevention (through partnerships with CCGs)
- Multi-professional Team assessment for disabled children with challenging behaviour

The commissioning challenges, including Section 136, are narrowed down to contractual issues and legacy issues. From the Kent perspective the discussion is now commissioner to commissioner.

Going forward:

- The aim is to hold sessions with clinicians and what would be good way of addressing Section 136.

- Developing a mental health policing partnership which is jointly chaired ensuring problems and solutions are shared issues.

- Street triage for young adults.

- Clarity is essential as well as collaboration with colleagues and endeavouring to get a meeting with London Area Team.
- Share information with education services.
- West Kent is holding a summit in January with CCGs.

Section136 not the same a Tier 4 (Tier 4 consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated)

It was agreed that a number of actions needed to be moved forward and the Steering Group for the Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions across South East Coast could lead this and the Network's Clinical Advisory Group could offer clinical support. The improvement actions were:

Pathway redesign

- Early intervention approaches to prevent escalation of mental health illness
- Crisis support and how 7 day access is provided; plus clarity on out of hours services
- Engagement with patient and the public (part of the SCN programme(s))

CAMHS – mapping emotional health and well-being pathways from beginning to end. We need to know the whole story rather than tinker round the edges.

Variation in services and how this is picked up – understand variation in quality and variation in service. Should consider the investment in terms of the future (commissioned CAMHS services will differ because some acute trusts have competing priorities to resource appropriately).

- Disconnect between other health areas – focus on commissioning intentions.
- Applying evidence based models
- Address transitional risks from children's service into adult services

Approach

- Start to talk about children and young people rather than CAMHS.
- Need to integrate with education as this has a long term impact on a young person's life.

Workforce

- Problem for high grade graduates getting CAMHS training placements. If they don't get the placement they then don't apply for jobs in that area (this will be fed back to Health Education Kent, Surrey and Sussex)

Partnerships

- How we engage: all the other implications e.g. social care, housing, police and justice. Having input from people not associated with this world can widen engagement – form partnerships – can include social, leisure arts.

Information

- Problems abstracting data from different sources: actions taken forward to remedy the gaps

Next steps

Clinical Commissioning Groups are accountable for addressing the key issues raised as part of the Partnership Summit.

A full plan, with accountabilities and timescales will be delivered with the support of the Strategic Clinical Network.

Steven Duckworth
Manager
SEC Strategic Clinical Networks and Senate, NHS England

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 31 January 2014

Subject: Adult Mental Health Inpatients Services Review: Implementation Plan

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the implementation plan of the adult mental health inpatients service review.

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

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1. Introduction

(a) On 9 March 2012 the Health Overview and Scrutiny Committee at Kent County Council determined that the proposals for a review into adult mental health inpatient services in Kent and Medway constituted a substantial variation of service. On 27 March 2012 the Health and Adult Social Care Overview and Scrutiny Committee at Medway Council made the same decision. In line with the regulations, The Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) met to consider this topic. It met on the following dates:

- 3 July 2012
- 13 February 2013
- 19 March 2013
- 30 July 2013

(b) The work of the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) into the Adult Inpatient Mental Health Services Review concluded at its meeting of 30 July 2013 with the following recommendation:

The Committee supports the NHS proposals and asks that the report and recommendations of the independent report commissioned by the JHOSC be presented to the CCGs when they are asked to consider the next steps set out in the NHS briefing paper on p.21 of the Agenda. In particular, the Committee asks for, in line with the independent report:

- *A significant increase in the retention for reinvestment, to be spent on further increases in crisis resolution/home treatment and a small number of additional acute beds*
- *A clear plan being developed for the delivery of the elements of genuine centres of excellence in the three remaining sites*

- *An action plan to be prepared within three months to be overseen by NHS England and Kent County Council and Medway Council Health Overview and Scrutiny Committees.*
- *Regular monitoring of performance to be undertaken in light of experience as changes progress.*

(c) The JHOSC will not meet again on this topic having concluded this review.

(d) The Health and Adult Social Care Overview and Scrutiny Committee at Medway Council subsequently referred the issue to the Secretary of State.[1] The Secretary of State then asked the Independent Reconfiguration Panel (IRP) to conduct an initial review and report back to the Secretary of State. The IRP concluded that the referral was not suitable for full review. The Secretary of State agreed with the IRP's initial assessment in full and agreed the implementation programme should be allowed to proceed as soon as possible.

(e) In line with the final recommendations of the JHOSC, and the HOSC Forward Work Programme, the Kent HOSC agreed to consider the implementation programme at its meeting of 31 January 2014. Members of the Committee were sent a previous version for information on 7 November 2013.

4. Recommendation

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

Background Documents

Agenda for the Kent and Medway NHS Joint Overview and Scrutiny Committee, 3 July 2012, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=4918&Ver=4

Agenda for the Kent and Medway NHS Joint Overview and Scrutiny Committee, 13 February 2013, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=5155&Ver=4

Agenda for the Kent and Medway NHS Joint Overview and Scrutiny Committee, 19 March 2013, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=5183&Ver=4

[1] http://democracy.medway.gov.uk/mgAi.aspx?ID=8599

Agenda for the Kent and Medway NHS Joint Overview and Scrutiny Committee, 30 July 2013, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=5337&Ver=4

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ACUTE SERVICE REDESIGN

SUMMARY REPORT

Version:	1	**Status:**	Draft	**Date:**	13/01/2014

DOCUMENT TRACKING

Programme Name:	Acute Service Redesign Programme				
Version:	1	**Status:**	Final Draft	**Date:**	13/01/2014
Owner:	Anne Markwick (Interim Director Acute Services)				
Author(s):	Philippa MacDonald (Acute Service Line Programme Manager) / Sarah Day (Programme Management Office [PMO] Project Manager)				
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REVISION HISTORY

Version	Status	Date	Issued to / Approved By	Comments

SUMMARY OF REVISIONS

Version	Date	Details of Revision

APPROVALS: This document requires the following approvals. A signed copy should be placed in the Programme files.

Programme Role	Name	Job Title	Signature	Date Approved

DISTRIBUTION: This document has been distributed to:

Version	Date	Name	Job Title

INTRODUCTION

A Project Initiation Document was developed in October 2013 outlining the projects within the Acute Redesign Programme.

Feedback from the consultation, further analysis and discussions has led KMPT to its current proposals for service development. These are:

- Development of three centres of excellence – improved inpatient environments.
- Increased capacity to manage demand.
- Development of alternatives to admission including, crisis houses, support time recovery [STR] investment to crisis resolution home treatment [CRHT] services and, intensive/acute day treatment service.
- Extension of PIC outreach.

