HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th March, 2014

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th March, 2014, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Lizzy Adam**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
UKIP (3):	Mr A D Crowther, 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

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UNRESTRICTED ITEMS

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

Item	Timings
1. Substitutes	

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

3. Minutes (Pages 5 - 14)

4. Membership

5. Musculoskeletal and Orthopaedic Care Pathways (Pages 15 - 22) 10.05

6. Medway NHS Foundation Trust: Update (Pages 23 - 52) 10.35

7. Accident and Emergency: North Kent (Pages 53 - 76) 11.15

8. CQC Inspection Report - Darent Valley Hospital (Pages 77 - 90) 12.00

9. Forward Work Programme (Pages 91 - 94) 12.30

10. Date of next programmed meeting – Friday 11 April 2014 @ 10:00 am

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
(01622) 694002

27 February 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, 31 January 2014.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr N J D Chard, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr A J King, MBE, Mr R A Latchford, OBE, Mr G Lymer, Mr C R Pearman, Cllr P Beresford, Cllr M Lyons and Ms Sarah Spence

ALSO PRESENT: Cllr Mrs A Blackmore, Cllr R Davison, Ms C J Cribbon and Mr S Inett

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Ms D Fitch (Democratic Services Manager (Council))

UNRESTRICTED ITEMS

10. Declarations of Interest
(Item)

(1) Mr Mike Angell declared a personnel interest in the Agenda as his partner was being treated through an orthopaedic care pathway.

(2) Councillor Michael Lyons declared an other significant in the Agenda as a Partnership Governor of East Kent Hospitals University NHS Foundation Trust.

(3) A Member emphasised to the importance of disclosing the type of interest they were declaring.

11. Minutes
(Item 4)

(1) RESOLVED that the Minutes of the meeting of 29 November 2013 are correctly recorded and that they be signed by the Chairman.

12. Membership
(Item)

(1) The Committee noted that Cllr Pauline Beresford had replaced Geoff Lymer as a District Council representative on this Committee.

13. Musculoskeletal Services
(Item 5)

(1) A Member expressed concern that the report detailed proposed changes to the service which would take effect from April 2014. It was suggested that the Scrutiny Research Officer liaise with the service to produce a note in advance of the next meeting detailing the types of symptoms and treatments for musculoskeletal and orthopaedic conditions; the reduction in the rate of injections given for low back pain and any implications this may have had.

(2) RESOVLED that this Committee notes the reports and looks forward to a further update on the re-design of Musculoskeletal and Orthopaedic Care Pathways at the Committee's meeting in March.

14. Child and Adolescent Mental Health Services
(Item 6)

Dave Holman (Head of Mental Health Programme Area and Sevenoaks Locality Commissioning, NHS West Kent CCG), Ian Ayres (Accountable Officer, NHS West Kent CCG), Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England), Steven Duckworth (SEC Strategic Clinical Networks and Senate, NHS England), Lorraine Reid (Managing Director - Specialist Services, Sussex Partnership NHS Foundation Trust) and Jo Scott (Programme Director - Kent and Medway Children & Young Peoples Services, Sussex Partnership NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests of the Committee and asked them to introduce the item. The representatives of Sussex Partnership NHS Foundation Trust (SPFT) began by setting out a short chronology and update on progress. SPFT took over the management of the service in September 2012, transferring 274 staff via TUPE arrangements from the seven previous providers, into a single Kent and Medway team. SPFT have created four hubs in Kent, three of which are fully staffed in Medway and Swale, South Kent and East Kent. Recruitment for the West Kent hub is continuing, and they have recently moved into their new offices.

(2) SPFT inherited the service with a legacy of extremely long waits. Young people referred before April 2013 have all been seen and external waiting lists have also been reduced to six weeks. An Out of Hours service has been established across Kent and Medway outside of routine working hours. The demand for this service has been much higher than expected with 150 Out of Hours assessments a month. Routine referrals have been delayed as a result of unscheduled urgent and emergency care referrals.

(3) SPFT highlighted two significant challenges: Common Assessment Framework (CAF) referrals and Tier 4 inpatient admissions. The current CAF process restricts access to universal services (Tier 1) making it easier to be referred unnecessarily to higher tiered services. SPFT are signposting back 23% of CAF referrals to Tier 1 which makes families feel like they are being rejected by CAMHS who only provide Tier 2 & 3 services. Commissioning for Tier 4 inpatient mental health beds has been transferred to NHS England. There is a national shortage of these beds with young people waiting in acute hospitals until a Tier 4 bed becomes available.

(4) The Chairman then invited The Rt Hon Greg Clark MP to speak as a guest of the Committee. Mr Clark thanked the Chairman for the opportunity to address the Committee. Mr Clark expressed his concerns regarding the adequacy of CAMHS in Kent, and in particular the Tunbridge Wells area. He had been contacted by a number of constituents who were concerned about long waiting times, the standard of communication from SPFT and the lack of a single point of referral.

(5) Mr Clark also expressed concerns that the waiting lists had been under-declared under the previous contract holder and data was missing from the performance report. Mr Clark added that there were further issues surrounding staffing levels, transition to adult services and waiting times for treatment which were having a considerable impact on children, their family and friends and their education.

(6) Sussex Partnership Trust representatives further explained that when they took over the services, they did not understand the extent of Tier 2 waiting times. SPFT believed that the previous providers had not been used to being performance managed. They explained that there would always be a level of wait for routine assessments as unscheduled urgent and emergency care referrals were prioritised. As part of their tender, SPFT had anticipated the waiting lists taking three years to resolve which was accepted by the CCG.

(7) SPFT confirmed that they were currently underutilising services, in order for staff to get used to working for a new provider and service model. They are demanding from staff a more efficient service than had been previously provided. There have been a number of issues regarding IT, a large exercise has been undertaken to transfer records in Kent onto the SPFT system. These issues have taken some time and SPFT have kept the commissioners informed. Ms Scott stated that has had a number of conversations with Mr Clark where she had explained that she was going to have no fixed base in Kent in order to enable her to travel to all sites.

(8) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A number of Members raised the importance of early intervention to prevent young people from reaching the point of crisis and the importance of interventions from parents and teachers. CCG representatives agreed with the concerns raised by Members including the importance of early intervention. The CCG had spent a huge amount of time with SPFT to improve their services and it had been made clear to SPFT that they need to demonstrate progress. NHS England representatives explained that CAMHS was recognised as a national challenge, and they were awaiting a report from the Secretary of State following a national review of CAMHS services.

(9) One Member referred to the lack of integrated commissioning between tiers 1 - 4 with Tier 2 & 3 services commissioned by NHS West Kent CCG and Tier 4 services commissioned by NHS England. CCG representatives agreed that the separation of the tiers by government was not helpful; an integrated pathway between tiers was required to ensure a seamless service. NHS

England representatives explained that the Strategic Clinical Networks were leading on pathway integration nationally.

(10) Members commented on the perceived lack of GP training in mental health for adults and young people. CCG representatives explained that NHS West Kent CCG had introduced a lead GP for mental health, Dr David Chesover, who had a specialist in-depth knowledge of CAMHS. Dr Chesover was working with GPs in West Kent to build upon their mental health knowledge and skills base. One Member enquired if a GP mental health advocate would be introduced in every CCG and suggested that this could be raised with the Secretary of State.

(11) Concerns were expressed regarding inequalities in service provision across Kent. CCG representatives explained that historically there had been underinvestment in CAMHS. The CCG were looking at ways to tackle service inequality through investment and commissioning at a more local level. Mr Ayres explained that the CCG would need to work with HOSC and the Health and Wellbeing Board regarding the proposed Section 75 Pooled Budgeting agreement.

(12) A Member enquired about the maximum length of wait for assessment. SPFT confirmed that the current longest wait for assessment was 26 weeks but explained that the family concerned had not been able to meet the appointments. The majority of young people were seen within seven weeks. Another Member enquired if the NHS West Kent CCG would be discussing CAMHS in a public meeting. The CCG representatives assured Members that they would bring CAMHS to the CCG governing body in March.

(13) Discussion also included the nature of the IT system used by SPFT and its compatibility with NHS England; collaborative working between KCC, CCGs and boroughs; transitions from children to adult services and transition between providers.

(14) In response to a question, the Chairman undertook for Dr Eddy to be supplied with a briefing note regarding HOSC's involvement with the CAMHS contract.

(15) CCG representatives confirmed that they would welcome the opportunity to report back to the Committee in three months; they announced that they would be taking immediate action from this meeting.

(16) Mr Chard proposed and Ms Harrison seconded the proposal which was agreed by the Committee and is set out in paragraph (18) below.

(17) The Committee also thanked its guests for their attendance and contributions today, asked that they take on board the comments made by Members during the meeting and looked forward to receiving a further update in the three months time.

(18) RESOLVED that this Committee write to the Secretary of State to ask him to assess the adequacy of the current CAMHS service in Kent and that the CCG be asked to identify an outstanding trust to assess improvements that can be

to made in the way in which the Sussex Partnership Trust is carrying out the Kent and Medway CAHMS contract and to report back to this Committee.

15. Kent and Medway Adult Mental Health Inpatients Review: Implementation Plan
(Item 7)

Ivan McConnell (Director of Transformation and Commercial Development, Kent and Medway NHS and Social Care Partnership Trust), Angela McNab (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the Committee's guests and asked them to introduce the item.

(2) Ms McNab updated the Committee on the progress of the plan following the conclusion of the Kent and Medway NHS Joint Health Overview and Scrutiny Committee (JHOSC). She reminded Members that Medway Council's Health and Adult Social Care Overview and Scrutiny Committee had subsequently referred the decision to the Secretary of State for Health. After an initial assessment by the Independent Reconfiguration Panel, the Secretary of State confirmed that the reconfiguration could proceed.

(3) Kent and Medway NHS and Social Care Partnership Trust (KMPT) had continued to move forward with implementation of the plan. One new ward had been opened at the Dartford Centre of Excellence site which had enabled the closure of the younger adults ward at Medway Maritime Hospital before Christmas. The remaining ward at Medway Maritime Hospital was to close as soon as possible once the additional bed capacity in Kent and Medway had been increased. The new ward in Dartford provided better facilities for patients including private bath rooms. Enhanced transport support had been provided for relatives and friends over the holiday period. KMPT had met regularly with service users during these changes and had received positive feedback. In addition, KMPT were recruiting to the enhanced Home Treatment and Crisis Teams. A key aim of KMPT was to reduce the use of crisis wards over time with improved community and home services; enhanced psychiatric liaison and street triage teams with Kent Police.

(4) In November, KMPT began piloting a new personality disorder service in Medway. If successful, they planned to role out the intensive day service across Kent and Medway. The outcome of the pilot was already looking very positive. 15 patients had been involved in the pilot; these patients had historically had multiple presentations leading to Section 136 or acute admissions. Since the beginning of the pilot, only one patient has had a presentation.

(5) KMPT were developing plans to enhance the number of beds with the introduction of 14 additional beds across Kent and Medway. The KMPT Board had agreed the capital spend to facilitate additional bed capacity at the Maidstone site. Discussions were taking place with regards to a capital build (new build) or a modular build to facilitate the additional beds. KMPT would

shortly be starting the refurbishment of Dudley Venables House in Canterbury which would increase acute care and improve accommodation. This facility was due to re-open in June or July.

(6) KMPT were working with service users and carers to clearly define the term Centre of Excellence. They were looking at the range of professionals and interventions that service users would have access to at all Centres of Excellence.

(7) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A number of Members enquired about the number of beds and additional capacity. KMPT explained that they currently provided 160 acute beds. Public Health had assessed the need for acute beds in Kent and Medway and revised the figure to 174 acute beds. KMPT were looking to increase capacity by 14 acute beds through the development of a new unit in Maidstone. These figures did not include forensic or hostel beds.

(8) A series of questions were asked about the street triage pilot with Kent Police. The initial twelve week pilot has been extended until the end of March. The pilot had been of great benefit with joint learning and increased Police confidence. However the current project was not scalable; KMPT were looking to identify a sustainable model for the whole of Kent. KMPT were looking to introduce a single number for the Police to contact to access the appropriate local mental health team when they come across a person presenting with mental health symptoms. If the person is known to the local team, the team would be able to give advice and guidance directly to the Police Officer.

(9) One Member commented about the provision of services for older adults. Ms McNab explained that services for older people were reconfigured last year which included the closure of a ward at William Harvey Hospital. KMPT were developing a plan to further improve older peoples services.

(10) A number of questions were asked about preventative services and early intervention. As part of their Transformation Programme, KMPT explained they were increasing engagement with GPs to support early intervention through primary care, in order to prevent an escalation in the patient's needs. For patients with an acute need, they would go to their closest Centre of Excellence in Canterbury, Dartford or Maidstone which would have consultant cover seven days a week. For patients who were not in crisis but had a secondary need, KMPT would be developing community hubs to deliver a range of services locally.

(11) Clarification of what was meant in practise by the introduction of seven days a week consultant cover. KMPT explained that they were looking to move step by step towards seven days a week consultant cover. They would not provide 24/7 cover instead they would identify key times of the day when consultant interventions were required.

(12) One Member expressed concern at KMPT's ability to finance and maintain facilities at the Centre of Excellence. Ms McNab explained that she had no concerns about funding of those facilities. Another Member enquired about services available in Sheerness. Ms McNab explained that she would write to

the Member detailing the services available in Sheerness. Questions were also asked about transition and integrated multidisciplinary teams.

(13) Members made a number of comments about the format of the report. It was suggested that in future information could be presented in the form of a map so that Members can assess the provision of services across Kent. Ms McNab agreed to take this idea forward and make the figures more visible in their next report.

(14) RESOLVED That the Committee thanks its guests, notes the good progress made and looks forward to a written update within six months.

16. Kent and Medway NHS and Social Care Partnership Trust: Update
(Item 8)

Ivan McConnell (Director of Transformation and Commercial Development, Kent and Medway NHS and Social Care Partnership Trust), Angela McNab (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) Mr McConnell introduced the presentation. He explained that the transformation programme was a clinically led programme, delivering a clinical strategy. The programme aimed to provide the right care at the right point by the person with right skills. A multidisciplinary team would work with the individual to provide medical and psychological interventions; nursing, carer and occupational therapy support and enable interactions with social services.

(2) KMPT outlined the four key aims of the clinical strategy which were:

1. Provide excellent community services close to home or close to home as possible, reducing the number of people who inpatient need care. Where necessary community services would support the length of stay being as short as possible

2. Better service integration and partnership working. KMPT were working with commissioners to enhance primary care mental health support. They were embedding community nurses within GP practices, educating and training nurses and GPs. David Chesover, NHS West Kent CCG lead GP for mental health, had been working with two West Kent consultants to deliver schizoaffective and bipolar disorder training to GPs. They were hoping to roll this out across the county.

