HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 11th April, 2014

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 11th April, 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 - 7 March 2014 (Pages 7 - 18)	
4.	Child and Adolescent Mental Health Services (CAMHS) (Pages 19 - 30)	10.00am
5.	Patient Transport Services (Pages 31 - 36)	11.00am
6.	Faversham Minor Injuries Unit (Pages 37 - 42)	12.00 pm
7.	Redesign of Community Services and Out-of-Hours Services - Swale (Pages 43 - 48)	12.30pm
8.	Folkestone Walk-In Centre: Written Update (Pages 49 - 54)	1.00pm
9.	East Kent Out-of-Hours Services: Written Update (Pages 55 - 62)	1.10pm
10.	East Kent Outpatients Consultation: Written Update (Pages 63 - 74)	1.20pm
11.	Date of next programmed meeting – Friday 6 June 2014 at 10:00 am	

Proposed items:

- East Kent Integrated Care Strategy
- East Kent Community Services Review
- East Kent Outpatients Consultation
- Kent and Medway NHS and Social Care Partnership Trust: Safeguarding and Dementia

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
(01622) 694002
3 April 2014

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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, 7 March 2014.

PRESENT: Mr R E Brookbank (Chairman), Mrs A D Allen, Mr N J D Chard, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr A J King, MBE, Mr C R Pearman, Cllr P Beresford, Cllr M Lyons, Mr J N Wedgbury (Substitute) (Substitute for Mr M J Angell), Mrs M Elenor (Substitute) (Substitute for Mr R A Latchford, OBE) and Cllr R Davison (Substitute) (Substitute for Ms S Spence)

ALSO PRESENT: Mr S Inett (Healthwatch Kent) and Cllr Mrs A Blackmore

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

UNRESTRICTED ITEMS

21. Declarations of Interest

(1) Mr Nick Chard declared a Disclosable Pecuniary Interest as a Non-Executive Director of Healthwatch Kent.

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

(3) Mr Adrian Crowther declared an interest as a Governor of Medway NHS Foundation Trust.

22. Minutes

(Item 3)

(1) Mr Nick Chard requested that the Minutes be amended to reflect the fact he declared a personal interest in the Agenda as a Non-Executive Director of Healthwatch Kent at the meeting.

(2) Dr Mike Eddy requested that the Minutes be amended to reflect the fact that Mr Angell declared a personal interest, rather than a personnel interest, at the meeting.

(3) RESOLVED that, subject to these changes being made, the Minutes of the Meeting held on 31 January 2014 are correctly recorded and that they be signed by the Chairman.

23. Membership

(Item 4)

(1) The Committee noted that Mr Crowther had replaced Mr Burgess as a UKIP representative and group spokesperson on this Committee.

24. Musculoskeletal and Orthopaedic Care Pathways

(Item 5)

Sean Crilley (Head of Planned Care Commissioning, NHS Ashford, Canterbury and Coastal, South Kent Coast and Thanet CCGs) and Karen Benbow (Chief Operating Officer, NHS South Kent Coast CCG) were in attendance for this item.

(1) The Chairman welcomed the guests of the Committee and asked them to introduce the item. The guests explained that they had been invited to update the Committee on the work of Musculoskeletal Services in East Kent. They had provided a paper which responded to questions raised by Members at January's meeting.

(2) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A number of Members enquired about alternative therapies. It was explained that osteopathy and chiropractics were not commissioned as part of the service in East Kent. The treatment criteria were based on clinical effectiveness which excluded many alternative therapies. The commissioning of alternative therapies may be considered by the CCG in the future.

(3) Acupuncture was only available through Community Orthopaedics which was permitted under NICE guidance. The review into Community Orthopaedics has been completed; the redesigned service will be implemented from 1 May 2014. The new service will enable direct GP referral rather than an assessment by the Community Orthopaedics team.

(4) Mr Crilley apologised for the data error in the previous report regarding the number of primary care referrals. The service was reviewing and developing corrective action for the next financial year.

(5) RESOLVED that the guests be thanked for their attendance and contributions today, and they be requested to take on board the comments made by Members during the meeting particularly with regards to alternative therapies and the Committee looks forward to receiving further updates in the future at the appropriate time within the next twelve months.

25. Medway NHS Foundation Trust: Update

(Item 6)

Dr Phil Barnes (Medical Director, Medway NHS Foundation Trust) and Mark Morgan (Interim Director of Operations, Medway NHS Foundation Trust) Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swanley CCG and NHS Swale

CCG), Dr Fiona Armstrong (Clinical Chair, NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests of the Committee and asked them to introduce the item. The representatives from Medway NHS Foundation Trust began by updating the Committee on the four main issues at the Trust: Quality Improvement Plan, Transforming Medway Programme, CQC regulatory action and Governance.

(2) The Quality Improvement Plan was produced to deliver the six recommendations arising from the Keogh Review in July 2013. Under the six recommendations 50 targets were produced; 90% of these had been completed or on track to be finished by the end of March. There was an emerging view that whilst the Trust would deliver the Quality Improvement Plan, the plan may not deliver a high quality acute hospital. There was a need for strategic focus to examine and deliver the Keogh, Francis and Berwick Reports; Urgent & Emergency Care Review and operational pressures.

(3) A new strategy, Transforming Medway, had been developed by the new executive team, following the decision not to proceed with the merger with Darent Valley Hospital. The strategy had the broad support of stakeholders and regulators. The strategy focused on seven high priority and high impact projects. The absolute priorities for the strategy were to improve the Emergency Care Pathway and to provide an excellent patient experience.

(4) To improve the Emergency Care Pathway, the Trust planned to create a single acute admissions area. Hospitals nationally had found that emergency care delivered in one area had improved the flow of patients, reduced length of stay, improved quality and mortality rates. At present, the acute medical unit in the Emergency Department had only sixteen bed spaces rather than the 65 – 75 beds required; other areas of the hospital were frequently opened up for acute admissions. The Trust was also piloting seven day services, recruiting staff and re-designing medical rotas to ensure senior doctors were at the front end of the patient pathway.

(5) To improve the patient experience, customer service issues such as car parking, appointment letters and the physical environment were being investigated to ensure a good healing experience for the patient; in addition to the concerns regarding quality and mortality rates.

(6) In regards to CQC regulatory action, Maternity Services provided by the Trust were inspected unannounced in August 2013. A number of significant issues were raised in the CQC report; the most pressing being staffing levels. A compliance notice was issued by the CQC which was met by the December deadline; the Trust now met the best practice levels of staffing. Maternity Services had not been revisited by the CQC but will be the focus, alongside the emergency department, of a forthcoming major inspection by the Chief Inspector of Hospitals.

(7) An unannounced inspection of the Trust's emergency department was carried out by the CQC on 31 December 2013. New Year's Eve had been one of the busiest nights for A&E in recent years and the Trust had requested a divert, as

the department had been so busy, but this had not been possible to be put in place. The inspection found significant breaches in infection control and cleanliness. The Trust accepted the findings in full and agreed an action plan with the CQC which were implemented by 28 February 2014.

(8) The emergency department was treating upwards of 90,000 patients a year in a building designed for 50,000 patients. The A&E department at Queen's Hospital in Romford was facing a similar challenge. Local media reported that Medway NHS Foundation Trust was the most challenged and worst performing in regards to length of A&E wait in January. An Executive Director of the Trust was physically on-site seven days a week; a significant amount of work had been undertaken to support the A&E department. For the last four weeks, the Trust had been running in internal incident mode with a tactical command team to improve emergency patient flow. By the end of March, the Trust was hoping to meet the 95% target of patients seen within four hours; last week's performance was 93.7%. Performance targets relating to infection control and elective surgery in non-emergency departments had been met.

(9) Increasing staff levels had come at a significant cost. The Trust had initially forecasted a small deficit (£1.2 million) for the year 2013/14; the cost of additional staffing has increased the projected deficit to £7.9 million by the end of the financial year. Improvements in quality and the use of new pathways could reduce future costs.

(10) The governance of the Trust had recently changed with the appointments of interim Chief Executive, Nigel Beverley and interim Chairman, Christopher Langley. Nigel Beverley was an experienced Chief Executive who was previously interim Chief Executive at Ipswich Hospital NHS Trust. Christopher Langley was an experienced Chairman who had helped turnaround two Foundation Trusts: Heatherwood and Wrexham Park Hospitals NHS Foundation Trust and Rotherham NHS Foundation Trust. Apologies were given on behalf of the interim Chairman and interim Chief Executive who were unable to attend this item on the Committee's agenda.

(11) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A question was asked about the sudden escalation of A&E attendances. Trust representatives explained that a significant increase had taken place in the last 10 -11 years across all Trusts. One of the issues for the Trust was that the emergency department was seen, both by users and members of staff in the hospital, as the place people should go. Improvements need to be made internally to ensure patients who require medical assessment, go to a medical assessment unit rather than the emergency department. For the public, the emergency department was a place known to provide 24/7 care.

(12) The Trust was looking at the whole of the urgent care pathway with Swale and Medway CCGs. There had been early discussions about an urgent care centre – a new build which would provide additional capacity. Patients would initially be seen by a specialist nurse or GP who would direct the patient to the most appropriate service. The Trust recognises that it was not in the best interest of the patient to be hospitalised; better joined up working would enable the delivery of services at home.

(13) In response to a specific question about seven day services; it was explained that Medway NHS Foundation Trust was selected to be one of thirteen Trusts to gain pilot status for seven day services. The Trust was developing plans and staff models to deliver seven day services focused on quality. Members expressed concerns that seven day services could place additional stress on the system.

(14) A Member expressed concern about the exclusion of finance as a key theme in the Quality Improvement Plan (QIP). It was explained that the QIP was developed with the regulator before the new management structure was in place; finance was not chosen to be one of the key themes of the plan. The additional transitional and on-going costs (£6 million) resulting from the Keogh Review correlated to the increased projected deficit from £1.2 million to £7.9 million. Following the Keogh Review, there was now an understanding across Trusts nationally that staffing levels should not be reduced to balance the budget; other efficiencies needed to be identified. Different forms of reorganisation were being investigated including vertically integrating community and social care services to deliver healthcare savings. There was also a national challenge to deliver and share services across larger areas to make them more sustainable.

(15) A further question on the provision of shared services was asked. The Trust has been in discussion with the CCGs about developing shared services; building on the cancer and vascular services provided in Medway to patients from Maidstone and Tunbridge Wells and parts of Dartford and Gravesham.

(16) A series of questions were asked about the leadership of the Trust. The new Chairman and Chief Executive had introduced a new management structure. Senior doctors were now responsible for the four business units focusing on three main areas: planned care, unscheduled care and cancer services. One of the immediate changes in the last month was that senior leaders had been requested to work across the whole organisation. An example was given; the Division Director for Surgery traditionally focused on planned care but was now additionally looking at the provision and delivery of unplanned care.

(17) A new team had been set up with the CCG, the Integrated Discharge Team, which had brought together health and social care teams to support the discharge of patients over the winter period. 20% of patients required additional support at home after being discharged. Different services had been working much more cohesively to deliver a better patient experience.

(18) A number of questions were asked about complaints, morale and winter pressure. It was explained that there were two key areas for complaints in Medway: communications and clinical care. There was a peak of complaints in January, when the hospital was at its busiest, many relating to the emergency department. The change of leadership had not been the only issue to affect morale. Scrutiny of the Trust has affected morale on the floor and in the boardroom. The absolute number of patients in A&E has not been as great as in previous years. However it has still been a busy winter with the acuity of patients being greater than normal.