These proposals will deliver the following benefits:

Increased alternatives to admission.
Greater skill mix of workforce including the use of people with lived experience and peer support.
Inpatient accommodation which is fit for purpose, meeting requirements for health and safety, privacy and dignity and promotes wellbeing and recovery.
Improved satisfaction.
Robust 24/7 services.
Improved performance.
Reduction in delayed transfer of care / transfer pressures.
Reduction in length of stay.
Decreased incidents of violence and aggression.
Reduction of external placements.
Reduction in staff sickness.
Improved retention and recruitment of staff.

The need to develop a range of services which provide alternative to inpatient care will be essential to the development of quality modern mental health services. Partnership working with a range of organisations and agencies will be core to the delivery of this; such as developing relationships with Medway to ensure a range of high quality services are developed for their residents.

Centres of Excellence
A Centre of Excellence is defined in the consultation as “A service that is delivered to a recognised high (national or world class) standard, in terms of measurable results and

innovation". In addition to performing its own core work effectively, it has an additional role in improving practice and knowledge throughout the rest of the organisation.

The defining features are:

- Well integrated multi disciplinary teams providing improved access that psychology, occupational health.
- Consultant cover seven days per week.
- Improved access to physical health support and interventions.
- Educational focus to drive up skills and quality drawing on best practice.
- Access to recovery resource centres.
- Improved physical environment, including single bedrooms.

There are a number of interdependent projects and enabler schemes which together deliver the Acute Services Redesign Programme. The projects/enabling schemes range from capital investment to develop bed capacity and quality of inpatient environments, to development of alternatives to admission which will provide choice and build capacity within acute care. In addition these projects/enabling schemes will deliver improved relationships with stakeholders, improved quality and will have a positive impact on outcome and satisfaction measures.

A new service will be available in Medway for people with personality disorders in crisis. The crisis care pathway includes intensive community support for up to 15 people for up to three months. Plus a therapeutic crisis house for residents to stay for up to seven nights. This will initially be a five bed facility in Medway.

This report summarises work to date, outlines next steps and proposed future developments.

NEXT STEPS

Project/Scheme	Progress Update	Progress this month	Dependencies
PIC Outreach	None required	Service in situ (Nov 2013) –scheme completed.	• none
Birch Ward Upgrade	3-6 month post implementation review to be completed. We would anticipate this review being completed in partnership with Medway CCG, Council, Carers and service users.	Refurbishment completed 09.12.13, Medway ward transfer completed 19.12.13	• none
STR Development	None required	Posts are being recruited to. Medway has recruited an additional 4 STR workers bringing the total of STR workers in Medway to 7.5 whole time equivalents. Additional medical capacity in Medway CRHT is planned to provide increased capacity to support people in crisis, locally. This is included in the Business Case for additional capacity in Maidstone to re-provide emerald ward	• On going commissioner support
Transport	3-6 month post implementation review to be completed. We would anticipate this review being completed in partnership with Medway CCG, Council, Carers and service users	Transport plan implemented at point of ward transfer from Medway in Dec	• none
Street Triage	• Evaluation of pilot • Planning undertaken during Jan & Feb 2014 with Kent Police to determine recommendations post pilot.	Pilot running September 2013 to March 2014.	• Commissioner support • Kent Police support • Identification and securing resource to run service post pilot.

	• Development of business case re options for future service post April 2014 • Agreement gained re future provision of service • Implementation of agreed option		
DVH refurbishment	• Finalisation of design • Procure providers • Commence decant preparation work • Ward decants to Edmund Feb/March • Refurbishment work commences • Ward moves to refurbished ward July 2014	Pre implementation - design & tender phase	• On going commissioner support in relation to additional capacity created
Additional capacity –existing wards	• Agree design and phasing • Develop tender and gain sign off • Authorisation to proceed acquired • Works commence • Additional beds operational June 2014	Pre implementation – design & tender phase	• On going commissioner support in relation to additional capacity created. • Permission from landlords re PFI building at Little Brook Hospital – Dartford.
Additional capacity – new emerald ward/modular build	• Develop design • Business case and approach approved • Identify preferred provider • Contractor appointed • Gain planning permission • Finalise design • Installation commences • Unit operational Feb 2015	Pre implementation: • Design phase Dec 2013 – April 2014 • Tender phase commences in May 2014	• Planning permission.

Acute Day Treatment	• Scope models and best practice • Visit leading centres • Develop model • Develop PID and Business case • Secure Resources • Identify base to deliver service from • Develop transport plan • Support to implement gained from Trust and CCGs • Implementation	Planning phase. Jan – March 2014 Implementation due to commence October 2014..	• Identification of suitable estate to deliver service. • Commissioner support • Resources
Crisis/ Recovery Accommodation	• Scope models of crisis and recovery accommodation used nationally • Identify potential partners • Explore development of supported accommodation with potential partners • Develop business case • Gain Trust and CCG agreement to implement.	Planning phase Jan –March 2014	• Commissioner support • Support from potential partners • Resources to deliver crisis /recovery accommodation (estate and staffing)
Personality Disorder Hostel Pilot	• Completion of capital works (Feb 2014) • Hostel opens end of Feb 2014 – for up to 5 females (who will be expected to participate in daily crisis pathway) • Crisis pathway moves from Canada House to Park Avenue Feb 2014	• PD Crisis pathway commenced 4 Nov 13 • Early indicators are that service is having a positive impact. • Capital project re refurbishment of Park Avenue has commenced (Dec 13)	• Completion of capital project • KMPT agreement regarding staffing ratios for PD Hostel • Securing recurrent funding post pilot.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 31 January 2014

Subject: Kent and Medway NHS and Social Care Partnership Trust (KMPT): Update

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

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

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1. Introduction

(a) Kent and Medway NHS and Social Care Partnership Trust (KMPT) have requested the opportunity to present an update to the Committee.

(b) Additional background information on mental health services is included in the covering report to Item 6.

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report from Kent and Medway NHS and Social Care Partnership Trust (KMPT).

Background Documents

None.

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Kent and Medway NHS
NHS and Social Care Partnership Trust

Trust Transformation Programme

KCC Briefing Paper

Version:	0.1	**Status:**	Draft	**Date:**	16/01/2014

Introduction

Programme Context

The Trust's Transformation Programme will deliver the Trust's vision to:

> … "Deliver excellent care personal to you, delivering quality through partnership. Creating a dynamic system of care, so people receive the right help, at the right time, in the right setting with the right outcome."