3. Improve quality and dignity in services including a high quality therapeutic environment and the promotion of mobile working as demonstrated by the street triage pilot and the police custody liaison services.

4. Expand and enhance the specialist services, where appropriate, to potentially provide those across a wider geographic area.

(3) The clinical strategy was a benefit-led approach for inpatient, planned care, urgent care/crisis and dementia programmes. In re-designing pathways, KMPT have identified the need to better communicate and engage with patients, demonstrate what the trust has delivered; enhance partnership working and learn from previous experience.

(4) Members of the Committee then proceeded to ask a series of questions and made a number of comments. One Member had attended the KMPT Board meeting on 30 January 2014 and was concerned that safeguarding was not discussed. In the board papers, a target was set for 80% attendance by KMPT practitioners when invited to a Child Protection conference. It was reported that in Margate and Thanet there was only a 32% attendance rate. Ms McNab explained that safeguarding was absolutely critical. She explained that at the board meeting, they were unable to drill down into detail. Instead this issue would be picked up by the board's Quality Committee who would investigate why staff felt it is not imperative to attend. Ms McNab offered to write to Mr Chard about this issue.

(5) Members expressed concerns that KMPT's existing service provision had not improved beyond adequate. They felt that KMPT should concentrate on the basics before introducing the transformation programme. Ms McNab explained that KMPT were making changes where necessary ahead of the transformation programme. The new strategy had been developed by clinicians who had the knowledge to deliver the best services. Service users had influenced the development of the strategy. Mr Ayres agreed that the basics should be right before expanding. However he explained that for commissioners it was important not to veto growth, if existing services were not performing as expected. He noted that CCGs across Kent had recognised the strength of leadership and improvement to services under Ms McNab's leadership.

(6) Members enquired about the inclusion of dementia in the transformation programme. A KMPT representative assured Members that dementia was a major part of the Transformation Programme. As part of the Transformation Programme, KMPT were developing and enhancing existing dementia services.

(7) The introduction of a dedicated telephone number, to be used when individuals were exhibiting signs of a mental health episode, was raised. Ms McNab explained that this is something that KMPT would like to see happen; they had successfully piloted a local street triage scheme with the Police. Mr Ayres explained that access to a single number was a national issue. However CCGs were developing strategies for a single point of access to both physical and mental health services.

(8) RESOLVED 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 return visit within six months to give an update on the transformation programme with particular reference to safeguarding and dementia.

17. Patient Transport Services: Written Update

(Item 9)

Ian Ayres (Accountable Officer, NHS West Kent CCG) was in attendance for this item.

(1) Mr Ayres kindly offered to stay for this item and answer Members' questions. A number of questions were raised about the possibility of decommissioning the Patient Transport Services. Mr Ayres accepted that the position with NSL Kent, the current provider, was not good and gave an assurance to the Committee that improvements would be made. Mr Ayres explained that there was a real threat in lead up to Christmas that the service could have lost its provider; the service has now been stabilised. The CCG were meeting with NSL Kent to reassess the contract on current activity including the vehicles and staff required to meet the peaks of demand. Additional funding had been secured to reassess the contract; external analysis of the current contract found that the money available and the services expected to be provided were out of balance.

(2) Mr Ayres acknowledged that the problems encountered with both providers: Sussex Partnership NHS Foundation Trust (CAMHS) and NSL Kent had been partly caused by incorrect information about service usage being given during the tendering process. Mr Ayres explained that under the previous provider a block contract was awarded which had led to a lack of record keeping on service activity. With the move to payment by results contracts, a key lesson has been learnt by the CCG about the importance of undertaking a year of recording service activity before going out to tender. The CCG would look to decommission the service if performance targets were not met under the terms of the reassess contract.

(3) Members enquired about the recent CQC Inspection Report. Mr Ayres acknowledged that the criticisms within the CQC report. He explained that the unannounced inspection took place in the same week as new manager started with NSL Kent. After due consideration the CQC decided to allow the service to continue; as it believed that the CCG and NSL would be able resolve the issues and make changes. Mr Ayres explained that the recommendations made by CQC had been implemented. The most significant recommendation, the Disclosure and Barring Service checks on staff, had been completed with the exception of staff on long term sickness absence. One of the Members requested the Scrutiny Research Officer to circulate the link to the CQC report.

(4) In response to a specific question about NSL Kent staff taking strike action it was explained that the GMB trade union members of NSL Kent's staff had voted to take strike action but had not yet called a strike. The vote was taken before new local management was introduced.

(5) There was a discussion about alternative providers for Patient Transport Services. Mr Ayres explained that there were a limited number of providers and it would take a minimum of six months for a new provider to be put in place. Further, the commissioning of a Kent and Medway wide service had put an unhelpful complexity into the system. One of the former providers SECAmb has performance issues in Surrey and Sussex and would be significantly more

expensive than the current provider. At the time of tendering, the previous providers from the hospital trusts did not want to continue; there was a consensus amongst them that there should be a single organisation to provide all services. Mr Ayres has spoken to a number of CCGs who have also commissioned NSL for Patient Transport Services. Commissioners in the West Midlands and West Country had been satisfied with provision whilst the East Midlands had had issues with the service. None of the commissioners had faced the scale of difficulties with NSL as experienced in Kent.

(6) RESOLVED that the Committee thanks Mr Ayres for his attendance and contributions today, asks that the CCG and NSL take on board the comments made by Members during the meeting and looks forward to a return visit by the CCG and NSL in April.

18. Faversham Minor Injuries Unit: Written Update
(Item 10)

(1) RESOLVED that the Committee notes the reports and looks forward to an update at the April meeting.

19. Forward Work Programme
(Item 11)

(1) A suggestion was made for the Committee to look into the provision of dementia services in Kent. It was recognised that these services were delivered by a number of non-NHS organisations including Kent Fire & Rescue Service and the voluntary sector. The Scrutiny Research Officer was asked to provide a scoping document for discussion at the next meeting of the Committee.

(2) RESOLVED that the Committee note the report.

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

Item 5: Musculoskeletal and Orthopaedic Care Pathways

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 March 2014

Subject: Musculoskeletal and Orthopaedic Care Pathways

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on Musculoskeletal and Orthopaedic Care Pathways.

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

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1. Introduction

(a) On 31 January 2014 the Health Overview and Scrutiny Committee considered the East Kent Federation of Clinical Commissioning Groups (CCGs) report on Musculoskeletal and Orthopaedic Care Pathways. The East Kent Federation brings together the following four CCGs:

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

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

- *RESOVLED that this Committee notes the reports and looks forward to a further update on the re-design of Musculoskeletal and Orthopaedic Care Pathways at the Committee's meeting in March.*

2. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report from the East Kent Federation of CCGs.

Background Documents

None.

Contact Details

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Health Overview and Scrutiny Committee

7 March 2014

Musculoskeletal Services in East Kent

Introduction

NHS Ashford, Canterbury and Coastal, South Kent Coast and Thanet Clinical Commissioning Groups (CCGs) provided a report for the 29 November 2013 Health Overview and Scrutiny Committee on the work they were jointly undertaking to re-design Musculoskeletal and Orthopaedic Care Pathways. The committee considered this report at their 31 January 2014 meeting and posed six questions. The questions and our responses are now detailed in this update.

Members of the Committee are asked to note the contents of this update and the commitment of the east Kent CCGs to return to the Committee with further updates.

Questions and answers

Question one: Can you provide an update on the proposed re-design of the Musculoskeletal and Orthopaedic Care Pathway?

Work to review and re-design the pathway is on-going. A number of workstreams are included within the review. Progress is as follows:

Completed

- Review of EKHUFT's hip replacement revision rates. It found that rates were comparable with EKHUFT's peers.
- Review of the Community Orthopaedics service provided by Kent Community Health NHS Trust (KCHT). The new service is expected to be implemented in May 2014.
- Review of EKHUFT's diagnostic arthroscopy rates (the examination of a joint by inserting a specifically designed illuminated device into the joint through a small incision). No concerns were found.

On-going

- Re-designing treatment for people with low back pain with injections. This is expected to be completed by the end of June 2014.
- Improvements to primary care refferal management. Work is underway to review data. This will inform whether plans need to be put in place to reduce referrals.
- Review of the Shoulder Surgery Pathway. Work is expected to be completed by September 2014.
- Plan to reduce 18 week referral-to-treatment backlog. The CCGs are reviewing this issue with EKHUFT.

Note: See annexe one for further detail on the review and re-design.

Question two: Can you provide a timeline for the developments of these proposals?

It is envisaged that work to review and implement changes to the pathway will be fully completed by September 2014.

Question three: What types of symptoms are associated with musculoskeletal and orthopaedic conditions?

'Musculoskeletal and orthopaedic conditions' is a very broad term encompassing approximately 200 different conditions, affecting the muscles, joints and skeleton.

The main symptoms of musculoskeletal conditions are pain, stiffness and joint swelling affecting one or more joints.

Note: See annexe two for further detail on the most common types of musculoskeletal conditions and symptoms.

Question four: What types of treatments are used in treating musculoskeletal and orthopaedic conditions?

The treatment of musculoskeletal and orthopaedic conditions is dependent on the nature and cause of the disease.

Treatments can include the use of painkillers, anti-inflammatory medicines, surgery (including key hole) and physical therapies – such as exercise programmes or acupuncture.

Note: See annexe three for further detail on treatments.

Question five: What is the rate of injections for low back pain per 1000 patients in east Kent CCGs and how does this compare with other Kent and Medway CCGs?

The table below details the rate of injections for low back pain per 1000 patients in east Kent CCGs compared with other Kent and Medway CCGs in 2012/13 and the reduction in the 2013/14 year-to-date.

	Ashford CCG	Canterbury and Coastal CCG	South Kent Coast CCG	Thanet CCG	Kent & Medway CCGs
Injections per 1000 patients 2012/13	6.23	5.22	6.45	5.73	4.90
Injections per 1000 patients 2013/14	5.01	4.60	5.38	5.32	5.15
Change in Rate	**-1.22**	**-0.62**	**-1.07**	**-0.41**	**+0.25**

Question six: Has the rate of injections for low back pain per 1000 patients in east Kent CCGs been reduced and have there been any implications as a result of this?

The table above indicates that the rate of injections for low back pain per 1000 patients in east Kent CCGs has reduced.

To date the only known implication of the change to the back pain pathway has been one pending complaint.

ENDS

Annexe one – Further information on review of pathway

Community Orthopaedics: This review has been completed. The east Kent CCGs have given formal notice to decommission Community Orthopaedics from April 2014. Negotiations with KCHT are underway as to the individual elements of this service that the CCGs will commission via a GP direct access route as of April 2014. Three of the east Kent CCGs (Ashford, South Kent Coast and Thanet) are near to concluding these negotiations and the timeline for implementing the new service has been adjusted to May 2014. NHS Canterbury and Coastal CCG has determined that they have sufficient MSK services in place to decommission Community Orthopaedics and not replace it with a GP direct access service. This element is expected to be completed within Q1 of 2014/15.

Improve primary care referral management: The earlier report stated that east Kent CCGs primary care referrals to EKHUFT Orthopaedics were under plan. This was an erroneous statement, further examination of referral data has found that referrals were above plan at that time. The east Kent CCGs are currently modeling their expected referrals for 2014/15, and as part of this will determine whether to develop plans to reduce referrals.

Review of the Shoulder Surgery Pathway: This is a joint project between the east Kent CCGs and EKHUFT, to review (and re-design) the Shoulder Surgery Pathway. This project is insufficiently advanced to provide an update at this time, but the project is expected to continue into Q1 & Q2 of 2014/15 at least.

An 18 Week Referral-To-Treatment Backlog Reduction Plan: This element involved the recruitment of two interim orthopaedic surgeons by EKHUFT to assist in reducing the number of patients waiting longer than 18 weeks for treatment. Due to challenges in recruiting and retaining interim staff and higher than expected referral levels, this element has not had the impact expected. The east Kent CCGs are currently reviewing this issue as part of contract negotiations with EKHUFT.

Annexe two - Common types of musculoskeletal conditions and their symptoms

- **Chronic Musculoskeletal Pain** - generally classed as a condition that has no identifiable underlying, serious or specific disorder and which has not resolved in 3 to 6 months.

- **Connective Tissue Diseases** - characterised by multi-organ inflammation and autoimmunity. Symptoms vary depending on the disease, but many share the common symptoms of joint aches and pains, fatigue, muscle pain and weakness, rashes, skin changes and inflammatory changes in different organ systems.
- **Juvenile Idiopathic Arthritis** – arthritis beginning in childhood. Can affect four or fewer joints (oligoarticular), more than five joints (polyarticular). Symptoms are swollen, painful joints, particularly knees and/or ankles. Other symptoms include tiredness and eye inflammation. There is also a type of juvenile arthritis (systemic onset) that usually starts before 5 years of age and begins with systemic symptoms such as fever, rashes, lethargy and enlarged glands. Other symptoms include joint and muscle pain, skin rashes and tiredness.
- **Osteoarthritis** – the most common form of arthritis, referring to a clinical syndrome of joint pain accompanied by functional limitation and reduced quality of life to varying degrees. Hip, knee and hand joints are most frequently affected.
- **Metabolic Bone Disease** – a term used to describe a range of conditions including Osteoporosis. These conditions cause bones to become fragile and break without too much force. Common fracture sites are the wrist, hip and vertebrae.
- **Inflammatory Arthritis** – causes inflammation in the joints. Symptoms can include severe pain, stiffness, fatigue, deformity and reduced joint function. Joints and organs can be affected, and severe inflammatory arthritis can shorten life expectancy. Conditions in this category include:
    - **Psoriatic Arthritis** – inflammatory arthritis associated with the skin condition psoriasis.
    - **Rheumatoid Arthritis** – chronic, progressive, disabling disease where the immune system attacks the synovial lining to the joints and other organs. It typically affects the small joints of the hands and feet. In established disease, most joints will be affected over time. Can also affect the internal organs, such as the heart, lungs and eyes.
- **Soft Tissue Rheumatism** – conditions affecting tissue surrounding a joint, such as ligaments and tendons, and includes conditions such as tendonitis, bursitis, fasciitis and fibromyalgia.

