HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 18th July, 2014

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 18th July, 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, MBE, 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 C P D Hoare
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 J Burden, Councillor R Davison and Councillor Mr M Lyons

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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 - 6 June 2014 (Pages 5 - 16)

4. Kent Health & Wellbeing Board: Update and Strategy (Pages 17 - 26) 10.00

5. Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy (Pages 27 - 38) 10.45

6. CQC Inspection Report and Royal College of Surgeons Report: Maidstone Hospital (Pages 39 - 122) 11.30

7. Patient Transport Services (Pages 123 - 128) 12.00

8. Faversham Minor Injuries Unit (Pages 129 - 142) 12.45

9. Future of Services at Dover Medical Practice (Pages 143 - 154) 13.30

10. Date of next programmed meeting – Friday 5 September 2014 at 10:00 am

Proposed items:

- Medway NHS Foundation Trust: Update
- NHS England: General Practice and the development of services
- East Kent Outpatients Services

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

10 July 2014

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 6 June 2014.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mr N J D Chard, Mr A D Crowther, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr C P D Hoare, Mr A J King, MBE, Mr S J G Koowaree (Substitute) (Substitute for Mr D S Daley), Mr G Lymer, Mrs P A V Stockell (Substitute) (Substitute for Mrs A D Allen, MBE), Cllr P Beresford, Cllr R Davison and Cllr M Lyons

ALSO PRESENT: Cllr Mrs A Blackmore, Mr S Inett and Mr M Ridgwell

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

UNRESTRICTED ITEMS

40. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item)

(1) Mr Nick Chard declared a Disclosable Pecuniary Interest as a Director of Engaging 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.

41. Minutes - 11 April 2014
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken:

(a) Minute Number 35 - Redesign of Community Services and Out-of-Hours Services – Swale. NHS Swale CCG had been asked for the proposed dates for procurement, public consultation and the board meetings to enable the development of a timetable to be agreed between HOSC and NHS Swale CCG. A response was awaited.

(b) Minute Number 36 - Folkestone Walk-In Centre: Written Update. a response from NHS South Kent Coast CCG regarding engagement activity in Deal on 24 April had been circulated to Members of the Committee.

(c) Minute Number 38 - East Kent Outpatients Consultation: Written Update. The Chairman had written to EKHUFT to clarify concerns

raised regarding the redeployment of non-clinical staff prior to the independent analysis of the consultation. A response had been circulated to the Committee on 5 June 2014.

(2) RESOLVED that the Minutes of the Meeting held on 11 April 2014 are correctly recorded and that they be signed by the Chairman.

42. Membership
(Item 4)

(1) The Committee noted that:

(a) Mr Hoare had replaced Mr Latchford as a UKIP representative on this Committee.

(b) Mr Elenor had replaced Mr Crowther as the UKIP group spokesperson on this Committee.

(c) Cllr Burden (Gravesham Borough Council) had replaced Cllr Woodward (Tunbridge Wells Borough Council) as a borough representative on this Committee.

(d) Cllr Davison (Sevenoaks District Council) had replaced Cllr Spence (Tonbridge & Malling Borough Council) as a borough representative on this Committee.

43. Community Care Review: NHS Ashford CCG and NHS Canterbury & Coastal CCG
(Item 5)

Simon Perks (Accountable Officer, NHS Ashford and NHS Canterbury and Coastal CCGs) was in attendance for this item.

(1) The Chairman welcomed Mr Perks to the meeting and asked him to introduce the item. Mr Perks thanked the Committee for the opportunity to present the community care review undertaken by NHS Ashford CCG and NHS Canterbury and Coastal CCG.

(2) Mr Perks noted that he had recently attended the NHS Confederation conference; a major theme of the conference had been the importance of community services. The review of health and social care services provided within a community setting was the CCGs response to this challenge.

(3) He explained that NHS Ashford CCG and NHS Canterbury and Coastal CCG were committed to providing health services closer to people's homes. The CCGs had inherited a significant number of community-based contracts covering a number of different services. To ensure that these services were high quality, value for money and fit for the changing health needs the CCGs had initiated a review of a cross-section of these services. The review was carried out in the broader context of tighter healthcare budgets and an ageing

population. It had been acknowledged that efficiencies would not meet these needs; new ways of care, both formal and informal, would need to be introduced. A joint appointment of a programme manager had been made by the CCGs and Kent County Council to lead this work. Mental health and children's services were excluded to make the scope of the project manageable.

(4) The review focused on actions which could be taken tactically to remove duplication of payments (without directly affecting services) and the strategic options for improving the commissioning of community-based services. Five work streams were identified:

1. Contracting and Procurement
2. Customer and Market Analysis
3. Finance and Information
4. Patient and Public Engagement
5. Quality and Safety

(5) Two key findings of the review were highlighted. Physiotherapy services were predominately used by adults of working age rather the frail and the elderly. More community spend did not mean better outcomes or improved patient experience; Canterbury spent more than £10 million on community services than Ashford but the quality of service was found to be the same.

(6) Community services principles were established, based on the findings of the review, to underpin commissioning of community-based services in the future. The principles were service development; market development; contracting and procurement; and performance management.

(7) A draft framework for commissioning community-based services was developed to ensure that health, social care and voluntary services were based around individuals and the communities they live and work. The framework had been termed Community Hubs and would be based around clustering of GP practices and local communities which the CCGs service. The CCGs would commission an integrated suite of health, social and voluntary services from local providers within a defined budget with more service-user centric outcomes. Selection and design of these services would be carried out in partnership with local patients, services users, provider and partner organisations. The services provided would be based on the needs of each local population.

(8) The concept had been well regarded by the CCGs' partners, providers and patients. The intention for the project was to move from the exploratory and high-level design phase into the localised detailed design and implementation phase of the community hubs. A high level implementation plan had been developed which set out a timescale and funding. It was estimated that £80 million (out of the current £400 million CCGs' funding) would be required by 2016/17 for Community Hubs.

(9) The Chairman asked Dr Eddy and Mr Crowther to comment on their visit to Victoria Memorial Hospital in Deal on 29 April with representatives from NHS South Kent CCG and Kent Community Health NHS Trust. The visit was

arranged for Members to gain a better understanding of the nature of the site and the services currently provided as well as have the opportunity to hear about how commissioning plans for developing community and outpatient services on the East Kent Coast were developing. Dr Eddy had found the trip to Deal Hospital very helpful. There had been discussions around potential services which could be provided at the hospital, these had yet to be confirmed. Mr Crowther found the visit to be interesting and informative; he was disappointed that only two Members attended.

(10) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A question was asked about the involvement of local elected Members in the review. It was explained that the CCGs had learnt a lot, following the situation at Faversham MIU, regarding the importance of involving The CCGs' now viewed elected Members as key stakeholders and wanted them to be involved in the process.

(11) A number of comments were made about the 'well' consuming a high proportion of community services and a higher community spend not leading to better outcomes. It was recognised that the CCGs needed to carry out more detailed analysis before commissioning in order to have a greater understanding of the need in their areas. It was recognised that commissioning should not be done in isolation as resources were scarce and it was difficult to map.

(12) A number of questions were asked about the development of community services in Ashford including the introduction of an x-ray facility. It was explained that the CCGs needed to explore the development of a community hospital in Ashford. The CCGs were looking to develop a community hubs at the William Harvey Hospital and the Kent and Canterbury Hospital which would enable the provision of acute and community services at the same site. The provision of an x-ray service to a small population would be economically very difficult; a potential option for Faversham MIU had been found.

(13) In response to a specific question about the implementation of the community hubs. It was recognised that it would take time to develop and implement the complex health and social care community-based services. The importance of moving services out of acute hospitals into the community was also stressed. A Member commented that they had felt a sense of déjà vu but believed that the CCGs were moving in the right direction.

(14) A Member highlighted a case which had been brought to their attention regarding access to equipment. It was acknowledged that long waits were associated with accessing equipment. This issue needed resolving as long waits could result in patients' requiring the use of acute services.

(15) A number of comments were made about co-funding, community services data, patient transport services and the style of the paper. It was acknowledged that co-funding was difficult as the CCGs were only responsible for the funding of NHS services. Partnership arrangements with social care and the voluntary sector were extremely important to develop community hubs. It was explained that there was only a limited amount of data held on community services; the CCGs were exploring ways to centralise community

services data. The importance of patient transport services was recognised and would be included in future designs. It was noted that the paper was written with the help of a management consultant.

(16) RESOLVED that:

(a) Mr Perks be thanked for his attendance and contributions to the meeting along with his answers to the Committee's questions.

(b) NHS Ashford CCG and NHS Canterbury & Coastal CCG be invited back to the Committee in the autumn to provide an update.

(c) A written update on the design of the community hubs to be produced by the CCGs and circulated to Members informally.

44. East Kent Outpatients Services: Consultation Update

(Item 6)

Simon Perks (Accountable Officer, NHS Ashford and NHS Canterbury and Coastal CCGs), Liz Shutler (Director of Strategic Development & Capital Planning, East Kent Hospitals University Foundation Trust), Rachel Jones (Director of Business and Strategy Development, East Kent Hospitals University Foundation Trust) and Marion Clayton (Divisional Director, Surgical Services, East Kent Hospitals University Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Shutler introduced the item and proceeded to give a presentation which covered the following key points:

- The Trust's justifications for change
- Consultation and engagement process
- Feedback from patients
- Outpatient Services Strategy
- The six proposed Outpatients sites
- Option appraisal for the North Kent site
- Next steps - decision-making at the EKHUFT and CCG boards

(2) The Chairman asked Miss Harrison to comment on the optional appraisals which she attended on behalf of the Committee on 22 April and 29 May. Miss Harrison observed that she had been impressed and surprised by the thoroughness of each appraisal. The final option appraisal in May was held following the receipt of information from NHS Property services.

(3) Mr Inett was also invited to comment. He explained that Healthwatch Kent had been working with the Consultation Institute; they had been using the consultation as a test case to look at their role as a critical friend. The focus of the consultation by the Trust had been on Landsley's four tests for service reconfiguration. Mr Inett highlighted that if there was a legal challenge, the Gunning Principles would be applied instead. One of the Gunning Principles was that consultation must take place when the proposal was still at a formative stage. Mr Inett requested additional information regarding the

public's involvement in option development. He also sought clarification about the support for six outpatients' clinics (question 7 on page 59 of the agenda pack) and the involvement of minority groups in focus groups. Mr Inett commented that the consultation focused on the North Kent site and that Healthwatch had been made aware of concerns from the public regarding the effectiveness of the one stop shop process. Healthwatch Kent was looking at one stop shops across the country. Healthwatch Kent were meeting with the Trust to discuss issues in detail.

(4) Ms Shutler responded to the comments and questions raised by Mr Inett. It was explained that the six sites were modelled technically looking at patients, travel times and demographics of the local communities. Patient and professional representatives were on the working group which developed the outpatients' strategy; patient surveys and public stakeholder meetings were also held. Concerns had been raised by elderly groups about the time appointments would take and facilities at the one stop shop. The Trust stated that giving more power to patients to book appointments would improve the flow and patient experience. The Trust commissioned the University of Kent to undertake the focus groups; the outcomes of these focus groups were detailed in the report. During the consultation period, the Trust was able to talk to other minority groups including the Nepalese community in Hythe. Ms Shutler indicated that she could provide further details to Mr Inett at their meeting.

(5) Members of the Committee then proceeded to ask a series of questions and made a number of comments.

(6) Members raised concerns about the Trust's investment of £455,000 to extend and modify public transport routes provided by Stagecoach. It was explained that the Trust had been in lengthy discussions with Stagecoach about additional services; Stagecoach had not been willing to look at additional routes without additional funding. The majority of the funding would be going to Stagecoach to provide additional routes. Details of voluntary sector transport services would be made available to patients in their information pack when booking appointments. In relation to a specific question about transport links in Deal and Walmer; it was acknowledged that the number of buses which run from Deal to Buckland Hospital per hour would be doubled. There was also a proposed route from Whitfield to Buckland Hospital which would run on to Deal, Sandwich and the QEQM Hospital. The Trust acknowledged the need to improve and invest in public transport; at present 80% of the Trust's patients travel by car to their outpatient appointments. The Trust was working with the current patient transport service provider to improve their response rate.

(7) A Member enquired about the quality of communication with patients. As part of the outpatients' consultation, patient administration services had been reviewed. The Trust had found issues with communication with patients and was looking to improve this aspect of their service. It was confirmed that letter writing had not been outsourced to a foreign company; letters were written by Trust staff locally.

(8) A Member expressed concerns that patients in Deal would have an increased journey time to outpatients' services as set out in the proposals. It was

explained that under the proposals the number of patients from Deal, who would be able to access care within the time frame, would increase. Residents in Deal generated 30,000 outpatient appointments a year, a third of these appointments (10,000) took place in Deal Hospital. 90% of appointments at Deal Hospital were follow-up appointments; patients would not access their entire pathway at the hospital.

(9) The Member raised a further concern that the residents of Deal had been misled in a previous consultation regarding Buckland Hospital and the service provision in Deal. It was explained that the consultation being referred to was a consultation on service provision in Dover which was led by East Kent Primary Care Trust in 2006. The consultation document looked at three options for outpatient services: services being provided as close to home as possible in a GP surgery or in a central Dover location; moving services from community to acute hospitals; and maintaining services at all sites including at Deal Hospital. The majority of respondents chose option G1 – providing services as close to home as possible in a GP surgery or in a central Dover location. Ms Shutler stated that she felt that this was a very clear consultation exercise. As a result of the 2006 consultation, East Kent Hospitals University Foundation Trust invested £23 million to develop a new hospital at the Buckland site.

(10) A number of comments were made about the consultation events, patient mobility and the capacity of the proposed system. The Trust offered to provide the Committee with data regarding outpatients accessing patient transport services. It was acknowledged that capacity was currently underutilised. Under the proposals, the working day would be extended which would increase the utilisation of the buildings and enable patients a greater choice of appointments. The workforce would be maximised and provide a more efficient service as staff would not be required to drive to 15 different sites. The Trust had forecasted demographic growth as part of future proofing and was confident the service would not be over capacity in the future.

(11) The Trust asked in their report for the Committee to 'agree that the public consultation process has met the required standards as set out in the Health and Social Care Act'. The Scrutiny Research Officer was asked to provide guidance on the recommendation. She explained that the legal duty to consult local authority health scrutiny bodies was distinct from the separate duties in the NHS Act 2006 (as inserted by the Health and Social Care Act 2012) on Trusts, CCGs and NHS England to involve service users in the development of proposals for service change; and it was important that the two duties were not confused or conflated. She stated that a recommendation, asking the Trust and CCG to take on board the comments made by Members during the meeting, would be more appropriate.

(12) RESOLVED that:

(a) The Committee records its appreciation of the hard work the Trust has put into the consultation.

(b) The comments made by Members of the HOSC are considered and taken into account.

(c) The Committee asks for a return visit in September when a final decision has been taken.

45. Interim Centralisation of High Risk and Emergency General Surgery at Kent and Canterbury Hospital
(Item 7)

Liz Shutler (Director of Strategic Development & Capital Planning, East Kent Hospitals University Foundation Trust), Rachel Jones (Director of Business and Strategy Development, East Kent Hospitals University Foundation Trust) and Marion Clayton (Divisional Director, Surgical Services, East Kent Hospitals University Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee and asked them to introduce the item. Marion Clayton began by updating the Committee on the Trust's service reconfiguration of adult high risk and emergency general surgery.

(2) A broad definition of high risk surgery was given: patients with a predicted mortality rate of 5%; patients undergoing emergency abdominal procedures, major gastric and bowel surgery; patients over 50 undergoing emergency redo surgery; and acute patients with comorbidities including renal, cardiac, respiratory and thoracic conditions. A number of examples were identified including laparotomy, removal of the spleen, gall bladder and appendix.

(3) Members were reminded that the Trust had presented their clinical strategy to the Committee in June 2013. A number of options for the provision of high risk and emergency general surgery were presented to the Committee including the centralisation of surgery and a potential hub and spoke model.

(4) In 2012 the Trust invited the Royal College of Surgeons (RCS) to assess and review surgical service provision. The RCS had found that the Trust was not providing a continuity of care for patients due to the provision of high risk surgery at three acute sites with different on call models and a mix of appropriately skilled substantive and locum surgeons. The RCS made a number of recommendations including the provision of continuity of care for patients and the recruitment of substantive posts.

(5) The Trust took on board the recommendations and identified the need to centralise high risk surgery at the Kent and Canterbury Hospital on an interim basis with a robust on call service. This would enable the Trust to provide continuity of care and expertise on a single central site. In January 2014, the Trust began a review into how this model would be delivered. A number of significant risks were identified including the transfer of patients to a central hub in Canterbury; the provision of beds in the Intensive Care Unit (ICU), the High Dependency Unit (HDU) and wards; and the requirement for additional theatre space. The Trust concluded that the centralisation of surgery would not meet the timescale for implementation.

(6) An interim solution was presented to the Trust Board by surgeons from the William Harvey Hospital and the Queen Elizabeth Queen Mary Hospital. The surgeons proposed a 1 in 8 model with 8 surgeons with the appropriate skills at each site providing an on call Monday – Friday rota.

(7) The Trust identified a number of risks with the proposed model; there were concerns that, without additional recruitment, patients would not receive continuity of care from a consultant with the appropriate skills. The Trust revised the proposal to a 1 in 8 model on a 4:3 split. Dedicated emergency surgeons with the appropriate level of skill would provide emergency surgery on Monday – Friday; the same model and level of service would be provided from Friday – Sunday. This would enable the Trust to increase the numbers of surgeons and remove the non-gastrointestinal surgeons (breast and thyroid) from the rota.The Trust was also looking to introduce a consultant led surgical assessment unit.

(8) The Trust identified six additional posts for gastrointestinal surgeons with additional skills. Interviews for colorectal surgeons were held in June. Four substantive colorectal surgeons were appointed and would start in September; three surgeons at William Harvey Hospital and one surgeon a Queen Elizabeth Queen Mary Hospital. The advertisement for upper gastrointestinal surgeons would be published in June and interviews would be held in July. The 1 in 8 model on a 4:3 rota would be implemented by the end of the year. The Trust stated that this was a temporary solution and the programme for a longer term solution was continuing. Thirteen work streams had been developed and were being led by a senior clinical lead.

(9) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A Member raised concerns about the provision of all high risk general emergency and high risk elective surgery on one site. A Member explained that he had raised similar concerns about the centralisation of vascular surgery. It was explained that there were a number of services where patients had to travel distances for care; patients in East Kent requiring highly specialised tertiary services such as neurosurgery were transported to London for care. On call surgeons were required to get to the hospital within a specific timescale. Highly specialised teams at registrar level were always available on site to prepare patients for surgery. It was not affordable to have consultants on site 24/7; life and limb surgery after midnight was very small. If a consultant was required out-of-hours, they would be called onto site. The majority of patients who require emergency surgery were seen during the working day when surgeons were on site. It was acknowledged that the co-location of vascular surgery in Canterbury had produced some of the best outcomes for patients nationally. Patients from East Kent no longer had to travel to London for vascular surgery.

(10) A number of comments were made about the cost and funding of the additional surgeons; service provision at the Kent and Canterbury; and the timeline for the implementation of substantive posts. It was reported that the Trust was funding the additional posts; £700,000 had been provided for the recruitment. It was explained that under the interim proposals, there would be no change to care provided at Kent and Canterbury Hospital; vascular surgery and neurology would continue to be provided at the site. The Trust was

expecting to meet the September 2014 target for recruiting substantive posts; four colorectal surgeons would begin in September.

(11) RESOLVED that the Committee thanks its guests for their attendance and contributions today, asks that there is ongoing engagement with HOSC as plans are developed with a return visit at the appropriate time.

46. Kent and Medway NHS and Social Care Partnership Trust: Safeguarding and Dementia (Written Update)
(Item 8)

(1) RESOLVED that the Committee note the report.

47. Kent and Medway Adult Mental Health Inpatients Review (Written Update)
(Item 9)

(1) RESOLVED that the Committee note the report.

48. Kent Community Health NHS Trust: Community Dental Services (Written Update)
(Item 10)

(1) A Member asked for clarification regarding the percentage of local patients who were seen at the Deal Clinic and the commissioner's view on the changes to community dental services.

(2) RESOLVED that the report be noted and that written clarification circulated to the Committee in regards to the percentage of local patients who were seen at the Deal Clinic and the commissioner's view on the changes to community dental services.

49. Child and Adolescent Mental Health Services (Written Update)
(Item 11)

Michael Ridgwell (Director of Commissioning, Kent and Medway Area Team, NHS England) was in attendance for this item.

(1) The Chairman informed the Committee that he had received a letter from Julian Brazier, who had also written to the Secretary of State and received a similar response. Mr Brazier had expressed his thanks to the Committee for their work to highlight this issue.

(2) Members requested an update on waiting times for assessment and initial treatment & the quality and outcome of treatment. Mr Ridgwell offered to co-ordinate a joint response and update on performance across the four tiers of the service.

(3) RESOLVED that the Committee note the report and it was noted that Mr Ridgwell would co-ordinate a joint response and update on performance across the four tiers of the service.

50. Date of next programmed meeting – Friday 18 July 2014 @ 10:00 am
(Item 12)

(1) A Member made a comment about the use of acronyms in the NHS reports. The Scrutiny Research Officer undertook to remind NHS colleagues to avoid the use of acronyms in their reports to the Committee.

(2) The Chairman confirmed that Faversham MIU would return to the Committee in July 2014.

(3) A Member requested an update on the local Health and Wellbeing Boards' relationship with the Kent Health and Wellbeing Board and the input of local Boards into the Kent Health and Wellbeing Strategy as part of the proposed agenda item on the Kent Health and Wellbeing Strategy for July. The Chairman undertook to ask Mr Gough to include this in his report to the Committee in July 2014.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 18 July 2014

Subject: Kent Health and Wellbeing Board – Update & Strategy

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

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

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1. Introduction

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

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

(b) The HWB is responsible for producing a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS). JSNAs are assessments of current and future health and social care needs in a particular area alongside an identification of the assets the local community has to meet the identified need. The JHWS set out how the needs will be met, in the context of identified priorities, as well as enabling the HWB to encourage integrated working between health, public health and social care commissioners. Both documents are to inform local authority and NHS commissioning plans. Where plans are not in line, an explanation must be provided.

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

2. Recommendation

RECOMMENDED that Mr Gough be thanked for his attendance at the meeting, and that he be requested to take note of the comments made by Members during the meeting and he be invited to attend a meeting of the Committee in nine months' time.

Background Documents

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

Contact Details

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By: Roger Gough, Cabinet Member for Education and Health Reform

To: Kent Health Overview and Scrutiny Committee

Date: 18th July 2014

Subject: **Kent Health and Wellbeing Strategy and local Health and Wellbeing Boards**

Classification: Unrestricted

Summary

The Joint Health and Wellbeing Strategy

The Health Overview and Scrutiny Committee has requested a report concerning progress of the Joint Health and Wellbeing Strategy and the local Health and Wellbeing Boards.

The Kent Health and Wellbeing Board is required to ensure that a Health and Wellbeing Strategy for the Kent area is produced and that it reflects the issues identified in the Joint Strategic Needs Assessment. An initial Health and Wellbeing Strategy was agreed by the Shadow Kent Health and Wellbeing Board at its meeting of 30th January 2013 as a one year strategy, recognising that in a time of great change to the health and wellbeing system this would be an interim measure prior to developing a full strategy in subsequent years.

The Kent Health and Wellbeing Strategy is due for renewal with a revised version for agreement at the Kent Health and Wellbeing Board on 16th July. This timescale will allow the final strategy to be endorsed in time to inform the next round of commissioning intentions for all parties that will commence in the autumn. The revised version of the strategy has taken into account feedback from stakeholders workshop which highlighted a clearer strategic alignment across the system; the identification of priorities and their connection with outcomes; the need to be more specific about children's issues and a clear statement of the case for change.