The Transformation Programme is an ambitious programme of change which focuses on the delivery of the aims and objectives defined within:

- The Clinical Strategy which aims to:
  - Provide excellent community services close to home reducing the number of people who need inpatient care. Where necessary our community services will support the length of stay being as short as possible.
  - Focus on the recovery model ensuring positive outcomes.
  - Improve quality and dignity in services including a better environment and improved use of technology.
  - Expand some of our strongest specialist services where appropriate to potentially provide those across a wider geography.
- The Commercial Strategy which aims to ensure that through the delivery of high quality outcomes the Trust:
  - Retains its existing market share.
  - Grows its market share within existing commissioners.
  - Grows into new markets where this is aligned to the delivery of its clinical strategy.

The Transformation Programme will be enabled through the implementation of the actions set out within:

- The Organisational Development Strategy
- The Quality Strategy
- The Finance Strategy
- The Estates Strategy
- The Information, Communications and Technology Strategy
- The Service User and Carer Engagement Strategy
- The Community Engagement Strategy

Our Transformation Vision

At KMPT our passion is to ensure that the service user is at the centre of everything we do.

Our vision is to provide … "Excellent care personal to you, delivering quality through partnership. Creating a dynamic system of care, so people receive the right help, at the right time, in the right setting with the right outcome."

Our major challenge is to move away from traditional models of service delivery and implement new models of care. Models of care which are focussed on preventing hospital admission and promoting the delivery of care closer to home which are recovery focussed in line with our clinical strategy.

We are committed to working with our service users, staff, carers and commissioners on this improvement journey. Through our whole systems approach we will focus on designing services which meet local needs. This will be achieved through our clinically led transformation programme which is focussed on delivering improved outcomes through changing how our services are delivered, supporting our staff to develop and improving how we work across organisational and service boundaries.

This means that across the organisation, irrespective of role or grade, that we must all take responsibility for ensuring that we challenge the things that we know do not work and that we work with our service users and within our teams to deliver the excellent services which we believe in.

The result of this will be that we improve service user access, service user and staff experience, clinical outcomes and our overall efficiency and effectiveness.

We fundamentally believe that if we do not meet these needs then we as an organisation will not grow and develop and we will not deliver the excellence which we are passionate about.

We will deliver our transformation through a benefits led programme

Our transformation vision will only be delivered if we take a benefits led approach to delivery. The Clinical Strategy identifies that the Trust must deliver high quality, safe and sustainable health and social care services that people identify as those they prefer to use to improve their health and well being.

In delivering our transformation we will seek to continually improve our services to provide consistent pathways of care which benefit from a skilled and modern workforce, modern technology and high quality estate.

The projects which contribute to the delivery of the overall Transformation Programme must create:

- a culture of excellence;
- strong clinical leadership which drives service improvements;
- a highly skilled and valued staff;
- commercial success based upon the quality and outcomes that we deliver.

.

The benefits of the programme are set out in Table 1 below.

Table 1: Transformation Programme Benefits

Transformation Programme Benefits
Improved service user and carer access to services
Improved clinical outcomes
Improved service user and carer experience and satisfaction of services
Continuous improvement in our performance
Employer of choice
Long term financial viability and sustainability
High quality therapeutic environment
Improved care through the use of technology
Work in partnership with service users, carers and other agencies to deliver a seamless service user experience

It is essential in adopting a benefits led approach to transformation that any project which is undertaken within the Transformation Programme reflects the Trust's core Values of:

- Respect – we value people as individuals, we treat others as we would like to be treated.
- Open – we work in a collaborative and transparent manner.
- Accountable – we are professional and responsible for our actions.
- Working together – we work together to make a difference for our service users.
- Innovative – we find creative ways to run efficient; high quality services.
- Excellence – we listen and learn to continually improve our knowledge and ways of working.

By adopting a benefits led approach to transformation we will ensure that:

- We have clarity of the objectives of our transformation programme.
- We can engage all of our key stakeholders in a benefits led discussion on the proposed activities of our programme and identify how they can be involved in making it a success.
- We build a culture of continuous improvement with a focus on delivering improved clinical outcomes.
- We can not only measure and track delivery, but celebrate our success when we achieve our objectives.
- We can learn from experience and ensure that when designing new initiatives we build in the lessons we have learned.

We will adopt a structured approach to programme delivery

We will only deliver our transformation objectives if we adopt a structured approach to programme delivery.

We have implemented robust programme governance structure which ensures that Trust's Transformation Programme reports to the Trust Board through the Finance and Resources Committee [FRC]. This ensures that we are held to account for the delivery of the agreed programme plans.

The Transformation Programme is managed on a Managing Successful Programmes [MSP] (lite) basis with each of its component projects being managed through a Projects in a Controlled Environment (PRINCE2) (lite) framework. This approach ensures that the Transformation Programme:

- Is governed effectively.
- Is accountable for its actions.
- Has a benefits led approach.
- Has an agreed approach to programme and project management ensuring that each project has:
    - an established project board and governance framework;
    - a supporting Project Initiation Document [PID];
    - a project benefits framework;
    - a clearly defined project plan;
    - a project risk plan;
    - a project communications and engagement plan;
    - a project resource plan.

The Transformation Programme is built of a number of projects which have a primary focus on delivering the Trust's Clinical Strategy to deliver high quality, safe and sustainable health and social care services that people identify as those they prefer to use to improve their health and well being.