(19) A series of further questions were asked about the upgrade to the Medway Emergency Village and triage. It was explained that the plan for the implementing the Medway Emergency Village was complex. Areas of the emergency department were being cleared, refurbished and put back into use as part of a sequence of moves. The Vanguard Unit, the temporary outbuilding was providing additional capacity during the upgrade. At present A&E could only triage patient to services within the hospital. The proposed Urgent Care Centre would be able to extend the hospital's ability to signpost to services such as social services, community wound management services and community diabetes services.

(20) Representatives from NHS Swale CCG were asked for their comments. Dr Armstrong explained that the quality of care and safety of patients in Swale was a key aim of the NHS Swale CCG; the CCG would like Medway NHS Foundation Trust to become a beacon of excellence and the hospital of choice. The issues at Medway could not be solved by the Trust alone. The CCG were working with the Trust, GPs and the public to develop a wider integrated primary care team enabling care in the community to work alongside hospital care. Ms Davies explained that it was important that quality improved at Medway; providing good basic care to the community. Trust finances were a concern for the CCG; the CCG were working closely with Monitor on this. There is a risk that if CCG finances need to be utilised to improve the financial position of the Trust, it would reduce the CCGs ability to invest in community care.

(21) RESOLVED that the guests be thanked for their attendance and contributions today, they be requested to take on board the comments made by Members during the meeting and that the Committee looks forward to the interim Chairman and interim Chief Executive attending the meeting of the Committee on 5 September 2014.

26. Accident and Emergency: North Kent
(Item 7)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust), Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG), Dr Fiona Armstrong (Clinical Chair, NHS Swale CCG and Clinical Representative for NHS Dartford, Gravesham and Swanley CCG), Dr Philip Barnes (Medical Director, Medway NHS Foundation Trust), Mark Morgan (Interim Director of Operations, Medway NHS Foundation Trust) and Elliot Howard-Jones (Director of Operations and Delivery, NHS England Kent & Medway)were in attendance for this item.

(1) The Chairman welcomed the guests of the Committee and asked them to introduce the item. Ms Davies began by explaining that an additional £10 million winter funding had been made available in North Kent: Darent Valley Hospital (£4 million) and Medway Maritime Hospital (£6 million). Both hospitals had introduced a system governance structure to utilise the funding with clinicians designing and developing the winter plans.

(2) Darent Valley Hospital had a challenging winter with wet but mild weather. The Dartford and Gravesham NHS Trust had developed good clinical relationships with the community team, mental health team and ambulance service to ensure the whole system worked well. The Integrated Discharge Team (IDT) was introduced as part of the winter funding in September to reduce inappropriate admission to hospital. The IDT were working with patients who initially required diagnostics and treatment in an acute setting but were quickly discharged to receive further care and support in the community. The IDT leadership team was hosted by Darent Valley Hospital; the CQC noted that the IDT was an area of excellence in their inspection report.

(3) The winter funds had also been used to develop telehealth and formulate the Better Care Fund application. Telehealth and telemedicine had been utilised in care homes enabling consultants to remotely monitor patients. The Better Care Fund application was proposing to expand the integrated discharge team and integrated primary care team. As part of the proposed collaborative model for primary care, district nurses would be moving back into GP practices. Changes in community services had moved district nurses out of surgeries; this had caused dissatisfaction amongst nurses who were not working with the same cohort of patients and did not have direct support and back up of specific GPs. Demand for primary care was phenomenal with a large proportion of GPs coming up for retirement. An integrated primary care team would generate a different type of workforce and utilise skills to provide care outside of hospital.

(4) Ms Acott noted that the IDT was created to respond to patients with more complex needs, such as dementia, who are not best served by coming into hospital. There had been an increasing number of patients presenting with dementia; half of all medically stable patients in the hospital had dementia. The introduction of telemedicine had supported home care; it had enabled patients with dementia who would have been previously admitted to hospital, when their nursing or residential home could not cope, to stay in a familiar environment and give confidence to nursing staff to support them.

(5) Mr Howard-Jones added that the current emergency system has been working at or near capacity for a large amount of time; redesign was required in response to the Keogh Urgent and Emergency Care Review. CCGs were redesigning services with their local populations and Urgent Care Groups were working to create system coherence with health and social care services. One of the key roles of the Urgent Care Groups was to monitor performance; these groups were looking more widely at the quality of care and management of acuity, rather than focusing on the 95% target of patients seen within four hours. Emergency management had been significant due to flooding; the response has been exceptional. The Sheppey Bridge incident was cited as another good example with the ambulance service, Darent Valley Hospital and Medway Maritime Hospital providing an excellent response.

(6) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member shared his personal experiences of visits to a Minor Injury Unit (MIU) and A&E. He expressed concerns about the difficulty in getting a GP appointment resulting in unnecessary A&E

attendances; limited services available at a MIU and a lack of connectivity between MIU and A&E with regards to triage.

(7) The Member also referred to a piece of work being carried out by Healthwatch Kent about A&E attendances. Mr Inett was asked to comment, he reported that a joint 'Enter and View' exercise was recently carried out by Healthwatch Kent and Healthwatch Bexley at Darent Valley Hospital's A&E department. Healthwatch found that patients were quite satisfied with the care and patient experience at the A&E department. Healthwatch Bexley were currently writing the report, once published, Healthwatch was planning a return visit as the department was quite quiet during the first visit. The report could be brought to HOSC at a later stage.

(8) Further, Healthwatch England recently published the results of a survey; 1 in 5 people who attend A&E know that it is not the most appropriate place for their care needs. Culturally, A&E had become the point of least resistance for immediate care. GPs, CCGs and NHS England had developed an urgent care pathway agreement to offer emergency GP appointments; GPs were being asked to sign up to this. Healthwatch Kent had found that people did not access the Faversham MIU as they are not aware of what services it provided and did not understand the difference between treating illness and injury.

(9) Clarification was sought regarding the increase in A&E attendance. Ms Davies explained that there had been demographic growth since the 1960s; however A&E attendance had significantly increased nationally in the last 10 – 12 years. A&E attendance at both Trusts has been fairly flat over the last two – three years. The Trusts were now looking to the future; NHS Dartford, Gravesham and Swanley CCG were anticipating additional pressure on their services as there had been a change of activity in South London with the London Ambulance Service diverting to Darent Valley Hospital. There was also projected demographic growth in Gravesham with the Ebbsfleet development over the next five years. NHS Swale CCG was looking to tackle health inequalities now, such as clinical obesity in 33% of children, to mitigate the impact on acute providers in the future. Both CCGs are working with the King's Fund to model future acute bed capacity.

(10) One of the Members enquired if the Sheppey Bridge incident affected Medway's A&E performance. Dr Barnes explained that A&E performance was better during the immediate period following the Sheppey Bridge incident. Accidents, minor and major injuries were included within the 95% target of patients being seen within four hours. Medway dealt well with accidents and minor injuries. It has been difficult to deal with major incidents due to increased ambulance conveyances and bed occupancy.

(11) A Member questioned why the changes to A&E had not happened before. Ms Davies explained that the reorganisation of the NHS from Primary Care Trusts to Clinical Commissioning Groups has enabled lead clinicians to design services and make decisions; bureaucracy had previously prevented clinicians getting involved. The winter funds had enabled clinicians to make key changes to improve A&E performance.

(12) The issue of inappropriate A&E attendance was raised. Ms Davies explained that the King's Fund had looked at the type of patients who attend A&E and admissions in NHS Swale CCG and NHS Dartford, Gravesham and Swanley CCG. Their research found that 20 – 25% of patient could have been better looked after in the community.

(13) A timeline for the Medway Emergency Village was requested. Dr Barnes explained that the Medway Emergency Village should be completed by Christmas this year. It was a very ambitious change programme. In the interim, the hospital was using existing ward stock to achieve different ways of working.

(14) A question about the major incident planning and practices was asked. Mr Morgan explained that emergency practices were tested regularly in all hospitals. From next year, emergency planning and testing would be built into the contracts with the CCGs which would be set out in the essential services plans. The Sheppey Bridge incident was a major incident test in real life. Medway NHS Foundation Trust had a formal committee for emergency planning which employed emergency planning officers who ensured key services take forward emergency plans and programme tests. Mr Howard-Jones added that in Kent there was a local health resilience conference which meets on a two-monthly basis to test resilience and review emergency plans. After a major incident, a formal debrief was held to evaluate and review the emergency plans. It is chaired by Mr Howard-Jones and the Director for Public Health at Kent County Council.

(15) A series of questions were asked about signposting to the most appropriate service. Mr Morgan explained that many patients did not know where they should go for urgent and emergency care. At the proposed urgent care centre in Medway, patients would be seen by a primary care clinician who would be able to signpost the patient to the most appropriate place for care. The urgent care centre would also be able book GP appointments and register patients for GP surgeries. Evidence had shown that if people were turned away, they would return at a later point. Dr Armstrong highlighted examples of signposting being piloted in North Kent such as the Health Now app. CCGs were working with NHS England, who commission primary care, to free up GPs to enable them to carry out greater numbers of same-day appointments. The future of the walk-in centre in Swale was being reviewed and would be consulted on; at present it enabled unregistered patients to directly access primary care. Ms Davies accepted that more education, training and signposting was required; walk-in centres and minor injury units needed to be more clearly defined to avoid confusion. A suggestion was made for the CCGs to advertise on borough and district websites.

(16) Questions were asked about GP retirement and recruitment and the use of decision-making tools. Ms Davies acknowledged that there was an issue with GP retirement: 33% of GPs in Swale and 20% of GPs in Dartford are due to retire in five years. An educational research hub was being developed in North Kent to attract new GPs. With regards to decision-making, Ms Davies explained that the guests represented different organisations, which had different governance structures. Decisions were taken through a board of

directors who had access to decision-making tools. When joint boards were convened, prioritising tools were used to help with commissioning intentions.

(17) Mr Inett enquired about the urgent care delivery group. Ms Davies explained that the group was convened by the CCGs within each health economy boundary. The patient representatives on the delivery groups were mainly from the voluntary sector. Ms Davies stated that she would be happy to involve Healthwatch in future meetings of the delivery group.

(18) A Member made a comment about the use of acronyms in the NHS reports. The Scrutiny Research Officer was asked to update the letter sent to the NHS to include a note about the use of acronyms.

(19) RESOLVED that:

(a) the guests be thanked for their attendance and be requested to take on board the comments made by Members during the meeting and a report be presented by the representatives to the Committee in nine months' time.

(b) a meeting be arranged between with Healthwatch Kent and Members of the Committee to consider how the work of Healthwatch Kent, in areas such as urgent and emergency care, could support the work of the Committee.

27. CQC Inspection Report - Darent Valley Hospital
(Item 8)

Susan Acott (Chief Executive, Dartford and Gravesham NHS Trust) was in attendance for this item.

(1) The Chairman welcomed Ms Acott and asked her to introduce the item. Ms Acott began by setting out the new CQC inspection process which was being overseen by Professor Sir Mike Richards. Dartford and Gravesham NHS Trust was selected as one of 18 Trusts to pilot the new inspection regime. The Trust was also selected to be one of three Trusts to pilot of the new rating system; Royal Surrey County Hospital NHS Foundation Trust and Heart of England NHS Foundation Trust were also included in this pilot.

(2) The inspection was preceded by an Intelligence Monitoring report and a very detailed data pack produced by the CQC which listed the Trust's achievements, outcomes, mortality statistics and demographic information on the population it serves. The inspection involved 40 inspectors who met with the public and held focus groups with junior and senior staff.