<u>Annexe three – Treatments</u>

- **Drug Treatments:**
    - **Analgesic agents –** the majority of musculoskeletal conditions present with pain, stiffness and swelling of joints. Mild to moderate pain can be treated with simple analgesia, usually in a stepped approach including paracetamol, ibruprofen or a weak opioid (such as codeine) or other analgesics.
    - **Corticosteroids** – used to treat inflammation by reducing the immune response. These are usually applied to the affected area externally (topical treatment) or can be injected into an affected joint.
    - **Disease-Modifying Anti-Rheumatic Drugs (DMARDS) –** used to slow down the disease progression of rheumatoid arthritis.

    - **Biologics** – used to block or modify specific immune responses, treating the underlying cause of a number of inflammatory conditions.
- **Physical Therapies** - physical therapy treatment may be offered in addition to drug treatments used to manage pain, in order to improve mobility and functioning. It may include a structured exercise programme, manual therapy (including spinal manipulation for low back pain) or complimentary therapies such as acupuncture.
- **Procedures for Soft Tissue Rheumatism** – there are a number of specific procedures used in the treatment of soft tissue disorders, including blood injections (taken from the patient and re-injected), shockwave therapy (a machine used to deliver sound waves to the painful area to stimulate healing), radiation therapy, and surgery.
- **Arthroscopy** - a type of keyhole surgery used to both diagnose and treat problems with joints. The procedure is most commonly used on the knees, ankles, shoulders, elbows and wrist. As well as allowing a surgeon to look inside a joint, an arthroscopy can also be used to treat a range of problems and conditions.
- **Surgery** – surgery can be used to treat specific joints. Types of surgery include total or partial joint replacement, joint fusion and removal of deformed joints.

Specific treatments can be found under the National Institute for Health and Care Excellence (NICE) pathway for musculoskeletal conditions (http://pathways.nice.org.uk/pathways/musculoskeletal-conditions).

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Item 6: Medway NHS Foundation Trust: Update

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 March 2014

Subject: Medway NHS Foundation Trust: Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the Medway NHS Foundation Trust.

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

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1. Introduction

(a) Medway NHS Foundation Trust attended the Health Overview and Scrutiny Committee on 6 September 2013. The Committee considered the Trust's Improvement Plan produced in response to the Keogh Review into the Quality of Care and Treatment provided by 14 Hospital Trusts. The minutes of this agenda item are appended to the report.

(b) Following the publication of the Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report), on 6 February 2013 Sir Bruce Keogh was asked by the Prime Minister and Secretary of State for Health to conduct an immediate investigation into the care at hospitals with the highest mortality rates and to check that urgent remedial action was being taken.[1]

(c) 14 Trusts were selected on the basis of being outliers for two consecutive years on one of two measures of mortality: Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR).[2] [3] HSMR measures whether mortality is higher or lower than would be expected. A high HSMR does not mean for certain there are failings in care but can be a 'warning sign that things are going wrong.' SHMI is a high level indicator published quarterly by the Department of Health. It is a measure based upon a nationally expected value and can be used as a 'smoke alarm for potential deviations away from regular practice'. [4]

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[1] The full set of documents relating to The Keogh Review are available on the NHS Choices website, http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/Overview.aspx

[2] NHS Commissioning Board, *Professor Sir Bruce Keogh to investigate hospital outliers*, 6 February 2013, http://www.commissioningboard.nhs.uk/2013/02/06/sir-bruce-keogh/

[3] NHS Commissioning Board, *Sir Bruce Keogh announces final list of outliers*, 11 February 2013, http://www.commissioningboard.nhs.uk/2013/02/11/final-outliers/

[4] The Keogh Review, *Report for Medway NHS Foundation Trust, Rapid Responsive Review Report for Risk Summit*, pp.33-34, 'SHMI and HSMR definitions', http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/Medway%20NHS%20Foundation%20Trust%20RRR%20report.pdf

(d) Medway NHS Foundation Trust was selected for the review due to a HSMR above the expected level for the last two years (a score of 115 for financial year 2011 and 112 for financial year 2012). A score greater than 100 indicates that a hospital's mortality rate exceeds the expected value. [5]

2. CQC Inspection – Maternity and Midwifery Services

(a) The Care Quality Commission (CQC) carried out an unannounced inspection of Maternity and Midwifery Services provided by the Trust on 19 August 2013. The CQC decided to look at this service after noticing a 'slight increase in the numbers of notifications of incidents which included ante and post natal women and neonates'.[6]

(b) The inspection was carried out by a team of five CQC inspectors, one compliance manager, two pharmacist inspectors and four clinical advisors who visited the maternity wards, delivery suite, antenatal clinic, and three locations in the community, over the space of four days and one evening. The team also held focus groups with expectant and new mothers.

(c) Following the inspection, the CQC served three warning notices to the Trust with action to be met by 31 December 2013. The warning notices set out the hospital's failure to meet national regulations in three specific areas:

- Staffing;
- Supporting workers;
- Assessing and monitoring the quality of service.

3. Recent Developments

(a) Medway NHS Foundation Trust announced the departure of Mark Devlin as the Trust's Chief Executive and Denise Harker as the Trust's Chairman on 30 January 2014.[7] Monitor, the sector regulator of NHS-funded health care services, announced the appointments of Christopher Langley as interim Chairman and Nigel Beverley as interim Chief Executive on 6 February 2014.[8]

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[5] The Keogh Review, *Medway NHS Foundation Trust Data Pack,* Slide 13, 'Why was Medway Chosen for this Review?', http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/130709-keogh-review-medway-data-packs.pdf

[6] CQC Inspection Report, *Medway Maritime Hospital (19 August 2013)*, http://www.cqc.org.uk/sites/default/files/media/reports/ins1-791174936_rpa02_medway_maritime_hospital_20130819_f2.pdf

[7] Medway NHS Foundation Trust, *Medway Chairman and Chief Executive announce their departure*, published on 30 January 2014, http://www.medway.nhs.uk/news-and-events/latest-news/medway-chairman-and-chief-executive-announce-their-departure/

[8] Monitor, 'Monitor takes urgent steps to improve troubled foundation trust', published on 6 February 2014, http://www.monitor.gov.uk/home/news-events-publications/latest-press-releases-13

(b) Sir Stuart Rose, former Chairman of Marks and Spencer, has been appointed to advise the NHS on how to attract and retain the best leaders to help transform the culture in under-performing hospitals. Sir Stuart will particularly look at the problems faced by the 14 trusts currently in 'special measures' including Medway NHS Foundation Trust.[9]

4. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report from Medway NHS Foundation Trust.

Appendix

Minutes, Health Overview and Scrutiny Committee, Kent County Council, 6 September 2013, https://democracy.kent.gov.uk/mgAi.aspx?ID=25799

Background Documents

Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published 6 February 2013, http://www.midstaffspublicinquiry.com/report

Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, Professor Sir Bruce Keogh KBE, published 16 July 2013, http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

Report for Medway NHS Foundation Trust, Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England, Rapid Responsive Review Report For Risk Summit, June 2013, http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/Medway%20NHS%20Foundation%20Trust%20RRR%20report.pdf

Medway NHS Foundation Trust, Data Pack, 9 July 2013, http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/130709-keogh-review-medway-data-packs.pdf

CQC Inspection Report, Medway Maritime Hospital (19 August 2013), published 2 November 2013. http://www.cqc.org.uk/sites/default/files/media/reports/ins1-791174936_rpa02_medway_maritime_hospital_20130819_f2.pdf

[9] Department of Health, 'Super-heads' review on how best NHS CEOs could take-on failing hospitals', published on 14 February 2014, https://www.gov.uk/government/news/sir-stuart-rose-to-advise-on-nhs-leadership

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Appendix – Agenda Item 5, Health Overview and Scrutiny Committee, Kent County Council, 6 September 2013

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

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

(b) It was further explained that most of the recommendations made by the review were in progress anyway. An example was given of the mortality working party set up by the end of 2012. This was chaired by the Medway Director of Public Health and involved Trusts with a good record around mortality. There were 50 points in the action plan and there were 6 areas where improvements were to be focused and these were set out in the Agenda on pages 38-40. HSMR and SHMI were useful as a 'smoke alarm' but did not tell the whole story of what as happening in a hospital. The SHMI at MFT was now at the lowest it had ever been and while the HSMR was still at 12, this was an improvement on the previous year.

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

Devlin explained that it would. He was proud of the way the hospital had dealt with the Sheppey Crossing accident and the MFT accident and emergency department was resilient. Consultants were always available on call and the hospital was set up as a trauma unit.

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

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

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

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

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

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

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

(k) The Chairman proposed the following recommendation:

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

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

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Medway NHS
NHS Foundation Trust

Medway NHS FT Update

KCC Health Overview and Scrutiny Committee

7 March 2014

CARING RESPECTING LISTENING LEARNING

Better care *together*

Medway NHS
NHS Foundation Trust

Update

- Quality Improvement Plan
- Transforming Medway Programme
- CQC regulatory actions
- Governance

Medway NHS
NHS Foundation Trust

Quality Improvement Plan

50 actions under 6 themes

1. Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients
2. Review staffing and skill mix to ensure safe care and improve the patient experience
3. Redesign unscheduled care and critical care pathways and facilities
4. Improve senior clinical assessment and timely investigations
5. Develop a strategy and action plan to create a culture that welcomes improvement, galvanises the good work that is already going on in some wards and adopts and rapidly spreads good practice
6. Improve public reputation

Achievement of Quality Improvement Plan is a binding agreement with Monitor as an undertaking on the Trust's licence

Medway NHS
NHS Foundation Trust

Quality Improvement Plan delivery

- 90% of our 50 actions are green or complete
- First cohort of clinical champions have started their service improvement training. Two further cohorts are planned
- Vacancy rates continue to fall, currently at 6.1%, as we continue our rapid recruitment campaign
- Work continues with Emergency Care Intensive Support Team to improve emergency pathway. Recent support visit in January reviewing models of medical care.
- We have aligned our *Speaking Out* campaign to the Nursing Times' SOS (Speaking Out Safely) campaign
- There have been two external reviews of our complaints and PALS service. A work stream to action review feedback, linking into the patient experience committee

Medway NHS
NHS Foundation Trust

Beyond Keogh – *Transforming Medway*

- Emerging view that the Keogh QIP would not of itself deliver a step change in quality
- Need for a strategic focus
  - Keogh, Francis, Berwick etc
  - Urgent & Emergency Care Review
  - Operational pressures
  - A new strategy now that merger with Darent Valley will not occur.

Medway NHS
NHS Foundation Trust

Transforming Medway

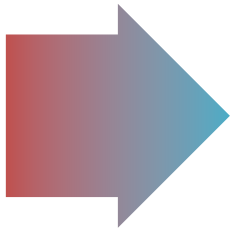
Principle: Focus on a number of high priority and high impact projects

7 overlapping high priority / high impact themes: -

- *Improved Emergency Care Pathway*
- *Adequate, properly skilled staff*
- *Improvement management of deteriorating patients*
- *Deliver fit for purpose information systems*
- *Provide an excellent patient experience*
- *Standardize key pathways to improve outcomes*
- *Improve communication and enable leadership through MFT*

Becoming a top performing hospital for emergency care

- Unmanageable workload disrupts patient flow and impairs quality
- Emergency care is variable and inconsistent
- Clear gaps in the establishment and difficulty recruiting
- Our management of deteriorating patients is not consistently robust
- Staffing and resource levels do not match demand round the clock
- Our staff are tired and have low morale making hard for them to support improvement
- Our clinical leaders lack the support, authority and accountability to drive change



A. Improve the Emergency Pathway
B. Ensure we have sufficient well trained staff at all times
C. Improve management of the deteriorating patient
D. Deliver fit for the future information systems
E. Provide an excellent patient experience
F. Standardise key pathways to improve outcomes
G. Improve communication and enable leadership throughout Medway FT

Medway NHS
NHS Foundation Trust

Transforming Medway

Absolute priorities

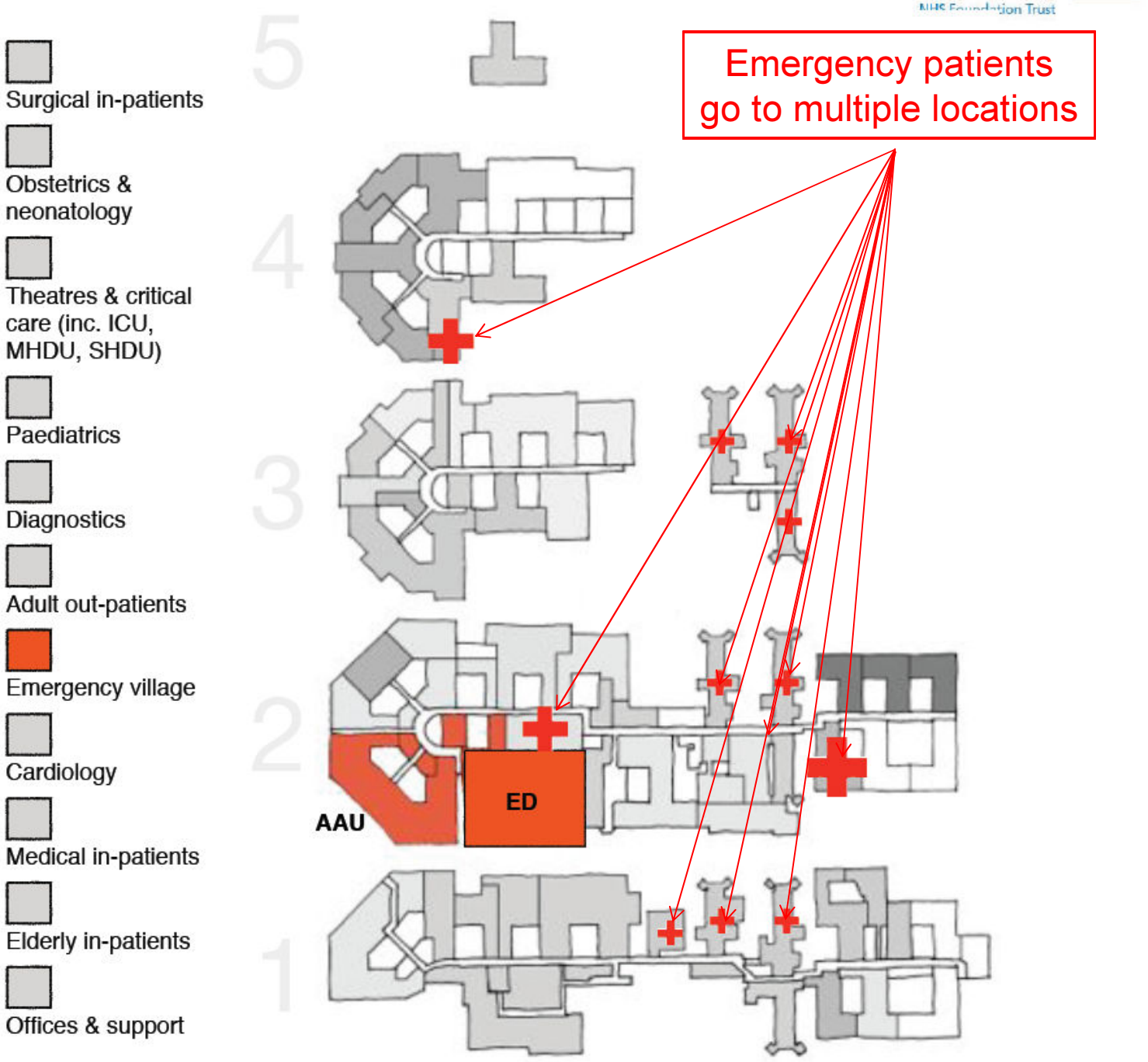
- ***Improved Emergency Care Pathway***
- ***Provide an excellent patient experience***
- *Improve communication and* ***enable leadership*** *through MFT*