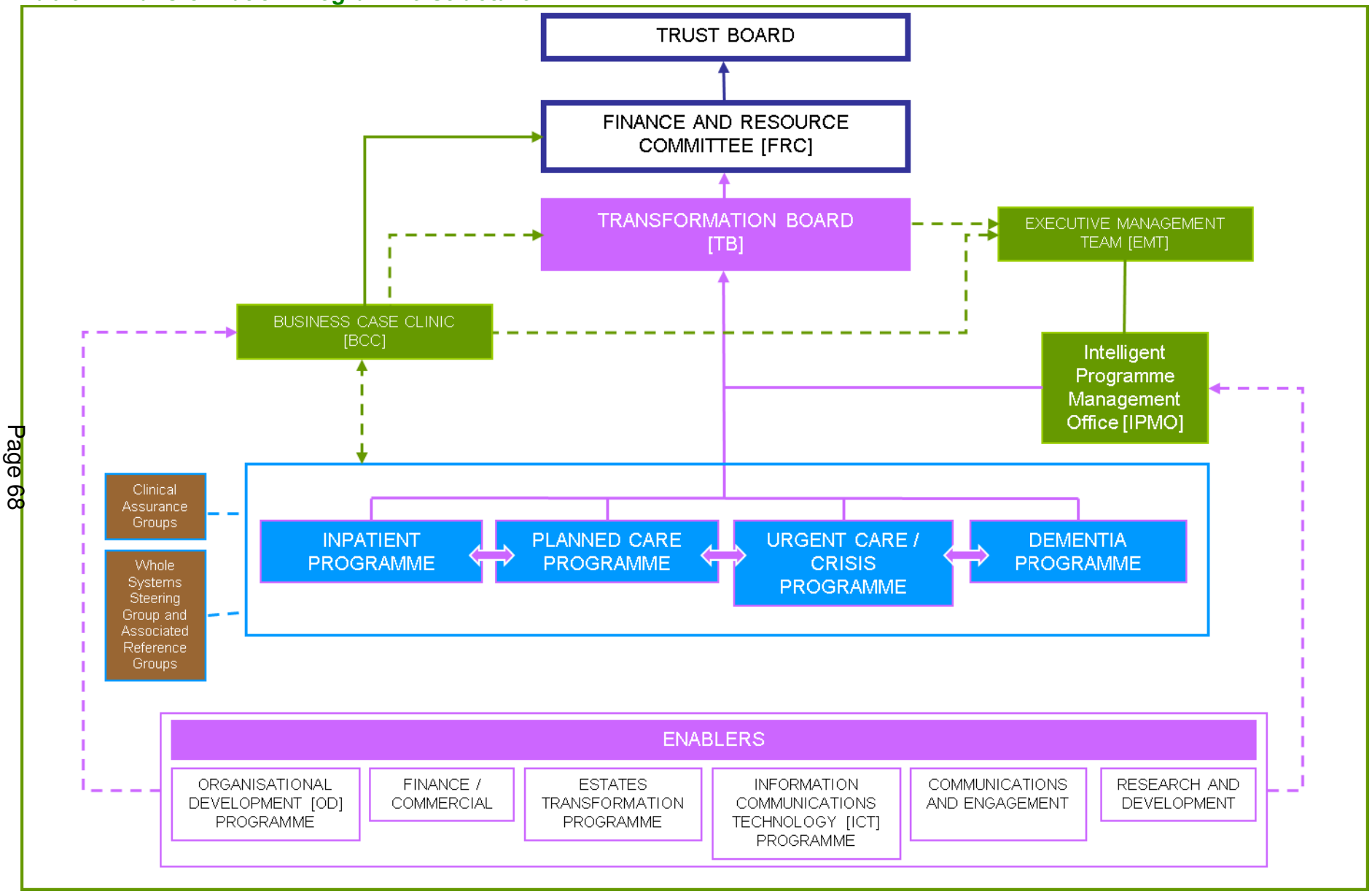
The programmes which will underpin our transformation are:

- Inpatient Programme
- Planned Care Programme
- Urgent Care / Crisis Programme
- Dementia Programme

Each project has a focus on ensuring that through delivery it will contribute to a continuous improvement in how we deliver our services to provide consistent pathways of care which benefit from a skilled and modern workforce, modern technology and high quality estate.

Table 2 below sets out the overarching programme management structure.

Table 2: Transformation Programme Structure



We will ensure that our Transformation Programme is underpinned by a robust programme of communications and engagement. The communications and engagement programme must:

- be both externally and internally facing;
- make use of existing channels of communications and engagement;
- develop new ways of engaging all stakeholders in programme design and delivery;
- be benefits led ensuring that we celebrate the success of our achievements;
- provide a mechanism to capture and share learning from project delivery, thereby promoting a culture of continuous improvement.

Summary on progress – including next steps:

The tables below provide a summary of the work that we have undertaken to date and are proposing on our transformation programme.

Inpatient Programme:

Project/Scheme	Progress Update	Progress this month	Dependencies
PIC Outreach	None required	Service in situ (Nov 2013) –scheme completed.	• none
Birch Ward Upgrade	3-6 month post implementation review to be completed. We would anticipate this review being completed in partnership with Medway CCG, Council, Carers and service users.	Refurbishment completed 09.12.13, Medway ward transfer completed 19.12.13	• none
Transport	3-6 month post implementation review to be completed. We would anticipate this review being completed in partnership with Medway CCG, Council, Carers and service users	Transport plan implemented at point of ward transfer from Medway in Dec	• none
DVH refurbishment	• Finalisation of design • Procure providers • Commence decant preparation work • Ward decants to Edmund Feb/March • Refurbishment work commences • Ward moves to refurbished ward July 2014	Pre implementation - design & tender phase	• On going commissioner support in relation to additional capacity created

Additional capacity –existing wards	• Agree design and phasing • Develop tender and gain sign off • Authorisation to proceed acquired • Works commence • Additional beds operational June 2014	Pre implementation – design & tender phase	• On going commissioner support in relation to additional capacity created. • Permission from landlords re PFI building at Little Brook Hospital – Dartford.
Additional capacity – new emerald ward/modular build	• Develop design • Business case and approach approved • Identify preferred provider • Contractor appointed • Gain planning permission • Finalise design • Installation commences • Unit operational Feb 2015	Pre implementation: • Design phase Dec 2013 – April 2014 • Tender phase commences in May 2014	• Planning permission.
Acute Day Treatment	• Scope models and best practice • Visit leading centres • Develop model • Develop PID and Business case • Secure Resources • Identify base to deliver service from • Develop transport plan • Support to implement gained from Trust and CCGs • Implementation	Planning phase. Jan – March 2014 Implementation due to commence October 2014..	• Identification of suitable estate to deliver service. • Commissioner support • Resources
Crisis/ Recovery Accommodation	• Scope models of crisis and recovery accommodation used nationally • Identify potential partners	Planning phase Jan –March 2014	• Commissioner support • Support from potential partners • Resources to deliver

	• Explore development of supported accommodation with potential partners • Develop business case • Gain Trust and CCG agreement to implement.		crisis /recovery accommodation (estate and staffing)
Personality Disorder Hostel Pilot	• Completion of capital works (Feb 2014) • Hostel opens end of Feb 2014 – for up to 5 females (who will be expected to participate in daily crisis pathway) • Crisis pathway moves from Canada House to Park Avenue Feb 2014	• PD Crisis pathway commenced 4 Nov 13 • Early indicators are that service is having a positive impact. • Capital project re refurbishment of Park Avenue has commenced (Dec 13)	• Completion of capital project • KMPT agreement regarding staffing ratios for PD Hostel • Securing recurrent funding post pilot.
OASSIS (Older Adult Safe Secure Inpatient Services)	• Project Board in operation • Public consultation completed • P21+ process completed and partner identified and commenced work • Work streams identified- inter dependant	• Currently agreeing phased approach- Canterbury first	• Commissioner intention/ CCG support • Infrastructures to support capital build • This also forms part of the Dementia programme

Urgent Care Programme:

Project/Scheme	Progress Update	Progress this month	Dependencies
Strengthening CRHT/STR Development	None required	Posts are being recruited to. There will be an additional 11.38 WTE Support Time Recovery Workers across North and West Kent. A similar increase has already been delivered within East Kent following relocation of inpatient services to Canterbury.	• On going commissioner support
Street Triage	• Evaluation of pilot • Planning undertaken during Jan & Feb 2014 with Kent Police to determine recommendations post pilot. • Development of business case re options for future service post April 2014 • Agreement gained re future provision of service • Implementation of agreed option	Pilot running September 2013 to March 2014.	• Commissioner support • Kent Police support • Identification and securing resource to run service post pilot.
Liaison Psychiatry	Discussions with Acute Hospitals and commissioners with view to establishing robust services across all three health economies and four Acute Trusts. Winter monies obtained to support delivery of services in Medway, DVH and MTW. Currently unable to provide a winter service to East Kent due to lack of workforce resource.	Business case developed to ensure robust service is delivered across each of the three health economies (four Acute Trusts).	• Service requires longer term financial commitment to enable service to develop. • Commissioner support • Acute Hospital Trusts support

	DVH currently remains on a CQUIN contract. As of April MTW will be on a main contract and not CQUIN.		
Urgent Response	• Development of improved urgent response with mental health teams • Partnership working with other urgent response agencies eg police, ambulance, A&Es, AMHPs for MHA. • Urgent response provided will be for ages 18 years onwards.	Revised CQUIN schedule agreed to be delivered by March 2014, which includes: • Development of standards and protocol for community mental health teams and Crisis Resolution Home Treatment teams including fast tracking for known individuals • Telecoms review to provide recommendations regarding the implementation of a single phone number per health economy. • Interim flyer to be developed per CCG indicating in hours and out of hours contact numbers for referrals and will include contact information should escalation be required. • On going engagement with CCG, primary care, and other stakeholders with regards to future development of an urgent care response.	Commissioning support Stakeholder engagement and support
Review and Redesign of the Medway Older Adult Acute Care Pathway'	• Completion of project documentation • Pathway Workshops held with stakeholders • MCH Site visit • Presentation to EMT/Business Case Clinic	• Project Board established • Non-Disclosure Agreement developed with Medway Community Health • MCH scoping exercise	• Commissioner intentions • Timescales for availability of estate and capital funding • This also forms part of the Dementia programme

Planned Care Programme:

Project/Scheme	Progress Update	Progress this month	Dependencies
Older Adult community Re-design	• Completion of project documentation • Instigated workforce review	• Future of OPMH community teams document developed	• Links and partnership working with CRSL • Future commissioning intentions for cluster 18 • Shared care arrangements • Current workforce demographic • This also forms part of the Dementia programme
Workforce	• Engagement with staff to review current service and identify issues, good practice and areas for development. • Review of workforce ensuring skill mix meets population and demand needs for service • Expansion of service to cover 7 day working • Development of workforce through education and providing future direction and vision of service • Develop plans to implement reconfigured service • Implementation	• Planning phase, aim to implement changes during 2014/15	• Estate availability and suitability • Commissioner support • Clinical support • Primary care engagement

Caseload	• Review of current case load and what that means for services. • Establish standards and protocols which addresses issues around complexity and grading of staff involved • Review pathway ensuring flow throughout service • Develop robust links with primary care • Embed reflective practice	• Planning phase due to deliver implementation during 2014/15	• Estate availability and suitability • Commissioner support • Clinical support • Primary care engagement
Hubs/Pods	• Ensure estate supports the delivery of service. • Redesign of community mental health to deliver a Consultant led service, greater presence within primary care, improved and development of robust links with primary care • Development of shared care • Development of wellness and recovery centres • Whole person approach which includes physical health as well as mental health. • Development of mobile working, ensuring systems are in place to support delivery of model.	• Planning phase - implementation due 2015/16	• Estate availability and suitability • Transport • Commissioner support • Clinical support • Primary care engagement • Information & technology

Horizons: supported accommodation	• Review current Horizons/supported accommodation services and rehab services • Define model • Develop relationships and improve partnership working with housing providers and 3rd sector organisations • Develop a range of accommodation to meet variety of need including crisis and rehabilitation.	• Pre planning phase implementation date to be determined.	• Links with inpatient programme • Support from commissioners • Stakeholder engagement • Development of strong partnerships with local authority, housing providers and 3rd sector • Estate: appropriate accommodation identified.

Dementia Programme:

Project/Scheme	Progress Update	Progress this month	Dependencies
Older Adult community Re-design	• Completion of project documentation • Instigated workforce review	• Future of OPMH community teams document developed	• Links and partnership working with CRSL • Future commissioning intentions for cluster 18 • Shared care arrangements • Current workforce demographic • This also forms part of the Planned Care programme
Review and Redesign of the Medway Older Adult Acute Care Pathway'	• Completion of project documentation • Pathway Workshops held with stakeholders • MCH Site visit • Presentation to EMT/Business Case Clinic	• Project Board established • Non-Disclosure Agreement developed with Medway Community Health • MCH scoping exercise	• Commissioner intentions • Timescales for availability of estate and capital funding • This also forms part of the Urgent Care Programme
OASSIS (Older Adult Safe Secure Inpatient Services)	• Project Board in operation • Public consultation completed • P21+ process completed and partner identified and commenced work • Work streams identified- inter dependant	• Currently agreeing phased approach- Canterbury first	• Commissioner intention/ CCG support • Infrastructures to support capital build • This also forms part of the Inpatient Programme.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 31 January 2014

Subject: Patient Transport Services (PTS)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on Patient Transport 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 is a definition of Patient Transport Services from the Department of Health:

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

(b) The Health Overview and Scrutiny Committee considered the subject of PTS on two occasions in 2013:

- 1 February 2013.
- 29 November 2013.

(c) At the end of the discussion on 29 November 2013, the Committee agreed the following recommendation:

- 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.

(d) The written update report is included in this Agenda. The Committee will return to this subject in line with the above recommendation later this year.

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

2. Recommendation

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

Appendices

None.

Background Documents

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

Health Overview and Scrutiny Committee, Kent County Council, Agenda 29 November 2013, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5076&Ver=4

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NHS
West Kent
Clinical Commissioning Group

Report to Kent County Council Health Overview and Scrutiny Committee

31 January 2014

Patient Transport Services

Background

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

This paper summarises the current status of the service which went live on 1 July 2013.

Previous service delivery

As previously reported, patient transport services used to be delivered in a variety of ways from in-house provision by acute providers, the emergency ambulance service and a range of ad hoc and private contracted arrangements. There was no means of assuring the services provided and the LiNK report identified a number of issues including a lack of consistency in eligibility and issues with booking arrangements.