(3) Ms Acott was very pleased, on the whole, with inspection: staff were found to be engaged and loyal, the organisation was caring, effective, safe and efficient. The following areas for improvement were also identified: A&E, qualifications of staff and a focus on the symptoms of very high occupancy. Pilot status enabled the Trust to shape and feedback to the CQC and

Professor Sir Mike Richards directly. Ms Acott reported that there was lots of goodwill towards the inspection and that confidence in the CQC inspection regime was returning.

(4) Members then proceeded to ask a series of questions and made a number of comments. An area identified for improvement by the CQC was the cascading of learning from a serious incident in a timely manner. The CQC found that it could take up to a year for learning from a serious incident to be implemented and staff often did not hear the outcome. A Member enquired about the steps that had been taken to address this. It was also suggested that the Committee look into key lines of enquiry used by the CQC.

(5) Ms Acott explained that the key lines of enquiry were drawn from the data pack produced before the inspection which was published on the CQC website for transparency. When a serious incident takes place, the Trust had to go through a specific investigatory process involving NHS England and the CCG. The investigation process was led by clinicians who carried out Root Cause Analysis. Following the CQC inspection, the Trust had introduced end dates to investigations, begun electronically reporting incidents and changed the Terms of Reference for its governance meeting to enable it to feedback outcomes and learning from incidents to staff.

(6) A series of questions were asked about the cost of a CQC inspection and serious incident inspection. Ms Acott explained that a serious incident inspection did not have a financial cost, only an opportunity cost to the Trust. The cost of a CQC inspection is unknown.

(7) The progress of single sex wards was raised. It was explained if there was a clinical need to mix the sexes, which mainly occurs at night, patients were moved to single sex wards as soon as possible. Incidents of mixed sex wards were reported to Ms Acott and resolved as soon as possible. Clinical need overrides the requirement for single sex wards.

(8) A question was asked about the Trust's response to the CQC inspection. Ms Acott explained that within 21 days of the CQC inspection, the Trust had to submit a compliance plan to the CQC with details of how it would resolve issues. Once the Trust informed the CQC that they had completed the compliance actions, the CQC would come back on an unannounced visit to check. The Trust also had to submit an Improvement Plan which was a developmental piece. The improvement plan had to be agreed with the CCG, NHS England, ambulance and mental health services and sent to the CQC. It is expected that the CQC would return in the summer or autumn to ensure any issues were concluded.

(9) A comment was made about the inclusion of older people's care in the medical care section of the inspection findings. Ms Acott explained that the CQC had chosen not to distinguish these types of care; she was surprised that they had not been separated. However inspectors distinctively looked at frail and elderly patients during their inspection.

(10) RESOLVED that Ms Acott be thanked for her attendance and that an update be submitted to the Committee at an appropriate time.

28. Forward Work Programme
(Item 9)

(1) Members considered the work programme as set out in the report and made a number of suggestions for additions to the work programme.

(2) It was suggested that a working group be established to consider the financial situation of the four acute hospital trusts' in Kent and Medway.

(3) RESOLVED that:

(a) the work programme as set out in the report be noted and that the following be added to the work programme:

- CQC Inspection Regime
- Integration
- Future Leadership of the NHS
- Profile of GPs in Kent

(b) A working group be established to consider the financial position the four acute hospital trusts' in Kent and Medway and report back to this Committee.

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

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 April 2014

Subject: Child and Adolescent Mental Health Services (CAMHS)

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

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

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1. Introduction

(a) On 31 January 2014 the Health Overview and Scrutiny Committee considered reports on Child and Adolescent Mental Health Services (CAMHS) in Kent.

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

- *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.*

2. CAMHS – Tier System

(a) Mental health services for children and young people in England are organised in a four tier system[1]. The tiers are described below.

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

- **Tier 2** - provides assessment and interventions for children and young people with more severe or complex health care needs, such

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

as severe depression. Services at this level are provided by community mental health nurses, psychologists, and counsellors.

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

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

3. Recommendation

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

Background Documents

Minutes, Health Overview and Scrutiny Committee, 31 January 2014, https://democracy.kent.gov.uk/mgAi.aspx?ID=27048

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NHS
West Kent
Clinical Commissioning Group

Child and Adolescent Mental Health Services (CAMHS) Update

Health Overview and Scrutiny Committee

11 April 2014

Patient focused
Providing quality, improving outcomes

KENT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

FRIDAY 11 APRIL 2014

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) UPDATE

SUMMARY

This report provides an update on progress on the actions taken across the system to improve performance of CAMHS in Kent.

RECOMMENDATIONS

The committee is asked to:

Note the report and comment

1. Background

- Child and Adolescent Mental Health Services (CAMHS) are commissioned at four levels:
    - Tier 1 – support delivered within universal settings
    - Tier 2 – targeted support
    - Tier 3 – specialist support
    - Tier 4 – Specialist mental health services

- It is important to understand the pathway of care for children's mental health and emotional wellbeing services. Although this paper focuses on Sussex Partnership NHS Foundation Trust (SPFT) which delivers Tier 2 and 3 provision, it is important that the committee recognises the wider context of CAMHS provision.

- Kent County Council commissions Tier 1 (emotional wellbeing services) from Healthy Young Minds.

- In 2011/12 the Kent cluster primary care trusts, in partnership with Kent County Council (KCC) retendered Tier 2 (targeted) and Tier 3 (specialist) services, following dissatisfaction with the previous service.

- As a result of this procurement, Sussex Partnership NHS Foundation Trust (SPFT) took over provision of Tier 2 and Tier 3 services from September 2012.

- These services are now commissioned by clinical commissioning groups (CCGs). NHS West Clinical Commissioning Group is the co-ordinating commissioner, on behalf of all the CCGs in Kent and Medway.

    - These services were previously provided by seven separate providers with different pathways and processes.

- Tier 4 (specialist mental health) services were retendered the year before (2010/2011) and are commissioned by NHS England specialist services team. The current provider is South London and Maudsley NHS Foundation Trust (SLaM).

2. Current national picture

- There is a growing recognition of the national problem with high demand, limited capacity and disjointed commissioning care pathway arrangements in children's mental health and emotional wellbeing services, including CAMHS.

- There is a wider understanding of the current disparity in resource allocation for children's mental health services compared to adult mental health, when the high percentage of mental health diagnoses in teenage years is taken into account.

- We anticipate that the current Health Select Committee inquiry into children's mental health and emotional wellbeing services, including CAMHS, and the NHS England review of Tier 4 beds will provide a clearer steer on future service developments and capacity.

3. Sussex Partnership Foundation Trust (SPFT) contract performance

- When SPFT took over the Tier 2 and 3 services, it rapidly became clear that there were significantly more children waiting for assessment and treatment than had been anticipated through the tender process. This led to considerable delays for assessment and treatment and failure to meet contract KPIs.

- SPFT rapidly undertook a review of the team structure it had taken over and restructured into a more appropriate workforce model. This led to high levels of vacancies in some teams which compounded the problems clearing waiting lists.

- Demand for the service has also been rising since the new service was introduced, this reflects the national picture. In Kent, this is exacerbated by the care pathway issues with universal services. Young Healthy Minds is responsible for CAF.

- SPFT has moved to a single information system from the previous multiple systems. In a number of instances, this has meant introducing computerised systems where previously only manual systems existed. This led to initial teething problems with the flow of electronic performance information which is now improving.

- SPFT has been a low reporter of clinical performance issues due to the need to develop Kent specific reporting systems.

- Recently, there has been a rise in the number of complaints from parents and MPs, together with interest from local media.

4. Section 136 issues and interaction with South London and Maudsley NHS Foundation Trust (SLaM)

- There is currently no identified section 136 suite available for young people under 18 in Kent.

- Soon after NHS West Kent Clinical Commissioning Group took over the lead for the SPFT contract, it became clear that the arrangements for caring for children picked up by the police under section 136 were not working, with a number of children waiting for far too long in A&E, and very occasionally, where the risk was too great, police cells, for an inpatient admission (placement by the Tier 4 service).

- SPFT teams are appropriately prioritising, assessing promptly and supporting young people in A&E, police custody and at home. The trust has recently established a home treatment team which is able to offer intensive support at home seven days a week.

- Nationally, the demand for Tier 4 CAMHS beds is significantly outstripping capacity and has led to the current position of beds only being available on a "one in, one out" basis. This is causing pressure across the entire system and leading to waits of days for young people requiring an inpatient bed. This is particularly problematic for those young people picked up by the police on a section 136.

- NHS West Kent CCG has been working with SPFT, SLaM and the police to understand the issues and take action to resolve them. It has become clear that there is a commissioning gap: the Tier 4 contract requires SLaM to place children needing a Tier 4 inpatient bed, but SLaM is not required to either provide a place of safety or look after them while they wait. The Tier 3 contract with SPFT requires them to respond and assess children for a Tier 4 service,

with the expectation a bed will be made available within hours. This leaves a critical gap in commissioned service.

- There is a temporary agreement with SLaM to use their section 136 suite at the Bethlem Royal Hospital in London and we are currently developing a local solution.

- There are also significant problems with SLaM finding placements when required. A number of children have either been placed a long way out of county or have had to wait in our acute hospitals or at home for a bed to become available. SPFT has incurred costs looking after children while a placement is sought. The shortage of Tier 4 beds is a national problem experienced across England.

5. Progress to date

- SPFT has re-aligned management to the Kent service which is giving a greater focus to improving delivery.

- SPFT has cleared the backlog from 1/4/13 and has prioritised assessing children to enable them to be treated in clinical order. Although this led to an improvement of waiting times for assessment, it has led to an increase in waiting times for treatment.

- SPFT has ensured all urgent referrals are treated within the 24 hour timeframe required.

- SPFT has completed the team restructuring and a number of rounds of recruitment to fill vacancies. Although vacancies still exist, the number of vacancies has been reduced to the point where these can be safely filled by agency staff. Teams are thus able to operate at close to full capacity.

- A performance notice has been served on SPFT by NHS West Kent CCG as the co-ordinating commissioner. This requires the trust to produce a recovery plan and deliver rapid improvements to ensure compliance with contract standards for waiting times for routine referrals (4-6 weeks from referral to assessment and 8-10 weeks from referral to commencement of treatment). The plan has been received and reviewed by the CCG. Performance is now being regularly monitored to ensure compliance. The plan will see full achievement of contract key performance indicators by the end of August 2014.

- Dr Steve Beaumont, NHS West Kent CCG's Chief Nurse, has met with SPFT to agree a quality dashboard and a process for reporting serious incidents.

- To resolve the immediate section 136 problems, NHS West Kent CCG has agreed to commission a place for safety for children held under section 136 and is close to concluding an agreement for this service. This service will be in Kent and will provide a short term fix to the issue. This proposal has been welcomed by Kent Police through the Strategic Police Partnership Board.

- NHS West Kent CCG has agreed with KCC and the Health and Wellbeing Board to jointly review commissioning arrangements for CAMHS with a view to bringing the commissioning of Tier 1 to 4 services into an integrated approach. This will help resolve some of the problems created by the current fragmented commissioning process. This review will also consider issues of transition and the interface with education and other agencies.

- NHS West Kent CCG and SPFT have written to NHS England which is responsible for commissioning Tier 4 beds to express shared dissatisfaction with the level of current provision and concern that young people are being put at risk as a result of delays in finding inpatient beds.