As a result of some of the key changes to the revised strategy it has clearer links with the Better Care Fund providing a strategic platform for change across the system - a revision to the wording of Outcome 5 to reflect holistic support for people with dementia and the stronger connections between outcomes and priorities.

The revised version also takes into account the views of Kent residents about the changes they would expect such as: timely access to support; and improvements to professional communication. Additionally, the revised

proposed strategy introduces an increased emphasis on key groups of vulnerable children and young people within Outcome 1.

The initial draft of the revised strategy has been well received and the general approach and structure of the strategy has been welcomed.

Suggestions for changes to the text have been incorporated where appropriate.

The revised strategy as presented to the Kent Health and Wellbeing Board on the 16th July is attached.

Local Health and Wellbeing Boards

The local Health and Wellbeing Boards based on the boundaries of the Clinical Commissioning Groups have been operating in Shadow and fully established form for over a year. They have been establishing themselves and organising their work programmes to complement the work of the Kent Health and Wellbeing Board whilst recognising the specific priorities of their own populations.

1. Introduction

(a) The original Health and Wellbeing Strategy was based on the Joint Strategic Needs Assessment of 2012/13. The strategy is built around 4 priorities designed to deliver 5 key outcomes through 3 main approaches:

The Priorities:

1. Tackle key health issues where Kent is performing worse than the England average
2. Tackle health inequalities
3. Tackle the gaps in provision
4. Transform services to improve outcomes, patient experience and value for money

Relevant priority outcomes:

1. Every child has the best start in life
2. Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
3. The quality of life for people with long-term conditions is enhanced and they have access to good quality care and support
4. People with mental ill health issues are supported to 'live well'
5. People with dementia are assessed and treated earlier, and are supported to 'live well'.

The Approaches:

- Integrated Commissioning
- Integrated Provision

- Person Centred

(b) In revising the strategy, it has been recognised that although much progress has been made in many areas it is unlikely that these outcomes have been fully achieved, or the priorities completely addressed, during the 12 months that the strategy was in operation. Whilst the Joint Strategic Needs Assessment has been refreshed and updated, these key elements of the strategy remain relevant to the population of Kent today. For these reasons it was agreed that the original strategy continues to articulate the priorities and outcomes that are still relevant and that they should be retained as the basis for the new document.

(c) The revised strategy is designed to give definition to the improvements that will be necessary to ensure that health and wellbeing priorities of the residents of Kent are properly addressed and the aspirations contained within the “I statements” are made a reality.

(d) The Better Care Fund (BCF) and its associated planning has also been a significant factor in the renewal of the strategy. The BCF is intended to promote large scale system wide changes to health and social care services to deliver an integrated health and social care system at greater pace and scale than hitherto envisaged. The potential impact of the BCF on all aspects of the health and social care system within the remit of the Health and Wellbeing Board is so great that the production of the new strategy has been purposely delayed in order that these implications can be reflected in the new document. In essence the BCF supports the main principles and aspirations of the existing strategy.

(e) The three approaches highlighted in the strategy are entirely reflected in the principles underpinning the BCF, the aims of the BCF cannot be delivered without addressing the four priorities, and the majority of the five outcomes are directly related to those of the BCF itself, (the exceptions being Every child has the best start in life and Effective prevention of ill-health by people taking greater responsibility for their health and wellbeing. These two outcomes are outside the specific scope of the BCF but are still of great importance in their own right). The renewed strategy is therefore designed to reflect the principles and aspirations of the BCF to improve public understanding of the changes that will be taking place.

(f) Beyond this, the relationship between the outcomes and priorities has been reshaped. The outcomes have also been considered and Outcome 1 – Every child has the best start in life – has been redesigned. This is to recognise that whereas the other outcomes mainly reflect different aspects of health and wellbeing for adults, all children’s issues were put together in Outcome 1. The revised strategy introduces an increased emphasis on key groups of vulnerable children and young people.

(g) The revised strategy was discussed at the Kent Health and Wellbeing Board at its meeting of the 28 May 2014. The Board agreed that the draft be published for public comment until 27 June with responses incorporated into a final draft of the strategy for presentation to the Kent Health and Wellbeing Board on 16th July. Also included in the final draft will be comments from the

Health and Wellbeing Board discussion relating to a greater emphasis on the patient experience and quality of care. The links to the JSNA are also more explicit.

2. Communication and Engagement

(a) Engagement and communication with the public and stakeholders is crucial to the acceptance of the strategy as the basis for health and social care commissioning in Kent. So far the principles and basic structure of the new strategy have been discussed in a variety of forums including local Health and Social Care Integration Programme meetings and a major workshop to which c. 120 representatives of organisations including the voluntary and private sectors attended. From all these meetings there has been general agreement to the approach for developing the new strategy, subject to a full engagement programme prior to final agreement from the Kent Health and Wellbeing Board. A communications and engagement group that includes representation from KCC, Districts, Healthwatch and the NHS has been established and a plan for communications and engagement developed. The approach recognises that the decision to delay refreshing the strategy to take account of the BCF and other developments somewhat curtails the time available and also that the new strategy is based in large part on the previous document which was also subject to consultation and wider engagement.

(b) The BCF informs the strategy but the substance of the BCF plans is not part of the public engagement for the strategy as it is contained within the CCG commissioning plans, and CCGs will have their own communication strategies. However, greater public understanding of the implications of the BCF will be critical to the successful transformation of health and social care services and engagement around the strategy needs to reflect this. Whilst the substance of the strategy remains from the previous edition, the pace and scale of change has been increased and the strategy can be a vehicle for engaging the public, patients and users of services in the debate about how these changes will be implemented. Much of this engagement will be required following the issuing of the final strategy and local health and wellbeing boards provide a useful mechanism to achieve this. It is proposed that the Kent Health and Wellbeing Board tasks the local boards to report back in November 2014 on how they are engaging local populations in the discussions concerning implementation of the strategy in their local areas. This should complement other activity such as the Public Health communications strategies, especially concerning Outcome 2.

(c) The engagement plan will include the development of key messages.

(d) The communications and engagement plan recognises that this process will continue after the strategy has been finally published to ensure that it is properly promoted and understood.

(e) To date the revised strategy has been warmly welcomed by the professional organisations that have responded. Following the publication of the draft revised strategy we received 13 e-mail responses that contained a number of suggestions as to how the document could be improved. All of these have

been carefully considered and the majority have been reflected in the final version attached.

3. Main amendments to first draft

(a) The suggestions received have led to the revision of Outcome 4 – People with mental health issues are supported to "live well". There is also an increased emphasis on wellbeing as opposed to a more purely "health" perspective.

(b) A number of respondents highlighted the need for the strategy to be delivered at a local level and the need for existing local plans (Mind the Gap – Inequalities Action Plan, CCG, Public Health and others' commissioning plans) to reflect the strategy. Local action plans would also allow for local priorities to be adopted in the implementation of the strategy. The issue of availability of resources to achieve proper implementation has also been raised.

(c) The need to be more explicit about the CAMHS service being consistent across the county has been raised and incorporated into the final version. Other measures and metrics have been refined further.

(d) We received some comments about the inequalities that arise from some specific conditions such as HIV and also specific groups such as Gypsies and Travellers. No specific amendments have been made on the basis of these as the strategy refers to inequalities more generally and these specific issues should be covered in the inequality action plans for the relevant area.

4. Links to other documents

(a) The Joint Health and Wellbeing Strategy shows a direct link to the priorities identified in the Joint Strategic Needs Assessment. It should also be clearly driving the commissioning plans of the CCGs, Public Health and Social Care including the BCF plans.

(b) While the Strategy has been based on priorities identified in the JSNA, there will inevitably be key needs for specific populations at a local level, which are not explicitly set out in the Strategy. However, the principles set out in the Strategy can be applied to the development of policies and plans across areas falling under the wider determinants of health, such as housing, or dealing with specific population groups, such as gypsies and travellers, and there is an expectation that the Strategy would be used to inform these.

5. Measurement and Metrics

(a) The initial strategy contained a number of measures that were designed to demonstrate whether progress was made in achieving the desired outcomes. Whilst these seemed very reasonable at the time experience has shown that there are a number of issues associated with the suite of indicators adopted. Data for some of the measures is not easily collated, there was a mixture of performance indicators and measurement of activity, and some measures were very aspirational and not easily quantifiable.

(b) These issues were considered by a wide range of stakeholders at a workshop where it was agreed that a new set of indicators should be incorporated that are more clearly designed to reflect progress against the outcomes. Work has also been progressing with the Board to develop an assurance framework and the revised strategy has incorporated some of these measures to promote greater consistency.

6. Local Action

(a) Another intention for the revised strategy is that it should be easier to relate to smaller populations within the county. Given the size and complexity of Kent, it is a challenge to make the strategy relevant at district, CCG and care economy (north, east and west) levels but if the strategy is to be more than a reference document it must be capable of translation into all of these.

(b) It is very difficult for any strategy to provide answers at district, Clinical Commissioning Group and health/care economy (north, east and west) levels. Therefore, local Health and Wellbeing Boards will be encouraged to develop their own action plans designed to achieve the outcomes in ways most relevant to their own populations supported by data and information aggregated to the appropriate level.

7. Review and Monitoring of Progress

Ongoing monitoring of the indicators associated with the strategy will be provided through the regular assurance report to the Kent Health and Wellbeing Board.

8. KCC Committee cycle

The revised Health and Wellbeing Strategy is scheduled to be considered at a number of KCC Cabinet committees and the Health Overview and Scrutiny Committee as well as returning to the Health and Wellbeing Board for final approval. These committees meet on the following dates:

Health Overview and Scrutiny	**18th July 2014**
*Cabinet committees***:**	
Children's Social Care and Health	**9th July 2014**
Adult Social Care and Health	**11th July 2014**
Education and Young People's Services	**23rd July 2014**

9. Local Health and Wellbeing Boards

(a) The local Health and Wellbeing Boards were established on the boundaries of the seven Clinical commissioning Groups as formal sub-committees of the Kent Health and Wellbeing Board. South East Coastal Board is the longest established having been part of the initial early adopter

programme for Health and Wellbeing Boards along with the Kent Board. The others have been set up since and have been operating in shadow and then formally constituted form and meeting in public for just over a year.

(b) The local boards are designed to bring together the CCGs, KCC, District Councils and Healthwatch to consider the health and wellbeing priorities of the local populations. The boards reflect the different geographies of the CCGs and their constituent members and each will include a varying number of District Authorities as there is limited co-terminosity.

(c) As with the Kent board there is no delegated decision making or budgetary responsibility to the local boards. Agreements at the local boards are subject to confirmation from the governing bodies of the member organisations.

(d) The local boards have developed in broadly similar fashion. This has involved gaining an in-depth understanding of the health needs of their populations and the priorities that ensue. A number of boards have then chosen to follow the approach of the Kent Health and Wellbeing Board in considering the five outcomes of the Health and Wellbeing Strategy and their application to local circumstances in turn. This has often been scheduled to allow the local issues to be discussed in preparation for the Kent level board meetings on these issues.

(e) The other main subjects that the local boards have considered include:

- The local commissioning plans of the CCGs and KCC – social care and public health;
- The Better Care Fund plans and the potential local implications for services; and
- Issues referred from the Kent Health and Wellbeing Board such as Falls and Health Inequalities

(f) The local boards will also be asked by the Kent Board to ensure that the latest Health and Wellbeing Strategy is properly reflected in the plans of the organisations involved and to demonstrate how the strategy will be used to engage the public in the ongoing debate about how services will be redesigned locally to meet the challenges of the Better Care Fund and wider integration agenda.

10. Background Documents

Kent Joint Health and Wellbeing Strategy – Outcomes for Kent Report to Kent Health and Wellbeing Board 30th January 2013

Kent Joint Strategic Needs Assessment - http://www.kmpho.nhs.uk/

Kent “Mind the Gap” – Health Inequalities Action Plan http://www.kmpho.nhs.uk/

Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategy and Timeline – Report to Kent Health and Wellbeing Board 17 July 2013

Better Care Fund plans – report to the Kent Health and Wellbeing Board 26 March 2014

CCG Commissioning Plans - report to the Kent Health and Wellbeing Board 26 March 2014

Kent Health and Wellbeing Strategy – report to the Kent Health and Wellbeing Board 28th May 2014.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 18 July 2014

Subject: Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Maidstone and Tunbridge Wells NHS Trust.

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

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1. Introduction

(a) Maidstone and Tunbridge Wells NHS Trust has asked that the attached report be presented to the Committee.

(b) Maidstone and Tunbridge Wells NHS Trust was established on 1 April 2000 to take over services previously run by the Kent and Sussex Weald NHS Trust and Mid Kent Healthcare NHS Trust. The Trust was responsible for three hospitals:

- Kent and Sussex Hospital in Tunbridge Wells
- Pembury Hospital
- Maidstone Hospital

(c) The two acute hospital sites in Tunbridge Wells (Kent and Sussex & Pembury) were consolidated into one modern facility, the Tunbridge Wells Hospital, on the former Pembury Hospital site. The Trust closed Kent & Sussex Hospital in September 2011, following the opening of the £230 million Tunbridge Wells Hospital. The Tunbridge Wells Hospital was a Private Finance Initiative (PFI) development and was the first NHS hospital in England to be built with 100% single rooms for inpatients.

(d) The Trust is a large acute hospital trust which provides a full range of general hospital services to around 500,000 people living in the south of west Kent and parts of north east Sussex. The Trust's core catchment area is Maidstone, Tunbridge Wells and their surrounding boroughs. The Trust employs around 4,750 whole time equivalent staff.

(e) In addition, the Trust provides specialist cancer services to 1.8 million people across Kent, Hastings and Rother, through the Kent Oncology Centre at Maidstone Hospital and unit at the Kent & Canterbury Hospital in Canterbury. The Trust also provides some services in community settings including the provision of stroke rehabilitation at the Tonbridge Cottage Hospital.

2. Recommendation

RECOMMENDED that the guests be thanked for their attendance and contributions today, and that there be ongoing engagement with HOSC as plans are developed with a return visit to a meeting of the Committee at the appropriate time.

Background Documents

Maidstone and Tunbridge Wells NHS Trust (2014) '*Annual Report and Summary Accounts 2013/14 (20/05/2014)*', http://www.mtw.nhs.uk/userfiles/Public%20Board%20Papers%20May%202014.pdf

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Maidstone and Tunbridge Wells NHS
NHS Trust

Developing a five year strategy

1. Introduction

We are working in one of the most challenging time in NHS history. Expectations on the NHS are constantly increasing, people are living longer and demand for services continue to grow whilst funding is tighter than ever before. There has been significant structural change within the NHS and there are a number of changes to the way in which regulation will work.

Maidstone and Tunbridge Wells NHS Trust (MTW) faces major challenges which require significant action. We need to continue to build on our successes to maintain and improve our performance in a range of areas, and if we are to realise our full potential. If we are to be financially sustainable and deliver safe, high quality and effective care for our patients within this context, we must embrace the opportunity to think and act differently – to be brave and push the boundaries on how and where we deliver healthcare. This presents an opportunity to look for and embrace new ways of working and innovative ways to deliver services. To achieve this will require working even more closely with our partners across health, social care and beyond and in particular with our patients, public and staff.

The purpose of this document is to share how we are developing our 5 year strategy and adopt a consistent and coherent approach to developing and transforming services. This begins with a review of the current clinical strategy to ensure that the Trust is able to respond to the changing national and local context and deliver sustainable healthcare services for its local population. The Clinical Strategy will be used to develop the Trust's Integrated Business Plan and Long Term Financial Model which will set out the plans for the future operation of the Trust.

2. Drivers for change

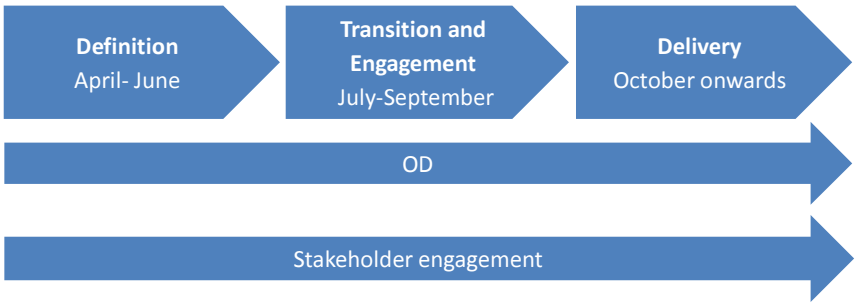
The key contextual drivers can be summarised in four main themes as follows:

- **National policy, guidance and recommendations**
  e.g. Sir Bruce Keogh's recommendations relating to seven day working and transforming urgent and emergency services/improved quality through centralization of some specialized services (e.g. Stroke Services, Major Trauma)
- **Local health economy changes and challenges**
  Organisations around us have significant financial and operating challenges. Plans to address this could affect the Trust
- **Financial context and financial planning to attain sustainability**
  Trust position of financial deficit
- **Demographics and the needs of the local population**
  The local health economy is seeing a trend of an increase in the age of the population, alongside an increase in the number of people with long term conditions

3. Timeline for developing strategy

This paper provides an overview of each phase for developing the Trust's strategy. These are:

- Phase 1 – Definition
- Phase 2 – Transition & Engagement
- Phase 3 – Delivery

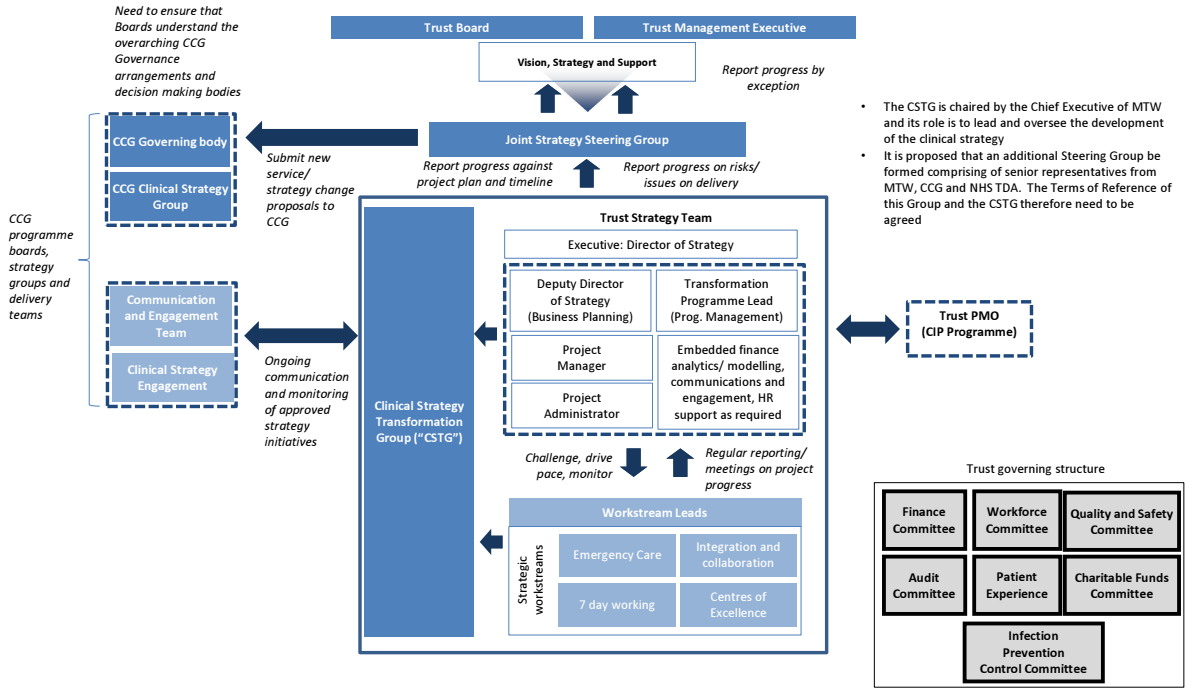


The Trust is currently beginning Phase 2 and would welcome input from HOSC on its key actions in relation to this phase, in particular with regards to the engagement strategy.

3.1 **Phase 1 Definition**

3.1.1 Governance Structure

As the requirements for developing MTW's five year strategy are refined the governance structure has been changed to provide the Trust Board with the assurance it will require throughout the process. The proposed governance structure can be seen below.



The Clinical Strategy Transformation Group (CSTG) was formed to lead and oversee the development of the clinical strategy. The CSTG is chaired by the Chief Executive of MTW. An additional Joint Strategy Steering Group is being formed also, comprising of senior representatives from MTW, CCG and NHS TDA. This will facilitate the requirement for a joined up approach with commissioners and other key stakeholders from the outset.

3.1.2 Mission, vision and objectives

The CSTG has met three times over the past four months. It has completed a number of pieces of work including carrying out a review of the Trust's current vision, mission and objectives to ensure that they are still relevant and appropriate for today's challenges and to meet future needs.

Following on from the review of the Trust's Mission, Vision and Objectives, discussions were held to establish areas of work and focus across the Trust that link with the Mission, Vision and Objectives and inform the development of the Trust's five year strategy.

A sub group of clinicians from the CSTG have identified four works streams that they believe are essential in the development of the strategy, taking into account national and local developments such as Keogh; recommendations for emergency care and seven day working; commissioning intentions (and the Joint Strategic Needs Assessment), Better Care and 'Mapping the Future'.

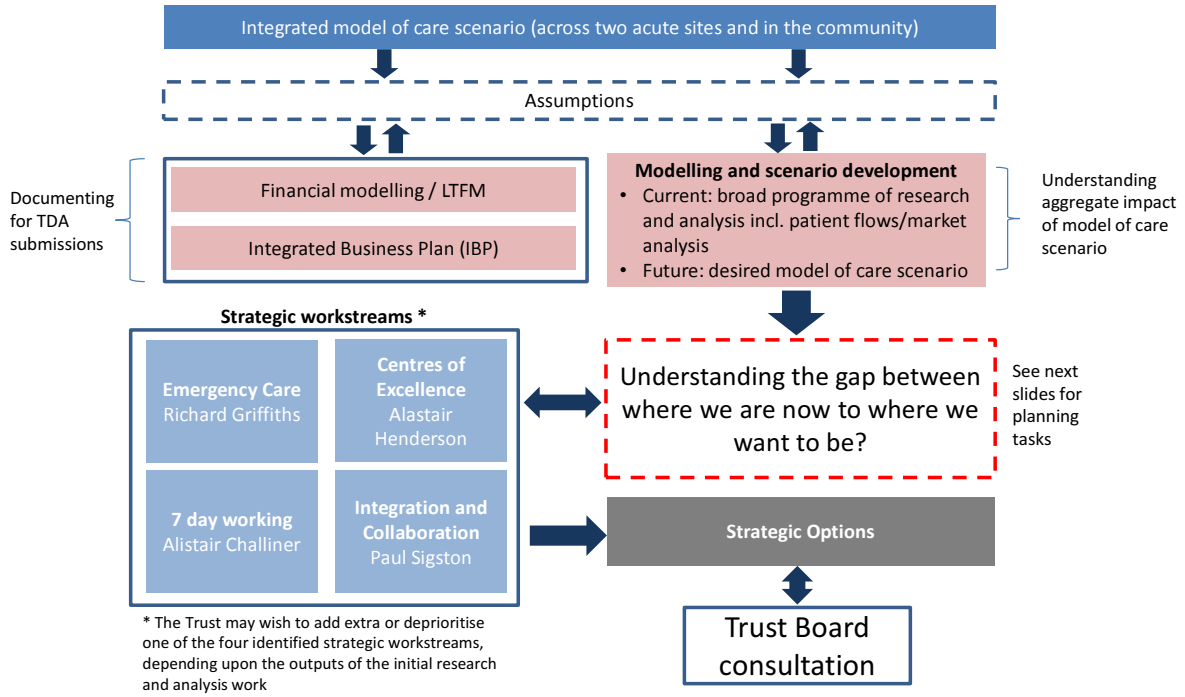
It is imperative that the Trust builds on the integrated model of care which will inform some of the baseline initiatives to be considered in each of the work streams. Each work stream, led by a clinician and made up of doctors, nurses and other professionals as well as CCG representatives, patients and other stakeholders as required. Workstream working groups have been established and are working together to identify key clinical and service changes required, clinical interdependencies, gather evidence and recommend areas of priority to inform the next phase of the strategy work.