Medway NHS
NHS Foundation Trust

Transforming Medway

Improved Emergency Care Pathway

- Physical Redesign
  - Enough beds
  - In the right place
- Redesign how we work
  - Increased senior involvement early in the pathway
  - Ambulatory care options
  - Focus on early intervention to allow early discharge
  - Avoid admissions where care can be better delivered in community settings
- Planning pathways that join up to the outside world

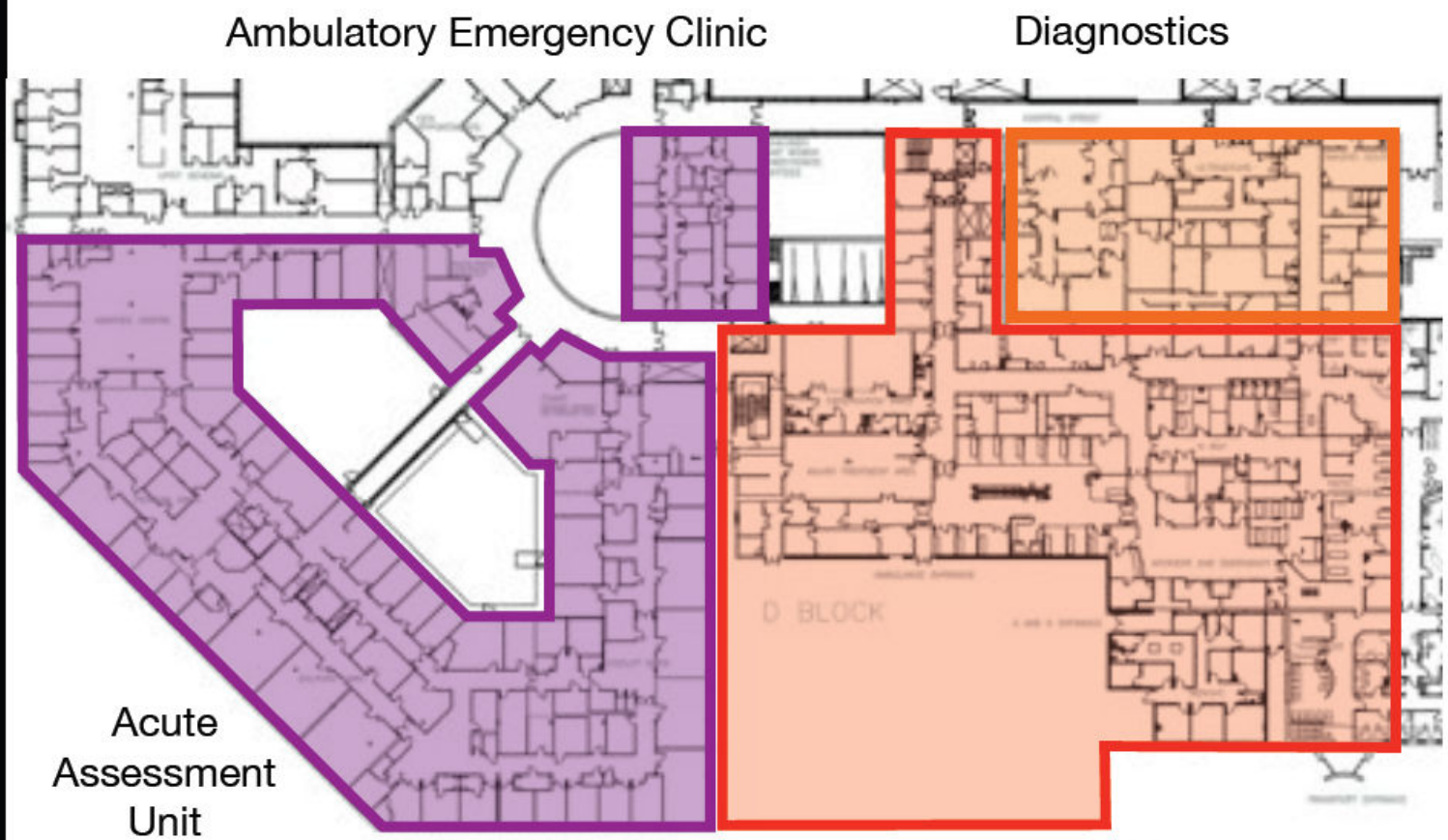

Surgical in-patients
Obstetrics & neonatology
Theatres & critical care (inc. ICU, MHDU, SHDU)
Paediatrics
Diagnostics
Adult out-patients
Emergency village
Cardiology
Medical in-patients
Elderly in-patients
Offices & support
5
4
3
2
1
AAU
ED
Emergency patients go to multiple locations

medway
emergency
village
project

Medway NHS
NHS Foundation Trust

Medway Emergency Village

Potential configuration, uniting ED, assessment & diagnostic capacity



cliniplan

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NHS Foundation Trust

Why this configuration?

- Fewer access points for emergencies
- Ease of transfer between zones
- All emergency care in one area
- No outliers
- Efficient staffing
- Improved clinical interactions
- Close to diagnostics – improving efficiency and reducing delays

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NHS Foundation Trust

Not just estates

- The success of the project depends upon different ways of working
  - Initially within the hospital
  - Then in partnership with other partners
    - Alternatives to hospital admission
    - Early (supported) discharge
    - Admission avoidance

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Patient experience

Working with patients and carers

- Develop a patient experience strategy
- Improve information for patients
- Improve interactions and communication with patients
- Improve access to senior medical staff
- Understand what causes patient experience trends
- Improve the physical hospital environment

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NHS Foundation Trust

Care Quality Commission (CQC)

Maternity department progress

- Action plan for each outcome is complete – signed off 19 December 2013
- Focus on gap analysis to compliance with the remaining outcomes not inspected in August
- Bi-weekly internal CQC panel review meetings continue
- Embedding and sustaining actions taken in relation to outcomes inspected
- 3 x weekly unit briefings continue

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NHS Foundation Trust

Emergency department

- CQC Inspection December 31st 2013 against two standards
  - **outcome 4** – care and welfare of people who use services
  - **outcome 8** – cleanliness and infection control
- Critical inspection report published in early March
- Issues in relation to clinical standards all addressed within action plan – completion date February 28
- Plans agreed for major £5m redevelopment of the department
  - Key areas will be completed in time for winter 2014/2015
  - Department's clinical staff have been closely involved in the planning

Context - Emergency Dept

- The Emergency Department has faced unprecedented levels of pressure this winter
- Designed to treat up to 50,000 patients a year; now treating 90,000 and rising
- When the CQC visited and at other times during the winter there were unprecedented levels of ambulance activity, many patients presenting with complex and acute conditions, local floods and norovirus outbreak
- Immediate action was taken:
  - Daily Executive Director-led reviews of the department
  - 7 days a week/bank holidays Executive Director presence on site
  - Strengthened leadership arrangements in ED
- Personal apology on behalf of the trust for letting our patients down

Medway NHS
NHS Foundation Trust

Emergency flow improvements

- Various recommendations from the Emergency Care Intensive Support Team
- Focuses on improving the efficiency of patient journeys through the hospital
  - from presenting in the emergency department, being admitted and discharged
- Actions to address recommendations are now close to completion
- To ensure embeddedness, this remains the key initial priority in the *Transforming Medway* programme

Current key actions

- Improved / more rigorous bed management
- Resist pressure to use assessment areas for admitted patients
- Focus on expected date of discharge (EDD) and working to this
- Whole hospital shared ownership for the Emergency Access standard (95%)

Medway NHS
NHS Foundation Trust

Performance - January 2014

- Trust Emergency Department performance against the maximum 4-hour waiting target was 84.33%, year-to-date 88.46%
- One C.diff case and no MRSA cases
- All cancer targets were met in December (reported one month in arrears)
- All 18-week referral to treatment targets met in January
- 27 single-sex breaches in month which equates to a financial penalty of £6,750
- All other contractual targets were met in the month

Medway NHS
NHS Foundation Trust

Trust Governance changes

- New Interim Chair & Chief Executive

- Chair: Christopher Langley
  - Experience of turnaround in two challenged FTs
  - Most recently Rotherham NHSFT

- CEO: Nigel Beverley
  - CEO and other senior roles since late 1990's
  - Most recently Ipswich NHS Trust

Medway NHS
NHS Foundation Trust

Trust Governance

- Changes to style and focus of Trust Board instituted by new Chairman
- Review of subcommittee structure and functioning underway
- Changes in interactions with Governors
- Implementation of actions from independent review of Quality Governance undertaken by KPMG
- Divisional restructuring underway to simplify lines of accountability and increase clinical leadership and ownership

Medway NHS
NHS Foundation Trust

Finance

Financial performance and forecast as at 31 January 2013

- Deficit of £1.51m in Month 10, £1.69m adverse to plan
- Year-to-date deficit is now £4.5m, £4.3m adverse to plan
- Current financial performance is generating significant pressure
- Cash position is £3.5m, £0.4m adverse to plan
- The Trust is currently on trajectory to deliver a £7.9m forecast deficit (£6.7m adverse to plan, excluding impairments) for the year 2013/14

Item 7: Accident and Emergency: North Kent

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 March 2014

Subject: Accident and Emergency: North Kent

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on Accident and Emergency: North Kent.

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

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1. Introduction

(a) On 18 January 2013 NHS Medical Director Professor Sir Bruce Keogh announced a comprehensive review of the NHS urgent and emergency care system in England. *The End of Phase One Report*, published on 13 November 2013, outlined the case for change and proposals for improving urgent and emergency care services in England.

(b) The report made proposals in five key areas for the future of urgent and emergency care services in England:

- Provide better support for people to self-care;
- Help people with urgent care needs to get the right advice in the right place, first time;
- Provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E;
- Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery;
- Connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

(c) Phase two of the review is now under way, overseen by a delivery group comprised of more than 20 different clinical, managerial and patients' associations. A report on progress is expected in spring 2014.

2. National pressures

(a) Keogh reported that the current system of urgent and emergency care is under 'intense, growing and unsustainable pressure' (Keogh 2013: 5). Each year the NHS deals with 438 million visits to a pharmacy in England for health related reasons; 340 million GP consultations; 24 million calls to NHS urgent and emergency care telephone services; 7 million emergency ambulance journeys and 21.7 million attendances at

A&E departments, minor injury units and urgent care centres. Demand for these services has been rising year on year with almost a 50% increase in emergency hospital admissions over the last 15 years.

(b) Further, Keogh stated that 'A&E departments have become victims of their own success' (Keogh 2013: 5). Keogh cites three reasons for the growing pressures on urgent and emergency care:

- A rising demand from an aging population with increasingly complex needs and often multiple, long-term conditions;
- A 'confusing and inconsistent array of services' outside hospital such as walk-in centres and minor injury units;
- A high public trust in the A&E brand.

3. Winter Pressure

(a) In August 2013, the Prime Minister announced that 53 NHS Trusts, identified as being under the most pressure, would benefit from an additional £500 million over the next two years to ensure their Accident and Emergency departments are fully prepared for winter.[1]

(b) £221 million of this fund has been allocated to Trusts for winter 2013/14 including Dartford and Gravesham NHS Trust (£4 million) and Medway NHS Foundation Trust (£6.1 million). This allocation was followed up in November 2013 by a further £150 million distributed across all 157 Clinical Commissioning Groups in England. [2] [3]

(b) Further initiatives to relieve winter pressure on A&E include a £3.8 billion integration fund to join up health and social care services and a £15 million cash injection to NHS 111 to prepare the service for potential winter pressures. [4]

4. Recommendation

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

[1] Department of Health, 'Prime Minister announces £500 million to relieve pressures on A&E', published 8 August 2013, https://www.gov.uk/government/news/prime-minister-announces-500-million-to-relieve-pressures-on-ae

[2] Commons Select Committee, 'Urgent and Emergency Care', published on 21 January 2014, http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/urgent-and-emergency-care/

[3] Health Service Journal, 'Government announces A&E fund winners', published on 10 September, http://www.hsj.co.uk/acute-care/government-announces-ae-fund-winners/5063077.article

[4] Department of Health, 'Prime Minister announces £500 million to relieve pressures on A&E', published 8 August 2013, https://www.gov.uk/government/news/prime-minister-announces-500-million-to-relieve-pressures-on-ae

Background Documents

Transforming urgent and emergency care services in England - Urgent and Emergency Care Review: End of Phase 1 Report, Professor Sir Bruce Keogh KBE, published 13 November 2013, http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

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Briefing to the Kent County Council HOSC Friday, 7 March 2014

Subject: Accident and Emergency – North Kent (Dartford, Gravesham and Swanley)

From: NHS Dartford, Gravesham and Swanley Clinical Commissioning Group, Dartford and Gravesham NHS Trust, Kent Community Health NHS Trust, Kent and Medway NHS and Social Care Partnership Trust and EllenorLions Hospices

Date: 25 February 2014

Introduction

The invitation to attend Kent County Council's Health Overview and Scrutiny Committee (HOSC) is warmly welcomed. The opportunity has been taken to engage key partners in the health economy of Dartford, Gravesham and Swanley (DG&S) to come together to prepare this briefing.

While the challenging winter period is not yet over, the health system has responded comparatively well to the demands placed upon all health services, albeit that this briefing concentrates upon the Accident and Emergency Department at Darent Valley Hospital (DVH) managed by Dartford and Gravesham NHS Trust. The main finance for these services comes from NHS Dartford, Gravesham and Swanley Clinical Commissioning Group - the lead commissioner. It was supplemented by an additional £4 million from NHS England in September 2013 to cover a five-month period. In return for the additional funds, the health economy must ensure 95 per cent of patients attending A&E receive treatment, be discharged or are admitted within four hours. Furthermore, 75 per cent of staff must have received a flu vaccination.