- Steve Duckworth (NHS England), who manages the Mental Health Strategic Clinical Network, has agreed to review Tier 4 services for Kent and also identify a number of providers elsewhere in the country who provide good Child and Adolescent Mental Health Services, which we can use to benchmark and support local services. This was requested by HOSC in Jan 2014.

6. Current position

- In February, the service entered a contractual performance regime. Commencing on Monday 10 February, activity targets have been set for all teams which are being reported on a weekly basis. Weekly performance monitoring and feeding the information back to the frontline teams has helped to establish process, structure and workforce data capture that previously caused concern and impacted on the trust's ability to keep partners informed.

- The impact of the additional focus can be seen clearly in the February report with a significant increase in contacts recorded and appointments offered.

Headlines February Performance Report

↑	6071 contacts recorded, up from 4735 January [increase 1336]
↑	6859 appointments offered, up from 5373 in January [increase 1486]
↑	112 Emergency referrals of which 79 presented out of hours, this is a slight reduction on January but still significantly above plan. 100 per cent were assessed

	within 24 hours. [Note: tender standard anticipated number of young people assessed out of hours to be 10 per month, 120 per annum.]

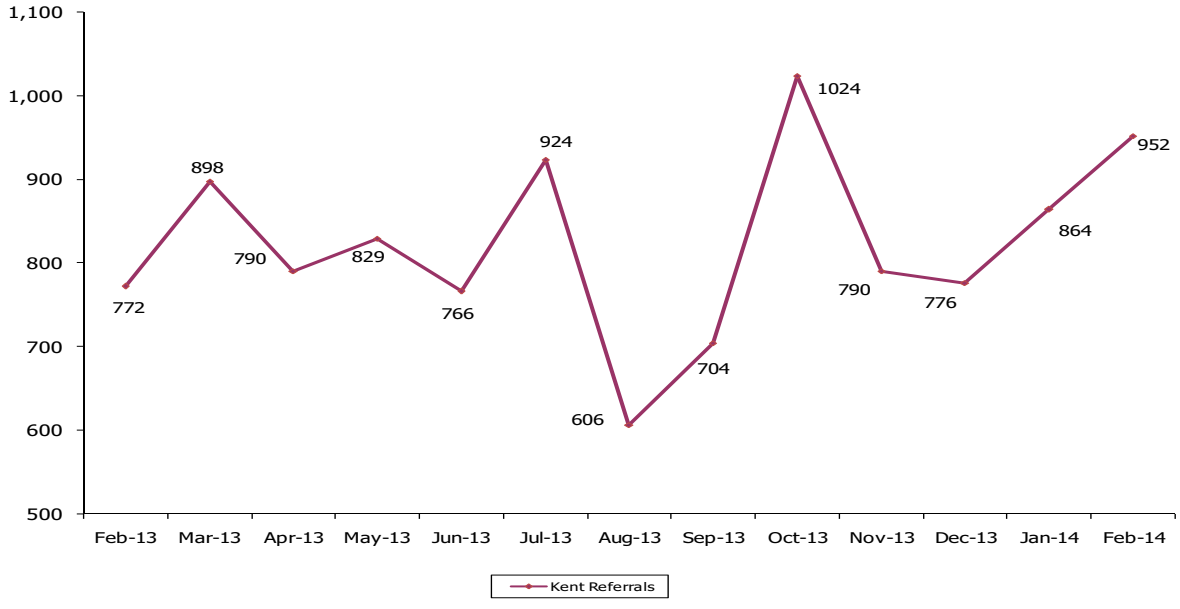
Apr-13	May-13	Jun-13	July-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
110	92	73	90	65	93	87	91	61	124	112

↑	Total referrals 952 [monthly average 737]
↓	1148 external waiting-list to assessment, down from 1230 in January [decrease 82]
↓	1009 treatment waiting-list, down from 1087 in January [decrease 78]
↑	9,763 caseload from 9,472 in December [291 increase in month, 703 discharged in month]

The overall picture is as follows:-

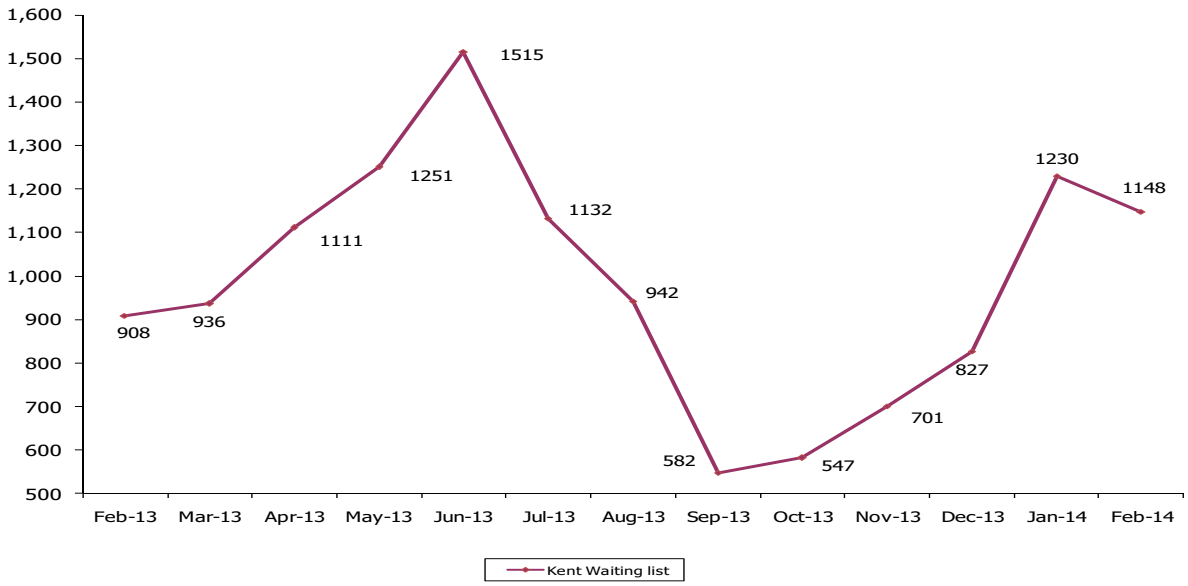
Number of referrals – February 2014

Month	Quarter	YTD
952	1,816	9,025



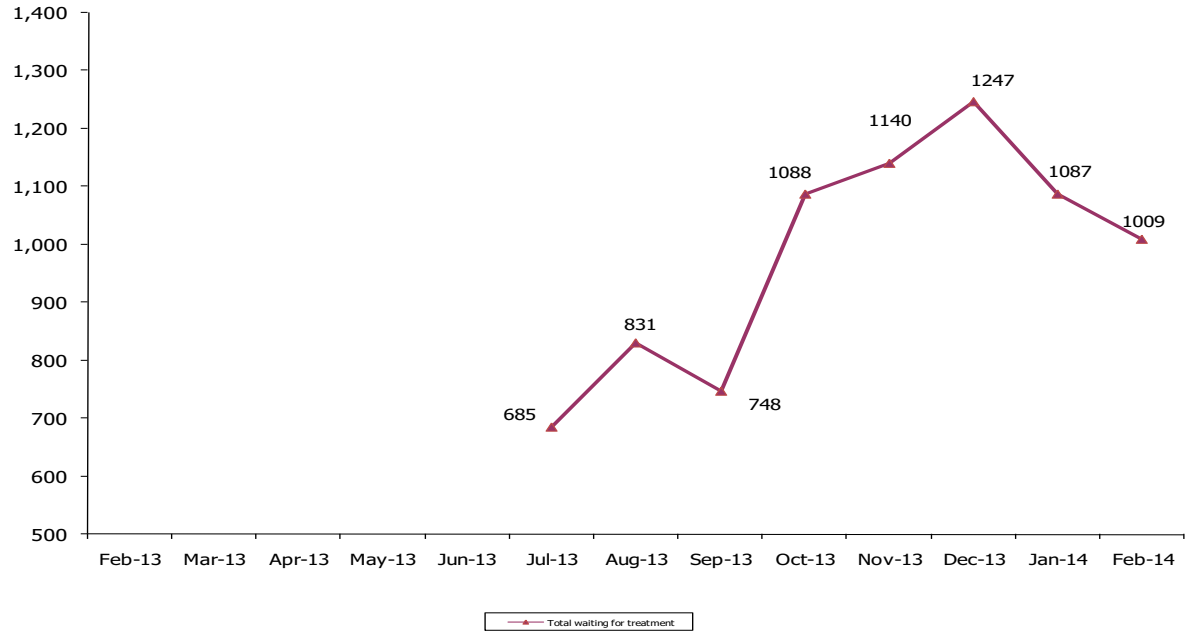
Number waiting for assessment – February 2014

Month end
1,148 for routine assessment



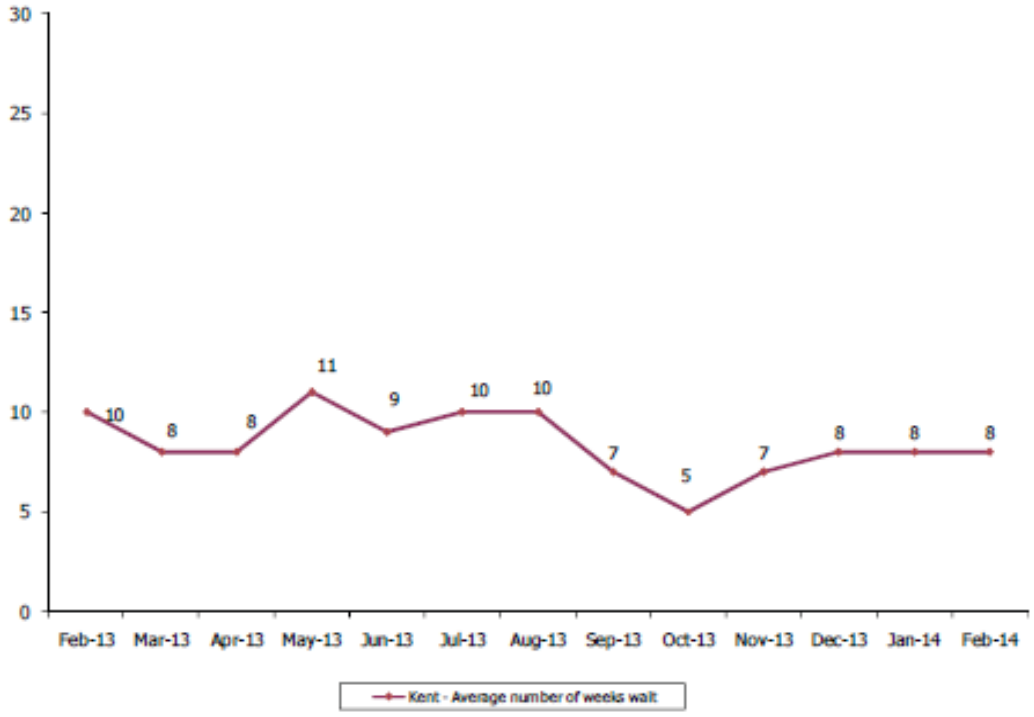
Numbers waiting for treatment – February 2014

Month end
1,009



Average weeks waiting for routine assessment from referral – February 2014

For those on manual wait lists
8



- Quality and serious incidents data are beginning to flow from SPFT and the quality committee is reviewing the information. This has provided improved assurance.

- Performance data are being provided from SPFT and are starting to show some indications of improvements to waiting times.

- SPFT has walked the CCG through the recovery plan and the CCG is assured that it is a robust plan.