A timeline relating to Phase 1 and Phase 2, developing a five year strategy, is appended to this document.

3.2 **Phase 2 Transition and Engagement**

3.2.1.1 Options appraisal

Each of the strategic work streams, identified in phase 1, will be encouraged to identify a full range of options for the Trust which will be developed for consideration by the Trust Board. As options are developed by the four strategic workstreams, assumptions for the integrated model of care are being discussed with the Trust finance team. Ongoing communication will enable live and up to date management of the assumptions that will drive the Trust's five year LTFM. An example of this process is outlined below.



3.2.2 Development of business model

In order to develop a Trust business model, a full analysis of services is being carried out over the summer. This analysis will continue to support the Trust with identifying strategic priorities, which will be directed through each strategic workstream. Workstreams will be asked to consider options for service redesign and strategic transformation which will be discussed at the Steering Groups and ultimately proposed to the Trust Board.

Following options analysis and selection throughout the 'definition' phase and at the start of the 'transition and engagement phase' (July-September) the business model will be developed following further discussion and detailed analysis which will include a market, stakeholder and Health economy analysis; capacity , demand , quality impact and activity and costs. This process will ensure that there is pace and rigour to developing the strategy. The process will take into account the requirements of the Governments four tests (2014/15 Mandate from the Government to NHS England) for service changes which include:

- Strong public and patient involvement
- Consistency with current and prospective need for patient choice
- Clear evidence base and
- Involvement and support from clinical commissioners

It is envisaged that the Trust will sign off the strategy in the autumn of 2014.

3.2.3 Engagement strategy

The engagement approach is an integral part of the change process and an essential component of the development of the strategy. It consists of a number of elements:

- Robust internal plans and events to ensure all staff groups have an opportunity to contribute to the strategy at different phases
- External stakeholder involvement – a mapping exercise is underway to identify key organisations, groups and individuals we need to involve in the development of our strategy
- Public, Patient & Carers – The public needs to be involved at the very beginning of the development of the strategy and throughout key stages of the process.

It is widely recognised that good patient and public engagement has a proven positive impact on the provision of healthcare and safe, high quality outcomes for both individuals and communities as a whole.

MTW has identified key individuals, groups and organisations to include in the early and subsequent stages of its communications and engagement work. This includes members of the public, patients, NHS staff and other healthcare professionals including support groups. The stakeholder list will be frequently reviewed and updated to include new audiences who can help shape and inform the Trust's strategy.

A high level stakeholder map can be found at Appendix 2.

The Trust will work closely with its local authorities and support agencies to help capture the experiences and future health needs of different audiences, including areas of high deprivation, and people within hard to reach groups. The Trust will work closely with partners at West Kent CCG and HealthWatch Kent to develop the full engagement programme.

4. Service development scenario

4.1 Clinical strategy for Stroke

Whilst the Trust started to develop its new clinical strategy in April of this year it had already undertaken an in depth review of the stroke services it provided, largely as a result of the objective for Stroke to become a centre of excellence. The review identified a number of opportunities for improvement of the stroke service based on the SSNAP audit results and a detailed comparison of the current service with that given in the draft Integrated Stroke care pathway service specification issued by the South East Coast Clinical Network. An action plan was subsequently implemented to address the matters raised.

The SSNAP audit results for the next period (July to Sept 2013) showed that the Stroke service had not improved, with both sites given an E rating (on a scale of A=highest, E=lowest). Although the service at Maidstone improved slightly (D, for the period Oct to Dec 2013) it was clear that the Stroke service was not providing the best care for its patients and there was an opportunity to transform the service.

4.1.2 Current status and next steps

The Trust has formed a Stroke Steering Group (SSG), chaired by the Medical Director, and is liaising with West Kent CCG regarding the proposals for improving the service. A draft Framework that sets out the process the Trust intends to follow in order to improve the Stroke service will be reviewed at the next SSG meeting.

Notwithstanding this, where possible, immediate action has been taken to improve the stroke service on both of our acute sites.

A draft Case for Change has been developed and a draft future Model of care is being finalised.

The Trust recognises the importance of engaging with all stakeholders, in particular patients and carers, and is finalising a draft Patient and Public Engagement programme, in conjunction with WK CCG.

The next step is for the Trust to share the draft Case for Change, the draft future Model of Care and the draft Patient and Public Engagement programme with WK CCG Clinical Strategy Group to gain their input and support.

The Trust will then initiate the engagement programme to listen to the views of patients, carers, the public, GPs, specific users groups eg Stroke Association and other key stakeholders with the intention of gathering their views on the current service, the proposed Model of Care and their suggestions of how the service could be delivered to meet the Model of Care.

Once the Trust has established a list of all possible alternative service delivery options it will assess these against defined assessment criteria that is currently being developed for all future clinical service changes arising as a result of the new clinical strategy.

The Trust will continue to liaise with all stakeholders throughout this programme.

Stakeholder mapping

- GPs
- Hard to reach/minorities
- HealthWatch Kent
- MTW members
- KSS Deanery
- MTW cons/nurses & local GP
- MTW staff (clinical leadership)
- MTW Board
- MTW staff (general)
- Maidstone BMA chair and members
- Campaign groups and affiliates (MASH)
- Kent HOSC
- Local Councils
- Local media
- MPS (standing and prospective)
- Volunteers and LOFs
- Patients/public
- Interest and support groups (Age Concern)
- Unions
- Kent Pioneer Forum
- Health bloggers
- Neighbour trusts/networks
- Royal Colleges
- PALS
- West Kent CCG
- Trust Development Authority
- NHS England

Appendix 1 Timeline for Developing a Five Year Strategy

Phase 1 – Define
Plan and preparation

May 2014 | **June 2014** | **July 2014**

Building capability and a core group of individuals who will lead strategy design

- Design programme structure for strategic documentation delivery
- Design Governance structure for strategic documentation delivery
- Plan for and resource strategy development team
- Board consultation and sign off throughout

Trust Strategy Team ongoing programme management

- Trust Board consultation and stakeholder consultation
- Manage workstream sessions
- Consolidate outputs from workstream sessions
- Summary of key messages and strategic options

Engagement with commissioners, patients, public and other stakeholders

- Engagement and communications plan incl. tools and templates
- Scenario planning consultation – information and view sharing (see example engagement process below), discuss options

Gather evidence with which to assess current position

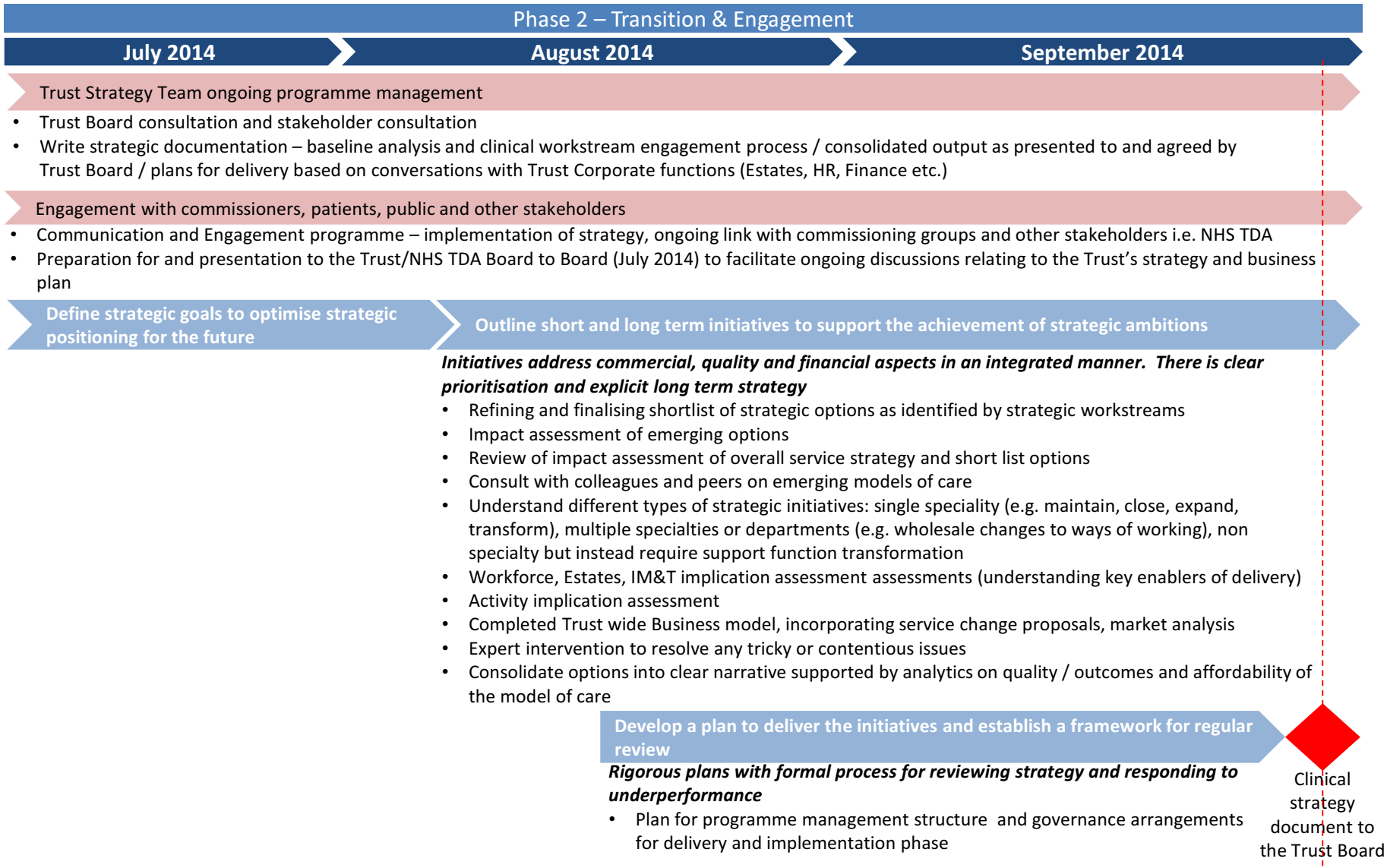
Clarity of current and implied future strategic positioning at service level backed with detailed external forecasts and local insight

- Data gathering (where we are now) analytics modelling forecasts etc.
- Scenario planning (market pressures/opportunities, what happens if we do nothing, where we want to be)
- Areas of strategic workstream focus to be confirmed
- Recruit workstream leads and members to partake in workstream scoping and planning
- Prioritise and agree workstream categories, agree scope/definition of workstream and role of members:
    - Define group
    - Establish building blocks/actions to achieve
    - Confirm any need for baseline information
- Establish meetings plan for strategic workstreams
- Board consultation and sign off throughout

Define strategic goals to optimise strategic positioning for the future

Specific and stretching goals which cover financial, quality and commercial aspects

- Strategic options development by workstream
- Jointly review:
    - Population needs
    - Current activity, flows, quality, finance and performance data
    - Evidence of models of care across Health Economy
    - Enablers
- Identify key areas of opportunity and list of ideas / options


Phase 2 – Transition & Engagement
July 2014
August 2014
September 2014
Trust Strategy Team ongoing programme management
• Trust Board consultation and stakeholder consultation
• Write strategic documentation – baseline analysis and clinical workstream engagement process / consolidated output as presented to and agreed by Trust Board / plans for delivery based on conversations with Trust Corporate functions (Estates, HR, Finance etc.)
Engagement with commissioners, patients, public and other stakeholders
• Communication and Engagement programme – implementation of strategy, ongoing link with commissioning groups and other stakeholders i.e. NHS TDA
• Preparation for and presentation to the Trust/NHS TDA Board to Board (July 2014) to facilitate ongoing discussions relating to the Trust's strategy and business plan
Define strategic goals to optimise strategic positioning for the future
Outline short and long term initiatives to support the achievement of strategic ambitions
Initiatives address commercial, quality and financial aspects in an integrated manner. There is clear prioritisation and explicit long term strategy
• Refining and finalising shortlist of strategic options as identified by strategic workstreams
• Impact assessment of emerging options
• Review of impact assessment of overall service strategy and short list options
• Consult with colleagues and peers on emerging models of care
• Understand different types of strategic initiatives: single speciality (e.g. maintain, close, expand, transform), multiple specialties or departments (e.g. wholesale changes to ways of working), non specialty but instead require support function transformation
• Workforce, Estates, IM&T implication assessment assessments (understanding key enablers of delivery)
• Activity implication assessment
• Completed Trust wide Business model, incorporating service change proposals, market analysis
• Expert intervention to resolve any tricky or contentious issues
• Consolidate options into clear narrative supported by analytics on quality / outcomes and affordability of the model of care
Develop a plan to deliver the initiatives and establish a framework for regular review
Rigorous plans with formal process for reviewing strategy and responding to underperformance
• Plan for programme management structure and governance arrangements for delivery and implementation phase
Clinical strategy document to the Trust Board

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Item 6: CQC Inspection Report and Royal College of Surgeons Report: Maidstone Hospital

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 18 July 2014

Subject: CQC Inspection Report and Royal College of Surgeons Report: Maidstone Hospital

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Maidstone and Tunbridge Wells NHS Trust.

It provides additional background information on the organisations that have produced reports on Maidstone Hospital, which may prove useful to Members. The CQC Inspection Report and Royal College of Surgeons Report have been appended to this covering paper.

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1. Care Quality Commission

(a) The Care Quality Commission (CQC) is the national regulator for health and adult social care. Its responsibilities include:

- maintaining a register and inspecting and reporting on all hospitals, care homes, dental and GP surgeries and all other care services in England against standards of quality and safety, which it sets;
- protecting the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act;
- taking enforcement action where appropriate (Local Government Association 2014).

(b) In April 2013, the CQC published their strategy for 2013-16, *Raising Standards, Putting People First*. The strategy proposed changes to the way the CQC regulates health and social care services, and followed extensive consultation with the public, staff, providers and key organisations. The changes acted on the recommendations of Robert Francis' report into the failings of Mid Staffordshire NHS Foundation Trust including the establishment of a Chief Inspector of Hospitals post. Two further Chief Inspector posts, for Adult Social Care and for General Practice, have been introduced (Care Quality Commission 2014).

(c) The Chief Inspector of Hospitals, Professor Sir Mike Richards, has introduced a new approach to inspection in acute hospitals. The new inspections involve larger inspection teams and take longer. The teams involve Experts by Experience (people who have experience of using care services) as well as clinical and other experts.

(d) Eight key service areas are inspected, along with others where necessary. The service areas are:

1. A&E
2. Acute medical pathway (including frail elderly)
3. Acute surgical pathway (including frail elderly)
4. Critical care
5. Maternity
6. Paediatrics
7. End of life care
8. Outpatients.

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

(f) An enhanced Intelligent Monitoring tool has been developed that identifies risk to service quality, and directs inspection. The tool is based on 150 indicators, which supports the five key questions all inspections will seek to answer. These questions are asked of every service:

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

(g) Under the new inspection model, acute trusts are awarded a new 'Ofsted style' ranking:

- Outstanding
- Good
- Requiring improvement
- Inadequate

(h) The timetable for the new inspection approach of acute NHS hospital has been published:

May 2014	Roll out of new inspection approach
May 2014	First ratings published
January 2016	All acute NHS hospital ratings published

(i) Ratings given prior to October 2014 will be 'shadow' ratings. Subject to legislation in the Care Act, formal ratings will be rolled out from October 2014. Ratings for all mental health and community health trusts; acute hospital (NHS specialist) trusts and ambulance trusts will be published by April 2016 (Care Quality Commission 2014).

(j) Maidstone Hospital was inspected by the CQC in February 2014 under the old inspection model. The old inspection model checked providers' compliance with 16 essential standards of quality and safety. Inspections would focus on one or more of the essential standards. Maidstone Hospital was inspected on four essential standards with a focus on surgery and paediatrics:

- Consent to care and treatment
- Care and welfare of people who use services
- Staffing
- Assessing and monitoring the quality of service provision

2. The Royal College of Surgeons

(a) The Royal College of Surgeons of England was established by royal charter in 1800 to promote and encourage the study and practice of the art and science of surgery. The Royal College of Surgeons is now the professional membership organisation for surgical and dental surgeons. The College 'exists to advance surgical standards and improve patient care' and to support its 20,000 members in the UK and internationally (Royal College of Surgeons 2014).

(b) The Royal College of Surgeons performs the following roles:

- Supervises the training of surgeons in approved posts;
- Provides educational and practical workshops for surgeons and other medical professionals at all stages of their careers;
- Examines trainees to ensure the highest professional standards;
- Promotes and supports surgical research in the UK;
- Supports audit and evaluation of clinical effectiveness;
- Provides support and advice for surgeons in all stages of their careers;
- Provides a mechanism whereby trusts can seek independent advice;
- Acts as an advisory body to the Department of Health, health authorities, trusts, hospitals and other professional bodies;
- Collaborates with other medical and academic organisations in the UK and worldwide;
- Seeks to convey the importance of, and provide support for, good, effective communication and interpersonal relationships between patients and surgeons.

3. Recommendation

RECOMMENDED that the guests be thanked for their attendance at the meeting, and that they be requested to take note of the comments made by Members during the meeting and that a written update be received by the Committee in three months.

Appendices

Appendix 1 – CQC Inspection Report
http://www.cqc.org.uk/sites/default/files/RWF03_Maidstone_Hospital_INS1-1214006307_Responsive_-_Concerning_Info_15-05-2014.pdf

Appendix 2 – Royal College of Surgeons Report (redacted)
http://www.mtw.nhs.uk/userfiles/RCS%20Report%20redacted%20and%20Press%20Release%20May%202014(1).pdf

Background Documents

Care Quality Commission (2014) *'Business Plan: 2014/15 to 2015:16 (22/05/2014)*', http://www.cqc.org.uk/sites/default/files/cqc_business_plan.pdf

Local Government Association (2014) *'A councillor's guide to the health system in England (01/05/2014)*',
http://www.local.gov.uk/documents/10180/5854661/A+councillor's+guide+to+the+health+system+in+England/430cde9f-567f-4e29-a48b-1c449961e31f

Royal College of Surgeons (2014) '*About (24/02/2014)'*,
http://www.rcseng.ac.uk/about

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Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Maidstone Hospital

Hermitage Lane, Maidstone, ME16 9QQ

Tel: 01622224796

Date of Inspection: 12 February 2014

Date of Publication: April 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	Maidstone and Tunbridge Wells NHS Trust
Overview of the service	Maidstone Hospital is an acute hospital operated by the Maidstone and Tunbridge Wells NHS Trust. The trust provides a full range of general hospital services to a population of around 500,000 people in West Kent and parts of North East Sussex. Maidstone Hospital offers most services associated with an acute hospital including a 24 hour accident and emergency service, medical and surgical inpatient facilities, a children's day unit, a midwifery led birthing unit and a range of support and diagnostic services. For this inspection we reviewed the care of patients undergoing surgical procedures, and the provision of care for children.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 February 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by other authorities and were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

When we visited Maidstone Hospital our inspection team consisted of 3 Compliance Inspectors, a hospital governance specialist, a Consultant Surgeon, a Pathology specialist, and two experts by experience.

All the patients that we spoke with were positive about the care they had received before and following surgery. However, some patients told us they were not happy about the number of cancellations and delays they felt that they had experienced whilst awaiting surgery.

We found that patients had not always had an opportunity to speak with their surgeon prior to their surgery. We also found that some patients were not asked for their consent until they were on a trolley waiting to go into the operating theatre. This meant that although patients had consented to surgery, they may not have had sufficient time or information to have made an informed choice.

We found that patients had not always received safe care either before or after their surgery. This meant that risks to patient's health, safety and welfare could be compromised because safe practices were not always followed.

We found that patients did not always receive care from appropriately qualified staff. We found that arrangements were not in place for patients to receive on-going care from their consultant. Children receiving care at Maidstone Hospital did not always have access to staff trained in paediatric medicine. The paediatric resuscitation team did not routinely contain a paediatrician out of hours.

We found the provider did not have adequate processes in place to assess or monitor the quality of the service. This meant that risks to patient's health, welfare and safety were not being managed appropriately.

Within this inspection report we have made some references to a report about the trust written by the Royal College of Surgeons (RCS). This report was commissioned by the trust following the deaths of 5 patients who had had similar surgeries. The trust was reviewed by the RCS in October 2013, and received the report from the review in December 2013.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 02 May 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before patients received any care or treatment they were asked for their consent.

Reasons for our judgement

SURGERY

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. However, we found the way consent was obtained was not always in the patient's best interests. For example, staff told us that surgical doctors sometimes obtained written consent for scheduled surgery from patients in the trolley area of the admissions lounge on the day of their planned surgery. During our visit we witnessed this practice. The provider might like to note that patients may not have had sufficient time to make an informed choice on the treatment they wished to receive.

We spoke with one patient who told us they had attended the pre-operative assessment unit on the previous day where they saw an anaesthetist and consultant surgeon. They said, "I was pleased to have the procedures all explained to me and knew what to expect". They went on to say, "The consultant came to see me separately and pointed out where he was going to operate on my body, then told me not to worry". This patient told us that the consultant surgeon informed them of the treatment they required, indicating that they would then feel much better. The patient told us that the staff they had seen were polite, kind and reassuring. Other patients we spoke with following their operation remembered signing a form. Some patients told us that they had been given good explanations by the nurse in the pre-assessment clinic and others said they had not had an opportunity for discussion with their consultant. Some patients said they were unaware who their consultant was.

We observed patient care in all areas of the operating theatre department. We also looked at audits of the World Health Organisation (WHO) Surgical Safety checklists. The intention of such a checklist is to ensure that all conditions are optimum for patient safety, and that all staff are identifiable and accountable. The checklist system ensures that errors in patient identity, site and type of procedure are avoided completely. By following a few critical steps, health care professionals can minimise the most common and avoidable risks endangering the lives and well-being of surgical patients.

We found that appropriate checks were made throughout the time before the operation as to whether a patient had given consent and if so, to which procedure.

PAEDIATRICS

We spoke with staff who cared for children in the accident and emergency department and the children's assessment and day surgery units. Children were seen in the accident and emergency department and admitted to the assessment or day surgery units up to the age of 16 years, or older if they had particular needs that were best met in a paediatric environment.

Staff we spoke with had some understanding of consent by competent children. We asked staff about what they would do if a young person attended alone, or with a friend, and did not want their parents informed of their attendance or given details of their condition. Most staff were aware of the guidance issued by the General Medical Council and Royal College of Nursing about consent by children and young people. However, the provider might like to note that two staff told us they would inform the parents automatically but re-thought their answer when we asked about emergency contraception or miscarriage. They said they would try to persuade all young patients to share information with their parents but would maintain confidentiality if requested and the child was deemed competent to give informed consent.

The parents or guardians of all children attending for day surgery had been asked to sign written consent for the procedure. This was often obtained at the pre-assessment clinic but was otherwise signed on the day of surgery. We observed a staff member working with one family who had attended a pre assessment clinic. We saw the mother was given time to ask questions and discuss concerns about her child's surgery.

From the documents we reviewed we could see that parents had signed consent and were given a copy of the consent form relating to their child. Records showed that staff ensured the adult signing the consent form for a child had legal parental responsibility and was entitled to sign consent. We saw that there was a space on the consent form for a competent child to give consent or a younger child to endorse their parent's consent. This meant that children were involved in decisions around consenting for their care when possible.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

SURGERY

We found that patient's needs had not always been appropriately assessed, and care and treatment was not always planned and delivered in line with their individual care plan.

We saw that patients had access to a nurse led pre-assessment clinic prior to their operation. We spoke with staff who told us that patients were given information about the procedure they would be having. We saw that observations were documented such as the patient's weight and medical history and patients underwent a series of tests for example blood pressure and an electrocardiogram (ECG) a test that measures the heart rhythm. They were also screened for Methicillin-resistant Staphylococcus Aureus (MRSA), a bacteria many people carry on their skin or in their nose. Staff told us that if there were any problems, for example with an ECG, the patient would be referred for further testing.