It is worth highlighting that all health bodies have benefited from the supplementary resources and worked together in partnership to assist in cushioning the effects of patients waiting for services in the A&E Department.

Governance

While Dartford and Gravesham NHS Trust has the day-to-day managerial responsibility for A&E services at Darent Valley Hospital, it is dependent upon efficient services throughout the health and social care system. To assist in delivering this objective an Urgent Care Delivery Group (UCDG) operates with a wide membership. It meets monthly and has the responsibility of holding to account each partner for the smooth operation of the operational management of the urgent care system.

The UCDG reports through to an Executive Programme Board, with representation of Chief and Accountable Officers. It covers all health matters and the interaction with social care.

The Executive Programme Board, which is wider than just A&E, is an opportunity for the whole system to come together to agree the medium to long-term approach for

sustainability. This includes a real focus on integration and the co-development of the Better Care Fund proposal which has been received well by KCC councillors.

Each health organisation regularly reports through to its statutory Board about the issues of A&E and the impact upon the rest of the service.

In addition to the above, GP Dr David Woodhead has established a Clinical Interface Group (CIG) which has, with a limited number of DVH clinicians, worked on the clinical systems, models and joint working between acute and primary care. This has resulted in the production of the Integrated Discharge Team (IDT) and a joint Service Level Agreement. This joint team consists of professionals from acute, mental health, community health and social care (medical, nursing and therapy).

To ensure that all partners are constantly aware of each other's pressure points and to assist in resolving operational challenges in recent weeks, daily (often more than once a day), Executive Team conference calls have been held to monitor service delivery. The local Area Team on behalf of NHS England and the Trust Development Authority each have a performance management role in the health system.

Performance Management

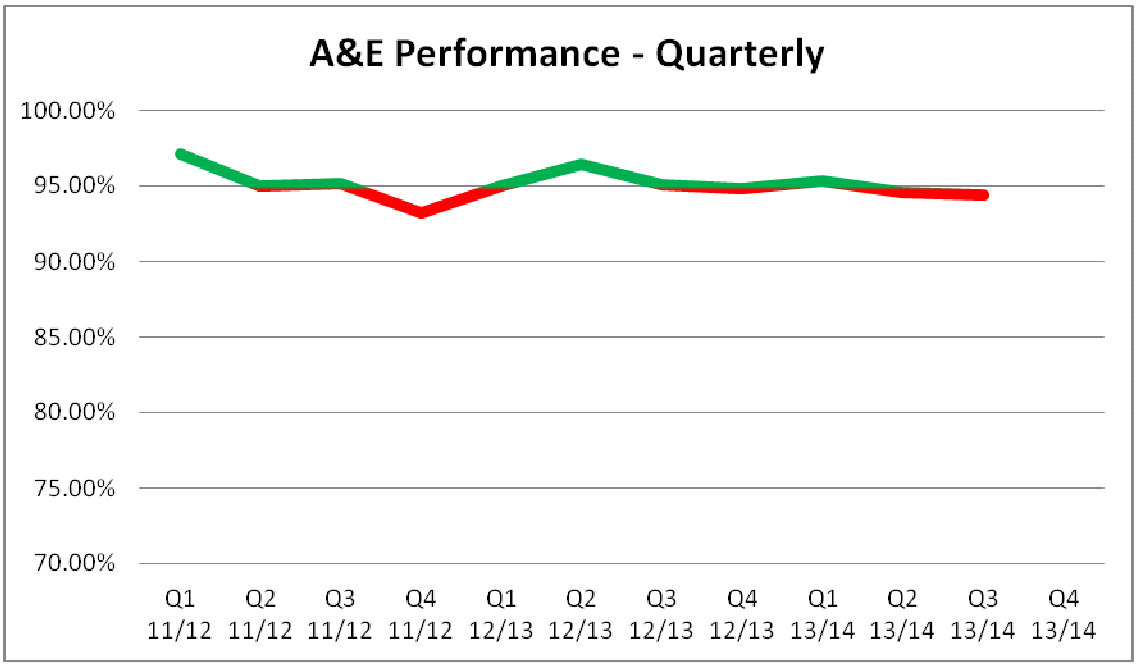
From the tables below, it can be seen that 94.6 per cent of patients are receiving their care within the prescribed four hours. To achieve 95 per cent by 31 March is going to be a challenge but all agencies remain committed to the target.

While the average number of patients attending A&E appears stable over the past two years at around 264 per day, the number admitted has risen significantly, from 63 to 77 per day, and demonstrates the pressure on beds and may indicate the increased complexity of health requirements of patients. This has had a significant impact on the number of beds needed at DVH.

Table 1 – A&E activity data

	Annual				Average - Daily		
	April 11 - March 12	April 12 - March 13	April 13 - January 14	Est. April 13 - Mar 14	April 11 - March 12	April 12 - March 13	April 13 - January 14
A&E Attendance	97,616	97,975	81,551	96,536	267	268	264
Emergency Admissions *(via A&E)*	22,965	26,130	23,749	28,118	63	72	77
Ambulance conveyances	25,145	25,763	22,008	26,275	69	71	72
A&E Performance against 4 hr target *(Average)*	95.1%	95.3%	94.6%	95.0%	95.1%	95.3%	94.6%
	Average - Monthly				Average - Winter Months (Dec-Feb)		
	April 11 - March 12	April 12 - March 13	April 13 - January 14	Est. April 13 - Mar 14	Winter 11/12	Winter 12/13	Est. Winter 13/14
A&E Attendance	8,135	8,165	8,155	8,045	25,521	25,615	25,570
Emergency Admissions *(via A&E)*	1,914	2,178	2,375	2,343	6,706	7,399	7,855
Ambulance conveyances	2,095	2,147	2,201	2,190			
A&E Performance against 4 hr target *(Average)*	95.1%	95.3%	94.6%	95.0%	92.7%	95.2%	93.7%

Table 2 – measuring performance against the four-hour target



Compliance with the flu vaccination rate, at DVH, is at the target level.

Financial Support and Winter Programme

As mentioned above, the health economy received £4 million on a non-recurrent basis against specific programmes with the objective of delivering a maximum waiting time of four hours in A&E. Key schemes are as follows:

Integrated Discharge Team (IDT) (£1,518k) *– the most significant of the winter schemes, involves all health and social care bodies in a collaborative partnership to focus on individual patients and their needs, wherever possible avoiding hospital admission and minimising hospital length of stay by providing appropriate services in the community . A Service Level Agreement has been signed by all parties including Kent County Council. One of the first objectives is to halve the number of medically stable patients who are inappropriately occupying a hospital bed from the current level which varies between 60 – 80 patients at any one time and reduce conversation to admission where care can be provided more appropriately in other settings including the patients own home. Although this team is embryonic, the CQC have noted in the recent Inspection of Hospitals, that it was an area of good practice across the whole system.*

Telehealth Project (£300k) *– ensuring that technology is in place to make contact with offsite carers to give safe and appropriate clinical guidance to avoid hospital admission. The technology is being targeted to care homes where referrals to hospital are highest*

Additional acute and community capacity (£1,268k) *– beds have been opened at Elm Court, Dartford. Currently 31 are open, with a further eight planned to open shortly. From December, additional escalation beds at DVH have been opened to meet demand although it is recognised that these are inappropriate.*

A&E Redesign (£560k) *- Additional senior medical and nursing staff are being recruited to ensure that there are sufficient senior staff with the skills to make early clinical decisions, particularly in paediatrics.*

Palliative and End of Life care resources (£225k) and Electronic Palliative Care Co-ordination System (£28k) *– the aim has been to keep people out of hospital where appropriate, especially at the end of life. Additional staff have been recruited to provide a more responsive service in patients' own homes and at the Hospice Inpatient Unit, to admit patients more rapidly as required, the majority on the same day as referred.*

Urgent care app (£50k) *- The Health Help Now app, developed with funding for Medway and Swale, has been marketed in Dartford, Gravesham and Swanley at a cost of some £20k. Further monies will be spent on a survey later this year to evaluate its effectiveness, particularly with the groups with the highest number of attendances at Darent Valley Hospital; young adults (18 to 34) and young children (0 to 4). Printed materials have been produced for other patients who prefer not to use online methods.*

Out-of-hours primary care (£33k) *– this is an investment by IC24 to provide GP primary care services within the A&E department to work alongside A&E staff.*

GP in the Emergency Operational Centre (£50k) – *this is an investment by South East Coast Ambulance Service NHS Trust (SECAmb) for a GP to be located in the call centre to help give advice. Two additional GPs are providing cover for eight hour shifts.*

Hospital Ambulance Liaison Office (HALO) at DVH (£48.1k) - *A HALO rota has been in place since 1 December 2013 providing 16 hours of cover every day and to provide a link between the ambulance crews and the A&E operational staff at DVH.*

Progress reports and key performance indicators (KPIs) are reviewed through the governance structures and, while it is too early to conclude the effectiveness of each scheme, there is evidence that collaborative working is developing, for the benefit of patients.

The financial resources are non-recurrent and, via the commissioning route, decisions about priorities are being developed. However, the Care Quality Commission (CQC) in its recent inspection commended the discharge arrangements for patients requiring multi-agency input, including the recently developed IDT.

Next Steps

The Better Care Fund (formerly Integration Transformation Fund) was announced by the Government in the June 2013 spending round to ensure a transformation in integrated health and social care. The BCF not only brings together NHS and local government resources but also provides a real opportunity to improve services and

value for money, protecting and improving social care services by shifting resources from acute services into community and preventative settings.

Locally, in DG&S, an approach to how the national policy is to be implemented was presented to the Kent Health and Wellbeing Board on 12 February 2014. The strategy looks to:

- Form integrated primary care teams (PCT)
- Establish local referral units (LRU) for crisis support services and Rapid Response
- Use technology to create a single record

In the short term there are three objectives:

1. IDT model expansion – with an objective of reducing hospital admissions by 10 per cent in 2014/15
2. Develop IPCT pilots from April 2014 and expansion across Swale and DGS throughout the year including Local Referral Unit (LRU) reconfiguration
3. Create a real focus on dementia support for patients and carers given the impact currently being seen, eg 32 patients out of 60 with a medically stable diagnosis in DVH have a diagnosis of dementia

It is also relevant to recognise the implications of the report produced in November 2013 by Sir Bruce Keogh, Medical Director of the NHS, which proposes a fundamental shift in the provision of urgent care with more extensive services outside hospital and patients with more serious or life threatening conditions receiving treatment in centres with the best clinical teams, expertise and equipment. Although these issues have already been considered for DVH as most trauma services are now handled by trauma centres, there is a need to audit compliance with the recommendations. All partners are engaging through the Urgent Care Delivery Group to ensure the recommendations are applied in the local health economy.

Nigel Edwards of the Kings Fund has been engaged to run a small number of workshops to help facilitate a joined up approach for the BCF and the provision of urgent care services. These workshops have allowed common goals and methods to be owned by all partners in the community. These workshops have also involved patient representatives.

Conclusion

In conclusion, it is clear that:

- The patient experience of the 2013/14 winter of accident and emergency services is likely to be one of relative satisfaction if the barometer of 95 per cent is used. There have, however, been significant numbers of hospital admissions that have placed huge pressure on Darent Valley Hospital's bed capacity.
- The opportunities presented by the Winter Fund have given a broad expansion of services and investments that have concentrated upon collaborative work across agencies.

- There is significant further work to be undertaken to deliver on the twin objectives outlined in the Better Care Fund and the Keogh Report into Urgent Care Services

Officers of the statutory bodies will be pleased to attend the meeting of the HOSC on 7 March to give clarification and further material in relation to the provision of Accident and Emergency services to the DG&S population.

END

Appendix

NHS England Response to HOSC question for 7 March

What role has NHS England taken with regards winter planning for A&E departments?

In preparation for winter 2013-14 NHS England ensured that each of the clinical commissioning group (CCG) led health economies (North, East and West) had effective winter plans in place.

These were **developed** through the CCG-chaired Urgent Care Working Groups (of which NHS England is a member, together with all providers) and signed off by all members of the group. The plans were aligned with the NHS England South Escalation Framework. These were reviewed locally by NHS England, feedback was provided and good practice identified and shared. The winter monies plans were also developed through these groups.

This ensured that the Kent and Medway Health economies had a shared command and control structure and a commonly understood escalation process and escalation criteria in place for winter pressures right through to major incidents which was understood by all in the economies.

NHS England ensured that the CCGs had completed the same action for the acute trusts (including all of those with A&E departments) that they commission.

NHS England also arranged for all of these winter plans to be tested via a series of three local and one regional exercise. Reports highlighting areas for improvement and good practice were prepared and circulated in time for all organisations plans to be updated before winter. All of these reports were taken to the Local Health Resilience Partnership and reviewed by the KCC Director of Public Health.

All of Kent and Medway's health organisations are represented on the Kent and Medway Local Health Resilience Partnership, which coordinates health planning for emergencies, including periods of significant pressure such as may occur in winter where, for example, this year normal business was disrupted by extreme weather. This group, which is co-chaired by NHS England Director of Operations and Delivery and KCC's Director of Public Health, coordinated a debrief of winter 2012-13. Each of the health economies reviewed their experience of last year to share lessons learned across the whole health economy prior to winter 2013-14.

Briefing to Kent County Council HOSC Friday 7 March 2014

Subject: Accident and Emergency – North Kent (Swale - Medway Foundation Trust)

Date: 21 February 2014

Introduction

This paper gives members of the Kent County Council Health Overview and Scrutiny Committee (HOSC) an overview of accident and emergency services within North Kent as they affect NHS Swale Clinical Commissioning Group (CCG).

The main provider of acute services for NHS Swale CCG is Medway Maritime Hospital run by Medway NHS Foundation Trust (MFT). NHS Swale CCG works in partnership with NHS Medway CCG as the lead commissioners for the accident and emergency services at MFT.

This winter has been particularly challenging. Following similar pressures in previous years it is known these challenges will continue throughout the next few months.

Additional funding was made available by NHS England to both NHS Medway and NHS Swale CCGs in September 2013 to support the achievement of the A&E access target for 95 per cent of patients attending A&E to receive treatment and to be admitted or discharged within four hours.

However, it was recognised in November 2013 when the funding was made available that MFT would be unable, mathematically, to achieve a 95 per cent target for the full year from 1 April 2013 to 31 March 2014. This was because of poor performance in the first two quarters of the year.

It was agreed between Monitor (the regulator for Foundation Trusts) and MFT that MFT would commit to achieving a week-on-week performance of 95 per cent or above from 1 November 2013.