- SPFT is now producing weekly situation reports for its teams and the CCG, which are helping to galvanise action and provide reassurance that the actions set out in the recovery plan are being delivered.

- Vacancy levels at SPFT continue to fall.

List of background documents

DH NHS Outcomes Framework

No Health Without Mental Health 2011

Draft Kent and Medway Emotional Wellbeing and CAMHS Strategy 2012

Kent Health and Wellbeing Strategy 2012

Health and Social Care Act. 2012

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 April 2014

Subject: Patient Transport Services (PTS)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on Patient Transport Services.

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

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1. Introduction

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

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

(b) The Health Overview and Scrutiny Committee considered the subject of PTS on three occasions since the beginning of 2013:

- 1 February 2013
- 11 October 2013
- 31 January 2014

(c) At the end of the discussion on 31 January 2104, the Committee agreed the following recommendation:

- *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.*

(d) The report from NHS West Kent CCG included in the Agenda for 31 January 2014 included the PTS eligibility/assessment criteria.[1]

[1] https://democracy.kent.gov.uk/documents/s44902/Report%20from%20West%20Kent%20CCG.pdf

2. Recommendation

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

Background Documents

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

Minutes, Health Overview and Scrutiny Committee, Kent County Council, 1 February 2013, https://democracy.kent.gov.uk/mgAi.aspx?ID=23758

Minutes, Health Overview and Scrutiny Committee, Kent County Council, 11 October 2013, https://democracy.kent.gov.uk/mgAi.aspx?ID=26033

Minutes, Health Overview and Scrutiny Committee, Kent County Council, 31 January 2014, https://democracy.kent.gov.uk/mgAi.aspx?ID=27050

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Patient Transport Services

Background

- The contract for patient transport services (PTS) is hosted by NHS West Kent CCG on behalf of all Kent and Medway CCGs.

- Historically PTS services were provided by a range of providers in Kent and Medway.

- The previous PCT cluster re-procured the service in 2011/2012 and NSL Care Services were appointed as a new provider for the whole of Kent and Medway.

- Two months before contract go-live the commissioner discovered that they had failed to advise all bidders of an additional 100 staff who needed to be TUPEd to the new provider. Discussions were held with NSL who agreed to take on these staff, subject to the Commissioner paying the additional costs. These additional costs are c£0.6m per annum.

- NSL took over the contract in July 2013.

Contract performance

- Following implementation of the new contract in July 2013 it became clear that the mobilisation was running into difficulties. Patients were not being collected on time. This meant patients arriving late for appointments or the trust not being able to discharge patients on time.

- NHS West Kent CCG worked with NSL to support the mobilisation and performance started to improve over the summer.

- However, by September 2013 it was clear that performance had plateaued at about 60 – 65 per cent of contact KPIs and was not improving. Over the period September into October performance began to drift downwards.

- NSL were asked for a recovery plan and trajectory which they produced but failed to achieve.

- A review of the number and types of journeys showed that actual activity compared to activity estimates included in the ITT and contract were significantly different. Although total activity was comparable the profile was very different:

- The number of journeys needing a stretcher or one person escort was much higher and the number that could be transported by care much lower – this was having a significant impact of the type of vehicles needed.

- The number of short journeys was much higher than anticipated and the number of longer journeys far fewer – this was having a significant impact on NSLs income as they had priced against a different profile.

- The number of journeys needed in the late morning to early afternoon was peaking at a much higher level than anticipated – this was having a significant impact of staffing requirements and rostering.

- As a consequence NSL were incurring significant additional costs hiring vehicles and crews to cover peaks in demand and were losing significant money on the contract. NSL sought to recover their losses from the CCGs.

- West Kent CCG briefed the NHS England Area team about the issues with NSL and contacted other commissioner across England who use NSL as a provider of PTS services. Whilst a number of other CCGs are having performance issues with NSL, none were of the scale experience by Kent & Medway. It is also worth noting that other CCGs with other PTS providers are having similar performance issues to those experienced by Kent and Medway.

Actions

- With the support of all Kent and Medway CCGs, NHS West Kent CCG took the following actions:

  - Requested NSL replace existing local management with a new local manager as we had lost confidence.
  - Brought in Alan Murray, an ex NHS Ambulance Trust CEO to review NSL's recovery plan and support the CCGs and NSL to turn performance around.
  - Negotiated a financial settlement for first six months (July – December 2013) to remove any risk of litigation or early contract termination. This settlement split the additional costs incurred by NSL 50/50 between commissioner and provider. The additional cost to the commissioner was £1m.
  - Allocated additional funding for December and January (£320k) to ensure capacity over these two winter months – this was funded for winter pressures money.
  - Commenced a formal activity review with NSL to rebase the contract activity, pricing and costings based on actual activity.

Current position

- NSL have brought in new management for the Kent and Medway service which is helping to re-build confidence in their local team.

- CCGs and NSL have concluded a re-basing of the contract and are signing the formal contract variation to conclude this. The additional cost for Kent and Medway CCGs is £1.6m per annum.

- NSL have recruited additional staff and leased additional vehicles to enable them to meet the revised demand estimates.

- A recovery plan has been agreed with NSL which will see performance hit most contract KPIs by Easter and all of them by June 2014. These are being monitored on a weekly basis and the early signs are that performance is beginning to improve in line with the trajectories.

ENDS

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 April 2014

Subject: Faversham Minor Injuries Unit

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

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

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1. Introduction

(a) The Health Overview and Scrutiny Committee initially considered Faversham Minor Injuries Unit on 29 November 2013. The Committee agreed the following recommendation:

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

(b) In addition, the Chairman was asked to write to the Secretary of State for Health setting out the Committee's concerns. The response received from the Secretary of State was included in the Agenda for 31 January 2014.[1]

(c) On 31 January 2014 the Committee considered a written update provided by NHS Canterbury and Coastal CCG and the response from the Secretary of State for Health. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOVLED that this Committee notes the reports and looks forward to an update at the April meeting.*

2. Recommendation

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

[1] https://democracy.kent.gov.uk/documents/s44763/Letter%20from%20the%20Secretary%20of%20State.pdf

Background Documents

Minutes, Health Overview and Scrutiny Committee, Kent County Council, 29 November 2013, https://democracy.kent.gov.uk/mgAi.aspx?ID=26458

Minutes, Health Overview and Scrutiny Committee, Kent County Council, 31 January 2014, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5394&Ver=4

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NHS
Canterbury and Coastal
Clinical Commissioning Group

Health Overview and Scrutiny Committee

April 2014

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

1. Background

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

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

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

1.4. At the November HOSC meeting, Members raised a number of questions and made comments about the procurement process. At the end of the discussion, the committee asked the CCG to set aside its decision to close the service to allow a new procurement exercise to be undertaken. It was requested that this was carried out in consultation with the people of Faversham and their democratically elected representatives.

1.5. At the January HOSC meeting, the CCG advised Members that the CCG Governing Body had decided to:

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

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

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

2. Progress

The CCG recognises that the review continues to be a work in progress. Since the January HOSC meeting the CCG has:

2.1. Formed a steering group which includes local patients, HealthWatch Kent, Swale Borough Council, Kent County Council and local GPs. The steering group is chaired by the Town Mayor and Chair of the Friends of Faversham Cottage Hospital.

2.2. The inclusion of the local GP practices and patient representatives has meant we have been able to demonstrate much stronger engagement than the CCG has been able to secure in the past.

2.3. The group has met on two occasions and to date has:

- Reviewed all documentation which was used in the unsuccessful procurement process.
- Analysed and commented on the work that was carried out by the CCG.
- Identified potential changes to the tendered model, including allowing potential providers to offer direct access X-Ray.
- Reviewed eight suggestions for the service, including different opening hours and running with and without an X-ray service.
- Agreed to a smaller working group to further explore the four most realistically deliverable and affordable scenarios. The working group has met twice and is due to report back to the steering group on 15 April with recommendations of preferred options.
- In working through the scenarios, it is clear that the group have recognised the affordability challenge of commissioning an MIU in Faversham that has in place the appropriate supporting services and can consistently deliver a quality service.

2.4. The CCG has received positive feedback that this approach has helped to restore relationships with the local community regarding the MIU. It is also appreciative of the input from all members of the steering group.

3. Next steps

3.1. The steering group will meet on 15 April and:

- Consider the revised scenarios
- Agree recommendations to the CCG governing body on the preferred model

3.2. The CCG also intends to keep HOSC Members updated on the final outcome of the steering group review.

3.3. The CCG will continue to extend the existing contract until the recommendations are implemented.

3.4. In the light of the benefits of this approach of co-design, the CCG intends to ask the steering group to also help develop the future of community services in and around Faversham. The CCG will also keep HOSC Members updated on developments.

ENDS

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 April 2014

Subject: Redesign of Community Services and Out-of-Hours Services - Swale

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

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

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1. Introduction

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

(b) General information on out-of-hours services is included in the covering report to this item as the first of these. This will be useful background for all the out-of-hours items.

(c) For reference, out-of-hours cover may include some or all of the services below (NHS England 2013):

- "GPs working in A&E departments or minor injuries units (MIUs);
- Teams of healthcare professionals working in primary care centres, A&E departments, MIUs or NHS walk-in centres;
- Healthcare professionals (other than doctors) making home visits, following a detailed clinical assessment;
- Ambulance services moving patients to places where they can be seen by a doctor or nurse, to reduce the need for home visits."

2. Recommendation

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

Background Documents

NHS England, *Out-of-hours services*, 28 January 2013
http://www.nhs.uk/nhsengland/aboutnhsservices/doctors/pages/out-of-hours-services.aspx

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Briefing on GP out-of-hours service and redesign of community services for the NHS Swale Clinical Commissioning Group area

1. Introduction

1.1 GP out-of-hours (OOH) services for the NHS Swale Clinical Commissioning Group (CCG) area was provided by IC24 (previously known as South East Health). However, the contract ended on 31 March 2014.

It has, therefore, been necessary to review the services required, taking into consideration the results of the Keogh Review and recommendations from the Emergency Care Intensive Support Team (ECIST) for Medway NHS Foundation Trust.

1.2 Both the Keogh Review into hospital mortality and feedback from ECIST recommended a much closer working arrangement between Medway A&E, community services and the OOH service. They said this would support improvements to the service.

This is of particular significance for NHS Swale CCG as, with the exception of the out-of-hours service, the majority of urgent care services for its population are focused around Medway NHS Foundation Trust.

1.3 It was, therefore, agreed by NHS Swale CCG that an interim arrangement be put in place to support the recommendations for greater working with Medway NHS Foundation Trust while the development work for redesigning an integrated community service provision continues. In addition, this change and rationale has been discussed at the local Health and Wellbeing Board and is supported by Swale Borough Council.

1.4 The GP out-of-hours service has therefore, transferred, for one year, initially, to Medway On Call Care (MedOCC) until a redesign, as outlined above, has been completed and a full procurement commenced. MedOCC is part of Medway Community Healthcare and also provides GP out-of-hours services for the population of Medway.

2. Service provision

2.1 During the process of changing service provider we have aimed to ensure maintenance of the current service, with the benefit of the closer working relationships across the urgent care system as advised by the Keogh review.

Patients in Swale who need a face-to-face appointment with an out-of-hours GP will continue to access this service at Sheppey Community Hospital in the evenings and at weekends, and at a base at Sittingbourne Memorial Hospital at weekends only. These are supported by a home visiting service.