We saw that patients were prepared for their operation in the admissions lounge before being taken to the operating theatre department. Staff told us that this involved physical examination of the patients as well as nursing assessments and safety checks. Staff told us that anaesthetic staff carried out physical assessments of patients in a private consulting room located in the admissions lounge. They said that there were no examination couches in the consulting rooms so when an examination requiring a patient to lie down was necessary; it took place in the trolley bed area of the lounge. We looked at one consulting room. We saw there was no examination couch in this room. We saw records that demonstrated anaesthetic examinations had taken place in the admissions lounge. The trolley bed area of the admissions lounge was not a private area and any discussion could be overheard by other patients waiting in the area. This had the potential to impact on the information that a patient shared with the person examining them.

Staff told us that pre-operative nursing documentation was recorded in "pathway booklets". Integrated care pathways are used within the trust as a tool to guide staff on the care required for patients undergoing particular treatments. Surgical care pathways are used by

the multidisciplinary team to plan and record care and to assist staff in determining that all is well following surgery. Their function is to ensure that all patients receive optimal care based on good practice guidance. We looked at the enhanced recovery colorectal surgery pathway. We saw that this documentation included; patient's name, date of birth, home address and next of kin details; relevant past medical history; allergies; current medication; an assessment of nursing requirements and a pre-operative check list. The pre-operative check list enabled staff to prepare the patients safely for their forthcoming operation. For example, by ensuring they were wearing a wrist band with the correct identification details on. The completed care pathway document showed us that staff had provided the appropriate care to the patient.

However, the RCS report of October 2013 detailed that there was a backlog on patients on the waiting list. It said that 85% of patients waiting over 18 weeks were waiting for upper gastrointestinal surgery appointments. The reason for the backlog and delay in treating was found by the report to be poor attendance by consultants at the outpatient clinics. Clinics were usually managed by surgical registrars rather than consultants. One incident report showed that, on one occasion, no doctors had turned up for the outpatient clinic. Patients received an apology but there was no investigation of the situation. This meant that patients did not always meet with their consultant prior to surgery.

On one of the wards we visited we saw that there was a completed 'Infection Control Rapid Risk Assessment for Patients with Diarrhoea or Vomiting Symptoms' in one patient's records. This identified that the patient required to be isolated to reduce the risk of cross infection to other patients. The assessment was dated 9 February 2014 and indicated that a side room had been requested. During our visit on 12 February 2014 we saw that the patient was still being nursed in a bay with other patients. Staff told us that there had been no side room available and that patient had continued to be nursed in the bay with other patients since the 9 February 2014. This placed other patients at risk of contracting the infection and was a particular risk to post-operative patients who are likely to develop complications from dehydration, the pressure of vomiting on wounds and systemic infection.

Patients' personal information was not always kept confidential by staff. We witnessed a member of staff discussing the personal details of one patient in a public area of a ward that could be overheard by other patients and visitors. In the admissions lounge we saw that there were three trolley bed areas adjacent to each other separated by fabric curtains. We witnessed a member of staff discussing intimate personal details with a patient in one of these areas that could be overheard by patients who were in the adjacent areas. We accompanied a patient from the admissions lounge to the operating theatre entrance and witnessed a member of staff discussing intimate personal details with a patient at the operating theatre entrance that could be overheard by other patients.

Care and treatment was not always delivered in a way that would ensure patient's safety and welfare.

We saw that there was a policy for the 'Safe Handling of Specimens in the Operating Theatre'. This outlined the procedure to be undertaken for any specimens that had been taken during the operation. We saw that it stated that, "Patient details should be checked with the patient's notes and not the operating list to avoid potential confusion with other patients with similar details". We saw that the patient's notes and specimen label had to be shown to the responsible person (a senior member of the theatre staff) prior to the specimen being sent to the laboratory. We observed a member of staff preparing specimens during one of the operating procedures. We saw that they checked the patient's

details on the consent form, specimen pot and specimen book. We saw that they showed the patient's notes and specimen labels to the responsible person before sending them to the laboratory. This meant that in the operating theatre, specimens were managed in such a way as to minimise the risk of them being mislabelled.

We looked at how units of blood were obtained when patient required a blood transfusion whilst in the operating theatre department. We saw that a written request was given to a porter who took it to the blood bank located in the hospital. The porter took the blood from the fridge and then returned to the operating theatre department with it. Staff told us that on a busy day with all four theatres running to capacity, this could sometimes be difficult and resulted in delays. Theatre staff sometimes had to wait for blood to arrive. We saw that the Trust had invested in a new electronic system, whereby theatre staff could enter the patient's details and the request for the units of blood would go directly to the blood bank. Porters would then use a bar code system to remove the units of blood and deliver to theatres. Currently, staff were undergoing training to be able to operate this system but it was not yet in use. We visited the blood sciences laboratory which included the blood transfusion service for the hospital. There was an acknowledged difficulty in the provision of an adequate out of hours service, mainly due to shortage of adequate and appropriate staff. We found that this situation had remained on the hospital risk register from October 2012. The blood transfusion laboratory submitted three incidents to Serious Hazards of Transfusing (SHOT), the national reporting scheme for transfusion incidents, in last the 12 months. These incidents were transfusion errors caused mainly due to inadequate system of blood tracking. We found that these incidents had not been listed in the Directorate Quality and Safety committee report (January 2014) which meant there was a lack of clear governance and therefore an inability to learn from these incidents to improve patient safety. This had a direct impact on patient care and welfare and placed people at risk of harm from incorrectly managed blood transfusions.

There was a written policy that governed the activity of transferring patients within the hospital. Staff told us that all patients taken to the operating theatre department were escorted by a member of staff. We saw a member of staff accompany a patient from the admissions lounge to the operating theatre department where the patient was handed over to staff in that department for further care. This meant that patient safety was maintained during transfer between the admissions lounge and the operating theatre department because a trained member of staff accompanied them.
For one patient, we observed appropriate manual handling techniques with enough staff to safely transfer the patient from the operating table to the trolley. The patient had been given regional anaesthesia, so was awake. We heard staff speaking to them reassuringly. The patient was transferred to the recovery area and was cared for by two recovery nurses. When we spoke with the patient they told us that they felt they had been informed about the surgery and any complications that could happen. We looked at care records and saw that charts, such as drugs charts, were updated regularly. Where risk assessments called for particular monitoring to take place, such as fluid intake, we saw that this had taken place.

We visited the surgical wards twice. On the first visit, we saw that the wards were calm with a quiet but friendly atmosphere and we observed staff chatting to patients on a one to one basis. This demonstrated good care, which the patients we spoke with all appreciated. On the second visit, we found the wards were much busier with a fire alarm sounding for a considerable time adding to the noise levels and unsettled feel of the ward. There was also a medical emergency situation occurring that we noted was dealt with well. We asked patients about how readily help and assistance was available on the wards. Several patients told us that it might be up to 30 minutes before a call bell was answered but two

patients, who had major surgery the day before, said, "Someone came quickly". All patients had the call bells within reach on one of the wards. On the other ward we noticed two patients who were unable to reach their call bells. We pointed this out to staff who immediately placed the call bells within the patients' reach.

Patient's care and treatment did not always reflect relevant research and guidance.

One member of staff told us that they were not aware if there were any hospital guidelines on the frequency that staff should check and record a patient's vital signs after surgery. For example, the patient's heart rate, blood pressure and respiratory rate. They told us that a patient's vital signs after surgery would be checked and recorded every 30 minutes for the first two hours, then every 60 minutes for the next two to four hours and thereafter every four hours. Another member of staff told us that there were local guidelines on the frequency that staff should check and record a patient's vital signs after surgery. Staff were unable to provide evidence of these local guidelines. This member of staff told us that a patient's vital signs after surgery would be checked and recorded every 15 minutes for the first hour, every 30 minutes for the next hour, hourly for the next hour, then two hourly for the next two hours followed by four hourly thereafter. There was little consistency in what staff told us about the frequency that staff should check and record a patient's vital signs after surgery. The frequency of observation did not appear to be governed by the condition of the patient or the complexity of surgery they had undergone.

We looked at one patient's records that demonstrated vital signs had been checked and recorded after surgery after 20 minutes initially, then after 25 minutes, followed by every 30 minutes for the next hour, then after 35 minutes, one hour and five minutes, hourly for the next two hours and then two hourly. Another patient's records demonstrated vital signs had been checked and recorded after surgery after 20 minutes initially, then 40 minutes, followed by one hour and 45 minutes and then eight hours later. This was inconsistent with the information staff told us.

There was a written policy that provided guidance for staff in the monitoring of adult patients using physiological observations (the patient's vital signs) as an early warning system if complications should arise. This policy did not specifically state the frequency that staff should check and record a patient's vital signs after surgery. The policy stated "Four hourly observations as a minimum for acutely unwell patients and new admissions to acute care wards" and, "Any increase in the frequency of observations will be determined by the patient at risk (PAR) score algorithm". PAR scoring is a system used by hospital staff to identify patients at risk of deterioration. Patient's vital signs are checked and recorded with each parameter being awarded a score. An overall PAR score is calculated by adding together the individual scores awarded to each parameter. The resultant score is compared to a flow chart informing staff of action required if any. For example, the flow chart indicated that an overall PAR score of four instructs staff to "Inform trained nurse, inform junior doctors, increase frequency of observations, consider continuous monitoring". This meant that there was a risk to patients that became unwell after surgery if their initial vital signs were stable with a PAR score of 0. Staff following the written policy would then check and record the patient's vital signs again in four hours. Post-operative patients whose condition deteriorated in that four hour period would potentially not be identified early increasing their risk of harm.

We saw that there were two types of vital signs records where staff documented patients' observations, such as heart rate and blood pressure. The adult observations chart contained information for staff on how to calculate a patient at risk (PAR) score whereas the adult neurological observations chart did not. The adult vital signs guidelines and

clinical standard stated "All patients should have their PAR score calculated on admission and for every subsequent set of observations". We looked at 246 sets of vital signs records. We saw that a PAR score had been calculated on 226 occasions. This meant that staff were not always following hospital policy each time a set of vital signs were checked and recorded.

There were arrangements in place to deal with foreseeable emergencies.

We saw that staff qualified in immediate life support (ILS) were on duty in the theatre and accident and emergency department. We looked at training records and saw that all theatre staff had received training in basic life support (BLS), ILS, moving and handling and fire evacuation/simulation. We saw that the hospital had procedures and equipment in place for dealing with foreseeable emergencies. There was an emergency trolley sited at appropriate point that contained emergency resuscitation equipment including a defibrillator. We looked at the records and saw that these were checked daily.

There was an adult resuscitation team available 24 hours a day 365 days a year, including a dedicated member of staff to manage the patient's airway. We saw good leadership skills by one doctor in charge of a patient's care during a medical emergency. Staff told us that there was a policy governing resuscitation activity in the hospital that was available to them on the intranet. They told us that the policy indicated that resuscitation equipment in each ward and department was to be checked daily. We saw records that demonstrated the resuscitation equipment on one of the wards we visited had been checked daily in February 2014. Staff on this ward told us that there was a system in the hospital that enabled them to replenish resuscitation equipment 24 hours a day and they experienced no difficulties obtaining replacement items. However, there were no records demonstrating that the resuscitation equipment in the admissions lounge was being checked on a daily basis in line with the hospital policy governing resuscitation activity. This meant that missing or broken equipment may not have been identified and placed people at risk in the event of a sudden collapse.

Staff told us that the procedure for deciding that a patient should not be resuscitated, in the event of a sudden deterioration in their condition, was detailed in the policy governing resuscitation activity in the hospital which was available on the intranet. We looked at the records of one patient where a decision not to offer cardiopulmonary resuscitation had been made and saw that staff had followed the policy governing resuscitation activity in the hospital when documenting the decision.

We saw that lead gowns, used to protect staff from ionising radiation, were in good repair. Anaesthetic gas shut-off valves were visible and accessible for emergency shut-off. We were told that the emergency call bell alarm system for each clinical area was checked daily in the morning. The provider had good systems in place that allowed staff to track which instruments and equipment had been used during which operation.

PAEDIATRICS

We were not able to speak with many families attending the accident and emergency department with children but were able to look at feedback provided by families as part of the 'Friends and Families test'. This is a method of evaluating services provided by hospitals that was first introduced in April 2013. Patients are asked the question "Would they recommend the hospital wards and / or accident and emergency department to a friend or relative based on their experience of using services there". The feedback we saw was positive. Comments included, " Everything fantastic here again," as well as,

"Excellent", "Super-efficient", "Fast", "Caring "and "Thorough".

Patient's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We visited the children's day surgery unit and saw that a pre-operative assessment clinic was being provided for children who were booked in for day surgery at a later date. The assessment clinic was led by a nurse with specific responsibility for assessing and preparing children and their families prior to surgery. Children were seen by appointment and we noticed that the time allocated to each child meant the process was unhurried and relaxed. This meant that children had time to become familiar and comfortable with the ward environment and that as a consequence the impact of hospitalisation was reduced.

Staff told us that special local anaesthetic cream was applied when the child was admitted so that they could have a cannula inserted without any pain. Staff told us that cannulas were usually inserted in the anaesthetic room, to further reduce discomfort and anxiety in the child. We observed that one parent was encouraged to remain with their child whilst they were being anaesthetised. Following surgery, when the child was ready to be discharged from the recovery unit, they were collected by a registered nurse with one parent. They were brought back to the ward where their bed area had been prepared with oxygen and suction equipment readily available for use in the event of an unexpected emergency.

Some specialist tests and services were carried out by visiting paediatric nurse specialists, such as an endocrine nurse. Children were admitted to the unit for blood tests and remained in the care of the nurse specialist throughout their stay. Other children attended daily to allow them to complete a course of intravenous antibiotics, for example, as outpatients. Good practice guidance recommends that children are admitted for the minimum time possible to prevent behavioural changes and reduce the impact of hospitalisation. The practice and use of the children's assessment unit demonstrated a commitment to this.

We saw that a new casualty assessment card had been introduced recently to improve the consistency of assessment records of children attending the accident and emergency department. The card had been amended to include revised guidance for staff as to the action they should take if the vital signs of a child fell outside accepted parameters. The scoring system had been improved to reflect the wider variance of children and young people's vital signs compared to those of adults in order to improve early recognition of a deteriorating child.

Children who needed further assessment or treatment were admitted to the Riverbank day unit. The unit was open daily from 8am to 8pm. The last admission to the unit was 7pm. Outside of these times children that needed further assessment were transferred to another hospital. Children were transferred by either ambulance or, if agreed with the doctor, in the care of their parents. A paediatric early warning system (PEWS) was in use to alert staff to any changes that might indicate deterioration in a child's condition. This allowed for the early reassessment by medical staff and rapid transfer, if necessary.

The Riverbank unit had a high dependency room for children awaiting transfer who were very unwell or who were considered infectious and required isolating. We were told that there were always senior paediatric nurses on duty who had completed training in the management of the deteriorating child, the PEWS system and EPLS training. Nursing staff rotated between all areas of the trust where children were cared for, including the

main paediatric unit at the other hospital (Pembury Hospital).

Care and treatment was not always planned and delivered in a way that was intended to ensure patient's safety and welfare.

Staff training records we looked at in the Accident and Emergency Department showed all the registered nurses in the department had completed Paediatric Immediate Life Support Training (PILS) and some also completed the higher level European Paediatric Life Support Training (EPLS). Junior medical staff working in the department had also completed the EPLS training. We were told by an emergency department consultant that the staff regularly took part in resuscitation practice scenarios to ensure they maintained their skill level and were working effectively as a team. We saw that there was dedicated equipment available in the department for the resuscitation of children and babies. Whilst there was no obstetrician or neonatologist on site, we were told that an anaesthetist with paediatric skills was always available for such an eventuality. However there was not always a paediatrician available for a preterm delivery in the accident and emergency department. This meant that staff were able to respond appropriately to an unexpected emergency situation involving children but that the recommended staffing levels for units that provide emergency care to children were not being met.

We looked at the care of children in the accident and emergency department and on the paediatric day surgery unit and children's assessment unit. The numbers of seriously ill children attending the accident and emergency unit at Maidstone hospital was limited because all such patients using the 999 call service were taken to one of two hospitals with a dedicated paediatric unit and support services. Those attending Maidstone hospital were brought in by their parents or carers, usually with relatively minor conditions and injuries. However, some parents are unaware of how sick their child is and some instinctively drive their child to the nearest hospital, as stated in 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012). There was a midwifery led birthing unit at Maidstone hospital but no neonatal support services were available on site. This meant that when pregnant women presented at the unit in premature labour; very occasionally this resulted in the delivery of a pre-term infant in the accident and emergency department.

Patient's care and treatment did not always reflect relevant research and guidance.

There was a separate waiting and play area for children, siblings and accompanying adults to the accident and emergency unit. Dedicated paediatric consulting rooms were sited immediately off the families waiting area. These rooms were brightly decorated and had been made as child friendly as possible. We noticed, however, that a child was being cared for in the 'majors' area of the main accident and emergency department, alongside acutely ill adult patients. We were told by nursing staff that all paediatric patients were triaged shortly after arrival in the department by a registered nurse with a minimum of 18 months experience in the unit. They were not necessarily a registered sick children's nurse but had all completed in-house training in the care of children. Their role as "navigator" was to triage patients and direct them towards the most appropriate level of care. This might mean transferring the child to a resuscitation room, to the 'majors' area or to see a doctor or nurse practitioner in the minor injuries area. This confirmed to us that children were not always cared for in an appropriate environment. The provider might like to note that the document 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012) recommends that children are always cared for in areas of the emergency department where there is visual and auditory separation from adult patients.

We asked staff how long children and babies were fasted for pre-operatively. We were told that for children could have clear fluid up to 6am on the morning of surgery and that babies could have milk feed at 2am. All children were required to be made 'nil by mouth' from 2am when the theatre list started at 8am. We asked what the latest time a child was taken for surgery was and were told by the nurse in charge that they had never known a later theatre slot than 11am. Patient information that we saw confirmed that what we had been told was in line with the hospital policy on pre-operative fasting. This adhered to the Royal College of Nursing guidance for multidisciplinary teams (produced in conjunction with the Royal College of Anaesthetists), 'Perioperative fasting in adults and children' 2005. There were arrangements in place to deal with foreseeable emergencies.

There was a paediatric resuscitation team available during normal working hours. Outside of this time there was no paediatrician available in the hospital. Staff told us that in the event of a paediatric resuscitation event outside of normal working hours, staff in the hospital would manage the emergency situation until a paediatrician arrived from home. This meant that children who required resuscitation outside normal working hours did not have the same level of expertise available to them which had the potential to impact negatively on their care.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet patient's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

SURGERY

There were not enough qualified, skilled and experienced staff to meet patient's needs.

We found that patients undergoing surgical procedures did not always see their consultant prior to or following surgery. Staff we spoke with told us there had been no surgical job planning for three years. NHS job planning is a professional agreement that sets out the duties, responsibilities and objectives of a consultant. They form an annual prospective agreement about the work a consultant will do for the NHS; it includes where and when they will work and how much time is spent on their NHS work. They were introduced in 2003 to improve patient care and safety. The lack of job planning at Maidstone Hospital meant that the responsibility of individual surgeons was unclear and the time spent conducting NHS work within the hospital was not specified. This impacted on the continuity of care for patients because surgeons did not routinely attend the multidisciplinary meetings and did not take responsibility for the care of patients from admission to discharge. The RCS standard for Good Surgical Practice 2014 says that consultant surgeons should take full responsibility for management of their patient, leading the surgical team to provide the best possible care. This responsibility should encompass pre-operative optimisation to post-operative recovery.

We looked at the job plans available. We were told they were not up to date. We found they were not an accurate reflection of the work that was being undertaken by surgeons within the hospital. The job plans did not correspond with the current practice of surgeons at the hospital. We found that the current working arrangements for the surgeons meant they operated on patients who they then were unable to see subsequently, due to being at the other site or involved in private work. The current working patterns did not allow consultants to discuss and obtain consent from patients, operate on them and then see them subsequently on the ward. This practice put patients at risk because it increased the likelihood that complications would not be identified in a timely manner.

Our analysts had reviewed all the data we hold on the hospital and compared it to other

similar hospitals. What they reported showed that poor oversight of patient care by surgeons was affecting patient outcomes. In four of the 13 specialities we considered, the emergency readmission rate following elective surgery was worse or much worse than expected. The specialities where the readmission rates were better were those where the surgery was minor, including paediatrics and dermatology.

We found that in order to help with emergency surgery at another trust location, two staff grades surgeons had been employed to provide cover for the consultant surgeons who were mainly at Maidstone hospital doing elective work. There was little or no consultant input into these high-risk cases and no data collection on outcomes. We were told by theatre staff that this was stressful for the consultants and coupled with the need to drive between hospitals meant they were constantly late for the start of surgical lists. The two trust hospitals were forty minutes' drive apart.

The October 2013 report by the RCS found that surgeons who had operated on a patient with post-operative complications were often not involved in their subsequent care. The report says that, sometimes, a surgeon was not contactable when the intensive care team wanted to involve them in a decision about the next steps in the care of critically ill patients.

We found that due to the poor job planning arrangements, surgeons sometimes travelled between sites during the working day and junior doctors operated on lists when the consultant in charge was not present and was on a different site: this was contrary to the guidance issued by the RCS and compromised patient safety and surgical training. This meant there were times when there were inadequate numbers of appropriately skilled and qualified staff to ensure patient safety. It also meant that, at times, patients who developed unexpected complications needed to be transferred between hospitals for an intensive care bed under the direction of a more junior doctor. This placed people at further risk of harm because there were not always adequate numbers of appropriately skilled and qualified staff to ensure patient's safety.

The RSC report further stated 2013 that some surgeons involved in upper gastrointestinal surgery, "Agreed amongst themselves, at short notice, who would attend a fixed clinical session such as an operating list". The reviewers were given a shared job plan and timetable but this bore little resemblance to what was actually happening. The report said, "The reviewers were told by the surgeons that the timetable was 'aspirational'. It was commonly reported to the reviewers that the physical whereabouts of the surgeons was often unknown due to the incomprehensible nature of their joint job plan".

All theatre staff we spoke with knew of the Association for Perioperative Practice (AfPP) guidelines for staffing levels of operating theatres. One member of the operating theatre department staff told us that, "99% of the time the guidelines were met". They said that sometimes shortages were filled with agency staff. Documents we inspected showed appropriate staffing levels. We were told that all of the theatre staff were multi-skilled and qualified to work in all three areas that is; anaesthetics, operating theatre and recovery.

Staff we spoke with told us that they felt valued and supported by their immediate colleagues. One member of staff told us that they had a "Supportive manager" whereas another member of staff told us "I receive little comment from management" and indicated that this left them feeling unsupported by their manager. One health care assistant told us that she "loved being part of the ward team". They said that they were a good team and when short staffed, everyone rolled up their sleeves and just "got through the work". They felt they were valued by the other staff. They said, "Even the doctors are polite and treat

me as an equal. I feel valued and love working here. I have worked here for six years. There are only three night staff (registered nurses) to cover 19 patients. This this is too low when people are so unwell".

We looked at the incident reporting system and saw that concerns about understaffing of the admission lounge had been identified as a concern. We saw these were being addressed. This was confirmed by a member of staff who told us that additional staff were being recruited in response to patient safety concerns being raised by staff in the admissions lounge.

We looked at the data that the trust managers provided us with. We saw that there was a noticeable shortfall in both qualified and unqualified nurses in post on the surgical directorate wards. The trust had calculated that there was a need for 191.6 full time registered nurses to staff the surgical directorate. There were only 164 in post. Unqualified nursing staff, health care assistants posts, were also unfilled with a determination that 72.3 full time staff were required but only 59.4 posts filled. This meant that the surgical directorate was running with almost a 20% vacancy rate for nursing staff.