In January 2013, NSL Care Services was awarded the contract and the new service commenced on 1 July 2013.

Key elements of the new service

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

Eligibility for the service

As discussed in some detail at previous HOSC meetings, there has been no change to the Eligibility Criteria as a result of implementing this new service. The criteria used in Kent and Medway are slightly more generous than the national criteria and are continuing to be used. Attached is a copy of the Eligibility Criteria that has been in effect in Kent and Medway for over five years.

Current and continuing challenges

Service delivery continues to be a challenge due to a number of different factors. A key factor is an emerging pattern of activity that is different from that which was tendered for. Though the overall volume of activity is broadly the same, there are significant differences in the patient mobilities, together with differences in the distances and timings of the journeys. For example, there are significantly more journeys that require stretcher vehicles, which have put pressure on the limited resource available. Similarly, peak demand in the middle of the day is of a level that was not appreciated by either the commissioners or providers and is outstripping the resources available. The differences in the time that the journeys are occurring and the journey lengths has also impacted performance across the service but has been particularly challenging during the out of hours period when the available resource is at its lowest. Although some improvement to performance has been seen, overall performance is still poor.

The difference between the activity expected and that experienced has led to a review of activity and a review of staff rotas which need to be changed to meet the current activity requirements. NSL is also conducting a reorganisation of the fleet which includes the purchase of new vehicles.

There was a significant change management challenge involved in the transitioning of staff from multiple NHS providers into a single outsourced provider. This manifested itself in a threat of industrial action and morale problems in the first three months of the service. At the insistence of commissioners, NSL has addressed these issues and have restructured the management of the service by bringing in additional senior staff with extensive PTS experience. The PTS drivers and team leaders from the previous provider organisations are now settling in and performance is improving both in terms of journeys but also staffing issues. NSL is actively recruiting in order to ensure that the revised activity demand can be met on a sustainable basis moving forward.

NHS Went Kent CCG is the lead commissioner for this service and continues to work very closely with NSL to resolve these issues and agree a way forward.

1. Introduction

A non emergency patient is defined as a patient who, whilst requiring treatment, does not need the skills of an ambulance paramedic or technician, but may require trained personnel to undertake a journey to or from a health facility.

The NHS expects patients to make their own way to and from outpatient and inpatient appointments unless there is a clearly defined medical reason why they can not use conventional transport options including:

- walking
- cycling
- public transport including bus, train, community transport schemes, voluntary transport schemes, taxi
- private transport including lifts by friends, carers, neighbours, relatives, or the patient's normal network of support
- Or a combination of the above.

The revised process and protocols for the eligibility criteria will be rolled out from April 2010 on all new and existing contracts across the South East Coast Strategic Health Authority to provide non emergency transport only to those patients who have a medical need.

Patient Transport Services (PTS) will continue to offer ambulances and care vehicles for eligible patients and will continue to provide appropriate transport where the medical need and entitlement criteria are applicable.

2. Principles

Not all patients attending a health facility will be entitled to non emergency PTS.

The Principle for the entitlement to non emergency PTS is defined as:

- The patient having a medical condition such that they require the skills of ambulance staff or appropriately skilled personnel on, or for the journey

And/or

- Following a documented clinical decision, it has been determined that the medical condition of the patient is such that it would be detrimental to the patient's condition or recovery if they were to travel by any other means

- Where the entitlement to PTS is clear the patient will be offered PTS regardless of distance and circumstances.

- An agreed assessment tool will be used to determine the patient's entitlement to PTS services and the type of PTS services that are available for patients to travel in, to and from their place of treatment

3. Patients who are entitled to Patient Transport Services (PTS)

- For mental health and learning disability patients -

1. All community patients and some in-patients (*identified below) should exercise all means available to them to reduce reliance upon health provided transport. This will include, walking, cycling, driving, utilising public transport, lifts from care home staff/partner/carer/family/friends or using a public taxi where affordable to access healthcare services and appointments.

2. If none of the above means of transport are available/accessible/appropriate on health grounds, people will be eligible to access health provided transport for the duration of their treatment if it is assessed as being required by an individual's care co-coordinator/care manager and it forms part of a care plan subject to regular review. This may be a car or ambulance type vehicle dependant upon assessed need.

3. For people receiving treatment for mental ill health/learning disability as an in-patient, health funded transport (this may be in the form of a vehicle retained at the hospital for patient transport) will be available for people detained under the mental health act 1983 (revised 2008) who will be escorted by at least one staff member for the duration of the journey.

4. *People receiving in-patient treatment on a voluntary basis and needing to access alternative healthcare services or appointments where transport is necessary if for whatever reason 2 above is not appropriate then 3 above shall apply.

- Patients with an intravenous infusion that requires medical supervision

- Patients requiring oxygen.

- Patients with a chest drain or morphine pump.

- Patients attending renal dialysis sessions two or more times per week (for the duration of treatment).

- Patients attending radiotherapy/chemotherapy sessions two or more times per week (for the duration of treatment).

- Patients where independent travel presents a clinical risk such as low immunity patients or patients with a reasonable possibility of an event occurring during transport that requires skilled assistance i.e. Epilepsy

- Patients who have a clear need to travel in a wheelchair (providing they do not have a specially adapted vehicle, a mobility allowance or are unable to use public transport)

- Patients who cannot walk without continual physical support (not including the use of aids such as walking sticks or Zimmer frames)

- Patients who cannot use public transport (bus, train, community transport schemes, voluntary transport schemes, taxi) because they:
  - Have a medical condition that would compromise their dignity or cause public concern.
  - Have severe communication difficulties which routinely prevent them using public transport.

- Patients who are Blind, profoundly deaf or have speech (not language) difficulties which mean they are unable to travel alone.

4. Assessment criteria

The following assessment criterion has been developed to ensure PTS is provided to patients who are entitled to it and to determine the type of vehicle they need.

A series of questions is proposed to enable those assessing a patient's entitlement to make a clear decision and to be able to give those asking for patients transport an understanding why they are not entitled to receive PTS and what alternatives exist.

Stage 1 Assessing entitlement

FULFILLING ANY OF THE ETITLEMENT CRITERIA IN SECTION 3 WILL MAKE THE PATIENT ELIGIBLE TO PATIENT TRANSPORT SERVICES

If the MEDICAL reason is not detailed in the entitlement criteria the assessment team will use the next series of questions

Part 1

- What medical condition does the patient have that requires skilled assistance to transfer to and from a vehicle?
- What disability or condition does the patient have that makes it impossible or medically undesirable to travel by Public transport?
- What medical condition does the patient have that means there is a likelihood that an event could occur during transit that would require skilled assistance?
- What medical condition or disability does the patient have that may result in a risk to themselves or others?