2.2 Under the previous provider (IC24), the nearest overnight bases, which also operate as the base for the overnight car, was at either Maidstone or Canterbury. This has been perceived to mean the service is less accessible to Swale residents, which has been raised by residents during the CCG public Boards and through engagement sessions. MedOCC will continue to operate the bases and provide the home visiting service but will use its Medway base at Quayside, Chatham Maritime, when a face-to-face appointment is needed between 1am and 7am.

2.3 The key changes for patients are therefore:

- Should a patient require a face-to-face visit after 1am, this will now be provided at Quayside in Chatham rather than in Canterbury. For the majority of people within Swale this means a shorter journey.
- Services will continue to be provided at both Sheppey Community Hospital and Sittingbourne Memorial Hospital. At weekends and bank holidays, there will be a change to the opening hours at Sittingbourne Memorial Hospital from the previous day time session to a morning (9am to 2pm) and evening (6pm to 10pm) session, providing cover when other advice services, such as pharmacies, may not be available.

2.4 There will be no change to the route of contacting the OOH service, which will continue via NHS 111, and the provision of home visits, which will continue to be provided throughout the out-of-hours period.

2.5 In order to ensure that the public are aware of the changes, details have been published in the local media, and also uploaded to the CCG website and other media websites. We have also used a variety of other methods to share this information:

- Via regular reminders about the changes broadcast on the CCG's Twitter feed.
- Letters sent to local taxi firms explaining the changes to late-night face-to-face appointments with directions and maps on how to reach MedOCC's base at Quayside.
- The engagement team provided written information to the CCG's Swale Patient Liaison Group (PLG) for distribution to members and sent letters to community health staff and GP practice managers for distribution.
- Letters to patients based on the media release were also produced and distributed through the PLG, GP practices and community health staff.

2.6 Patient experience data gleaned over the past two years about out-of-hours services was used and the engagement team will be talking to patients and other stakeholders to monitor the new service and to inform development of the future model to be implemented.

2.7 In line with arrangements for all healthcare providers, the CCG will closely manage performance of this service, particularly during the transition period, to ensure that patient outcomes and experience are not adversely affected.

3. Community Services Redesign

3.1 Following feedback from our member practices, Swale CCG commenced a review of community services in 2013. The aim of this review has been to identify the key issues and develop plans for sustainable, transformational change to achieve greater integration of teams and improve management of long-term conditions.

3.2 The review has included significant work with our patients, public and health and social care partners. This feedback has identified a key need for services to be integrated across all sectors of healthcare (primary, community and secondary care, including mental health) as well as with social care, ensuring a patients needs are addressed swiftly and smoothly.

This review has been extended to include acute and community services across North Kent, and commenced with an audit by The Oaks Group, followed by stakeholder workshops facilitated by the Kings Fund, in November 2013 and February 2014.

3.3 For Swale / Medway (ie the population served by Medway Foundation Trust), the review of patients within the acute Trust, identified that:

- Up to 15% of adult admissions could have been avoided:
  - 13% were due to consultant related issues
  - 48% of acute admissions could have been avoided by providing a variety of services at home.
  - 18% of acute admissions could have been provided for on sub-acute (eg community) wards.
  - Additionally, 8% of all admissions required supported living environments.
- 50% of the continuing stay days were avoidable:
  - Some delays due to discharge planning issues.
  - 23% of continuing stay days could have been avoided by providing a variety of services at home.
  - Additionally, 38% of continuing stay days required were for supported living environments.

3.4 The agreed areas of focus, and plans – including KPIs, milestones, and system wide impact – have been used to underpin CCG commissioning plans for 2014 -16 and beyond, as well as the development of the Better Care Fund proposal. Key within these plans is the development of integrated teams in primary care and within the acute trust (Integrated Discharge Team) to ensure that people, particularly older people with multiple or complex conditions, are supported by health, social and mental health care professionals to maintain their independence for as long as possible.

3.5 The next stage of this review is to continue the bed utilisation review with an expectation that this will be completed early summer 2014, giving further detail on the bed base, including community beds, required.

4. Primary Care Services

4.1 In addition to the community service review described above, there are a number of other system-wide developments which will impact on the future format of GP OOH services. These include:

- the implementation of the new GP contract which includes a commitment to provide seven-day services
- the review and re-design of the Walk-In Centre provided at Sheppey Community Hospital and out-of-hours contracts that end in March 2016
- the development of the CCG Primary Care Strategy and release of the national Primary Care Strategy.

4.2 While processes are in place to ensure communication across the variety of services available to patients in primary care and the community, there remains fragmentation across the system, particularly in urgent care and between health and social care providers. Though the 111 service can provide support and signposting, this fragmentation can make it confusing for people to know which service will best meet their needs.

5. Conclusion

5.1 The current transfer of OOH services is aimed at ensuring clinical consistency across the local urgent care system, while maintaining services for local people. However, in the longer term the CCG recognises the need to improve the totality of local services to meet identified health needs and provide seamless continuity of care between each service, in such a way which supports people to make use of the most appropriate service for their needs.

5.2 To ensure the longer term model for out-of-hours care is integrated with wider services and remains relevant to the needs of local people, it is necessary to consider integration with other services. This work has commenced as part of the community services redesign and Better Care Fund work, with both local and Kent Health and Wellbeing Boards and will continue, with feedback from patients, the public, GPs and health and social care providers being key within this process.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 April 2014

Subject: Folkestone Walk-In Centre

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

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

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

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1. Introduction

(a) NHS South Kent Coast CCG requested the opportunity to bring the attached report to the attention of this Committee.

(b) For reference, NHS walk-in centres offer access to a range of treatments. Walk-in centres are often open 365 days a year and outside office hours; patients do not need an appointment to access treatment (NHS England 2013).

(c) There are around seven million attendances at type 3 A&E services (walk-in centres, urgent care centres and minor injuries units) in England, dealing with minor illnesses and injuries (NHS England 2013).

(d) Walk-in centres have proved to be a successful complementary service to traditional GP and A&E services. However, they are not designed for treating long-term conditions or immediately life-threatening problems (NHS England 2013).

(e) The CCG will be taking a decision on the proposed changes before the Committee's next meeting in June. The CCH has offered to provide details of a named person who Members can contact if they have any concerns prior to the decision to being taken which will be circulated by Scrutiny Research Officer after the meeting.

2. Recommendation

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

Background Documents

NHS England, *NHS walk-in centres*, 27 February 2013
http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Walk-incentresSummary.aspx

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Health Overview and Scrutiny Committee

Friday 11 April 2014

Proposed changes at Folkestone Walk-in-Centre

1. Introduction

1.1. NHS South Kent Coast CCG is committed to ensuring that there is good quality out-of- hospital care for people living in the Deal, Dover, Shepway and Romney Marsh areas.

This includes providing consistent, reliable and equally accessible urgent care, no matter which part of South Kent Coast people live in.

1.2. The CCG is currently engaging with local patients and stakeholders to develop its commissioning plans for 2014 – 2019. Part of this engagement involves standardising the way in which treatment for minor injuries and illnesses is provided.

1.3. By making small changes to the service in Folkestone and bringing it into line with services provided in Dover and Deal, the CCG has recognised that it can provide a more equitable service to a broader range of people across the area.

It can also begin to divert some of its resources into better care for the frail and elderly through improved community services, particularly rapid response nursing teams.

2. Current service provision

2.1 In the majority of the South Kent Coast area, minor illnesses are treated at GP surgeries and through the out-of-hours GP service.

2.2 NHS South Kent Coast CCG currently commissions minor injuries services at Deal and Buckland Community Hospitals and at the Royal Victoria Hospital walk-in-centre in Folkestone. The key difference between minor injuries and walk-in-centre services is the additional provision of minor illness treatment.

3. The case for change

3.1 In July 2013, the CCG held a Shepway public engagement event, and urgent care was one of the key topics for discussion. A series of questions were put to the public to test both their understanding and overall satisfaction of current local services, including urgent care.

3.2 When asked: Do you think it is important that a professional treating you for a minor illness has access to your medical history, more than 80 over cent of people attending the event answered “yes”.

The walk-in-centre does not have access to patient medical history when clinically assessing / treating patients for minor illnesses. Therefore it would be more appropriate and safer for these patients to be treated at local GP practices or by the out-of-hours GP.

3.3 When asked: “Do you agree or disagree that patients who use A&E or MIU inappropriately should be redirected to more suitable services for their needs after clinical assessment”, more than 90 per cent answered “yes”.

Analysis indicates that the numbers of people who are likely to be redirected for minor illness from Folkestone if it becomes a Minor Injuries service, on any given day is around 14 patients across 17 GP practices. This would average between 0.3 and 1.6 additional new appointments per practice per day, depending on proximity to the walk-in-centre. This has been discussed with local GPs who agree that this level of increase is marginal and can be absorbed.

4. Key changes being proposed

These changes include:

4.1 Working with providers to redirect patients requiring treatment for minor illnesses to GP practices and the out-of-hours GP service.

4.2 Working with the out-of–hours provider (to ensure that they are fully able to deal with the potential increase in demand for their services). This service is also located in the hospital alongside the MIU and operates 7pm -10pm Monday to Friday and 9am-10pm at weekends.

4.3 Standardising the opening hours in Deal, Dover and Folkestone when patients can attend their local hospital for the treatment of minor injuries to between 8am and 8 pm.

4.4 Improving community services locally to enable the more vulnerable members of our community to be cared for safely in their own homes.

5. Benefits of the changes

5.1 As well as providing a safer and more appropriate way of treating patients with minor illnesses that is consistent across the South Kent Coast area, the CCG would free-up funding for investment in other services.

5.2 The CCG is committed to the expansion of the community rapid response service. This initiative forms part of the local Better Care Fund Plan which has jointly been agreed with Shepway and Dover District councils.

5.3 This investment in the rapid response service and other community nursing services will reduce the need for hospital admission for our most vulnerable patients.

6. Next steps

6.1 The CCG recognises that a small number of people may be unhappy with the proposed changes and is fully committed to engaging with those people, and working with them through service providers to alleviate those concerns.

6.2 The CCG intends to replicate the work they have initiated in Deal, where local GP members work closely with patients and other stakeholders to consider the range of local community based services which could be enhanced or delivered locally to reduce reliance on hospital care and increase the resilience of locally based health and social care.

The proposed timeline for the changes is outlined below:

Month	Action
April	• Changes presented to HOSC
May	• Joint engagement and communications plan agreed with KCHT and OOH provider (IC24)
June	• Engagement and Communication plan implemented
July	• Hours reduced (8am - 8pm)
July-September	• WiC begin to engage with patients on services better suited to their needs i.e. GP, pharmacy, self-care
July-September	• Ongoing involvement of local patients on changes to minor illness provision and co design of community based care
September	• Implement full change • Change WiC service to MIU service • Patients signposted following clinical triage to most appropriate service for their needs for example, GP, out-of-hours GP, pharmacy, self-care.

Further information

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 April 2014

Subject: East Kent Out-of-Hours Services

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on out-of-hours services.

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

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

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1. Introduction

(a) The East Kent Federation of Clinical Commissioning Groups (CCGs) has asked that the attached report be presented to the Committee. The East Kent Federation brings together the following four CCGs:

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

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

2. Recommendation

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

Background Documents

None.