We looked at the staffing arrangements in the pathology department. The histopathology laboratory was operating as two separate laboratories; we found that some staff trained in one area of the laboratory unable to support the other due to lack of competency and familiarisation of laboratory procedures. Staff told us that the laboratory "Feels like working in a factory, was "Overstretched", and that they "Do not feel supported". Staff said they felt "cut-off from the lab".

Staff told us about a serious incident that had occurred in May 2013 where the biopsy specimens for two patients had become confused. We were told that at the time of this incident the department was experiencing an increased workload, with pathology services being provided to a neighbouring Trust. We were told that some staff were, "double-booked on benches" (meaning they were expected to do two jobs at the same time). Our Specialist Professional Advisor found that that new staff had not been adequately inducted in laboratory procedures.

On the day of inspection we found that the staffing in the laboratory and office was inadequate and inappropriate for the volume and complexity of workload. We found that this compromised the ability of the hospital to provide a safe and quality assured service. Use of agency staff was restricted. Bank office staff were being used on a very short term basis. This meant that permanent staff had to oversee the constant induction and training of new staff and created inconsistencies in output. The close supervision that is required for 'new' staff affected the productivity of existing staff. This situation was confirmed by staff that we spoke with and the staffing rota for the laboratories.

On the day of inspection we were informed that there were approximately 1000 histopathology diagnostic reports outstanding, over a period of two weeks. This meant that patients who were awaiting treatment had delays to their care as the clinicians did not have the test results on which to base their treatment plans. Staff informed us that a lack of adequate and appropriate staff in the laboratory and office had resulted in a backlog of reports to be sent out.

PAEDIATRICS

We found shortfalls in the staffing levels for children related to the hospital 'Out of Hours' provision. Staff told us that there was not always a paediatric nurse on duty in the hospital.

The hospital employed one paediatric emergency nurse practitioner but they were not able to cover all shifts. This resulted in times when there were no nurses with paediatric qualifications available to care for sick or injured children. The guidance document 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012) recommends that, "Sufficient Registered Nurse(child) are employed to provide one per shift in emergency departments receiving children. Maidstone hospital was not meeting this standard.

We spoke with staff in the accident and emergency department about their experience and training in the care of sick children. We were told that the triage nurse had at least 18 months experience in the department but was not necessarily a paediatric nurse. We were told that the Emergency Nurse Practitioners were, "Very experienced and used to dealing with children". Staff told us they all felt competent and sufficiently knowledgeable to care for very ill babies and children but there was no formal assessment of their capabilities to do so. The document 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012) recommends that, "In emergency care settings where nurses work autonomously to see and treat patients (usually called EPNs) they undergo an assessment of competencies in the anatomical, physiological and psychological differences of children". Maidstone Hospital was not following this recommendation and as a consequence, it was unclear whether staff were fully competent to meet the needs of sick children.

We found that out of hours paediatric advice and support was not always immediately available at Maidstone Hospital, including at night and during weekends.

We were told by medical and nursing staff that a junior doctor worked from 9am to 7pm on Monday to Friday on the children's day unit. They were supported on site by a paediatric consultant from 9am to 10am and by a registrar from 10am to 6pm. Paediatricians were sometimes also on site during the day at their outpatients clinics and could be called if there were serious concerns about a child. From 6-7pm a consultant paediatrician was on call. We were told that the registrar liaised with the accident and emergency staff about any children who were being seen in the department and that they would not leave the hospital until a plan of care for the child had been established. Staff told us that clinical staff in the accident and emergency department had a minimum level of knowledge, skills and competencies in caring for children and young people. This included recognition of a seriously ill child, basic life support, pain assessment and recognition of vulnerable children. However, we were also told that the arrangements for medical cover for paediatric patients meant that although there was adequate representation on the paediatric cardiac arrest team during the day, this was not the case at night and at weekends when there was no paediatrician.. As there is no time when a child is more likely to suffer a cardiopulmonary crisis, the current arrangement for providing resuscitation to a child meant that children may be at risk of harm.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that patients received.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The trust has had stable senior leadership at board level for a number of years. There was a clear organisational structure to board committees. One of the key roles of the board was to understand the nature of the risks the organisation faces and to assure themselves that everything possible was being done to manage those risks. We found that this was not the case at Maidstone hospital; the board members that we spoke with could not provide that level of assurance.

We found that the trust undertook significant public and patient engagement through its Patients Experience Committee. However, this committee's links to the trust's Quality and Safety Committee had not been reviewed to ensure that performance reporting lines and escalation arrangements were clear. This meant that information gathered through engagement was not necessarily fed upwards to inform the board. Information was being gathered but not used.

The Quality and Safety Committee had undertaken substantial work on operational oversight, such as the development of dashboards of care. A dashboard is snapshot of data relating to a particular ward or department. Dashboards use several performance indicators to help staff and managers see how well a part of the service is doing compared to other areas or how well it is doing over a period of time. We saw examples of how the number of falls on individual wards had been reduced overtime.

The board also relied on the quality and safety committee to provide strategic assurance too when this should have been the responsibility of the whole board. We saw that the Quality and Safety Committee met for just 12 hours a year.

We saw that the membership of the Quality and Patient Safety Committee was wide and this meant that is was unclear as so to 'who is holding who to account'. The wide range of membership had the potential to confuse the answer to this key assurance question. The current arrangements meant that the non-executive and executive directors worked

together to hold the directorate managers to account. It was less clear how the non-executive directors held the executive team to account and whether they were aware that this was their ultimate responsibility. One non-executive director that we spoke with made it clear that they were unable to say that they were fully assured about the safety and welfare of the patients at Maidstone hospital under the current governance arrangements.

The board had a programme of 'Board to Ward' visits (board members visit wards and departments to monitor the quality of care being provided) which can be very effective ways of checking that what directors were told in board reports happened in practice. However, when we spoke to staff and non-executive directors we found that these did not appear to have a data driven purpose and would have benefited from a greater structure and focus to add to the informal listening approach that was in place. The visits were used as an opportunity for non-executive directors to meet staff rather than as an opportunity to gather data and check information provided at board meetings.

We found that non-executive directors did not take part in visits to wards and other areas where patients received care (with the exception of the chair) between October and December 2013. One ward manager commented that their ward had only had one visit in the last year. This key aspect of verification of information and communication had been flagged previously to the trust board in an external assurance report on the trust's Quality Governance Assurance Framework in September 2013.

There was evidence that learning from incidents and investigations did not take place and was not robust. We found that appropriate changes were not implemented.

Following the deaths of five patients who underwent complex surgery at Maidstone hospital over the preceding two year period, an RCS review of the surgical speciality was commissioned by the trust. The deaths related specifically to patients undergoing complex laparoscopic upper gastrointestinal surgery. From discussion with board members and managers, we found that the review of upper-gastroenterological surgery by the RCS in October 2013 had not been purposely used to date by the board to assess whether similar issues exist elsewhere in the trust. It was not recorded on the trust's Risk Register. This meant that poor surgical practice and risk to patients was possibly more widespread across other surgical specialities.

We reviewed how well the trust monitored the quality of the services it was providing. We found that there was inadequate collection and verification of data by the trust and that this had resulted in poor care being allowed to persist. Data the trust used was heavily dependent on a commercial organisation to provide and analyse information relating to the hospital. We found that some of the data being used was inaccurate. The trust acknowledged that they had, "Issues with data collection and validation processes" historically. For example, issues with data collection and validation had resulted in inaccuracies in the mortality rate data recorded for individual surgeons.

The governance committee of an acute NHS hospital should be collecting data as a minimum (by named consultant) for transfusion rates, infection rates, readmissions within 30 days, returns to theatre, transfers to high dependency and intensive care, mortality rates and survival rates for oncology cases. They should be required to explain the discrepancies and concerns highlighted by their information and governance teams. We saw from data reviewed by our analysts that orthopaedic surgeons at the trust were undertaking up to four times as many operations as the national average. This is something that should have been explored to determine whether it posed a risk to patients.

We spoke with senior staff about how medical and surgical care was monitored at the hospital. We found that there had been no dissemination of learning over four recent serious incidents'. We did not see any drive or determination to ensure that the risk of recurrence was reduced. Our judgement about this was based on discussion with senior staff in the operating theatres, the surgical wards and with a consultant surgeon from the speciality where one of the serious incidents had occurred. None of the staff we spoke with were aware that there had been a serious incident. This meant that the organisation was not demonstrating learning from incidents and that risk to patients had not been reduced.

We saw that the hospital had a policy governing resuscitation activity that was dated October 2011 with a review dated of October 2013. This meant that this policy was out of date. However, we saw that minutes of the Standards Committee meeting that took place on 13 December 2013 indicated that the committee had extended the review date of this policy to 31 March 2014. We looked at six other hospital policies. For example, the patient transfer policy and procedure. We saw that they were all dated indicating when they came into force and that they all contained planned review dates. This meant that the hospital had a system in place to ensure that policies were kept up to date. Policies contained details of how the hospital would monitor and audit activity governed by the policy. This meant that the hospital had a system in place to assess staff compliance with the guidance set by the policies.

There was a policy governing incident reporting and management. Staff told us that it was available to them on the intranet. Staff we spoke with were aware of how to report an incident or near miss using the hospital reporting system. One member of staff described reporting a recurring incident situation that resulted in action being taken in the hospital to resolve the issue. Another member of staff said that when they reported an incident they subsequently received no feedback. In the Pathology laboratories, we noted from discussions with staff and from examination of some documents that learning from incidents was adhoc and not shared. Staff told us that the communication system was not open and transparent.

Staff described a variety of ways that governance issues were communicated to them including; verbally by their direct line manager; via email; through group meetings, such as bed meetings; via the hospital intranet; at staff meetings; during handover; via staff notice boards. We were given a copy of a memo dated 4 December 2013 from a ward manager to the ward staff. This memo showed us that there had been an incident with a centrally placed intravenous catheter recently that had been cited as a reason a patient became suddenly unwell due to an air embolism entering their circulation. If an air embolism stops blood getting to the brain, tissue in the brain will be starved of oxygen and die. This can cause permanent brain damage. The memo asked staff to check all lines on all shifts and introduced new working practices on the ward.

Staff told us that they were aware that there was a whistleblowing policy available on the intranet (entitled the speak out safely (SOS) policy and procedure) that governed the reporting of concerns they may have, such as malpractice. Staff we spoke with were able to describe the action they would take to raise any concerns. However, none of the staff we spoke with had witnessed any concerns and therefore had no experience of using this system in the hospital. The report provided to the trust by the RCS in October 2013 had criticised the trust response to whistle-blowers. We were told that there was an open and transparent culture but that is not what the team from the RCS found. A group of staff had complained anonymously to the GMC about a surgeon. This had been investigated internally by one of the trust managers but had been dismissed as malicious and

inaccurate. The RCS review team found that some of the issues raised with the GMC had some substance to them, such as a lack of presence on the wards, and were not malicious. During the review visit by the RCS, the team interviewed staff who reported feeling intimidated when raising concerns about the surgeons.

We found weakness in the quality assurance and governance processes in the pathology laboratories. We were provided with a copy of a Serious Incident (never event) dated 11 Sept 2013. This showed that the slides were mislabelled and described the context in which this incident happened – transfer of workload and staff from neighbouring trust, staff vacancies, cramped laboratory space and lack of checks on accuracy of slide labelling. The serious incident was only discovered after three months during which two patients were harmed. A slide check on labelling had not been carried out at the time although this had been resolved at the time of our inspection with a second slide check introduced. We saw the standards operating procedure for the slide labelling and checking had subsequently been revised.

A lack of laboratory space had also been identified as a factor contributing to the incident. Additional space was identified as necessary but on the day of inspection we observed that staff continued to work in a cramped space which increased the risk of closely placed slides becoming muddled. This demonstrated that despite being aware of issues that compromised patient safety the hospital failed to implement the necessary actions to reduce the risks.

A review of 229 cases near the time of incident found no other mislabelling errors. We were told by pathology staff that the serious incident report had not been seen by 'all' histopathology staff including the consultant histopathologists; this demonstrated a lack of sharing of learning. There were no further audits nor reviews of procedures or clinical cases to assure quality improvements had become embedded in practice. This demonstrated that there was a lack of robust quality and governance processes.

We saw the minutes of the Pathology Quality Committee dated November 2013 and those of the Directorate Quality and Safety Committee dated January 2014. The minutes demonstrated that quality and safety issues were discussed by senior staff at managerial level. It showed us that relevant matters were disseminated to staff in team meetings, at quarterly intervals. However, staff were not involved in the design of the preventative action or in sharing the learning, confirming a lack of openness and transparency and thus lack of a robust governance process within the pathology department.

We saw a document called the service continuity plan. It stated that managers must assess staffing levels against workload to determine the impact of staffing level and that they were required to communicate concerns to senior managers. We were informed that, despite this document, secretarial staff shortage in histopathology office has not been addressed and had impacted on a significant number of histopathology diagnostic reports awaiting submission to clinical requestors to enable appropriate patient care. Although the hospital and department had appropriate strategies in place to identify staffing concerns, these were not translated into operational improvements. We found that turnaround time of histopathology reports was not monitored due to a breakdown of the monitoring system.

When we looked at how the care of sick children was monitored. We found that the local arrangements were effective with ward and department level staff working to ensure that the service they provided was well led and safe. However, we did not find any evidence of board level oversight of the services for children at Maidstone Hospital. The guidance

document 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012) recommends that all providers or urgent and emergency care monitor the care provided for children using nationally defined indicator sets and use this, and additional data, when planning service improvement and proposing future quality indicators. When we spoke with staff and managers, they were not able to tell us how many children were seen in the accident and emergency department each month or each year.

The report issued by the RCS following their review of upper-gastroenterological surgery raised concerns that surgeons were not attending the multi-disciplinary team (MDT) meetings to discuss the treatment options and advise on the best surgical care for patients. Their recommendation was that surgeons should be present for at least 75% of all MDT meetings. There was no evidence that this was happening at the time of the inspection and no clear drive by the executive team or board to ensure that progress was made towards this target. This meant that decisions about care and treatment were not always made by the appropriate staff at the appropriate level. It demonstrated that the monitoring systems across the hospital were not sufficiently robust to inform a cycle of continuous improvement.

The report from the RCS in October 2013 discussed the governance of the complex upper gastrointestinal surgery services at Maidstone hospital. The report said that a clinical nurse specialist had undertaken a range of audits relating to the service. The review team noted the audits were well conducted but were concerned that the positive outcome of audits relating to issues, such as GP letters and whether patients received copies of letters, may have created a false sense of security and masked the serious concerns that the review team identified.

We looked at data given to us by the trust which related to extended anticoagulant therapy in cancer patients undergoing major abdominal surgery. The collection of this data was following changes to the National Institute for Clinical Excellence Guidance (NICE) number 92 recommendations. We saw that at the time the guidance was published a hospital audit for the year ending December 2012 showed 63% compliance with the trust policy. The initiative to improve the level of compliance was put in place and followed up with a subsequent audit ending in January 2014. There was a significant improvement with 83% compliance with the trust policy at this time. We were told that this had been brought about by working with junior doctors, through staff training, awareness raising and by ensuring there were prompts on the surgical pathway documentation. Ongoing monitoring to ensure the improvements were embedded was via the ward dashboards. This demonstrated that some aspects of care were monitored effectively and that the hospital was able to bring about improvements where individual members of staff took responsibility for the initiative.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person must ensure that service users are protected against the risk of receiving care or treatment which is unsafe through ensuring the planning and delivery of care and treatment meets the individual needs and ensures their welfare and safety. Regulation 9 (1) (b)
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The registered person must take appropriate steps to ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying out the regulated activity. Regulation 22
Regulated activities	Regulation

This section is primarily information for the provider

Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The registered person must protect services users and others who may be at risk, against the risk of unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to: regularly assess and monitor the quality of services and identify and manage risks relating to the health, welfare and safety of service users and others who may be at risk form the carrying on of the regulated activity. Have regard to the complaints and comments made and views of expressed by service users and those acting on their behalf. Any investigation carried out by the registered person, appropriate professional and expert advice. Where necessary make changes to the treatment or care provided in order to reflect information of which is it reasonable relating to analysis of incidents and the conclusions of local and national service reviews Regulation 10 (1) (a) (b) (2)(a) (b)(i) (ii)(iii) (iv)(v)(vi) (c) (i) (ii)(d(i)(ii)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 02 May 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

INVITED REVIEW MECHANISM

A SERVICE REVIEW REPORT ON BEHALF OF:

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND
35 – 43 LINCOLN'S INN FIELDS, LONDON WC2A 3PE

ASSOCIATION OF SURGEONS OF GREAT BRITAIN
35 – 43 LINCOLN'S INN FIELDS, LONDON WC2A 3PE

REPORT ON UPPER GASTROINTESTINAL SERVICE

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

2-4 OCTOBER 2013

REVIEWERS:

[redacted] **THE ROYAL COLLEGE OF SURGEONS OF ENGLAND**

[redacted] **ASSOCIATION OF SURGEONS OF GREAT BRITAIN**

[redacted] **LAY REVIEWER**

RCS
ADVANCING SURGICAL STANDARDS

Acknowledgements

The reviewers would like to thank the Maidstone and Tunbridge Wells NHS Trust for the assistance given to them during the course of the review and in particular [redacted] for undertaking the pre-visit arrangements, and [redacted] for supporting the reviewers during the visit.

Contents

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1. Background to the review

Please note that the description in this section of the report, of the circumstances leading to this review being requested, is based on information that was provided to the Royal College of Surgeons (RCS) by the Trust when they completed the RCS' service review request pro-forma. It does not represent the view of the RCS or its reviewers on these circumstances.

On 22 May 2013, Dr Paul Sigston, Medical Director, Maidstone and Tunbridge Wells NHS Trust wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of the Trust's upper gastro-intestinal surgery service. This followed concerns about the outcomes for patients undergoing oesophageal cancer resections. The basis for requesting the review was to explore concerns about an increase in mortality, as well as issues with clinical team functionality and team working.

This request was considered by the Chair of the Royal College of Surgeons of England (RCS) IRM and a representative of the Association of Surgeons of Great Britain. It was agreed that an invited service review would take place and a review team was appointed. An invited review visit was held on 2-4 October 2013.

The background to the review is that concerns have been raised over the past few years about several aspects of the service. In December 2012, two deaths occurred on consecutive days (the operations for these patients had taken place several weeks apart). Both deaths were sudden and unexpected and the trust took the decision to delay operations over the Christmas period whilst an internal review was undertaken. Dr Foster data over the most recent 12 month period available, showed four deaths in 39 patients who had undergone oesophageal cancer resections. On investigation, the trust considered that the service was safe. It reported 'a good track record, with no deaths in 2011'.

The resection service resumed in January 2013. However, the service was again suspended following three deaths in February, April and July 2013. A briefing note provided to the review team indicates that the trust did not consider it appropriate to record these deaths as serious incidents, 'as each case has been examined and was not felt to be inappropriate'. The briefing note stated: 'The mortality reported in the literature is high, with a 1 year survival of approximately only 75%'.

Nevertheless, the Medical Director felt unable to assure the Chief Executive that the service remained safe and took the decision, on 25 July 2013, to suspend oesophageal resection surgery with immediate effect. Neighbouring trusts were informed at the beginning of August 2013 that 'oseophagectomy only' would be suspended and that 'gastrectomy and junctional tumours' would continue to be undertaken. This remained the position at the time of the invited review visit.

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the RCS's review visit between the RCS and the Trust commissioning the review, and were provided to the surgeon that is the subject of the review.

Review of the Specialist Oesophagus and Gastric Resection team at Maidstone and Tunbridge Wells NHS Trust, under the Invited Review Mechanism.

1. To consider concerns about the Upper Gastrointestinal Surgical Team, with specific reference to **outcomes for resection of oesophageal and gastric cancer**. These concerns were raised following a number of unexpected deaths. In addition, unsubstantiated claims about a high rate of complications have been made, some of which were anonymous. It is known that there is a difficult relationship between some surgeons and some of the anaesthetic team, but it is unknown whether this impacts on patient care.

2. The reviewers will then make recommendations for the consideration of the Chief Executive and Medical Director of the Hospital as to:

    - Whether there is a basis for concern about the Upper Gastrointestinal Surgical Team in light of the findings of the review;
    - Possible courses of action which may be taken to address any specific areas of concern which have been identified.

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3. Details of surgical team being reviewed

Maidstone and Tunbridge Wells NHS Trust provides the oesophageal resection service to the Kent and Medway population of 1.6 million. Patients are referred to the trust from East Kent Hospitals, Medway and Darent Valley.

The trust has 12 general surgeons (upper and lower gastro-intestinal) and services are provided over two sites situated 14 miles apart. Emergency surgery, endoscopy lists, outpatient clinics and some day surgery lists are undertaken at Tunbridge Wells Hospital. Elective gastro-intestinal services, including oesophageal cancer resection surgery, are provided at Maidstone Hospital. Outpatient clinics are held at a number of locations.

The oesophageal and gastric cancer resection service is provided by four upper gastro-intestinal surgeons. Mr Haythem Ali was appointed to the trust in 2005 and established the oesophageal and gastric resection service. He was joined by Mr Amir Nisar and Mr Maduabuchi Okaro in 2006. The fourth surgeon, Mr Ahmed Hamouda, was appointed in 2010. Mr Nisar is currently the clinical lead.

Three of the surgeons, Mr Ali, Mr Nisar and Mr Hamouda, operate as a distinct unit within the upper gastro-intestinal team, performing the majority of their cancer resections using minimally invasive surgery. There are slots for three trainee grade registrars, although there appears to be only two working at any one time. These trainees are assigned to the unit of three surgeons. Mr Okaro does not have any trainees assigned to him, but does have non-training grade doctors.

During the past five years there have been significant challenges for the Trust regarding the provision of emergency general surgery. This was split between both sites, but it is now provided only at Tunbridge Wells.

The surgical team are supported by five upper gastro-intestinal clinical nurse specialists (3.2 whole time equivalent). The specialist nurses provide a range of service, including a dedicated telephone follow up clinic for pancreatic/HPB (Hepatic, Pancreatic and Biliary) surgery patients.

There is currently no out of hours endoscopy service provided by the Trust. However, senior clinical management stated that gastroenterologists are being appointed and a seven day endoscopy service will be running by the end of 2013.

4. Royal College Review team	
Lead reviewer	[redacted] FRCS
Clinical reviewer	[redacted] FRCS
Lay reviewer	[redacted]
A brief biography of each member of the review team can be found at appendix one.	