Performance against this revised target has been variable. Reasons have included the need to embed the Keogh recommendations following the risk summit in May 2013 and the need to recruit additional medical and nursing staff which has taken time to complete. MFT has also recently appointed new Executive Directors in Medicine and Nursing whose impact on the culture of the Trust is taking time to embed.

NHS Medway and NHS Swale CCGs have worked (and continue to work) in partnership with MFT, the South East Coast Ambulance Service NHS Trust (SECAmb), social care partners Kent County Council and Medway Council, mental health trust Kent and Medway NHS and Social Care Partnership Trust (KMPT), and the providers of community services for Medway and Kent to develop initiatives to support the delivery of the access target during the winter months. This has been more challenging because MFT has a number of quality and performance issues from its 'special measures' status.

NHS England released £6.1 million for a five-month period. A number of initiatives across both health and social care were agreed to support delivery of the four-hour access target at Medway Maritime Hospital. A summary is on page 3.

Governance

Although day-to-day responsibility for A&E services at Medway Maritime Hospital sits with the Foundation Trust, it also depends on the support of the other health and social care systems. The system has worked exceptionally hard in an integrated way to support the

Trust. The Trust accepts that pace and involvement within the delivery of urgent care has been 'suboptimal' for a number of internal reasons. However, both the new Medical Director and Nurse Director are committed to the redesign of urgent care with commissioners and local partners. This has led to a number of Kings Fund workshops to discuss how the system can work together better across two complex local authority and health systems.

The urgent care programme is managed through the Medway and Swale Urgent Care Programme Management Group which has representatives from all stakeholder organisations. The group meets monthly to develop strategies to support the delivery of urgent care. A&E performance is monitored through a whole-system dashboard. Relevant actions are agreed to rectify issues where a whole-system approach is required.

The Urgent Care Programme Management Group reports into the Executive Programme Board. The Executive Programme Board, made up of chief and accountable officers, oversees delivery of the urgent care programme with a particular focus on progress against the winter-funded initiatives and the Better Care Fund proposals.

On a day-to-day basis, pressures within urgent care are managed by twice-weekly operational conference calls supported by the Single Health Resilience Early Warning Database (SHREWD) which is updated every day by providers. Information including bed capacity within the acute and community hospitals; ambulance journeys; A&E activity and waiting times; and staff availability can be shared with all organisations. It provides the information required to anticipate and manage pressures in the system on an operational level, particularly relating to issues around capacity and transfers of care which can impact on service delivery.

The minutes of these calls are shared with the Executive Team and the local Area Team of NHS England. During times of intense pressure, conference calls are held daily to monitor service delivery across North Kent.

A weekly report is submitted to the local Area Team, giving information on compliance with the A&E access target, known pressures and risks within the system and the actions agreed to mitigate and address those risks.

Because of MFT's 'special measures' status, the Trust and health economy report through the Quality Surveillance Group (QSG), chaired by the Director of Nursing of the Area Team, to ensure all service improvement and redesign has been quality checked. It ensures it receives the widest support, not only from the local economy but from the wider healthcare system. Both Kent and Medway Healthwatch leaders are involved at QSG level to ensure the patients' voice is central to the improvements made.

Performance Management

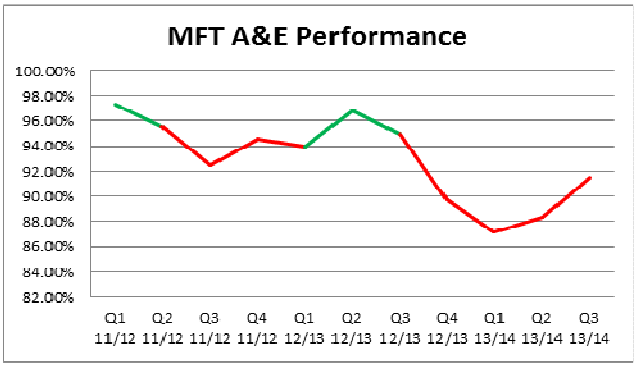
The tables below highlight the significant challenges that have been faced in achieving the 95 per cent access target. Delivery has been significantly below target over the past few months. All agencies are committed to achieving the 95 per cent target on a weekly basis by 31 March. This will be supported by the initiatives funded through the winter money.

The average number of patients attending A&E has been relatively stable over the past two years although in January and February there were more attendances and admissions through A&E. This has had an impact on the availability of both acute and community beds.

Table 1 – A&E activity data

	Annual			Average daily		
	Apr2011_Mar 2012	Apr2012_Mar 2013	Est. Apr2013_2014	Apr2011_Mar 2012	Apr2012_Mar 2013	Est. Apr2013_2014
A&E attendance	73688	73431	74264	201.88	201.18	203.46
Emergency admissions (via A&E)	25139	24177	25923	68.87	66.24	71.02
	Average monthly			Winter average		
	Apr2011_Mar 2012	Apr2012_Mar 2013	Est. Apr2013_2014	Winter 11/12	Winter 12/13	Winter 13/14
A&E attendance	6140.67	6119.25	6188.67	22997	22169	23176
Emergency admissions (via A&E)	2094.92	2014.75	2160.25	8196	8241	9255

Table 2 – measuring performance against the 4 hour target



Financial Support and Winter Programme

As mentioned above the health economy received £6.1m on a non-recurrent basis against specific programmes with the objective of delivering a maximum waiting time of four hours in A&E at Medway Maritime Hospital.

Key performance indicators have been agreed to monitor the success of all the winter-funded projects. A Programme Management Office, reporting to the Executive Programme Board, oversees progress against the delivery of these. The KPIs have been agreed by all partners for the sustainable achievement of the 95 per cent target from 31 March 2014.

Although it is too early to see the impact of most of these schemes on urgent care delivery, the collaborative approach in developing these provides a concrete foundation for future integration.

The key schemes are:

- **Integrated Discharge Team** (**£177,833)** – Based at Medway Maritime Hospital. The integrated health and social care team focusses on the individual needs of the patient. It avoids hospital admission where possible and minimises length of stay by facilitating a safe and timely discharge, thus reducing the number of medically stable patients occupying hospital beds. This scheme has been successfully implemented through a collaborative partnership between all health and social care agencies. The scheme has been running for the same duration as the Darent Valley Hospital (DVH) Integrated Discharge Team but its outputs have not been as successful. One of the reasons (we believe) can be traced back to the leadership and ownership of the team. All DVH integrated discharge team members, regardless of their employing organisation, report into one line management structure. The Medway and Swale IDT do not operate under one line management. Therefore, the employees are not operating in a fully integrated way. The Medway and Swale system is reviewing the outputs and implementation of the IDT in line with the DVH system to ensure that this integrated team has the best opportunity for success. Again, all partners are committed to this approach.

- **Expansion of the Mental Health liaison psychiatry services (£90,064)** - to provide 24/7 cover in A&E

- **Patient education through the development of the Health Help Now web app, associated marketing and evaluation on behalf of east Kent, north Kent and Medway, and further communications (£227,000).** Health Help Now is a web app, aimed at groups with the highest number of attendances at Kent and Medway A&Es: mothers with babies and young children (up to four) and young adults (18 to 34); and also people of working age who are generally healthy. People said they wanted a simple decision tree with advice and detailed information about local services. The app was developed to offer this, using digital technology. By agreement with NHS Medway CCG and NHS England Area Team, the funding included the cost of developing and marketing the app across the Kent and Medway CCGs that wanted to participate. It has been rolled out across east Kent, north Kent and Medway. It can be used on a mobile phone, tablet, laptop and desktop computer. It is now being developed as a downloadable app where people can save their own information, to support self-care and healthy lifestyles. Monies have also been spent on materials for people who do not use the internet or smartphones.

- **Increased staff for Medway A&E department (£451,000)** – provision of additional senior medical and nursing staff with the skills to make early clinical decisions.

- **Extended hours in MFT Pharmacy (£118,000)** - to facilitate discharges weekday evenings and Saturdays.

- **Handover Ambulance Liaison officers in A&E (£50,884)** - to improve clinical handover of patients between SECAmb and A&E, leading to improved clinical handover and compliance with the Handover Policy. HALO cover provided seven days a week during core hours 8am to 2am.

- **Provision of additional community beds (£285,269)** – to support timely discharge from the acute Trust to additional community-based health and social care beds.

- **Increase capacity of dementia crisis support (£88,530)** - increasing the number of healthcare assistants and specialist nurses to support a reduction in unnecessary unscheduled episodes of care under the direction of a consultant geriatrician

- **Enhance seven-day occupational therapy (£59,000)** - at the acute and community hospitals to speed up rehab and therefore discharge.

- **Increase in the community respiratory team (£64,364)** - increasing contacts in the community for respiratory patients, preventing an unnecessary visit to A&E.

- **Increased out-of-hours clinical capacity (£370,449)** - to manage winter demand, support primary care out of hours and the A&E and ambulance pathways

- **Enhanced support to Swale care homes (£175,000) –** through the introduction of Community Matrons, Community Geriatrician, GP-led Visiting Medical Officers, Palliative Care Facilitator and an out-of-hours advice and guidance service to prevent unnecessary 999 calls and subsequent conveyances to A&E.

- **GP in the Emergency Operational Centre (£100,000)** – to support paramedics only to convey with permission reducing the number of conveyances to MFT.

Next Steps

The Government announcement of the Better Care Fund in June 2013 provides the opportunity to transform the system in North Kent to meet the needs of a rapidly ageing population by easing the pressure on acute services through the provision of integrated preventative services in the community. This will involve redesigning acute, mental health, primary and community care provision, bringing existing and new services together to provide the best care to local people in the most efficient way.

The agreed strategy of the North Kent Health and Wellbeing Board commits to the following to achieve the best outcome by 2016:

- **Integrated Discharge Teams**: IDT at Medway Maritime Hospital hosted by MFT to provide a seven-day-a-week service to facilitate supported timely discharge under a one-line management structure.
- **Crisis Response Services:** with access to shared Anticipatory Care Plans by the Ambulance service. Enhanced Rapid Response, Mental Health Crisis Response/ Home Treatment Teams, Enablement Services and Voluntary Sector-based crisis response services. This includes developing integrated Enhanced Rapid Response to support patients in their home and to support them to return to their homes from hospital.
- **Integrated Care Home Support**: Integrated teams including consultant and GP support; Use of technology to care homes/Extra Care Housing providers to prevent unnecessary admissions to hospital
- **Non-Acute Bed Provision**: Step down and step up; consultant and GP support; Integrated Care Centres; Extra Care; Rehab Units; Community Hospital beds; Private Residential and Nursing bed provision
- **Integrated Primary Care Teams for Long-Term Conditions support**: 24/7 access to multi-disciplinary teams coordinated by GP, including mental health/dementia/learning disability; risk stratifying patients; anticipatory shared care planning; access to one care plan for patient/service user and professionals
- **Integrated Access through a Local Referral Unit**; Seven-days-a-week direct access and 24/7 crisis response; access to one care plan based on integrated platform Integrated Therapy Services in the acute community, social care and housing settings
- **Improved data sharing:** Promotion of NHS number, better exchange of health information, use of the health and social care information centre, patients accessing own health records, GPs linked to hospital data

The North Kent Executive Commissioner (KCC, Provider and CCGs) meeting held on 29 January recognised the plan would require mobilising now to enable testing and acceleration of delivery and agreed the following three priorities for 2014/15:

1. Expansion of the Integrated Discharge Team model – with this being hosted by MFT under one line management structure.
2. Integrated Primary Care Team pilots within Swale CCG from April 2014, including reconfiguration of the Local Referral Unit
3. A focus on dementia support for patients and carers

A redesign of health and KCC estates and continued focus on shared IT infrastructure and records to support the priorities.

The strategy to deliver on the Better Care Fund is supported by the report produced in November 2013 by Sir Bruce Keogh, Medical Director of the NHS, which proposes a fundamental shift in the provision of urgent care with more extensive services provided outside of hospital to support patients with self care in the community. The Integrated Primary Care Team and the provision of acute physicians outreaching into the community through the Integrated Discharge Teams will support a 'hospital without walls' model.

Conclusion

The A&E target of 95 per cent has not been met by Medway Foundation Trust since the quarter 3 period of 2012/13.

The Better Care Fund and the Winter Funding for 2013/14 has provided the opportunity for a more collaborative, integrated approach to service delivery across the urgent care programme. Although there is still significant work to be undertaken, the collaborative approach has set the precedent for the model of future partnership working to deliver improvements in both health and well-being and in increasing patient satisfaction.

END

Appendix

NHS England Response to HOSC question for 7 March

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Medway NHS
NHS Foundation Trust

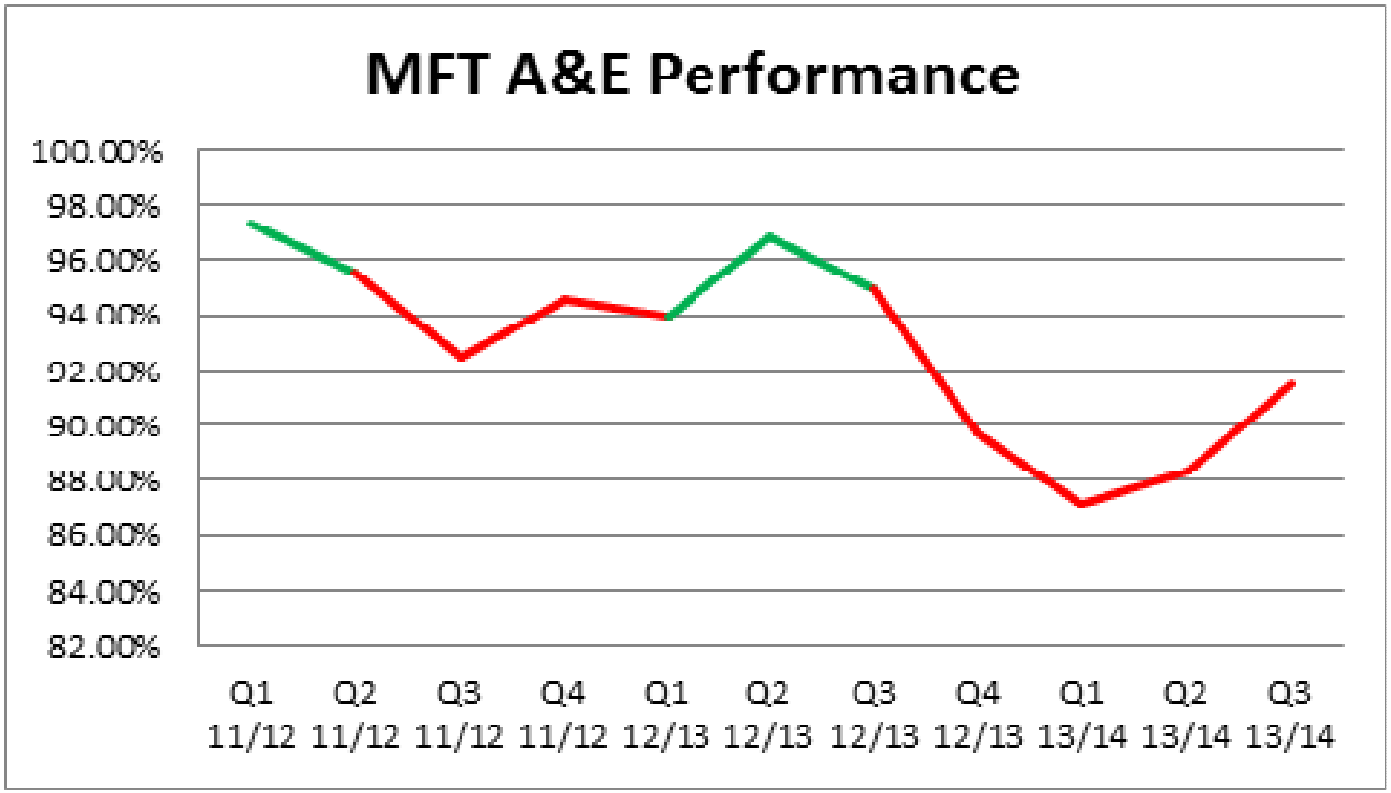
Update to A&E in North Kent
Medway FT issues