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Meeting:	Health Overview and Scrutiny Committee
Date of Meeting:	11 April 2014
Subject:	Briefing Paper: Out-of-hours procurement
Action Required:	This paper is for information
Purpose:	To update the Health Overview and Scrutiny Committee on the pending procurement of east Kent's out-of-hours (OOH) GP service as part of the urgent care programme

1.0 Background

1.1 East Kent Hospitals University Foundation Trust (EKHUFT) has struggled to keep the number of patients seen and treated in A&E in under 4 hours above 95 per cent in quarters 3 and 4 during 2013/2014. An analysis of attendances to the accident and emergency department has highlighted a high proportion of patients are choosing to go to A&E for a range of conditions that would benefit from primary care interventions such as their GP surgery. Attendance profiles suggest that these attendances peak towards evenings and weekends.

1.2 Local analysis has highlighted of up to 40 per cent of attendances to A&E are patients presenting with conditions that could be seen and treated by GPs in their local area.

1.3 National studies undertaken by the Department of Health and NHS England have identified that urgent care services currently represent "a confusing and inconsistent array of services outside of hospital and high public trust in the A&E brand" *Sir Bruce Keogh (Medical Director, NHS England, 2013).*

1.4 A recent analysis of referral patterns with the 111 service has highlighted an increase in 999 calls where operators have referred patients to 999 directly rather than accessing local services.

1.5 A strategic goal of the East Kent's CCGs is to develop the integration of urgent care and long-term conditions strategies. This is intended to improve local services by providing better options for patients to access local care. The wider objectives of this programme are:

- Modernising and integrating services to wrap around patients' needs within their local community
- Reducing unnecessary attendances to hospital
- Promoting greater independence within the community

- A progressive approach to long-term conditions management within the CCGs
- Structured local initiatives for improving access to primary care and providing more care in patients' homes
- Successful hear and treat strategy within South East Coast Ambulance Service (SECAMB).

1.6 Neighbourhood Care Teams (NCTs) have been successfully implemented to provide social and community care locally. These currently provide:

- Outreach services in the community to support patients with long-term conditions
- A community service to ensure that patients retain independence.
- In-reach services to the acute site to support with navigation.
- Signposting to local community services.

1.7 CCGs are keen to develop their NCTs to provide a wider range of response services and access for patients.

1.8 In June 2013, local health economy providers came together to identify bottlenecks in the urgent care system. It was identified that common causes of delays in urgent care could be resolved.

2.0 Next steps in urgent care

2.1 A programme of work has been developed across east Kent. This will review and modernise the approach to urgent care provision and will have a greater focus on integration and local accessibility. Schemes to be developed include:

- Community geriatricians – providing a care of the elderly consultant working in the local community area to support frail patients who are at risk of falling under a shared care service plan.

- Streamlining discharge processes – to improve care home and residential home discharge pathways to hospital at weekends.

- Primary care hubs in A&E – providing primary care expertise to support patients arriving in A&E with primary care sensitive conditions. These are already in place within William Harvey Hospital (WHH) and the Kent and Canterbury Hospital (KCH). Plans around a primary care integrated model are currently being developed at Queen Elizabeth the Queen Mother (QEQM). This will be developed within the financial year.

- A new approach to health economy systems pressure management. Providers will use data analysis to forecast local hotspots and plan to mitigate service pressures.

- Integration of services in the community.

2.2 Projects for delivery over the next year:

- Review and enhancement of the GP OOH contract: This will provide a comprehensive review of the OOH service to provide a seamless 24/7 service, integrating with multiple providers to enhance support offered to care/residential homes and local resident with minor illness/primary care conditions out of hours. It will improve service responsiveness and reduce delays to provide better outcomes for patients.

- Integrated urgent care – east Kent CCGs are developing plans to integrate care providers across east Kent. This will provide a suite of multi-disciplinary services which will wrap around patients when they present to hospital to help them to access out of hospital care with minimal delays.

- Investment and development in new pathways of medicine to help patients to be seen, treated and discharged back home with an effective community support package on the same day.

3.0 Out-of-Hours

3.1 The current east Kent OOH contract operates between 18:30 – 08:00 hours across four CCGs; NHS Ashford, NHS Canterbury and Coastal, NHS Thanet and NHS South Kent Coast. This provides non-emergency primary care to patients either over the phone, at a contractually agreed base or in a patient's home. This contract is due to come to an end on 31 March 2015.

3.2 With the introduction of 111 in July 2013, it was recognised that advice and guidance would decrease and the current contract was amended accordingly. However, during recent data analysis, it has become evident that the current OOH service is underutilised. Local factors have influenced emergency demand, including:

- Fragmentation between 111 and the OOH provider
- Fragmentation between OOH and A&E
- Ease of access to timely care within the local A&E environment.

3.3 An OOH working group has been created to look at current issues, key deliverables and to support the design of a service specification to procure a new OOH service. The group recognises that:

- A clear pathway that includes all services from 111 through OOH, primary care and A&E needs to be developed. The general aims of this pathway will be to reduce A&E activity and increase the number of calls being directed to primary care OOH first time and the number of patients seen in their local community.
- Caps on referrals need to be removed in order to improve productivity.
- The existing OOH service needs to be urgently reviewed to maximise value and optimise its use, including 111 interface and productivity.

3.4 The work undertaken by this group will agree a specification which will inform a procurement aimed at integrating services to maximise efficiency and improve patient experience across east Kent.

3.5 To support the evaluation of tenders following procurement, the evaluation panel will include of impartial clinicians, operational staff and patient representatives.

4.0 Progress of the OOH procurement

4.1 A working group including clinical leads and CCG support staff and lay representatives from all four CCGs has been initiated to support the development of key principles and to draft a delivery model for the east Kent OOH service. So far outputs from the group have been:

- Development of a service model's supported by key principles
- To identify the right models to support each CCG, both in terms of commissioning approach and options for service
- Options will be developed to provide high level service principles and scope for local variation to best support the local requirements within each Clinical Commissioning group.

4.2 An action plan has been put in place to present these options to each CCG to ensure that the program delivers their plans as a key element of developing out of hospital care with 8am to 8pm delivery.

4.3 CCGs are currently considering options to align the procurement of the OOH service to coincide with the 111 procurement in 2016. This will integrate our key services for primary care response out of hours. This approach has been recognised nationally as best practice as referrals from 111 to A&E are higher with a fragmented service.

4.4 The public engagement team will be supporting the process and liaising with local patient groups to inform the design of the service model.

5.0 Next steps with the OOH procurement

5.1 A contract variation with the current provider is being sought with the OOH service whilst procurement options are agreed.

5.2 The OOH working group will explore co-locating within A&E and Minor Injury Units to:

- Enable faster handover of patients
- Encourage more throughput
- Generate greater economies of scale for the CCGs alongside the operational interdependencies of OOH and 111
- Better integrate key services.

5.3 Key performance indicators and service measures will be explored to support each CCG's data requirements and agree a reporting mechanism.

5.4 Links will be made with other urgent care initiatives and community projects to ensure interdependencies are recognised and included in service outputs.

5.5 A service specification for OOH will be developed for consultation and will be ratified under each CCG's clinical board as well as patient reference groups.

6.0 Recommendation:

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

For further information and questions, please contact:

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 11 April 2014

Subject: East Kent Outpatients Consultation: Written Update

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

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

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

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1. Introduction

(a) Representatives from East Kent Hospitals University NHS Foundation Trust initially attended the Health Overview and Scrutiny Committee on 7 June 2013 to discuss the Trust's developing clinical strategy.

(b) The outpatients' strategy was one of the areas of particular focus during this meeting. The recommendation agreed by the Committee on 7 June 2013 was the following:

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

(c) On 11 October 2013 the Committee considered a written update provided by East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group. At the conclusion of this item, the Committee agreed the following recommendation:

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

(d) Dr M Eddy, Mr R Latchford, OBE and Councillor Michael Lyons formed a working group to read and comment on the draft consultation document.

(e) The intention is for this item to return to the Committee at its June meeting.

2. Summary of the Consultation

(a) Towards the end of 2010, East Kent Hospitals University NHS Foundation Trust (EKUHFT) began work on developing their clinical strategy. Four work streams were established:

- Emergency care;
- Trauma;
- Outpatients; and
- Planned care.

(b) The consultation covered part of the outcomes of the work from the Out-Patient Clinical Strategy Group. The public consultation ran from 9 December 2013 to 17 March 2013 (extended from the original date of 9 March). The results of the consultation will be analysed independently by the University of Kent and then proceed for decision by the Boards of Canterbury and Coastal CCG and EKHUFT.

(c) The core proposals within the consultation involve consolidating outpatient services from the current 15 sites to 6. 5 of these sites are those owned by EKUHFT:

1. William Harvey Hospital, Ashford;
2. Kent and Canterbury Hospital, Canterbury;
3. Queen Elizabeth The Queen Mother Hospital, Margate;
4. Buckland Hospital, Dover; and
5. Royal Victoria Hospital, Folkestone.

(d) The sixth site is to be in the north Kent coast area. Several sites are considered, with the consultation document naming Estuary View Medical Centre as the preferred option.

(e) Based on travel times for patients in Canterbury and Coastal, Thanet, Ashford and South Kent Coast CCG's areas, choosing these six sites (including Estuary View) will lead to an increase in the percentage of patients within a 20 minute drive of outpatient services than is currently the case (83.5% compared to 70%).

(f) NHS Canterbury and Coastal agreed to partner EKUHFT on the consultation. Ashford, Thanet and South Kent Coast CCGs decided that they would be consulted by the Trust on the proposals.

(g) A couple of other service developments are mentioned in the consultation document, but were not covered in the consultation. NHS South Kent Coast CCG is separately working on services to be provided from Deal Hospital. NHS Swale CCG is also separately commissioning a one-stop outpatient centre in the Sittingbourne area, creating a seventh site for outpatient services. According to the business case for the outpatients clinical strategy the seventh site, along with service innovations, is key to realising the benefits of the strategy.

3. Recommendation

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

Background Documents

Minutes, Health Overview and Scrutiny Committee, 7 June 2013
https://democracy.kent.gov.uk/mgAi.aspx?ID=25151

Minutes, Health Overview and Scrutiny Committee, 11 October 2013
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5075&Ver=4

Consultation on Outpatient Services in East Kent, East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group.

Outpatients Clinical Strategy Full Business Case, East Kent Hospitals University NHS Foundation Trust

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Kent Health Overview and Scrutiny Committee April 2014

Progress report on the Outpatient Consultation in east Kent on behalf of East Kent Hospital University Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group

1. Background

1.1 East Kent Hospital University Foundation Trust (the Trust) currently provides a comprehensive range of general outpatient services from its three acute sites: the William Harvey Hospital in Ashford (WHH); Kent and Canterbury Hospital, Canterbury (KCH); and the Queen Elizabeth the Queen Mother Hospital, Margate (QEQMH). Outpatient services are those where a patient attends a hospital or clinic but does not stay overnight. These services may include a consultation with a clinician, diagnostic tests such as phlebotomy, X-ray or MRI and a treatment plan being discussed, or treatment being given. The Trust also provides a range of general outpatient and diagnostic services from the Royal Victoria Hospital Folkestone (RVH) and Buckland Hospital Dover (BHD) and a number of community hospitals which include Faversham Cottage Hospital (FH), Whitstable and Tankerton Hospital (W&T), Queen Victoria Memorial Hospital in Herne Bay (QVMH) and Victoria Hospital in Deal (VHD).

1.2 In addition to these the Trust has delivered a range of "specialty specific" outpatient services throughout the local area in various facilities owned by other Trusts and at GP surgeries. These specialty specific outpatient services include dermatology, paediatrics, obstetrics and midwifery services, renal, therapy clinics and neurological nurse-led clinics, and have grown out of various arrangements over the years.