5. Visit timetable	
Wednesday 2 October 2013	
08.00-9.00	Case note review
09.00-9.30	Dr Paul Sigston, Medical Director
09.30-10.30	Case note review
10.30-13.00	Case note review
12.50-13.15	[redacted] Associate Director of Nursing, Planned Services
13.15-15.00	Case note review
15.00-15.45	Glenn Douglas, Chief Executive
15.45-16.00	Case note review
16.00-16.30	[redacted] Consultant Anaesthetist
16.30-17.00	[redacted] Consultant Anaesthetist
Thursday 3 October 2013	
07.30-09.00	Case note review
09.00-09.30	[redacted] Locum Consultant Surgeon
09.30-10.00	[redacted] Sister, Cornwallis Ward [redacted] ICU Clinical Educator [redacted] ITU Senior Sister
10.00-10.30	[redacted] Clinical Director, Critical Care
10.30-11.00	[redacted] Specialist Trainee
11.00-11.30	[redacted] Clinical Director, Surgery
11.30-12.00	[redacted] Consultant Anaesthetist
12.00-13.00	Case note review / lunch
13.00-13.30	[redacted] Senior ITU Dietician [redacted] Clinical Specialist in Respiratory Physiotherapy [redacted] Clinical Nurse Specialist, Palliative Medicine
13.30-14.00	[redacted] General Manager, Surgery [redacted] Complaints Manager
14.00-14.30	[redacted] Consultant Upper Gastro-intestinal Surgeon

14.30-15.00	[redacted] Cancer Data Manager
15.00-15.30	[redacted] Consultant Anaesthetist
15.30-16.00	Case note review / break
16.00-16.30	[redacted] Consultant Radiologist [redacted] Consultant Pathologist
16.30-17.00	[redacted] Consultant Upper Gastro-intestinal Surgeon
Friday 4 October 2013	
07.30-08.00	Case note review
08.00-08.30	[redacted] Consultant Gastroenterologist [redacted] Consultant Gastroenterologist
08.30-09.00	[redacted] Consultant Anaesthetist
09.00-09.30	[redacted] Consultant Upper Gastro-intestinal Surgeon
09.30-10.00	[redacted] Upper Gastrointestinal Clinical Nurse Specialist [redacted] Upper Gastrointestinal Clinical Nurse Specialist
10.00-10.30	[redacted] Consultant Medical Oncologist [redacted] Consultant Medical Oncologist [redacted] Consultant Oncologist
10.30-11.00	[redacted] ST3, General Surgery
11.00-11.30	[redacted] Consultant Upper Gastro-intestinal Surgeon
11.30-12.00	[redacted] Consultant Upper Gastro-intestinal Surgeon (Benign Surgery)
12.00-12.20	[redacted] MDT Co-ordinator
12.20-13.45	Reviewer discussion
13.45-14.00	Feedback to: Dr Paul Sigston, Medical Director Glenn Douglas, Chief Executive

No patients were interviewed or examined during the course of the Invited Review visit.

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6. Documents reviewed as part of the Invited Review visit
Trust management structure; Clinical directorate and management structure
Job planning, appraisal and related documentation: • Shared job plan for Mr Ali, Mr Nisar, and Mr Hamouda. • Summary information showing job plans across surgery. • Curruiculum vitae for Mr Ali, Mr Okaro, Mr Hamouda, and Mr Nisar, and a statement from Mr Nisar detailing his personal contribution to the trust. • Medical appraisal forms for Mr Ali, Mr Hamouda, Mr Okaro, and an extract of an appraisal form for Mr Nisar.
Rota documentation: • Shared weekly timetable for Mr Ali, Mr Hamouda and Professor Nisar. • Weekly timetable for Mr Okaro. • Team rota for the consultants, associate specialists, staff grades and registrars. • Upper gastrointestinal oncall rota. • Surgical on call rota for Maidstone and Tunbridge Wells at Pembury Hospital.
Policies and pathways: • Pathway for upper gastrointestinal clinical nurse specialist/dietician led follow up clinic for postoperative gastrectomy and distal gastrectomy patients. • Operational policy for upper gastrointestinal clinical nurse specialist follow up clinic of postoperative resection patients. • Cancer waiting times quick guide. • MDT policy documentation: local and specialist management of upper gastrointestinal cancers. • Oesophageal, gastric and pancreatic rapid access referral proforma (2 week wait). • Care of patients on intensive care unit following transhiatal or multi-stage, open or minimally invasive oesophago-gastrectomy. • Details of the process for the verification of positive histologies.
Documentation regarding Clinical Nurse Specialist services: • Note by [redacted] Upper Gastrointestinal Clinical Nurse Specialist, about the nurse led clinics to support major post op resection patients with upper gastrointestinal cancer. • Survey of psychological support, wound review and dietary advice for patients in post op follow up clinics. • Proforma for nurse led follow up clinic for upper gastrointestinal patients following oesophago-gastrectomy surgery.

• Clinical supervision log/competency document for upper gastrointestinal nurse led follow up clinic.
Complaints and incidents: • Upper gastrointestinal surgery complaints August 2011-August 2013. • SIRI (Serious Incident Requiring Investigation) Root Cause Analysis reports for two cases. • Incident forms relating to upper gastro-intestinal service: Ref: Web1064 ID: 43119; Ref: Web2313 ID: 45125; Ref: Web11697 ID: 55216; Ref:Web17663 ID:61184; Ref:Web17360 ID:60881; Ref: 2010/14339 ID: 39819; Ref: 86215 ID: 44593; Ref: Web696 ID: 42544; Ref: Web11211 ID: 54730; Ref: Web14757 ID: 58276; Ref: 78005 ID: 36644; Ref: Web4408 ID: 47882; Ref: Web12406 ID: 55925; Ref: Web10338 ID: 53857; Ref: Web1550 ID: 43746; Ref: 2010/1929 ID: 35984; Ref: Web9257 ID: 52775; Ref: 68897 ID:41246; Ref: 82388 ID: 40499; Ref: 83453 ID:39933; Ref:81176 ID:37048.
Activity data: • Upper gastro-intestinal activity by consultant by year, April 2011-September 2013 (daycase, elective and non-elective). • Mortality data provided by Mr Ali, Mr Nisar and Mr Hamouda. • Surgeon level reporting for oesophageal and gastric resections. • Surgical procedures for patients diagnosed in the period 1 April 2011 to 31 March 2012.
Correspondence: • Email exchange between Dr Paul Sigston, Medical Director and [redacted] Consultant Physician and Gastroenterologist, and Division Director for Planned Care, following inquest into a patient death following an oesophago-gastrectomy (5-7 October 2010). • Letter from Dr Paul Sigston, Medical Director, to Medical Directors, Kent and Medway, informing them of decision to temporarily suspend oesophageal resection surgery in Maidstone (6 August 2013). • Email exchange between [redacted] Quality Manager, National Peer Review and Dr Paul Sigston, Medical Director, and [redacted] concerning communication of the decision to suspend services (30 July 2013). • Letter from Dr Paul Sigston, Medical Director, to Amir Nisar, detailing decision to suspend oesophageal resection surgery with immediate effect (25 July 2013). • Email from Dr Paul Sigston, Medical Director, to Ian Abbs, Guys and St Thomas' NHS Foundation Trust, informing him of decision to suspend the service (25 July 2013). • Letter from Dr Paul Sigston, Medical Director, to Professor David Black, KSS Deanery, in response to details of patient safety concern highlighted in the GMC National Training Survey (17 May 2013). • Letter from Professor David Black, KSS Deanery, to Glenn Douglas, Chief

Executive, regarding a patient safety issue raised by the GMC (13 May 2013).

- Letter from Dr Paul Sigston, Medical Director, to Mr Simon Bailey, Clinical Director – Surgery, regarding two postoperative deaths in December 2012 and suggesting that surgery resume. (10 January 2013).
- Email from Dr Paul Sigston, Medical Director, to Mr Simon Bailey, Clinical Director – Surgery, requesting data on oesphagectomies from 1st October and delaying all oesphagectomies until data has been reviewed (21 December 2012).
- Letter from [redacted] MP to Glenn Douglas, Chief Executive, regarding allegations in the local press from a surgeon representing the consultant general surgical group (10 May 2012).
- Letter from Glenn Douglas, Chief Executive, to [redacted] MP, in response to [redacted] correspondence (16 May 2012).
- Letter from Mr Amir Nisar, Consultant General and Upper GI Surgeon, to Dr Walter Melia, Consultant Gastroenterologist, Darent Valley Hospital, informing him of suspension of 'oesophagectomy only' (1 August 2013).
- Letter from Mr Amir Nisar to Dr Paul Sigston, Medical Director, requesting a meeting to discuss issues regarding the Upper GI department (9 December 2011).
- Anonymous letter (from 'concerned staff at Maidstone Hospital') to the General Medical Council reporting 'dangerous and unethical practices' in surgery, and specifically concerns about the consultant upper gastrointestinal surgeons, theatre administration, and cross cover arrangements for oncology and urology (May 2011).
- Letter from [redacted] Investigation Officer, General Medical Council, to Dr Paul Sigston, Medical Director, enclosing the anonymous complaint received by the General Medical Council (2 June 2011).
- Letter to Mr Simon Bailey, Clinical Director – Surgery, raising issues about the surgeons relating to the wards at Tunbridge Wells Hospital (20 September 2013).
- Email exchange between [redacted] Consultant Anaesthetist and Clinical Director, Ali Haytham, Upper gastro-intestinal consultant surgeon, and Amir Nisar, Upper gastro-intestinal consultant surgeon (18 March 2013).
- Letter to Mr Simon Bailey, Clinical Director – Surgery, regarding surgical attendance at the Upper GI MDM (5 August 2013).
- Email to Mr Simon Bailey, Clinical Director – Surgery, regarding surgical and radiological attendance at a specific, undated, MDM meeting.
- Email to Mr Simon Bailey, Clinical Director – Surgery, regarding surgical attendance at an upper GI MDM on 29 August.
- Letter from six consultant anaesthetists to Mr Simon Bailey, Clinical

Director – Surgery, regarding the scheduling of patients having oesophago-gastrectomy for intensive care (26 April 2012). • Letter to Mr Simon Bailey, Clinical Director – Surgery, regarding concerns about the numbers of patients requiring multiple dilatations following fundoplication (21 September 2012). • Letter to Mr Simon Bailey, Clinical Director – Surgery, raising concerns about one of the upper gastrointestinal surgeons (20 December 2012). • Letter to Mr Ali, Consultant Surgeon, raising concerns about interprofessional communication and junior staff competencies (4 December 2012). • Email to Mr Simon Bailey, Clinical Director – Surgery, concerning a planned [redacted] (6 August 2013).
Documentation provided by clinical nurse specialists: • Upper gastro-intestinal cancer support group patient involvement forum (June 2012, September 2011). • Audit of copy letters to patients (March 2013, April 2012). • Audit for 'Policy for communication of diagnosis to GP' (April 2012). • Survey: Outcomes for patients' in postoperative upper gastrointestinal nurse led follow up clinic (August 2012). • Report following data collection for the period of March and April 2013 of upper gastro-intestinal clinical nurse specialist (CNS) calls into the CNS office and outcomes from CNS calls returned (June 2013). • Audit of surgical pathway (March 2012). • Audit of the non-surgical patient follow up calls with outcomes recorded on KOMS (September 2013). • Kent and Medway oncology patient experience audit (Spring/Summer 2010). • Survey of pathway timescales for patients receiving neo-adjuvant chemotherapy and surgery (May 2012). • Surgical pathway audit (May 2013). • East Kent upper gastro-intestinal referral to specialist centre audit (2011).
Multidisciplinary Team Meeting documentation: • Upper gastro-intestinal morbidity and mortality meeting diary 2011/2012. • Multidisciplinary team minutes (13 April 2011). • Upper gastro-intestinal morbidity and mortality meeting attendance record (7 September 2011, 8 February 2012, 2 March 2012, 7 March 2012, 6 June 2012). • Upper gastro-intestinal morbidity and mortality meeting agendas (7 September 2011, 8 February 2012, 7 March 2012, 6 June 2012). • Minutes of the Diagnostic Radiology Audit and Clinical Governance meeting (13 June 2013).

7. Information reviewed that supports the conclusions reached

The following information represents a summary of the information gathered by the reviewers during the interviews held during the service review visit and from the documentation submitted. It is organised under the headings of the themes that emerged. The information presented reflects the viewpoints of those individual staff members being interviewed; it does not necessarily reflect the views of the RCS or its reviewers on these circumstances.

(i) Surgical outcomes

This invited review was triggered by concern about two unexpected deaths in December 2012, followed by three deaths that occurred in February, April and July 2013. A further, sixth death relating to this type of surgery had occurred earlier in 2012. The terms of reference directed the review team to consider postoperative mortality in addition to "unsubstantiated" claims about a high rate of complications.

The reviewers considered the following evidence relating to surgical outcomes:

- Documentary evidence provided by the Trust, including correspondence from staff;
- Verbal accounts provided by interviewees during the invited review visit;
- The case notes relating to each of the six deaths. In order to put these deaths in context, and also to reach a view on claims of a high rate of complications, 84 sets of notes relevant to the terms of reference were also reviewed. The reviewers were provided with patient records dating back to 2006. Records were then randomly selected by the reviewers. The number of records reviewed represented approximately half the oesophogastric cancer resections performed in Maidstone since 2006.

Postoperative mortality

The review team has had sight of only limited data on patient outcomes following oesophageal and gastric cancer resection surgery. The data showed the following:

- In 2012, 40 oesophago-gastrectomies were performed (this compared with 49 in 2011, and 56 in 2010). There were three deaths following this surgery during 2012.
- Overall 30 day mortality was reported as having been 4.6% since 2005, however the total and in hospital mortality combined was 7.1% in 2010, 7.5% in 2012 and peaked at 15% in 2013 just before the service was suspended.
- A cluster of mortality in 2010 was attributed to the introduction of enteral feeding protocols, and two consultants operating and building job plans to accommodate this.

The invited review team was asked to consider the more recent cluster of deaths between December 2012 and July 2013. Following the deaths of two patients in December 2012 who had undergone oesophageal resections, a review took place. The Medical Director formally reported that this review of oesophageal resections over the previous four years had confirmed the death of seven patients, out of a total of 206 (3.4%). This compared with national data of 3.2%. He reported that outline data suggested a mortality for open cases of less than 5% and half that for minimally invasive cases.

A decision was made to resume oesophageal surgery, on the grounds that: 'It appears that there is no link between the two recent deaths and whilst we will keep a close eye on outcome data, there is no reason to alter the majority of the unit's practice'.

The reviewers were told that the operating surgeon was the same for four of the six postoperative deaths in oesophageal resections.

Some of the interviewees suggested that the mortality rate would have been higher were it not for the skills of the intensivists. The quality of care provided by the intensive care unit appears to be high. This is supported by the observation that despite high postoperative complication rates, the minimally invasive oesophago-gastric surgical unit had mortality rates within acceptable limits compared to national figures. The anaesthetist team appeared well motivated and highly engaged in providing the best possible outcomes for patients, which seems to have kept the postoperative mortality at an acceptable level.

Postoperative complications

The reviewers considered the following documentary and verbal evidence about complications:

Length of stay

- Data showed that the average hospital stay for patients undergoing oesophago-gestrectomy was 23 days, with an average intensive care unit stay of 12 days. Both the overall length of stay and intensive care stay are long by national standards.

- Oral evidence was that the length of intensive care stay reflects that the unit also provides high dependency care; there is no step down ward. However, some interviewees considered that the length of stay also reflected the rate of postoperative complications.

- In 2012, consultant anaesthetists formally raised concerns about scheduling of patients having oesophago-gastrectomomy for intensive care. The Intensive Care Unit post-oesophagectomy protocol aims to discharge patients to the ward on the third postoperative day, however the anaesthetists reported 'this rarely occurs'. Uncomplicated patients – reported to comprise about 30% of oesophago-

gastrectomomy – were described as usually having a five day stay, but most patients were reported to stay on the intensive care unit for between eight to 10 days, with some staying several weeks or even months. The presence of a large number of upper gastro-intestinal patients was cited as creating issues in terms of patient safety (by compromising the ability of intensive care to manage unplanned, acutely critically ill patients), for other major planned surgery, and having financial implications for the intensive care unit.

Unexpected complications

- Many interviewees expressed concern about complication rates, particularly for anastomotic leaks. Some staff had formally documented their concerns in correspondence with clinical managers.

- Following review of the two deaths in December 2012, the Medical Director reported that the unit's rates for anastomotic leak were 4% and 10.6% in the preceding two years. He had described these rates as being within the expected range. However, an internal audit suggested the leak rate might be higher; this issue remained unresolved as no definition of anastomotic leakage could be agreed upon.

- The reviewers observed from the case notes a number of unexpected complications, namely bleeding from the liver following injury during a thoracoscopic port insertion, colonic necrosis following injury to the colonic blood vessels during gastric mobilisation, and aorto-enteric fistulae following thoracoscopic mobilisation of the oesophagus.

Complications associated with laparoscopic techniques

- Interviewees repeatedly raised concerns about complications experienced by patients who have undergone minimally invasive oesophago-gastrectomy. Often interviewees were not able to quantify these complications, but the recurring message from staff from different disciplines was that more postoperative problems seemed to occur in patients undergoing minimally invasive or laparoscopic surgical techniques.

- All interviewees were asked by the reviewers whether they would recommend the oesophago-gastric unit at Maidstone Hospital to family and friends who needed surgery for upper gastro-intestinal cancer. Many said they would not recommend the unit. Of these, many volunteered that their lack of faith in the unit related to the minimally invasive approaches to surgery and not to open operations.

- One of the three surgeons who has been performing laparoscopic oesophago-gastrectomomy reported that, recently, he had stopped undertaking oesophageal surgery using laparoscopic techniques due to concerns about complications. The

fourth surgeon only performs open oesophago-gastrectomomy and said this was because he was unconvinced of the benefits of laparoscopic techniques.

Management of complications

- Verbal accounts raised concern about the way the upper gastro-intestinal surgeons have tended to respond to complications in their patients. One interviewee said: 'There are no proper discussions of an anastomotic leak and when you mention the word 'leak' to a surgeon they become very defensive.' Others described at least two of the surgeons as being unreceptive to feedback or challenge. One said: 'There is no ethos with them to look at leaks and consider how to do things differently'.

- There was verbal evidence of a defensive response to an investigation into the incidence of anastomotic leakage by one of the ICU consultants. Some of the surgeons were reported as having said that the wrong definition of a leak was being used.

- Case note review identified that some cases of postoperative leakage had been managed by using stents, when revisional surgery/insertion of a t-tube etc. would have been a more appropriate and accepted treatment.

- A letter to one of the upper gastro-intestinal surgeons at the end of 2012, raised concerns about a 'complete lack of communication over some patients' and a lack of understanding by junior staff regarding biliary drainage of a patient.

- The reviewers observed from the case notes that the surgeon who had operated on a patient with complications postoperatively was often not involved in the subsequent care of that patient. The reviewers heard that, on occasions, the operating surgeon was not contactable by phone when the intensive care team tried to involve him in the decision making process about next steps for the patient.

Clinical decision-making

Concerns were expressed to the reviewers by some interviewees about the quality of the decision-making by the three upper gastro-intestinal surgeons who favour laparoscopic approaches. There was evidence to support this in the following areas:

Palliative pathway

Some interviewees questioned whether patients with advanced disease have been put down a radical treatment pathway when palliation would have been more appropriate. There was a belief that some palliative care patients were being kept in hospital for too long.

There was some suggestion that the surgeons placed little importance on certain services (for example, palliative care) that patients might have expected elsewhere. Furthermore, patients undergoing an oesophago-gastrectomomy underwent CPEX testing (a fitness for major surgery test), but such testing was not routinely requested for patients having a gastrectomy; the rationale for this was not clear to the reviewers.

Management of complications

The management of some post- oesophago-gastrectomomy complications raised questions about some of the clinical decision-making of the surgeons. An example of this, mentioned previously, is multiple stent insertion for anastomotic leakage.

TPN

The use of TPN (total parenteral nutrition) for all oesophago-gastrectomomy patients and for prolonged periods, raises concerns about clinical decision-making. The upper gastro-intestinal surgeons explained that this was their response to two cases of small bowel necrosis with a feeding jejunostomy (a feeding tube placed surgically into the small intestine at the time of the operation). This is a recognised complication of these tubes and is thought to be due to an excess feed rate soon after surgery. The reviewers were not aware of other units routinely using TPN as an alternative, or of an evidence base for such practice. Any worry about complications from feeding jejunostomies should have been addressed by changing technique, changing the feeding regimen or stopping the use of feeding jejunostomies.

Benign surgery

Benign surgery was outside the scope of the terms of reference for this invited review, however the verbal reports indicated the following: a high incidence of dysphagia after routine anti-reflux surgery; a case of stenting or dysphagia after anti-reflux surgery; and a case of [redacted]
With regard to the latter, the reviewers saw correspondence from August 2013, which had formally questioned the rationale for a [redacted] by one of the surgeons on a [redacted] In 2012, documentation shows that concerns were raised about the numbers of patients requiring multiple dilatations following fundoplication (a routine operation to treat acid reflux and heartburn).

(ii) Team working

Intra-departmental

The four upper gastro-intestinal surgeons were repeatedly described by interviewees as being a 'dysfunctional team'. Three of the surgeons work as a distinct unit, agreeing amongst themselves at short notice who will attend a fixed clinical session such as an operating list. One of the three consultants told reviewers that managers had encouraged them to work together in this way but there was no evidence available to support this claim. When pressed, the same surgeon admitted that this style of working was not ideal and that it would be better if each consultant looked after their own patients. The reviewers noted that trust headed paper for the department listed only the three surgeons, although reportedly this had been changed more recently. One interviewee described the working practices of the three surgeons as 'secretive'. Many interviewees highlighted problems caused by this way of working, which are covered in the following section.

The fourth surgeon works very much in isolation to the other three, undertaking his own lists and clinics, and reviewing his own patients. Some interviewees expressed concern about this surgeon working in an isolated way and about a lack of cover in his absence. Nevertheless interviewees commented that they knew that he would be present at clinic and endoscopy, and that his patients knew that he would be the surgeon in charge of their surgery. This was not the case with the other three. The surgeons reported that they cross-cover each other's patients, including those of the fourth surgeon. However, oral accounts suggested that this was not borne out in practice. Furthermore, a number of interviewees observed tensions between the unit of three surgeons and the fourth surgeon. For example, accounts were given of confrontations between the fourth surgeon and the other three at multidisciplinary meetings.

Inter-departmental

The terms of reference for this review indicated: 'a difficult relationship between some surgeons and some of the anaesthetic team, but it is unknown whether this impacts on patient care'.

The reviewers were told that tensions have existed for some time between some of the consultant anaesthetists and the upper gastro-intestinal surgeons. It was reported that problems have persisted despite a mediation meeting between the two teams some time ago.

Interviews with members of the two teams suggested a complex picture. On the one hand, working relationships between the upper gastro-intestinal surgeons and anaesthetists were described as 'dangerous'. Personality issues were cited between two consultant anaesthetists and two of the upper gastro-intestinal surgeons. However, a number of the anaesthetists were reported as having concerns about working with one

surgeon in particular, and broader concerns about the three. One described one of two surgeons who attracted most concern as having 'zero insight'.

A general lack of communication between the gastro-intestinal surgeons and the anaesthetists was reported to be a problem. This was supported by documentary evidence highlighting tensions between the two teams over the scheduling of oesophago-gastrectomomy patients. More than one interviewee reported that they do not know when oesophago-gastrectomomies are to be appear on a theatre list, which creates planning problems for the anaesthetic team in making sure that a suitably experienced consultant anaesthetist is available.

An internal email exchange highlighted difficulties between the upper gastro-intestinal surgeons and one anaesthetist, such that the surgeons felt unable to work in theatre with that anaesthetist. However, in interview none of the upper gastro-intestinal surgeons expressed any concerns or reported problems about working with their anaesthetic colleagues.

Good working relationships were reported between the anaesthetists and the fourth surgeon who undertakes open surgery. No concerns were reported about working relationships amongst the team of anaesthetists.

With nursing staff

The working practices of the three surgeons were reported to result in frequent changes to a patient's management plan, which undermined team working on the ward. The reviewers heard that one surgeon would prescribe a plan, which might be altered by another of the three surgeons on review of the patient. Staff described having to cope with this inconsistency and the confusion that sometimes arose.

Staff reported that patients needed to explain to the surgeon what had happened to them in the previous days because the surgeon had not visited the patient previously and may not have even scanned their notes. Interviewees described how this undermined patient confidence in the surgeons and impacted negatively on their experience of care. Patient feedback about their experiences on the ward was reported to highlight problems around a lack of consistency and continuity of care (explored further in the following section).

An anonymous complaint to the General Medical Council from 'concerned staff at Maidstone Hospital', in May 2011, alleged: 'The consultant upper gastrointestinal surgeons very rarely see their patients either after admission or after operations. This task is left for registrars and nurses.' This was supported by correspondence in the run up to the invited review visit, which highlighted a range of concerns by nursing staff at Tunbridge Wells Hospital, including an alleged failure by one upper gastrointestinal surgeon to attend 8am handover when on-call or to see patients at weekends as the on-call consultant, and a failure by all the upper gastrointestinal surgeons to follow the

agreed upper gastrointestinal pathway, specifically by not following up patients transferred to Tunbridge Wells Hospital. This was resulting in poor patient experience, delays in implementation of the pathway and an increase in length of stay. The author of the correspondence stated: 'I cannot accept this level of service to our patients'.