Part 2

- How would the patient usually travel to see their GP?
- Does the patient routinely (at least monthly) get into a normal car by themselves and travel as a passenger?
- Does the patient use public transport (at least once a week)?

Patient Transport Services will be provided if after answering any combination of the above the patient achieves the assessment weighting of +5 as assessed by the assessment team

If patients do not have a medical reason listed or are assessed as not eligible for booking Patient transport Service the following advice should be offered.

- **Patients should be reminded that Hospital transport is only provided for those people with a medical need.**
- **Advise Patients of alternatives i.e. Volunteer Car Bureau (48 hours notice required, charges apply, approximately half price of Taxi cost)**
- **Train and bus time tables along with maps and routes to hospitals can be found at (input local information websites)**
- **Patient may be able to get Travel Expenses (HTCS) reimbursed if eligible.**
- **HCI forms for future help or HC5 form for refunds are available from Finance or from www.nhsbsa.nhs.uk**
- **Helpline 0845 8501166**

Stage 2: Assessing the type of patient transport

Does the Patient need to travel lying down on a stretcher?	For Patients up to 18 stone in weight, book as a Normal Stretcher (NS) Mobility Note: - HCT address assessment required For Patients over 18 stone in weight, book as a Bariatric Stretcher (BS) Mobility (State number of Assistants required to transfer, 2, 3, 4, 5 or 6) Note: - HCT address assessment required
Does the Patient need to use a wheelchair or more than one assistant to walk? (Please specify if essential that wheelchair travels with patient and/or an electric wheelchair is being used)	For Patients able to transfer to a seat for transit? Book as Wheelchair Assist (WA) Mobility (State number of Assistants required to transfer 1, 2, 3 or 4 and if oxygen required) For Patients unable to transfer to a seat for transit, book as a Wheelchair In-situ (WI) Mobility (State number of Assistants required to transfer 1, 2, 3 or 4 and if oxygen and / or hosting equipment required) For Patients over 18 stone in weight, book as a Wheelchair Bariatric (WB) Mobility (State number of Assistants required to transfer, 2, 3, 4, 5 or 6 and if over 25 stone) Note: - HCT address assessment required
Can the Patient travel seated in a vehicle, can they walk and climb steps either independently or with the help of one person?	Book as a Walking Patient (WP) Mobility (State if oxygen required)

Patients and Carers

ESCORTS AND CARER'S WILL BE PROVIDED OR ALLOWED

- **When transferring a patient to/from a secure area (i.e. under Mental Health Section).**
- **For all persons under 16 years of age.**

If a patient requests an escort or carer to assist them, and they do not fit into the categories above the following information will be sought to ensure a carer/escort is only considered in the appropriate cases:

- **The patient's condition is such that they require constant attention or support, as confirmed by clinical assessment.**
- **The patient has severe communication difficulties for example, Blind, profound deafness or speech (not language) difficulties, and therefore is routinely unable to travel alone.**
- **The patient has a mental health condition that makes it unsuitable / unsafe for them to travel unaccompanied.**

Proposed assessment weighting linked to questions

Part 1

- What medical condition does the patient have that requires skilled assistance to transfer to and from a vehicle?
- What disability or condition does the patient have that makes it impossible or medically undesirable to travel by Public transport?
- What medical condition does the patient have that means there is a likelihood that an event could occur during transit that would require skilled assistance?
- What medical condition or disability does the patient have that may result in a risk to themselves or others?

Part 2

- How would the patient usually travel to see their GP?
- Does the patient routinely (at least once a week) get into a normal car by themselves and travel as a passenger?
- Does the patient use public transport (at least once a week)?

Assessment score for entitlement +5

Part 1

- Medical Condition/Disability is such that further assessment is not needed + 5
- Medical Condition/Disability is such that further assessment is needed + 3

Part 2

- Patient uses public transport, taxi, own car or walks to see GP - 3
- Patient only receives home visits from GP + 2
- Patient routinely travels in a car as a passenger - 3
- Patient routinely uses public transport - 3

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 31 January 2013

Subject: Faversham Minor Injuries Unit

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

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

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1. Introduction

(a) Item 7 of the Agenda of 29 November 2013 was, 'Faversham MIU update and the development of the urgent care and long term conditions strategy.'

(b) At the conclusion of this item, the Committee agreed the following recommendation:

- *AGREED that this Committee asks that the decision to close the service on 31 March 2014 is set aside. This will allow a new procurement exercise to be undertaken after taking advice and with full consultation with the people of Faversham and their democratically elected representatives*.

(c) In addition, the Chairman was asked to write to the Secretary of State for Health setting out the Committee's concerns. The reply from the Secretary of State is attached.

(d) A written update from NHS Canterbury and Coastal CCG is also included. The CCG have asked to return to the Committee on 11 April 2013.

2. Recommendation

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

Background Documents

Agenda, Health Overview and Scrutiny Committee, Kent County Council, 29 November 2013,
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5076&Ver=4

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Robert Brookbank
Chairman, Health Overview and Scrutiny Committee
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- 6 JAN 2014

Dear Cllr Brookbank,

Thank you for your letter of 5 December 2013 in relation to the procurement process for the future provider of the Minor Injuries Unit (MIU) at Faversham Cottage Hospital.

As you will appreciate, this is a locally led process and it would be inappropriate for me to intervene.

However, Departmental officials have contacted NHS England to enquire about the matter.

I am informed NHS Canterbury and Coastal Clinical Commission Group (CCG) has agreed with the current provider, ic24 (formerly known as South East Health Ltd), that it will continue to provide the service until the end of September 2014.

I understand this is to allow time for the CCG to carry out further consultation where necessary and to consider the future of the MIU alongside a review of community services across the Canterbury and Coastal area.

Following the review, the CCG confirms it will make a decision about whether or not to re-run the procurement process.

Finally, the CCG has assured officials it will closely engage with Kent County Council, Swale Borough Council, Hugh Robertson MP, local GPs and 'Friends of

the Faversham Cottage Hospital and Community Health Centres', during the review process.

I hope you have found this reply helpful and I would encourage you to continue to engage with the CCG during its review of community services.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

NHS
Canterbury and Coastal
Clinical Commissioning Group

Health Overview and Scrutiny Committee

31 January 2014

Update on the review of the procurement process for Faversham Minor Injuries Unit and further consultation with the people of Faversham and elected representatives

Background

1.1 In November 2013 NHS Canterbury and Coastal Clinical Commissioning Group (CCG) made a request to attend the Kent County Council Health Overview and Scrutiny Committee (KCC HOSC). This was to brief members on the outcome of the procurement process for Faversham Minor Injuries Unit (MIU) and the development of the urgent care and long term conditions strategy. Dr Mark Jones, Clinical Chair and Simon Perks, Accountable Officer, attended the meeting and briefed members.