1.3 As part of a wider clinical strategy, over the last two years, the Trust has reviewed its outpatient services with staff and patients and a wide range of stakeholders to see how the Trust could improve the quality of care and offer greater local access to services. Recognising that the NHS and all public services are being challenged to make the 'best' use of resources the Trusts' proposals are to:

- reduce the number of facilities used from 15 to concentrate services on six sites offering a much wider range of outpatient services across all specialities including diagnostic support
- extend the clinical working hours from 7.30 a.m. to 7.00 p.m.to offer better access to patients, and make more effective use of staff time including offering Saturday clinics 9 a.m. to 11.30 am
- invest in the clinical environment to support high quality clinical services and offer a comfortable patient experience in a welcoming environment at all six facilities
- develop the one-stop approach across more services, this is currently offered in breast surgery, urology and dermatology and

- expand the use of technology such as telehealth and telemedicine to reduce unnecessary follow up appointments and support patients monitoring their progress at home or in a GP practice.

1.4 In response to concerns about transport the Trust is also working with bus companies on proposals to improve the local public transport network to support better access to services.

2. Early engagement in development of the Outpatient strategy

2.1 From the beginning the review has been led by the outpatient department working closely with their clinical colleagues and has involved a broad range of staff. The staff have worked hard over a two year period to engage a broad range of stakeholders including GPs, local authorities, voluntary and community sector organisations, patient and carers groups and of course the Trust's governors and members to test out ideas and develop plans based on the feedback received. Over the past two years the Trust has attended or hosted 130 meetings to discuss the plans and listened to approximately 4,000 stakeholders.

2.2 In 2011 the Trust conducted a survey of 2,000 patients to assess what patients would like to see in terms of the clinical appointments times, out of hour's services, how they currently travelled to appointments. This was to test the likelihood of patients traveling routine further if they could access more services and be offered a one-stop service. The 1,650 responses to the survey showed that respondents would appreciate a wider range of opening times than 9 – 5 p.m.

Respondents	Early	Daytime	late	Saturday Yes	Saturday No
Men	230	401	78	558	136
Female	249	591	113	763	172
Total	480	996	191	1321	308
Percentage	29%	60%	11.5%	81%	19%

The respondents also showed a strong reliance on car travel as a means of travelling to their appointments:

- 80 per cent of respondents travel by car
- 9 per cent by bus
- 1 per cent by Patient Transport Service
- 5 per cent walk
- less than 1 per cent travel by train and
- 3 per cent use another form of travel.

2.3 Seventy-nine per cent would be prepared to travel further if they could receive all their consultation with a clinician and diagnostic tests and treatment plan in one single visit.

2.4 These results were tested again on a smaller scale with 200 patients in May 2013 to check that patients' requirements and the views remained the same. The Trust also conducted a broader postcard survey (5,000 distributed) in September 2013, with 1,000 respondents who were asked an open question about what patients would like improved.

Common themes included:

- reducing waiting time for appointments
- improving the timing of clinics
- having adequate seating
- better parking
- tea/coffee facilities.
-

2.5 This postcard survey also showed that more than 90 per cent of the patients who responded were in favour of having their assessment, diagnostic tests and treatment plans on the same day and 80 per cent were in favour of extended outpatient clinic hours, in mornings, evenings and weekends.

2.6 Collectively the results of the patients' surveys and the discussions with stakeholders have informed the proposals for improving outpatient services.

2.7 The clinical commissioning groups (CCGs) have, throughout their shadow phase, been key stakeholders who have been part of the early engagement with the Trust discussing their plans with their membership and governing bodies as they developed. All four CCGs have helped raise awareness of the consultation process and attended the meetings which took place during the consultation process to listen to the discussions. Of the four, only NHS Canterbury and Coastal CCG (The CCG) has been actively involved in the formal consultation process and attended all of the public meetings (held in their area) to listen to peoples' views and respond to questions raised. They along with the Trust will take account of the responses received and the independent report from the University of Kent before taking a decision on the way forward.

3. Consultation

3.1 The consultation on outpatient services took place from 9 December 2013 to 17 March 2014. The consultation was extended (from the original closing date of 9 March) to allow for requests for additional meetings in Herne Bay and Faversham, which took place on 13 March 2014.

3.2 Throughout the consultation a range of methods have been used to promote the consultation process including:

- Advertisements in December and January were placed in local papers and online via the Kent Messenger newspaper group across east Kent with a combined circulation of 119,914 and an estimated readership of 395,340.

- Two BBC Radio Kent interviews (Stuart Bain CEO, MP Sir Roger Gale, MP Gordon Henderson and campaigners took part)
- News items on BBC South East and Meridian at launch and subsequently on 13 March 2014 covering the second public meeting at Herne Bay.

- Adverts or articles in Clinical Commissioning Group newsletters, HealthWatch alerts and various patient and voluntary groups' newsletters.

- 3,005 emails were sent to local councilors, MPs, health network members (local people and organisations who have registered an interest in health and working with their local clinical commissioning group), voluntary and community organisations, NHS organisations, professional committees, local authorities, patient reference groups, patient participation groups, carer organisations and HealthWatch Kent with a request to consider the information and respond as well as a request to pass the information on.

- The Trust website had a dedicated online site http://www.ekhuft.nhs.uk/patients-and-visitors/consultation-on-outpatient-services/ with all the information available and NHS Canterbury and Coastal Clinical Commissioning Group website had suitable links to the Trust website. Social media such as Facebook and twitter was also used to promote the consultation.

- It was a standing item on NHS Canterbury and Coastal Clinical Commissioning Group governing body meetings held in public from December 2013 to March 2014.

- 500 posters on display, 3,000 full consultation documents and 14,000 summary documents were distributed to GP practices, hospital waiting areas, all outpatient clinics, libraries, community centers; gateway centers pharmacies and local councils across east Kent. They were also available at focus groups, public meetings and patient meetings or events that the Trust and engagement team were invited to attend. (Four HOSC members were given the early draft to comment upon).

- To enable access and encourage a broad response consultation documents were available in large print and an easy read version for people with communication difficulties which were available online and at every meeting.

- The Trust staff and KMCS engagement team were invited to attend six patient groups who requested more information to answer any questions and enable patients and carers to respond to the consultation. The Trust also went to Dover Adult Strategic Partnership and the Thanet District Council Scrutiny Committee.

- An online email address and telephone number has also been given so that people could request additional information, ask questions or request copies of the consultation document.

4. Public conversation

4.1 During the consultation there were a series of 12 public meetings held at varied times. These were advertised as part of the whole consultation detailed above.

4.2 Generally at these three hour public meetings Liz Shutler Director of Strategic Development and Capital Planning and Marion Clayton Divisional Director, Clinical Support Services presented information on the proposals, the reasons for it, the principles for improving services, the early engagement which influenced the strategy, the outcome expected of the proposals, the steps taken during the review, the options considered for the sixth site on the north Kent coast, potential improvements in bus transport routes and how people could contribute their views.

4.3 This was followed by half an hour open question and answer session, then an hour of detailed round table discussions looking at the principles for improving services, the plan for reducing sites from 15 to 6, the options for the sixth site and the criteria and findings of the Trust, and the potential for improvement via the one-stop shop approach and wider use of technology. Every part of those conversations both the question and answer session and the round table discussion were recorded and collated and have been logged and sent to the University of Kent for the independent analysis of all responses.

4.4 At a few of the meetings the number of people attending was so large that there wasn't enough space to safely accommodate the round table discussions. Instead, an extended question and answer session was held, followed by staff remaining to talk to individuals and answer any remaining questions. The Trust, with representatives of the CCG for public meetings in the Canterbury and Coastal area, have supported the process by ensuring a generous number of staff from the front line as well as the executive were available to listen to people and answer their questions.

4.5 At each meeting there were evaluation sheets to learn how the events had worked for people. The agendas allowed people to put forward written questions if they didn't want to raise them during the meeting and there were copies of both the full consultation document and summary document for people to complete to take away for friends and family.

4.6 Throughout the review the NHS has taken care to reach those communities of need who have expressed an interest in the review. In addition to the public meetings, the University of Kent has conducted four focus groups with people from distinct communities of need including those with learning disabilities, mental health service users, people with

physical disabilities and people for whom English is a second language, to ensure their views on outpatient clinics were included in the consultation. The University worked with four local organisations in east Kent to facilitate these focus groups and we would like to thank them for their support.

4.7 As part of the consultation there was an open offer to attend any group or organisation that would like to know more and preferred that Trust staff and the engagement team to come to their meeting rather than attend the public meeting. Seven different patient and community groups took up this offer and their views have been recorded and sent onto the University for analysis.

5. Response levels

5.1 People have been able to contribute their views in a range of ways from writing an email or letter, completing a survey either online or on paper, or attending a meeting or focus group. Two petitions have been received one from the Herne Bay Labour Party with 450 signatures and a further petition was presented at the first public meeting in Herne Bay with 326 signatures.

5.2 There have been 41 telephone enquiries, 40 emails and letters, 273 online surveys and 205 paper surveys have been received.

5.3 The numbers attending these events has varied at the early meetings few people came to the December meeting in Hythe, partly due to a clash with the busy Christmas period and consultation fatigue. But as the consultation progressed across the whole of east Kent the interest increased. Overall approximately 1,330 people attended 12 public meetings, and a further 39 took part in four focus groups, with approximately 100 at the additional meetings we attended.

5.4 As expected the attendance has been highest in the five events in Herne Bay, Deal and Faversham where a mixed audience of MPs, councilors, campaigners, patients and interested citizens have had vociferous discussions about the proposed options, and heard some of the patient concerns about the future of the community hospitals, patients positive experience of services, their praise for staff and concerns about travel issues.

5.5 The local media have also been regularly updated via press releases and news statements. Both the broadcasting media and local newspapers have featured the consultation proposals and 64 articles appeared. In the main the articles encourage people to have their say on the consultation and to attend meetings. Others include MP Charlie Elphicke's survey about Deal hospital, MP Sir Roger Gale urging people to 'rally to the defence' of the QVM, Herne Bay, or campaigners calling on people to challenge the plans particularly where they feared the impact on their local community hospital. Certain newspapers were supporting the campaign at

Herne Bay and Faversham. The Trust spokespeople were featured setting out the benefits the expanded services will bring, and the transport link plans to improve access. Some articles featured the public reaction at meetings and others the political debate between parties and 48 letters were published continuing the debate or expressing concerns.

5.6 Across these differing means of engagement 2,000 people have been directly involved in the consultation on outpatient services with a much higher number having heard about it through the media coverage and online social media.

6. Next steps

6.1 The responses have all been logged during the consultation from phone calls and email enquiries for information, to seven personal visits, four focus groups and twelve public meetings. A total of 273 online surveys have been submitted, 205 paper surveys have been received and several stakeholders have sent in written submissions. These have all been sent to independent researchers from the University of Kent who will collate and analyse all of the information and report to the East Kent Hospital University Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group.

6.2 In April the Trust and NHS Canterbury and Coastal Clinical Commissioning Group will visit the four potential sites being considered for the sixth clinical site on the north Kent coast. They have requested up to date information from NHS Property Services so that the two organisations can look again at the options and re-appraise them with updated information. We would welcome two members of the HOSC attending to observe the process so that they able to offer their fellow Members and the public assurance that due process has been followed.

6.3 Both organisations will return to the HOSC in June to discuss the findings and their proposals to act upon the information, before both organisations take their final decision later in June.

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