(iii) Working practices

Joint job planning

The three surgeons who work as a unit reported that they have a combined job plan and that programmed activities (PAs) are shared between them equally. The fourth surgeon has his own individual job plan. This arrangement appears to have been instigated when Mr Ali was the clinical lead.

The reviewers were provided with conflicting information regarding the PAs of the four surgeons. In interview, clinical managers reported PAs for the upper gastro-intestinal surgeons that were significantly higher than was indicated in documentary evidence. The surgeons themselves reported PAs that did not marry with the numbers described by clinical managers or was supported by documentary evidence.

Documentary evidence showed totals for the four upper gastro-intestinal surgeons, ranging from [redacted] PAs each. Yet the job plans for Mr Ali, Mr Nisar and Mr Okaro, which were in discussion stage as of April 2012, indicated PAs ranging from [redacted]. These appeared to represent proposed changes for 2013/14. No job plan was provided to the reviewers for Mr Hamouda.

The evident disparity in PAs for the three surgeons with a shared job plan was difficult for the reviewers to understand. Managers similarly described being unable to comprehend how many fixed sessions each of the three surgeons was meant to be doing.

The way the weekly timetable worked was unclear and it proved impossible to understand how the three surgeons covered all the fixed sessions detailed on the timetable. The reviewers were told by the one of the surgeons that the timetable was 'aspirational'. It was commonly reported to the reviewers that the physical whereabouts of the three surgeons was often unknown due to the incomprehensibility of their joint job plan. The reviewers developed the impression that this may have not been accidental.

There was evidence of difficulties caused by the joint job planning arrangement across the patient pathway:

- Outpatient clinics: A backlog of patients are on the waiting list, and over 85% of patients waiting more than 18 weeks are upper gastro-intestinal patients. Yet attendance at clinics by the three upper gastro-intestinal surgeons was reported to be poor. Staff were routinely uncertain which of the three surgeons would turn up

to clinic. Oral evidence was that clinics were often undertaken by registrars. The endoscopy clinic at Maidstone is, according to one of the three surgeons, 'almost exclusively' covered by Associate Specialists. One reported incident (Ref: Web11697 ID: 55216), labelled 'shortage of doctors', highlighted that at one upper gastro-intestinal clinic (on 31 Aug 12), no doctors had arrived in clinic. The incident form indicates that patients received apologies, but no investigation was recorded. The fourth surgeon's attendance at clinics was considered to be reliable and consistent. An audit of the surgeons' attendance at outpatient clinics was underway at the time of the review visit.

- Operating lists: Members of the team working alongside or supporting the surgeons in theatre described not knowing which of the three surgeons is operating until the day of surgery. Numerous attempts have been made to pin down the three surgeons to a specific operating list. Some oral accounts suggested that patients receive little notice of their operation date, as the surgeons decide at their Wednesday meeting who to operate on the following Monday. Others said it is known which patients are on the list two weeks in advance. However, difficulties scheduling surgery were also reported amidst accounts that it was not unusual for operations to be cancelled. Two of the three surgeons have been operating jointly since the cluster of deaths. It should be noted that some of the theatre staff were very positive about the care patients receive in theatres. No concerns were raised about the practice of the fourth surgeon in theatres.

- Intensive care unit (ICU): One of the minimally invasive surgeons would attend the ICU daily but evidence from the case note review found that most daily input was from the Associate Specialist surgeon working on the oesophago-gastric unit (this individual has since left the department). It is possible that one of the consultants was seeing patients daily but this is not recorded in the notes. There were mixed accounts of how accessible the surgeons are when their input is needed on ITU because of complications.

- The wards: The reviewers heard that there is no fixed ward round at Maidstone. At least one ward round will be conducted daily, but ward staff are unclear which of the three surgeons will conduct the ward round, or when. Ward rounds by the three surgeons are not considered to be consultant led, raising issues for trainee learning as well as patient care. Uncertainty over where the three surgeons are at any one time was a recurring theme. One interviewee talked about a 'return to old ways of working in the past' citing reports that one surgeon would often arrive late to the ward, leave early and only see some patients. The three surgeons were described as 'not easy' to get hold of, and not often visible on the wards. Locum staff and senior trainees were described as the constant presence on the ward and kept the service going – although communication issues with locums, resulting in poor handovers and delays in management plans, was also reported to be an issue. The working

pattern for the fourth surgeon was considered to be more predictable and transparent, and his presence on the wards at Maidstone was consistent.

Joint patient care

The three surgeons have decided on a very unusual way of managing individual patients. This might involve one of them seeing a patient to tell them the diagnosis, another surgeon consenting the patient for surgery, a different surgeon actually doing the surgery and the postoperative care provided by someone else. The result was that no-one was clear about who was ultimately in charge of a patient's care. Although the reviewers were not able to interview any patients, there was concern that patients would not feel any sense of continuity of their surgical care with this model of joint working.

A number of interviewees observed that by working interchangeably to provide services to patients, the three surgeons do not provide continuity of patient care. Some interviewees reported that patients will often request to see a particular consultant at clinics, but staff have no idea whether that consultant will be attending the clinic. Interviewees reported that patients like to see people they 'know and trust' all the way through the process. Confusion over who has responsibility for patients was evident and interviewees highlighted a lack of 'ownership' of patients and the patient pathway. Some interviewees said the service felt disjointed and one said: 'it feels less and less of a consultant service'.

Interviewees articulated the particular importance of continuity of care for patients with cancer. One said: 'You need to see the same face when you are dealing with long term care for cancer. That's how I'd like to be treated.' Some interviewees advise friends and family, or private patients, to go elsewhere for oesophageal surgery as they are not confident they will receive the quality of care that they should be able to expect.

One of the three surgeons conceded in interview that there was no continuity of care, but he considered this to reflect practice across the NHS. However, he added that if he was redesigning the system he would have consultants following patients through the pathway to facilitate continuity of care. Another of the three surgeons explained that their working arrangements enable patients to be seen and operated on in time, and that they always receive consultant input. He added that there was continuity of care by the consultant team, and that their arrangements allowed them to standardise and provide for equality of care.

However, the evidence was that their joint working arrangements did not provide for standardised care and in fact undermined the quality of patient care. The three surgeons said that they provide cross cover for each other's patients, but this was not borne out in practice when colleagues approached them with queries about a patient. Reports that the three surgeons sometimes contradicted each other with requests, creating confusion for colleagues and patients, was further evidence that their joint approach does not provide

for better standardised care.

Further evidence that raised questions about the patient focus of the surgeons came from reports that one of the surgeons performs surgery under live televised links beamed to trainees in other locations. Interviewees had mixed views about these 'live links': some said they made them feel under pressure in theatre, while others were content that they did not impact on patient care. One live broadcast required theatre staff to attend the theatre at 5am, which some interviewees considered compromised the team.

(iv) Consent

The reviewers received evidence that the three upper gastro-intestinal surgeons have not been consenting patients properly.

The four surgeons receive referrals according to geographical patch. The three surgeons who work as a unit explained how they cover the pool of patients referred to them. Patients are told that they will be operated on by one of the three. The bias of these three surgeons has been to undertake oesophago-gastrectomomy using minimally invasive surgical techniques (although one has more recently ceased taking this approach due to complications).

The reviewers heard that all patients referred to the three surgeons are not routinely presented with the option of laparoscopic or open surgery, or given an appraisal of the risks and benefits of each approach, which would enable them to make an informed choice. At the MDM, the three surgeons will discuss treating the patient using minimally invasive surgical techniques. The evidence was that these surgeons will agree with the patient to start the operation with minimally invasive techniques and only proceed to open surgery if necessary. The fourth surgeon, who undertakes open surgery, reported that he never receives referrals from his surgical colleagues of patients wanting to have open surgery.

Oral accounts were that patients of the three surgeons are usually consented on the day of surgery. One surgeon reported that he takes consent, but another said that most patients were consented by associate specialists. The reviewers heard accounts that trainees would sometimes take consent.

(v) Multidisciplinary Team Meeting (MDM)

A recurring theme from interviewees was poor attendance by the upper gastro-intestinal surgeons at the MDM, including by the MDM Chair. There were reports that rarely more than one of the four surgeons attends, even though the meeting is meant to be led by the surgical team and chaired by the lead upper gastro-intestinal surgeon. The surgeon who operates outside the unit of three was reported to attend the MDM most frequently and to stay for the whole meeting. Attendance by the others was described as sporadic and even when they attended, interviewees reported that they will stay for only about an hour.

Other MDM attendees described frustration at this and observed that treatment plans for patients were discussed without their surgeon being present. The patient caseload is structured on a geographical basis, with Dartford patients discussed last, when attendees are reduced in number and fatigued. Insufficient focus on the patient was highlighted as an issue.

'Significant concerns' regarding the attendance record of the upper gastrointestinal consultants at the upper gastro-intestinal MDM were raised formally by the radiological department in August 2013. These concerns were also highlighted in the minutes of the Diagnostic Radiology Audit and Clinical Governance meeting held in June 2013, which reported that attendance by the upper gastro-intestinal surgeons 'is consistently poor and is affecting the quality of the MDM therefore placing patients management at risk. Large numbers of patients have been discussed in the absence of the managing surgeon. Patients are therefore repeatedly discussed week on week'. The minutes continue that the gastro-intestinal surgeon who chairs the MDM 'rarely attends the meeting himself' and reports that in the preceding weeks 'a single MTW [Maidstone and Tunbridge Wells] surgeon was present for only half an hour on two occasions.' It was even suggested that radiological support for the upper gastro-intestinal MDM should be withdrawn until the issue with surgical attendance was resolved.

Other MDM attendees try to work around what are clearly perceived as shortfalls in the surgical input to these meetings. One member of the anaesthetics team said: 'As anaesthetists we try very hard to patch up the difficulties'. The oncology team was also perceived as being 'strong' and pulling the meeting along.

Confrontations between the upper gastro-intestinal surgeons caused other attendees to feel uncomfortable at the meetings. A lack of visible chairing was reported to be an issue.

Interviewees observed that other cancer specialists take 'full ownership' of their patients from discussing them at MDM meetings and along the patient pathway. One interviewee said: 'these three don't take responsibility in the same way….they just do not know their patients'. The three surgeons were perceived as being hampered from inputting into

MDM discussion by uncertainty over which of them will perform the operation.

In interview, the three surgeons reported that they regularly attend the MDM. One said that any perceived dysfunction in their interactions with each other reflected that they were trying 'to do our best for patients'. The surgeons also reported that they attend two local MDMs (at Dartford and Gravesend) in addition to the Maidstone MDM. It was not evident to the reviewers which patients are discussed at the local MDMs and which at the main one.

The reviewers observed that the MDM printed outcomes were poorly structured, making it difficult to pinpoint the patients pre-treatment stage and management plan. It was impossible from the MDM outcomes to see which clinician was in charge of the patient's care or to identify their keyworker.

The reviewers heard that there is a process for verifying all positive histologies to ensure that these are discussed at MDMs. This was described as a 'backup process' to the clinical process, where clinicians and histopathologists add patients to the MDM as required. The Cancer Data Manager outlined what appears to be a robust process for recording and extracting treatments from the database and validating that patients are appropriately discussed in the MDM.

(vi) Clinical governance

Interviewees generally considered clinical governance arrangements within the trust to be robust. Staff surveys were reported by senior management to reflect a culture of openness. However, documentary evidence showed almost two months had lapsed before one serious incident requiring investigation (SIRI) was declared (incident 2010/14339). The evidence also showed a death from pulmonary embolism in a patient who had an oesophago-gastrectomomy for cancer (ref:Web17663 ID:61184). Trust staff had considered that there was 'no learning to be gained' from raising this death as a serious incident. One of the allegations made in May 2011 as part of the anonymous complaint to the General Medical Council was that the upper gastro-intestinal service had a high complication rate that was not reported at local clinical governance meetings.

Specialty-specific mortality and morbidity (M&M) meetings

The upper gastro-intestinal surgeons had conducted a number of specialty-specific M&M meetings between 2011 and 2012. These meetings provided for internal scrutiny of upper gastro-intestinal outcomes. However, no minutes were shared with clinical managers (or the review team), only four meetings had been held and they had been discontinued since June 2012. Only one upper gastro-intestinal surgeon had attended the March 2012 meeting and no upper gastro-intestinal surgeons had been present at the June 2012 meeting.

One interviewee described discussion of cases at these meetings as being 'at a rudimental level'. Another said that there had not been complete 'buy-in' to the meeting due to a perception that it was 'a boxing ring' between the surgeons.

General surgery M&M meetings

The only other mechanism that exists for the gastro-intestinal surgeons to discuss complications as a team is the monthly general surgery M&M meeting. However, some interviewees expressed concern that a full agenda of general surgery cases means that 'learning experiences' for upper gastro-intestinal surgery are not explored sufficiently at this meeting.

Complaints

An overview of themes arising from upper gastro-intestinal surgery complaints received during August 2011 to August 2013 highlighted some concerns about communication, waiting for treatment, postoperative complications and uncertainty over diagnosis.

Audits

The Clinical Nurse Specialist (CNS) team undertake a range of annual audits, including of GP communication, patients receiving copy letters, and patient satisfaction. An audit of the nurse led postoperative clinics for 2012 and 2013 was being processed at the time of the Invited Review. The review team observed that these audits were well conducted but may have given false reassurance to all concerned that everything was functioning appropriately and safely.

(vii) Clinical leadership

There has been a change in clinical leadership within the upper gastro-intestinal surgeons. Unfortunately, the lead surgeon has been absent from the trust for an extended period during the last year.

Senior clinical managers made reference to long-standing 'noise' in the system about the upper gastrointestinal consultant surgeons. The reviewers also saw numerous emails and letters to clinical managers raising concerns. Mostly the correspondence highlights concerns about the upper gastrointestinal surgeons as a group, however specific and serious concerns have been raised about one individual surgeon. Verbal accounts supported the concerns about this particular surgeon, but also frequently cited difficulties working with a second surgeon as well.

The documentary evidence showed whistleblowing by staff from different disciplines. The evidence shows that some staff have felt obliged to speak out in the interests of patient safety. This invited review was initiated to inform management whether there is a basis for concern regarding mortality and complications of oesophageal and gastric cancer resections. The managerial response to other concerns relating to the surgeons, either as

a group or as individuals, was not evident. The clinical manager who looked into the allegations made to the General Medical Council described the letter as 'inaccurate and malicious'. Yet interviewees supported some aspects of the allegations – for example, in terms of a lack of ward presence. This led the reviewers to question the robustness of the management response to whistleblowers' concerns.

In interview some staff described feeling intimidated about raising concerns, even suggesting that the team of upper gastro-intestinal surgeons enjoy a special status within the trust. One interviewee described the three surgeons as 'untouchable'. A lack of consistency by clinical managers in responding to concerns was reported to be an issue.

At the end of 2011, one of the gastro-intestinal surgeons wrote to the trust Medical Director noting 'an ongoing resistance and malicious campaign against us from various directions over the last few years and currently this is being conducted with unparalleled ferocity which makes us all concerned.' This letter referred to the anonymous allegations made to the General Medical Council, as well as to a local MP and the media. This surgeon said that the service had embedded itself well and become 'a well-known centre running a high standard practice at national level'. He reported that 2011 had been 'an excellent year' with no mortality from oesophago-gastric cancer patients and very low morbidity.

The appraisal forms for some of the upper gastrointestinal surgeons allude to difficulties experienced as a result of service reconfiguration and split site working. One of the surgeons described the latter part of 2012 as very stressful 'with major leadership and managerial challenges' and 'a lot of outside scrutiny' of the upper gastro-intestinal team.

8. Conclusions

Basis on which conclusions are reached

The following conclusions are reached on the basis of the documentation reviewed (as set out in section 6 above) and the interviews held with staff at Maidstone and Tunbridge Wells NHS Trust (as described in section 5 above).

Overall conclusions about the surgical service under review

Surgical outcomes

The reviewers have serious concerns about the clinical quality of the oesophageal and gastric cancer resection service. The review team had understood that the risks to patient safety had been mitigated by the suspension of the service. However, it has become evident from correspondence with the trust since the visit that oesophagectomy only has been suspended and that gastric cancer surgery has continued. Given that many tumours occur at the oesophageal-gastric junction, there is little sense in suspending only oesophagectomy. Moreover, the terms of reference for this review were to consider concerns relating to outcomes for resection of oesophageal *and* gastric cancer. The reviewers therefore considered the service in the round and have identified concerns that apply to the whole service, not only to oesophagectomy.

The reviewers conclude that patient safety concerns exist for the following reasons:

1. A high complication rate associated with the laparoscopic techniques that have been used;
2. Poor management of complications that have arisen;
3. Some deaths have occurred as a result of unusual complications, probably associated with the minimally invasive surgical techniques that have been used;
4. Poor insight by the minimally invasive consultants into deficiencies in the service they have provided;
5. Dysfunctional working relationships between the three minimally invasive surgeons and the fourth surgeon;
6. Inadequate consent process by the minimally invasive surgeons prior to oesophago-gastrectomy;
7. Ineffective MDM working due to poor attendance by the minimally invasive surgeons (particularly by the Chair of this MDM), reports of unproductive discussions between the surgeons at the MDM, and a number of questionable decisions to proceed with radical surgery in the presence of advanced and incurable cancer.

The reviewers conclude that a number of patients with pre-treatment staging of advanced disease (T3N2-3), with significant co-morbidities, were put down a radical curative pathway when a palliative pathway would have been more appropriate. Some of these patients had poor outcomes, such as early recurrence of cancer, within 3-6 months of having chemotherapy and surgery. This is a marker of poor patient selection and/or poor treatment – one year survival is accepted to be a good indicator of the quality of a service, and most

teams would expect 70-80% of their patients who had radical therapy to be alive at one year.

Based on the case notes, the reviewers identified a high complication rate associated with the laparoscopic techniques that have been used. A common complication was anastomotic leakage, which resulted in long intensive care and total hospital stays. The National Oesophago-gastric Cancer Audit 2013, shows that an anastomotic leak increases the median length of stay from about 14 days to 30 days and increases the in-hospital mortality five times. The risk of needing further surgery after a leak is 10 times higher.

The management of anastomotic leaks was substandard and often involved the inappropriate use of oesophageal stents. Principles of drainage of sepsis and establishment of cutaneous fistula were not in evidence. Stents rarely control anastomotic leaks, have a very limited role in their management and are potentially dangerous due to erosion of the stent into the airway and into major vascular structures.

The reviewers also observed that functional problems, relating to vomiting and poor eating, were commoner than would be expected after oesophago-gastrectomy. This may have been due to the way the surgeons made the gastric conduit, formation of the oesophago-gastric anastomosis too low in the chest, not performing a pyloroplasty, or a combination of all three factors. Consequently, many patients have undergone multiple endoscopies and pyloric dilatations after surgery, suggesting that they have experienced gastric conduit dysfunction which is usually avoidable if preventative measures are taken.

Open surgery, which was mostly performed by the surgeon who operated outside the group of three, appeared to be less likely to result in serious life threatening complications compared with the laparoscopic surgery performed by the other three surgeons. Furthermore, the complications seen after laparoscopic surgery tended to be unusual and severe. For example, necrotic transverse colon after distal gastrectomy, liver injury causing fatal haemorrhage after thoracoscopy and early tumour recurrence in thoracotomy or port site wounds. Other unusual complications were Aorto enteric/tracheal fistulae, Colonic ischaemia and a high anastomotic/partial gastric dehiscence rate.

The reviewers conclude that the management of complications was sometimes poor, and on occasion haphazard and even illogical. Discussion about complications was often not evident in the patient's notes.

The case note review found that much of the day to day postoperative care for patients having minimally invasive oesophago-gastric surgery was provided by an Associate Specialist. This individual provided a high level of care and continuity. However, there was little evidence of a regular involvement by the three minimally invasive consultant surgeons. The Associate Specialist doctor has since left the department, leaving a gap in the postoperative care provided to patients of these three surgeons.

Patient centred care

There is ample evidence to support a conclusion that the working practices of the three upper gastro-intestinal surgeons do not provide for a patient-centred, consultant delivered service, and are not in the interests of patients in several respects. To the contrary, the working arrangements appear to exist to support the surgeons, by accommodating opaque job plans on multiple sites.

The consequence of this is a lack of personal responsibility for patient care by the three surgeons, and a lack of responsibility for their professional practice. This has an impact for the fourth surgeon, who from all accounts demonstrates a much more patient-centric approach. By excluding and isolating this fourth surgeon from the team, his patients risk a lack of cover in his absence. This creates issues about the long-term sustainability for services provided by an isolated surgeon.

The reviewers agree with the observations by a number of staff that, by working interchangeably to provide services to patients, the three surgeons do not provide continuity of patient care. These working arrangements can create inconsistency in requests to staff and confusion for patients. This can only add to the anxiety patients feel when undergoing major surgery for life-threatening conditions. Continuity of care is particularly important for patients with cancer, and a lack of such continuity is undoubtedly to the detriment of patient experience.

The reviewers are concerned that patients are not being provided with sufficient information to enable them to provide informed consent for oesophageal surgery. There is evidence that patients living in geographical locations that see them referred to one of the three surgeons with a laparoscopic bias have not been given a full appraisal of the pros and cons of open surgery. This is particularly concerning in the light of the conclusions reached about complications associated with laparoscopic surgical techniques.

Other concerns about consent include about the timing, with patients consented on the day of surgery. This reflects the particular working practices of the three surgeons and the late decision-making over who will conduct surgery on a given list. It is not in the interests of patients, who are likely to feel anxious on the day of surgery and may feel under pressure to give their consent. Further investigation needs to be undertaken by the trust to establish who is taking consent.

Consent for complex surgery such as oesophago-gastrectomomy should be done by the consultant surgeon proposing this treatment and be obtained well before the day of surgery. Written information about the risks and benefits should preferably be provided to the patient and their relatives early in the clinical work-up so that they have had an opportunity to consider the issues and ask questions at the time of consent.

Leadership

Concerns about the upper gastrointestinal service have persisted for some time. A number of staff have bravely and openly escalated their concerns to management. Others have felt it necessary to raise issues anonymously. Some staff have clearly felt intimidated about raising concerns, even suggesting that the team of upper gastro-intestinal surgeons enjoy a special status within the trust.

The reviewers conclude that senior management has not demonstrated sufficient responsiveness to the breadth of concerns raised of staff. It has understandably found it difficult to establish whether there has been a case to answer regarding concerns about mortality and complications; this invited review seeks to assist in this respect. However, other concerns about the working practices, and sometimes behaviour, of three of the upper gastro-intestinal surgeons, appear to have been brushed aside too readily. This has created a perception that the upper gastro-intestinal surgeons have a privileged position within the trust.

There is a case to answer regarding dysfunctional team working, a lack of accountability for working practices and attendance at fixed sessions – including endoscopy, clinics and the MDM – and it is for managers to ensure that the three surgeons are accountable in these and other areas. Job plans should make clear the commitments that each surgeon is individually accountable for.

Clinical leadership within the upper gastro-intestinal surgeons has been subject to change and has suffered from unavoidable staff absence. Nevertheless, evidence of split team working, disparate working practices, and failing team functionality, suggest that leadership within the department has been extremely weak. The paucity of surgical leadership at the MDM meetings is a concern for the overall effectiveness of the MDM.

The upper gastro-intestinal surgeons and anaesthetists

The reviewers did not find evidence that working relationships between the upper gastro-intestinal surgeons and the anaesthetic team were impacting negatively on patient care. However, this is primarily because the anaesthetists, particularly the intensivists, demonstrate a strong patient-focused approach. Difficulties in the past between particular individuals appear to have receded. Reservations about some of the upper gastro-intestinal surgeons persist for some staff, but not others who describe the surgeons more favourably.