1.2 They informed the committee that the procurement process had been lengthy, starting in 2009. It had involved extensive discussions with GPs, patient groups, friends of the cottage hospital and members of the public to develop and agree a service specification which people in Faversham said they wanted. The procurement also formed part of a wider strategy to develop an east Kent wide specification for minor injury services. This was to ensure that a consistent service is provided across the area.

1.3 Despite having conducted a thorough procurement process, fully in line with Department of Health (DoH) guidelines, Dr Jones informed the committee that the CCG had been unable to find a provider who could deliver the service to the clinical specification set out by the CCG or within the nationally set financial framework. As a result, the CCG governing body had to regrettably take a decision to close the service on 31 March 2014.

1.4 At the November HOSC meeting, Members raised a number of questions and made comments about the procurement process.

1.5 At the end of the discussion, the committee asked the CCG to set aside its decision to close the service to allow a new procurement exercise to be undertaken after taking advice and with full consultation with the people of Faversham and their democratically elected representatives.

2. Progress

Since the HOSC meeting on the 29 November, the CCG has:

2.1 Discussed the HOSC request at its 4 December governing body meeting. The governing body noted its appreciation of the HOSC's scrutiny and reaffirmed its intention to continue to work with Members and keep them updated on developments. The governing body also agreed to approach the current provider to extend the service until September 2014 to allow a review of the procurement process and further consultation with local people and their democratically elected representatives. This will take place alongside a wider

review of all services which are delivered in the community (known as the 'Community Services Review').

2.2 Dr Jones, Simon Perks, Cllr David Simmons and Dr Simon Lundy (Faversham GP) met key stakeholders on December 6 including Hugh Robertson MP, representatives of the local council and local GPs. At this meeting it was agreed to :

- Extend the current contract for the MIU until after the conclusion of the Community Services Review.

- Consider the future of the MIU alongside the findings of the Community Services Review. The Community Services Review will look to ensure a long term viable future for Faversham's Cottage Hospital that meets the needs of the town in the years ahead.

- Conduct the review of the MIU procurement process by engaging with The Friends of the Hospital, all of Faversham's GPs, their patient groups and the town's elected representatives including councillors and MP.

2.3 Attended a public meeting on December 6 to hear local people's concerns about the potential closure of the MIU and outline the way forward. The CCG noted the strong views of local people and their wish for the CCG to do everything possible to keep the MIU open.

2.4 Formed a steering group to review the procurement process which includes representatives from:

- Faversham GPs (Dr Simon Lundy)
- The Friends of the Faversham Cottage Hospital and Community Health Centres and Faversham Town Council (David Simmons)
- Faversham GP practice patient groups (Brenda Chester)
- Swale Borough Council (Amber Christou)
- Kent County Council (Henry Swan)
- Healthwatch (Steve Innet).

2.5 Agreed with Swale Borough Council, the scope of a review of the CCG's decision which takes into account feedback from local people and stakeholders.

The review will include four workstreams to examine the:

- Development of the tender specification
- The procurement process the CCG followed
- Suitability of the current site to house X-ray
- All X-ray activity in Faversham, including both the MIU and wider access to X-ray services for Faversham residents.

2.6 Agreed with Swale Borough Council key objectives for the review which is to:

- Carry out a transparent and honest review of the work the CCG carried out to procure a new MIU service for Faversham.

  And either:

  a. Highlight any changes that could be made to ensure that, in the event of a further procurement, a successful bidder emerges,

  Or

b. Provide very clearly evidence (with agreement from stakeholders) why a future procurement would also lead to the same outcome as the last one (i.e. no successful bidder).

2.7 Responded to a request from the Secretary of State (SoS) for Health to provide further information on Faversham MIU. This was requested to inform the SoS's response to the letter he received from the Chairman of HOSC, Mr Robert Brookbank.

3. Next steps

3.1 The CCG has agreed a review process with the steering group which will:

- Form stakeholder sub-groups for each of the four workstreams.
- Share all documentation which was used in the unsuccessful procurement process with each sub-group to provide opportunity to analyse and comment on the work that was carried out by the CCG.
- Hold an initial review meeting to agree what, if any, further work needs to be done in each area of the review.
- Compile a short report for each workstream.
- Reconvene the sub-group for each workstream to agree and sign off the report.
- Present the final reports to the steering group for sign off.

3.2 The CCG has also approached HOSC to attend the April 2014 committee meeting to update Members on the outcome of the review.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 31 January 2014

Subject: Forward Work Programme

Summary: This report invites the Health Overview and Scrutiny Committee to approve a suggested Forward Work Programme pending the development of a longer term Forward Work Programme in the near future.

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

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1. Introduction

(a) A meeting was arranged between representatives of the new Clinical Commissioning Groups and the Chairman, Vice-Chairman and Group spokespersons with a view to drawing up a longer term Forward Work Programme based on information about the forward plans of the local NHS. The first meeting took place on 16 January 2014.

(b) Based on this meeting and work already in progress, a Forward Work Programme for the next couple of meetings is set out. A full Forward Work Programme for the rest of the year is being developed. This is likely to include consideration of the 2 and 5 year strategic plans being developed by the CCGs. The optimum way of considering these plans is being considered.

(c) In addition to the topics set out below, the following are ones which the Committee may wish to consider in the future:

- Dementia services;
- Musculoskeletal services.
- NHS 111;
- Accident and Emergency;
- Audiology;
- Ophthalmology.

2. Outline Forward Work Programme

(a) 7 March 2014:

- Medway NHS Foundation Trust: Update.
- Accident and Emergency: North Kent.

(b) 11 April 2014:

- Faversham Minor Injuries Unit.
- Patient Transport Services.
- East Kent Community Services Review.
- East Kent Strategic Plans.

(c) Subsequent meetings in 2014:

- Fri, 6 June
- Fri, 18 July
- Fri, 5 September
- Fri, 10 October
- Fri, 28 November

(d) There is a need to retain as much flexibility as possible in the forward work programme in order to deal appropriately with issues which may arise within the health economy. The exact scheduling of some of the items listed above may vary.

(e) In order to assist with forward planning, the forward work programme will be circulated to all NHS Trusts in Kent. If any Member has any specific question on any of the items on the forward work programme which they would like asked of the relevant Trust(s) in advance of the item being discussed, please pass them to the Research Officer for inclusion in the list of questions submitted to the NHS in advance.

3. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to approve the Forward Work Programme.

Background Documents

None.

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