KCC Health Overview and Scrutiny Committee
7 March 2014

CARING RESPECTING LISTENING LEARNING

Better care together

Performance



Medway NHS
NHS Foundation Trust

Winter pressures funding

Local Health Economy total: £6 million
of which Trust share: £2.34 million

Trust use of money - Initial bids total £2,155k

£1,355k 'Temporary Wards'. Provision for additional medical input, staffing escalation beds and increased therapy input

£455k Emergency Department. Additional medical staff, staffing of STAR unit, nurse practitioners and extra equipment

£263k temporary Pod outside Emergency Department. Cost of Pod rental, enabling works, manager and increased energy usage

£81k Extended pharmacy hours. Provision for extra pharmacist and technician support to enable prompt discharge.

Medway NHS
NHS Foundation Trust

Winter pressures funding

Trust use of money - Additional bids total £190k)

£99k Emergency department additional staffing. Shift co-ordinator and additional middle grade doctors to support 95% target

£91k Ambulatory Ward. Staffing of an ambulatory ward 9am – 5pm to ease pressure from ED and provide phone advice to GPs around specific patients so do not need to be assessed at MFT.

Medway NHS
NHS Foundation Trust

Keogh Urgent & Emergency Care Review

Working alongside local partners in work supported by Kings Fund on local solutions for joined up approaches to urgent care

Will cooperate with commissioner led work on impact and recommendations of Keogh Urgent & Emergency Care Review

Focus and priority for MFT on becoming a high quality emergency focused hospital

Long term sustainability for MFT and health system more widely (probably beyond Medway & Swale) is a focus for the five year plans of all health providers in Kent & Medway.

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Item 8: CQC Quality Report – Darent Valley Hospital

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 March 2014

Subject: CQC Quality Report – Darent Valley Hospital

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the CQC Quality Report - Darent Valley Hospital.

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

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1. Introduction

(a) Following on from the publication of the Francis Report in February 2013, the Care Quality Commission was asked to establish the post of Chief Inspector of Hospitals. Two further Chief Inspector posts, for Adult Social Care and for General Practice, were also then introduced.

(b) The appointment of Professor Sir Mike Richards as Chief Inspector of Hospitals was the precursor to a radical review being undertaken of the way the CQC inspects hospitals. These new inspections will involve large inspection teams than previously and take longer. The teams will involve trained members of the public as well as clinical and other experts.

(c) Eight key service areas will be inspected, along with others where necessary. These eight are:

- A&E
- Acute medical pathway (including frail elderly)
- Acute surgical pathway (including frail elderly)
- Critical care
- Maternity
- Paediatrics
- End of life care
- Outpatients.

(d) Public listening events will be held on the first day of each inspection and after the inspections, Quality Summits will be held. HOSCs will have the opportunity to play a role in these summits.

2. First and Second Waves of Inspection

(a) The first wave of inspections was announced in July 2013. These were in effect to be a way to help develop and test the new approach. In Kent, Dartford and Gravesham NHS Trust was included in wave 1, with

the inspection starting from 25 November. 18 Trusts in total were included.

(b) On 24 October, and following the closing of a CQC consultation on changing their inspection regime, the CQC named the next 19 Trusts which were to be inspected from January 2014. In Kent, East Kent Hospitals University NHS Foundation Trust (EKHUFT) has been included. The aim is to inspect every NHS Trust by December 2015.

(c) These 19 Trusts will be the first to be awarded the new 'Ofsted style' rankings of:

- Outstanding
- Good
- Requiring improvement
- Inadequate

3. Intelligent Monitoring

(a) These 19 Trusts were selected for a number of reasons. Some were follow ups to hospitals which were part of the Keogh Review. Some were Trusts which Monitor asked the CQC to look at, or are Trusts applying for Foundation Trust status. Others again were ones which showed a higher risk with CQC's new intelligent monitoring system or which showed an intermediate risk to enable the intelligent monitoring tool to be tested. EKHUFT was one of these intermediate rated Trusts.

(b) This new intelligent monitoring tool is based on 150 indicators based around the five key questions all inspections will seek to answer. These questions are to be asked of every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

(c) Together with any local information which the CQC has obtained, this intelligent monitoring tool has been used to group all 161 Acute Trusts into six bands based on the risk that people may not be receiving safe, effective, high quality care - with band 1 being the highest risk and band 6 the lowest. A Hospital Intelligent Monitoring report has been produced for each Acute Trust. The CQC are keen to stress that a high band does not mean people are at risk, but rather that there are issues which the CQC needs to look into.

(d) Bandings for Hospital Trusts in Kent, with links to the full reports:

- Medway NHS Foundation Trust – Band 1. http://www.cqc.org.uk/sites/default/files/media/reports/RPA_101_WV.pdf
- East Kent Hospitals University NHS Foundation Trust – Band 3. http://www.cqc.org.uk/sites/default/files/media/reports/RVV_101_WV.pdf
- Maidstone and Tunbridge Wells NHS Trust – Band 5. http://www.cqc.org.uk/sites/default/files/media/reports/RWF_101_WV.pdf
- Dartford and Gravesham NHS Trust – Band 5. http://www.cqc.org.uk/sites/default/files/media/reports/RN7_101_WV.pdf

(e) More detailed information on the hospital inspection regime can be found on the CQC website: http://www.cqc.org.uk/public/news/more-hospital-inspections-announced

4. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the reports on CQC Quality Report – Darent Valley Hospital.

Background Documents

CQC, 'Chief Inspector of Hospitals announces inspection plans', published on 18 July 2013, http://www.cqc.org.uk/media/chief-inspector-hospitals-announces-inspection-plans

CQC, 'More hospital inspections announced', published on 24 October 2013, http://www.cqc.org.uk/public/news/more-hospital-inspections-announced

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CQC INSPECTION OF DARTFORD AND GRAVESHAM NHS TRUST

The report forms part of the new style inspections being trialled and overseen by Professor Mike Richards, Chief Inspector of Hospitals. It is based on a combination of observation through an inspection visit, information from the CQC's 'Intelligent Monitoring' system and information given by patients, staff and stakeholders. The visits included announced and unannounced visit.

The visit concluded:

"Maternity, Outpatients, Children's Services and End of Life Care were found to be good. In all services across the Trust, staff were committed to the Trust and said it was a supportive environment to work. Patients were generally positive about their experience the care they received."

"Medical Care, Surgery, Critical Care were found to be safe, effective and caring but the high bed occupancy compromised patients dignity in some cases, through the use of escalation beds and some mixed sex bays."

"The main challenge was in A&E which faced rising demand. The Trust was managing day to day but not solving the underlying problems it is acknowledged the Trust can't solve these problems on its own and will require a whole health economy approach."

The key areas for improvement required:

- A reduction in the reliance on middle grade locums in A&E and more nurses with a paediatric qualification in A&E, more consultants.
- A reduction in bed occupancy leading to a reduction in escalation beds, mixed sex breaches and delays in being discharged from ITU.
- Improvements to the speed to implement learning from incidents.
- Plans with the health economy require review to ensure emergency care is managed safely and effectively.

Following receipt of the textual report and data pack, a 'Quality Summit' was held with the Trust and Stakeholders. The report was presented by the CQC. The acute Trust presented its initial action plan, but in relation to the pressures on A&E and bed occupancy, other social and health economy organisations were asked to contribute to the solution. This was particularly in respect of alternatives to hospital admission and support with earlier discharge for complex cases.

The Trust is required to state how it will address improvement within 28 days. The issues internal to the Trust can be improved within a 3 month period. The more complex problem of reducing bed occupancy will take longer and require significant action from Stakeholders, including primary care, social services, mental health, commissioners and Community Health services. A focussed six month period will be needed to deliver significant change.

A summary of the report is attached. The full report and data pack is available on the CQC website.

Care Quality Commission

Dartford and Gravesham NHS Trust
Darent Valley Hospital
Quality report

Darenth Wood Road
Dartford Kent, DA2 8DA
Telephone: 01322 428100
www.dartfordgraveshamnhstrust.nhs.uk

Date of inspection visit:
5 and 6 December 2013
Date of publication: February 2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Overall summary

Darent Valley Hospital offers a comprehensive range of acute hospital-based services to around 270,000 people in Dartford, Gravesham, Swanley and Bexley. The hospital opened in September 2000. The hospital building is run as part of a private finance initiative. This means the building is owned by The Hospital Company (Dartford) Limited, a private sector company, and the trust leases the building. Darent Valley Hospital now has around 463 inpatient beds and specialties that include day-care surgery, general surgery, trauma, orthopaedics, cardiology, maternity and general medicine. The hospital has a team of around 2,000 staff.

Dartford and Gravesham NHS Trust was selected as part of the Chief Inspectors of Hospitals' first new inspections as a trust considered to be in the middle ground between low and high risk of poor care. This inspection focused on Darent Valley Hospital.

Dartford and Gravesham NHS Trust is registered for the following regulated activities to be provided at Darent Valley Hospital:

- Diagnostic and screening procedures
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury.

Since the trust registered with the Care Quality Commission (CQC) in 2010, Darent Valley Hospital has been inspected four times. At the last inspection in November 2012 the trust was found to be compliant with all regulations inspected.

Our inspection team included CQC inspectors and analysts, doctors, nurses, patient 'Experts by Experience' and senior NHS managers. Experts by Experience have personal experience of using or caring for someone who uses this type of service. The team spent two days visiting the hospital, and two further unannounced visits were conducted the following week. One of these included an evening/night time visit.

Maternity, outpatients, children's services and end of life care were found to be good. In all services across the hospital, most staff were committed to the trust and said it was a supportive environment to work. Patients were generally positive about their experience and the care they received.

Summary of findings

Overall summary

The trust faced challenges after the recent collapse of merger plans, and it had not yet developed an alternative vision for the organisation. There were a number of examples of good practice and examples of shared learning in the hospital, although in some cases the changes in practice in response to learning from serious incidents took up to 12 months to implement. The main challenge was the demand on the accident and emergency (A&E) department and the rise in emergency admissions. A significant causal factor had been the recent reduction of acute services in the immediate vicinity. The trust was managing issues on a day by day basis but not solving the key underlying problems, in particular bed management/capacity and inappropriate attendance at A&E. It is acknowledged that the trust cannot solve these problems on its own, as they will require a whole healthcare community approach.

The trust had taken action in some areas where staffing issues had been identified. This had included increased nursing staff levels on some wards, an increase in the number of porters in the pharmacy department and the recruitment of additional midwives. In A&E there were insufficient numbers of nurses qualified in the care of children and a high use of locum middle grade doctors, which had the potential to impact on patients' safety.

Patients' dignity was being compromised by the continued use of mixed sex wards and facilities in the Clinical Decision Unit where staff told us they always have mixed sex accommodation and the Medical Assessment Unit, which we observed as a mixed sex ward. This also occurred in the intensive care area when patients no longer required intensive care. Patients' right to privacy was being compromised by personal information being on display in open areas, for example on computer screens in the A&E and confidential information being discussed in public areas such as corridors. The area in the operating theatre where people were received into the department also compromised patients' privacy and dignity, as it was an open area. Since April 2011, the hospital's bed occupancy rate had consistently been above the national average of 86.5%, rising as high as 96.1% for the period of April to June 2013. This was impacting on patient safety through the use of additional beds in areas not designed or equipped for this purpose.

In some areas, the trust was considering and implementing national guidelines, but in A&E we found guidance was not always being followed, for example with the management of children's pain. Also some of the guidance that was available was not the most current such as resuscitation guidelines. Staff told us that the trust was a supportive environment in which to work and that training was available, though its own training records showed that attendance at the trust's mandatory training was below its expected level. This was as low as 66% in some areas compared to the trust's target of 85%. There was a system in place to monitor attendance at the trust's mandatory safety training and follow up non-attendance, but this was ineffective in some cases. There were 285 members of staff whose training was out of date and were not booked to attend a session.

Overall, we found a culture where staff were positive, engaged and very loyal to the organisation. The staff and management were open and transparent about the challenges they faced.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Medical care, surgery, critical care, maternity, end of life care and outpatients were found to be safe. In other areas staff told us that patients' safety was sometimes being affected by the hospital's high bed occupancy and the use of additional beds in areas not designed to be used for patient care. The trust had identified challenges with staffing, and in some cases it had taken action to address the issues. However, concerns remained in the accident and emergency (A&E) department, where there were insufficient nurses qualified in the care of children and a high use of locum middle grade doctors. This had the potential to have an impact on patient safety. Care pathways had been implemented to manage the risks associated with pressure ulcers, venous thromboembolism and urinary tract infections. Most staff were clear about their responsibilities to report incidents, though in some areas staff felt that they did not hear about the outcomes of these. The trust investigated serious incidents and produced reports and action plans. However, it could take the trust up to a year to implement learning. Patients were also being placed at risk in the A&E department due to the layout of the triage facilities in the minors area, the area where people walk in to the department and the lack of clear signage. This meant that patients' needs may not have been addressed in a timely manner as they had not been triaged or booked into the department. We had no concerns about the way patients were triaged in the majors area of the department.

Are services effective?

Maternity, outpatients, children's services, medical care, surgery, intensive care and end of life care were found to be effective. The integrated discharge team had developed good links with the community and the hospital social services department. This was helping to ensure effective discharge planning for patients on all inpatients areas. In A&E, pain relief was being well managed and assessed for adults but not for children, meaning that effectiveness was not being monitored in line with national guidelines. Guidelines in some areas had been reviewed and updated. However, in A&E there was guidance that was out of date or not the most current version and therefore not in line with national or good practice guidance which had the potential to impact on the effectiveness of care and or treatment. The trust had introduced new initiatives to help with the care and support of patients with dementia that had been effective.

Are services caring?

Maternity, outpatients, children's services, medical care, surgery, intensive care, accident and emergency and end of life care were found to be caring. Patients in all areas told us that they were well cared for, received the information they required and that their questions were answered. In all areas we observed a caring approach from most staff. We also observed that there was a dementia buddies scheme in place, which was supported by volunteers.

Summary of findings

The five questions we ask about hospitals and what we found

Are services responsive to people's needs?

The trust demonstrated that it had responded to a number of different issues in order to ensure that people got the treatment and care they needed. These included: the need to ensure effective, safe and timely discharge; staffing levels; the care of patients with dementia; and safe use of naso-gastric tubes. Of concern was that the hospital bed occupancy levels had been consistently above the national average of 86.5%, rising as high as 96.1% for the period of April to June 2013. The trust was actively reviewing its current position, had implemented a number of actions including opening additional beds and was looking at ways to create a sustainable trust for the future. Though there was still the potential for patient's to be placed at risk if they could not be cared for in the right area to ensure their needs were met in a timely way. There was a complaints system in in place, and it had been reviewed in recognition that the trust had not been consistently responding to complaints in a timely way.

There were occasions when we saw that patients' privacy was not always respected, with personal and confidential information on display. For example, in open areas in the A&E on computer screens, and discussions were witnessed taking place in open areas and in areas other than the wards where they could be overheard. In the medical assessment unit and the intensive care unit, patients were being cared for on mixed sex wards and in some areas, had to share bathroom facilities with members of the opposite sex. People who were no longer in need of intensive care but not able to move to a general ward also had their dignity compromised by the lack of bathroom facilities available on the unit.

In addition we were concerned that patients' privacy and dignity was not always respected in the operating theatre. This was because the area where patients were received in to the department was open and more than one patient could be in this area at any one time. We were also concerned by some of the practice observed around the consenting of patients for surgical procedures.

Are services well-led?

The trust faced challenges following the recent collapse of the merger plans, and it had not yet developed an alternative vision for the organisation. There were a number of examples of good practice and examples of shared learning in the organisation. However, in some cases changes in practice in response to learning from serious incidents took up to 12 months to implement. Although senior staff felt that there was an emerging vision, this had not yet been formally agreed. There was said to be a strong executive team that was visible throughout the trust which was supported by staff. The executive team had a clear understanding of the key risks in the organisation, particularly the current situation in A&E and the trust's occupancy levels. The trust had implemented a number of actions, but there had not been any clear measurable improvements. There were no clear timelines with projected outcomes and impacts.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

We found that A&E had the potential to be unsafe as there were insufficient numbers of appropriately skilled staff to deliver care. This was because there were not enough nurses qualified in the care of children and the medical staff team was not staffed to the agreed capacity and skill mix. The triage system in the minors area led to some patients' needs not being assessed in a timely manner as it was not clear that patients were required to wait to attend triage in one area and then book in and wait in another area. Staff were not always able to access current national and best practice guidelines to deliver safe effective care. Staff were caring and responsive about patients' needs but did not always maintain patient privacy. We observed examples of good individual leadership at department level but there was evidence that ongoing safety issues, for example insufficient substantive staffing, had not been resolved at a higher level.

Medical care (including older people's care)

Overall, the standard of care and treatment in medical care was good. Teams were well-led and supported by leaders at all levels in the service. Staff were listened to and had access to specialist training. There was positive feedback from the patients, relatives and visitors who we spoke with. They described caring and responsive staff who met their treatment needs. On a number of wards changes had been introduced in October 2013. These included increased staffing numbers. During our visit we could see that improvements were taking place. However, there had been insufficient time for many changes to have become embedded. This meant that the hospital was still improving against current performance indicators. Patient records were generally up to date with full details available to ensure that staff could provide safe and consistent care. The use of window bays, witnessed during the unannounced visit, showed that there was pressure on the hospital to cope with the level of demand. Staff were concerned about the use of 'window bay beds' and the potential impact on quality and safety.

Surgery

Patients generally received safe and effective surgical care. We saw that some wards worked with fewer staff than needed. However the trust was aware of this and recruitment had taken place. A number of staff were due to commence employment in the new year. There was a multidisciplinary approach to providing effective patient care.

Staff we observed were caring. However, patients' privacy and dignity were not always maintained. Staff responded appropriately to changes in patients' care and treatment. Staff told us how they responded to the increased workload when admission numbers increased, particularly when extra beds were placed on the ward. However, actions the trust was taking to respond to fluctuating demands of the organisation did not prevent these situations reoccurring. Staff told us they worked in a well-led organisation. They told us the culture was open and transparent, and there was a clear willingness by all staff to learn.

Intensive/critical care

We found that the intensive care and critical care service was safe and effective, performing within expectations for a unit of its size according to the Intensive Care National Audit and Research Centre data. It was responsive to the needs of patients and had caring and attentive staff. We found that the unit was well-led. Pressure was placed on the unit when transfer of patients was delayed due to bed occupancy challenges faced by the trust. Though the unit coped with the situation, these patients were cared for in a mixed sex environment and had to use the bathroom and toilet facilities in the adjacent ward.

Summary of findings

What we found about each of the main services in the hospital continued

Maternity and family planning

We found that the midwifery unit provided safe and effective care for women. Feedback from women using the service was positive. They told us that staff were kind and sensitive to their needs and that they were given effective advice and support in their chosen method of feeding their babies. The service was well-led with clear shared goals and objectives which were known to all staff we spoke with. Women said they had been well supported throughout their stay in the maternity services.

Children's care

In the main children's department parents told us that staff were responsive to their needs and that they listened to them. They were included in decisions about the care and treatment of their children. They said staff responded quickly to requests for assistance. Patients received safe and effective care and treatment. The environment was well maintained and engaging for young people. There were sufficient numbers of staff on the wards and in the outpatient area, and there was a system for the management of staffing levels and skill mix to ensure children were cared for safely.

This was not the case in the A&E department where there was an insufficient number of nurses qualified in the care of children. We also found in the A&E department that national guidance was not being followed in relation to the management of pain in children.

The trust was monitoring the quality of the service and making changes were they were needed. The views of children and families were being used to inform the service provision in the main children's department. There was a team in place to monitor and address any safeguarding concerns, and the trust had planned further developments.

End of life care

We found that end of life care provided at the trust was safe, effective, caring, responsive and well-led. The trust no longer used the Liverpool Care Pathway and was in the process of reviewing its end of life pathway. The palliative care team worked closely with staff on wards to ensure that patients had individualised end of life care provided in a positive, supportive environment. The team also had close links to community services. Patients and their families were involved in decisions about care and treatment in a dignified, respectful manner. Staff spoke positively about the support they received from the team. They felt this improved the patient experience and ensured patients received choices regarding end of life care and treatment.

Outpatients

The main outpatients department was a large area, with good access and seating for patients. Patients received effective treatment and information and felt happy with the care they received. The trust was monitoring appointment targets for waiting times and clinic start and finish times. It had sought the views of patients, and we saw that it had listened and responded to patient feedback by changing the layout of the department. Clinics were well managed and organised. When unavoidable delays occurred and clinics ran late, staff kept patients informed and provided them with information. Staff told us that they received training and supervision to enable them to provide effective care. All staff we spoke with told us that outpatients was a positive environment to work in.

Summary of findings

What people who use the hospital say

In September 2013, 406 people completed the inpatient Friends and Family Test, which asks patients if they would recommend services to people they know. Of these, 95.1% were either 'likely' or 'extremely likely' to recommend the ward they stayed in to friends or family. Some 662 people completed the test for A&E. Of these 96.1% of patients were either 'likely' or 'extremely likely' to recommend the trust's A&E department to friends or family.

In CQC's Adult Inpatient Survey 2012 the trust performed about the same as other trusts in the nine areas of questioning. However, it performed worse than other trusts in the 'Hospital and Ward' area. The trust was in the bottom 20% nationally for four of the questions relating to poor choice of food, assistance with eating meals and sharing facilities with members of the opposite sex.

In the 2012/13 Cancer Patient Experience Survey the trust performed in the top 20% of trusts in four questions They performed within the bottom 20% of all trusts nationally for 19 out of 64 questions.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that the required number of staff with the correct skills are employed and managed shift by shift, to demonstrate that there are sufficient staff to meet people's needs.

Action the hospital should take to improve

- The trust needs to ensure that learning from the reporting of incidents is cascaded and that any changes to practice required following a serious incident are implemented in a timely manner.
- Patients should be treated with dignity and respect at all times, particularly in the area of the operating department where patients are received.
- Patients' privacy and right to confidentiality should be respected at all times. In particular there needs to be more awareness in the A&E department of the ability for information to be seen and heard by others.
- The trust must ensure that at all times patients are cared for in a safe environment that is designed to meet their needs. It needs to consider the use and management of escalation beds in response to challenges with the higher-than-average occupancy levels, which, in turn, is impacting on the trust's use of mixed sex accommodation.
- The trust should take action to ensure that good practice guidance is being considered and used in all areas, particularly A&E. The trust should also ensure that children's pain relief is administered and the effectiveness monitored in line with good practice guidelines.
- The trust should develop an agreed vision with identified timelines and projected outcomes and impacts.
- The trust should review the plans with the local healthcare community to ensure that patients needing emergency care are managed safely and effectively.

Other areas where the trust could improve

- Although compliance with the trust's mandatory training was relatively high, the actual attendance levels were generally below the trust's desired level. Its own monitoring system was not always ensuring attendance. The trust could review the actions taken to address non-attendance at mandatory training.
- The trust needs to ensure that nursing staff are not disturbed when administering medication.
- The trust could ensure that all staff are aware of the Mental Capacity Act.
- The trust needs to ensure that it follows good practice with regards to the consenting of patients prior to surgical procedures.

Summary of findings

Good practice

- An integrated discharge team had been introduced to help with the safe, effective and timely discharge of patients.
- The number of midwives had been increased and changes had been made to the environment in the maternity unit to meet the needs of women and their partners using the service.
- The hospital's bed management meetings were multidisciplinary and included executive team members and ward sisters to ensure trust-wide understanding and involvement in the decision-making process.
- End of life care provided at the hospital was safe, effective, caring, responsive and well-led.
- There was a positive approach to managing the needs of people with dementia. Consideration had been given to good practice guidelines and recommendations. Environmental changes had been made on the ward where most people with dementia were cared for. There was a Dementia Buddies scheme in place, which was supported by volunteers.
- A code of conduct for nursing assistants had been developed and launched in the trust.

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Item 9: Forward Work Programme

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 March 2014

Subject: Forward Work Programme

Summary: This report invites the Health Overview and Scrutiny Committee to approve the revised Forward Work Programme.

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

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1. Introduction

(a) On 31 January 2014 the Health Overview and Scrutiny Committee approved the Forward Work Programme. Based on this meeting and work already in progress, a revised Forward Work Programme for the next couple of meetings is set out.

2. Outline Forward Work Programme

(a) 11 April 2014:

- Faversham Minor Injuries Unit.
- Patient Transport Services.
- Child and Adolescent Mental Health Services.

(b) 6 June 2014:

- East Kent Community Services Review.
- East Kent Strategic Plans.
- Kent and Medway NHS and Social Care Partnership Trust: Safeguarding and Dementia

(c) 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 Scrutiny Research Officer for inclusion in the list of questions submitted to the NHS in advance.

3. Dementia

(a) A suggestion was made at the 31 January 2014 meeting that the Committee to look into the provision of dementia services in Kent. The Scrutiny Research Officer was asked to provide a scoping document for discussion at the 7 March 2014 meeting of the Committee. A briefing note detailing the County Council's Select Committee review of dementia services in Kent and the monitoring of its recommendations is appended to this report.

4. Recommendation

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

Background Documents

None.

Contact Details

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APPENDIX – Select Committee: Dementia – a new stage in life

(a) The Adult Social Care and Public Health Policy Overview and Scrutiny Committee proposed the establishment of a Select Committee to look at issues around services and support for people living with dementia in Kent. This was agreed by the Policy Overview Co-ordinating Committee on 16 October 2009.

(b) The Dementia Select Committee was established at the end of 2010. The Select Committee examined issues around the quality outcomes for people with dementia and their carers in Kent; identified good practice and innovation in Kent and elsewhere; identified factors militating against achievement of quality outcomes and made recommendations for improvements.

(c) Witnesses included people with dementia and their carers; representatives from voluntary and community sector, NHS and other local authorities. A full list of the witnesses who submitted written evidence, attended hearings and focus groups is given in Appendices 2 & 3 of the final report. The final report of the Committee was published in September 2011.

(d) The report was presented to Adult Social Care and Public Health Policy Overview and Scrutiny Committee on 10 November 2011 and Cabinet on 5 December 2011. It was debated at full County Council on 15 December 2011 which endorsed the Select Committee report and its recommendations subject to resources being identified.

(e) The Adult Social Care and Public Health Cabinet Committee received a report that outlined the implementation plan to deliver the 17 recommendations made by the Select Committee at its meeting on 30 March 2012.

(f) The implementation plan was reviewed (one year after the report had been considered by County Council) by the Social Care and Public Health Cabinet Committee on 11 January 2013.

(g) The Dementia Select Committee was reconvened on 5 February 2013 and received a full report on progress with implementing the 17 recommendations in the Select Committee's final report.

(h) In light of the amount of work already carried out by Members and Officers on this important area, it is suggested that this is not duplicated by the Health Overview and Scrutiny Committee. It should be noted that the Kent and Medway NHS and Social Care Partnership Trust, the main provider of dementia services in Kent, will be bringing an update on their transformation programme with specific reference to dementia to Health Overview and Scrutiny Committee on 6 June 2014 and therefore the Committee will have the opportunity to ask questions on this service.

Background Documents

'Dementia – a new stage of life' Select Committee Final Report, Kent County Council, September 2011
https://shareweb.kent.gov.uk/Documents/council-and-democracy/select%20committees/dementia-select-committee-report/Dementia%20Select%20Committee%20-%20FINAL%20for%20website.pdf

County Council, Kent County Council, Minute Number 85, 15 December 2011
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=113&MId=3486&Ver=4

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