RCS
ADVANCING SURGICAL STANDARDS

9. Recommendations

The following recommendations are for Maidstone and Tunbridge Wells NHS Trust to consider.

Prioritised patient safety actions for the Trust

1. **The oesophageal *and* gastric cancer resection service should be suspended until the other recommendations made below have been addressed**, and significant improvements have been demonstrated to the working practices, team working and insight of the three upper gastro-intestinal surgeons who have been working as a distinct unit.

2. **Oesophageal *and* gastric cancer resections performed using laparoscopic techniques should be suspended indefinitely**, as the upper gastro-intestinal surgeons in post have not been able to demonstrate sufficient attention to the detail of surgical outcomes or clinical decision-making to provide a safe service to patients.

Consideration should be given to the implications of these recommendations for upper gastro-intestinal surgery for benign conditions and particularly using laparoscopic surgical techniques.

3. **The structure of MDM printed outcome forms should be reviewed** to make clear the patient's pre-treatment stage, management plan, keyworker and the clinician in charge.

4. **Improved surgical attendance at MDMs should be mandated**. The gastro-intestinal surgeons should be present for at least 75% of MDM meetings, as per peer review requirements, and when they attend they should be there for the whole meeting.

5. **The clinical decision-making of the upper gastro-intestinal surgeons must be improved**, with particular attention given to the appropriate pathway for patients with pre-treatment staging of advanced disease and with significant co-morbidities, and to the appropriate treatment response to postoperative complications.

6. **The management of postoperative upper gastro-intestinal complications requires attention**. In particular:

a) The upper gastro-intestinal surgeons should make contemporaneous entries into a patient's records documenting any discussions about complications and their management;
b) It should be clear to all staff within the multidisciplinary team which surgeon has

responsibility for a patient and is overseeing their ongoing care;

c) The three upper gastro-intestinal surgeons who have operated as a distinct unit need to individually increase their presence on the intensive care unit and on the wards; and
d) The job plans of the upper gastro-intestinal surgeons should be organised in such a way that other staff within the multidisciplinary team know where the surgeons are should they need their advice about the management of postoperative complications.

7. **Monitoring of postoperative complications must be strengthened and systematised**. Complications associated with the upper gastro-intestinal surgeons should be recorded and collated by an independent person suitably experienced in this type of surgery and monitored in real-time, with external scrutiny by a consultant from another trust who is completely impartial. The impact on patients of any postoperative complications should be discussed as part of a more patient-centred approach to upper gastro-intestinal surgery, and this may be a role for the Clinical Nurse Specialists to lead.

8. **Arrangements for consenting patients must be reviewed.** All patients must be provided with adequate written and verbal information and consent obtained by the consultant intending to operate, well in advance of the proposed day of surgery. This should be documented clearly in the patient's records.

9. **The working practices of the consultant surgeons should be reorganised to provide for continuity of patient care in a consultant-delivered service**. Annual appraisal should include discussion about how the surgeons demonstrate their commitment to patients.

10. **Live links of upper gastro-intestinal surgery should not be conducted outside of standard operating times**.

11. **Consultant surgeons should attend fixed sessions in person and not delegate these responsibilities to others**.

12. **Chairing of the upper gastro-intestinal multidisciplinary meeting should be given to the consultant oncologists**. A review of the caseload discussed at these meetings should be undertaken with a view to making the meetings shorter and more tightly focused. The upper gastro-intestinal surgeons should be freed of other commitments (with the exceptions of on-call) and held to account for their attendance for the duration of the meeting.

13. **There should be a separate MDM for HPB cancer patients**. This is a requirement if the hospital is to run an Oesophago-gastrectomy Cancer Centre. If, however, this ambition is not realised then a generic upper gastro-intestinal MDM is acceptable.

Given the breadth and seriousness of these recommendations, the trust is advised to share this report with the Care Quality Commission and to involve commissioners in discussions about the future provision of this service.

The trust should also discuss the contents of this invited review report with its GMC Employment Liaison Adviser and with NCAS, to seek advice on the ongoing management of the individual surgeons named here and to ensure that patient safety is preserved.

Responsibilities of the Trust in relation to the recommendations of this report.
This report has been prepared by The Royal College of Surgeons of England and the Association of Surgeons of Great Britain under the IRM for submission to the Maidstone and Tunbridge Wells NHS Trust. It is an advisory document and it is for the Trust concerned to consider any conclusions and recommendations reached and to determine subsequent action. It is also the responsibility of the Trust to review the content of this report and in the light of these contents take any action to protect patient safety that is considers appropriate.
Further contact from the Royal College of Surgeons following final report.
Where recommendations are made that relate to patient safety issues, the Royal College of Surgeons will follow up this report with the Trust to ask them to confirm that the Trust has addressed these recommendations. The College's Lead Reviewer may be available to support this process. Where the College is not satisfied that these recommendations have been addressed within a reasonable period of time following the issue of the final report, the College, the Association and/or the Reviewers reserve to themselves the right to disclose in the public interest but still in confidence to a regulatory body such as the General Medical Council, the National Patient Safety Agency or the Care Quality Commission or any other appropriate recipient, the results of any investigation and/or of any advice or recommendation made by the College, the Association and/or the Reviewers to the Hospital. The College will also contact the Trust to carry out an evaluation of its services following the issue of the final report.

10. Signature of Reviewers

[redacted] FRCS DATE: 9th December 2013

[redacted] FRCS DATE: 9th December 2013

[redacted] DATE: 9th December 2013

11. Appendices to the Report

[redacted]

[redacted]

RCS
ADVANCING SURGICAL STANDARDS

11.2 Appendix 2 - Review of patient notes

Scope of the case note review

In total, 83 patients' records were assessed by the two Clinical Reviewers. This included the notes of the six patients who died postoperatively in 2012 and 2013, referred to in the Terms of Reference for this review, and 77 patients chosen at random from the records provided by the Trust.

Reviewer One

38 randomly selected case notes examined of patients having oesophageal or gastric resections for cancer from 2006 – 2013

Of the 38 case notes reviewed, 27 patients had an oesophagectomy (24 had minimally invasive surgery) and 11 had a gastrectomy (eight minimally invasive).

Deaths

Nine postoperative deaths (9/38 = 23% 30 day/in-hospital) were identified; six after oesophagectomy and three after gastrectomy.

Cause of death was anastomotic leak/conduit necrosis (3), Bleeding (3), ARDS (1), MI (1) & MOF (1).

Two of the patients who died were clearly high risk for surgery due to respiratory disease and cirrhosis but the remaining seven patients were not high risk.

Unexpected complications

One of the eight patients undergoing a laparoscopic gastrectomy developed an ischaemic colon due to an injury to the colonic blood supply. This resulted in the patient returning to theatre and having a right hemi-colectomy. This is an unusual complication.

Two patients undergoing a minimally invasive oesophagectomy developed loco-regional recurrence of their tumour within three months of surgery and died of their recurrent disease. Both had advanced disease (T3N3) on pathology and the notes suggest that there was enough pre-operative evidence to have predicted this before submitting them to radical surgery. A palliative care plan would have been more appropriate.

One patient (included in the nine postoperative deaths) developed an early anastomotic leak after a minimally invasive oesophagectomy and then died from bleeding secondary to an aorto-enteric fistula.

Reviewer Two

45 randomly selected case notes examined of patients having oesophageal or gastric resections for cancer from 2006 – 2013

Of the 45 case notes reviewed, 28 patients had an oesophagectomy (18 had minimally invasive surgery) and 16 had a gastrectomy (six were performed minimally invasively). One further patient had surgery for benign pathology.

Deaths

Eight postoperative deaths (8/45 = 18% 30 day/in-hospital) were reviewed from 2006-2013; four after oesophagectomy and four after gastrectomy.

Cause of death was anastomotic leak or conduit dehiscence in three (including one with colonic infarction), Aorto-enteric fistula in two, small bowel perforation in one, Cardiac in one and Pulmonary Embolism in another.

Unexpected complications

Two patients developed aorto-enteric fistulae, which is a very unusual complication. One of the anastomotic leak patients suffered ischaemic bowel after division of the Middle Colic artery intraoperatively; again a very rare complication after oesophago-gastric resection.

Of the 18 minimally invasive oesophagectomies, seven (39%) had major open surgery (thoracotomy/laparotomy or both) to deal with postoperative complications.

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Maidstone and Tunbridge Wells NHS
NHS Trust

Report to: Kent County Council; Health Overview & Scrutiny Committee

Subject: Summary of CQC Compliance Inspection visit to Maidstone Hospital

Date: 3rd July 2014

Context:
The Care Quality Commission (CQC) undertake unannounced visits through out the year to test compliance against a number of standards or outcomes. The trigger for a visit may due to emerging trends from published data, concerns raised by members of the public or as part of their own routine inspection schedule.

Maidstone Hospital Visit and findings:
The CQC visited Maidstone Hospital on 12th February 2014. This was an unannounced visit to review four standards.

The standards reviewed were:

Consent to Treatment
Care and welfare of people who use services
Staffing
Assessing and monitoring the quality of service provision

The visit was triggered, in part, by the publication of the Royal College of Surgeons report into the Upper Gastroenterology (GI) surgical services and the occurrence of a Never Event in the Pathology Laboratories.

The inspection team noted some examples of good practice. Throughout the report the feedback received from patients was uniformly positive about their experience.

The Trust was deemed to be compliant with the standards for Consent to Treatment.

Action was required in the other three standards reviewed. The non-compliance has been rated as being of moderate impact. No improvement notices were issued by the CQC.

Care and welfare of people who use services:
Issues to be addressed included:

Review of the clinical observations policy to describe the application of the early warning system, Patient At Risk (PAR), for patients having neurological observations.

Having a clear description of the frequency of clinical observations for patients following some specific surgical procedures.

Provision of Registered Childrens Nurses

Out of Hours Paediatric emergency care provision on the Maidstone Hospital site.

Staffing:
Issues to be addressed included:

Consultant level posts (x2) with emergency surgical expertise (already in post)

Registered Nurses (Child) for Accident & Emergency – as noted above.

Improved Surgical staff job planning

Readmission rates following some specific surgical procedures

Reviewing administration support for the Pathology Laboratories

Assessing and monitoring the quality of service provision
Issues to be addressed included:

Frequency of meetings for the Quality & Safety Committee

Mortality Review meetings at both Directorate and Executive level.

Evidence of learning from Serious Incidents and Never Events

Provision of data to inform Non-Executive visits to wards and departments.

Response and action planning:
The Trust has welcomed the report and views it as an opportunity to improve the quality of the services it provides.

The attached action plan details the key actions that either now completed or currently in progress.

Progress on this action plan is monitored by the Trust Board, and at the bi-monthly Quality Review meetings held with the CCG.

July 2014.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust action plan to address issues raised following a CQC unannounced inspection to Maidstone Hospital.

Standards: “Care and Welfare of people who use services”, “Staffing” and “Assessing and monitoring the quality of service provision”.

No.	Issue / concern	Action(s) to be taken	Success criteria	Nominated leads	Start date	Estimated completion date	Progress and evidence to support completion	Current Status	Date of follow up audit or N/A	Monitoring committee	Regulatory outcome link
1	Staffing: paediatric RNs for Maidstone A&E Dept for 24/7	Review emergency care pathways for children. Consider 'in hours' supervision of service by strengthening links with Riverbank. Include Maidstone provision in the overall review of paediatric emergency care review	Provision will meet Royal College requirements	Chief Nurse	19-5-14	30-9-14	Emergency paediatric pathway review group established, with dates set for meeting and options review. Stage 1 is to separate emergency paediatric pathway from adult pathway. Business case being developed.	In Progress	Yes	Quality & Safety	4, 13
2	Staffing: Paediatrician availability out of hours	Review current provision to ensure compliance with national standards	Compliant with national standards	Chief Nurse	30-4-14	30-6-14	Being reviewed against national standards and Royal College guidance	In Progress	Yes	Quality & Safety	4, 13
3	Assessing & monitoring quality: Frequency of Quality & Safety Committee meetings	Review frequency, implement 'Deep Dive' or focus approach on alternate months	Focused/themed meeting take place on alternate months to review areas of specific concern	Chief Nurse	1-4-14	19-5-14	Terms of Reference have been reviewed, amended, agreed and approved. Deep Dive methodology established, 2 meetings held, with further dates set.	Completed	N/A	Quality & Safety	16

No.	Issue / concern	Action(s) to be taken	Success criteria	Nominated leads	Start date	Estimated completion date	Progress and evidence to support completion	Current Status	Date of follow up audit or N/A	Monitoring committee	Regulatory outcome link
4	Assessing & monitoring quality: Board members not undertaking data driven visits	Implement Board member 'pairing' arrangements; issue revised guidance to Board members undertaking visits; and increase the reporting of findings from visits at Trust Board meetings. These visits will be informed by data	Regular department / ward visits by all Directors with use of data as agreed by Trust Board	Chief Nurse / Trust Secretary	1-4-14	30-6-14	Board member, 'pairing' arrangements agreed by the Trust Board. Regular data driven visits reported to Trust Board	In Progress	Yes	Quality & Safety	16
5	Assessing & monitoring quality: Board level oversight of services for children at Maidstone.	Develop a reporting mechanism to the Board that provides assurance against nationally defined indicators for emergency paediatric care	Regular reporting at Quality & Safety Committee	Chief Nurse	17-3-14	30-9-14	Dashboard for emergency paediatrics to be discussed at Quality and Safety Committee	In progress	N/A	Quality & Safety	16
6	Care & welfare: transfusion; Provision of 24/7 transfusion lab service	Review staffing requirements and introduce a shift system for transfusion trained staff	At least one transfusion trained member of staff on duty, on site, 24/7	Clinical Director Diagnostics	3-2-14	30-4-14	Shift system in place. Business case and recruitment process in train for strengthening sustainability.	Complete	Yes	Quality & Safety	4
7	Care & Welfare: Blood Tracking System inadequate	Implement 'Intelligent Fridge' for blood products	Reliable accurate tracking of blood products	Clinical Director Diagnostics	3-2-14	31-7-14	System in place. Staff training in progress with full go live anticipated July 2014	In Progress	Yes	Quality & Safety	4
8	Staffing: Readmission rates following elective surgery	Report readmission data to Directorate Leadership Team monthly to identify trends in a timely manner	Directorate Leadership Teams receive monthly data on readmission rates	Medical Director	24-3-14	5-5-14	Monthly data provided and variance understood, with action taken as appropriate	Complete	Yes	Quality & Safety	4, 13

No.	Issue / concern	Action(s) to be taken	Success criteria	Nominated leads	Start date	Estimated completion date	Progress and evidence to support completion	Current Status	Date of follow up audit or N/A	Monitoring committee	Regulatory outcome link
9	Staffing: Pathology staffing levels	Review lab staffing and clerical staffing and ensure recruitment and induction processes in place	Staffing levels to meet agreed standards	Clinical Director Diagnostics	17-3-14	27-3-14	Vacancy rates and use of temporary staffing. At present 1WTE vacancy	Complete	N/A	Quality & Safety	13
10	Assessing & monitoring quality: validation issues with mortality data for individual surgeons.	Revised data capture system to be established for mortality and morbidity.	Validated data 'owned' by teams	Medical Director	24-3-14	30-9-14	Data collection methodology agreed, data base in development complete by June 2014, with full implementation planned for completion by September 2014.	In Progress	Yes	Quality & Safety	16
11	Assessing & monitoring quality: Path Labs, re-audit of slide labelling.	Implement programme of regular audit on slide labelling	Audit data, and action plans to address any issues identified as a result of audit.	Clinical Director Diagnostics	6-1-14	31-3-14	Plan in place and audits being undertaken	Complete	Yes	Quality & Safety	16
12	Admissions Lounge: space between trolleys does not provide sufficient space for privacy	Review of admissions lounge working practices, review of patient pathway and/or location of lounge.	Space between trolleys will be sufficient to provide a level of privacy and will be compliant with any building regulation or guidance in force at the time of implementation.	Associate Nurse Director Surgery	7-4-14	30-9-14	Pathway review group being established to agree and implement revised pathway.	In Progress	Yes	Quality & Safety	4
13	Care & Welfare: Observations: No guidelines for the frequency of pos t-operative observations	Develop guidance for post-operative observations, to be linked to Observation Policy	Guidelines in place, and post-operative observations undertaken and acted upon accordingly	Associate Nurse Director Surgery	7-4-14	16-6-14	Review of literature undertaken, examples of policies & guidance from other Trusts obtained. First draft completed and currently being peer reviewed.	In Progress	Yes	Quality & Safety	4

No.	Issue / concern	Action(s) to be taken	Success criteria	Nominated leads	Start date	Estimated completion date	Progress and evidence to support completion	Current Status	Date of follow up audit or N/A	Monitoring committee	Regulatory outcome link
14	Care & Welfare: Observations; PAR Score not detailed on neurological observation chart thus not compliant with current Observation Policy	Review Observation Policy, Review Neurological Chart, consider approach to ensuring safe recording of observations and subsequent actions	Clear consistent policy and procedure in place	Associate Nurse Director Surgery	7-4-14	31-7-14	Policies and procedures in place and evidence of compliance against policy	Not Started	Yes	Quality & Safety	4
15	Staffing: Surgical Job Planning; all Consultant Surgeons to have up to date appropriate job plans	Review job plans as part of the current year appraisal cycle.	All Consultant Surgeons will have a current agreed job plan.	Clinical Director Surgery	3-2-14	31-7-14	Job plans have been reviewed for Upper GI. Ophthalmology in progress and due for completion May/June. Urology, gynae, general, breast, ENT due end July	In Progress	Yes	Workforce	13
16	Staffing: staff grade surgeons employed to cover consultant work	Appoint two consultant surgeons with expertise in emergency surgery	Posts filled.	Simon Bailey	1-10-13	31-1-14	Staff in post.	Complete	N/A	Workforce	13
17	Care & Welfare: Privacy & dignity of patients in the Admissions Lounge	Need for a couch for physical examination in consultation room	provision of couch	Associate Nurse Director Surgery	7-4-14	30-6-14	Provision of couch in both consulting rooms.	In Progress	N/A	Quality & Safety	4
18	Admissions Lounge: Designated private area for consent and other private conversations	Identify area, inform staff and enforce practice	All patients requiring privacy for private conversations in including consent will be provided with an appropriate space/area/room	Associate Nurse Director Surgery	7-4-14	30-9-14	Pathway review group being established to agree and implement revised pathway.	In Progress	Yes	Quality & Safety	2, 4

No.	Issue / concern	Action(s) to be taken	Success criteria	Nominated leads	Start date	Estimated completion date	Progress and evidence to support completion	Current Status	Date of follow up audit or N/A	Monitoring committee	Regulatory outcome link
19	Assessing & monitoring quality: Acute NHS Trust should be collecting outcome data by 'Named Consultant' for specific indicators	Present and discuss Consultant Level data at Quality and Safety Committee	Data to be available by named Consultant and discussed at Quality and Safety Committee	Medical Director	1-5-14	30-8-14	Consultant level data is already available for some outcome measures	In progress	N/A	Quality and Safety	16
20	Assessing & monitoring quality: Learning from incidents and investigations not robust	To review learning from incidents and investigations at clinical governance committee and directorate governance meetings.	Clear evidence of learning from incidents and investigations and evidence that same issues are not reoccurring	Chief Nurse	1-4.14	30-06-14	Minutes from Clinical Governance Committee and directorate level governance meetings. Minutes from Quality and Safety Committee. Audit of Serious Incident report action plans	In progress	Yes	Quality and Safety	16

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 18 July 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 (Department of Health 2007).*

(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
- 11 April 2014

(c) At the end of the discussion on 11 April 2104, the Committee agreed the following recommendation:

- *RESOLVED that Mr Ayres and Mr Souter be thanked for their attendance and contributions to the meeting along with their answers to the Committee's questions, and that a written update be submitted to the Committee in July.*

(d) The Chairman has asked for a representative of NHS West Kent CCG to attend on 18 July 2014, rather than provide a written briefing, to update Members on the status of the contract with NSL.

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

2. Recommendation

RECOMMENDED that CCG colleagues be thanked for their attendance at the meeting, and that they be requested to take note of the comments made by Members during the meeting and that they be invited to attend a meeting of the Committee three months.

Background Documents

Department of Health (2007) '*Eligibility Criteria for Patient Transport Services (23/08/2007)*', http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_078372.pdf

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (01/02/2013)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=23758

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (11/10/2013)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=26033

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (31/01/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27050

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (11/04/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27878

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

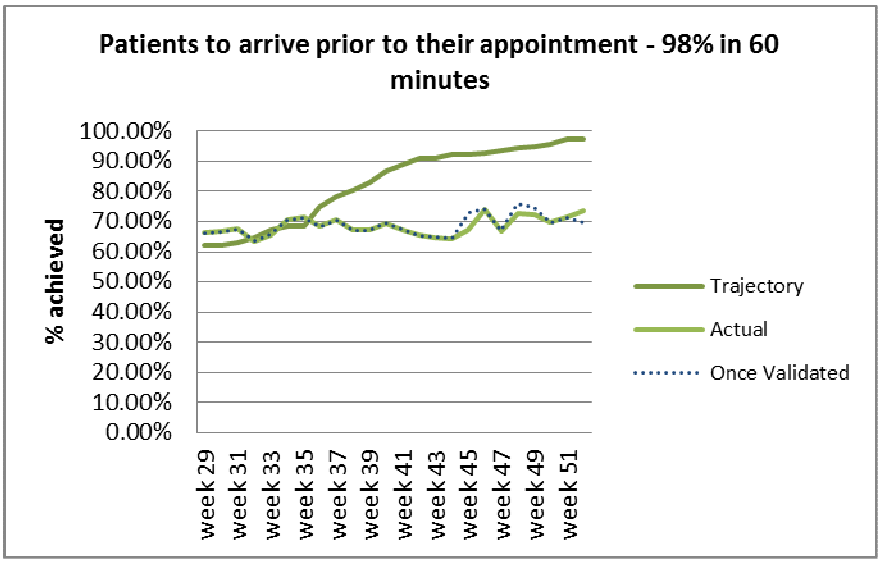
Patient Transport Services Contract

Update to Kent HOSC – 18 July 2014

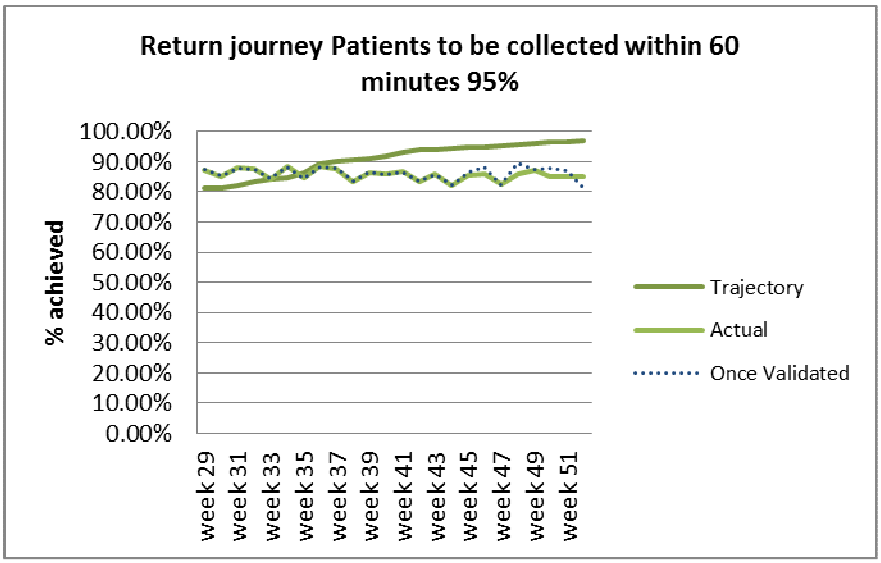
This short report updates HOSC on performance of the PTS contract since the 8 April meeting.

The CCG continues to discuss performance with NSL (the PTS service provider) on a weekly basis. Attention remains focused on the six key indicators:

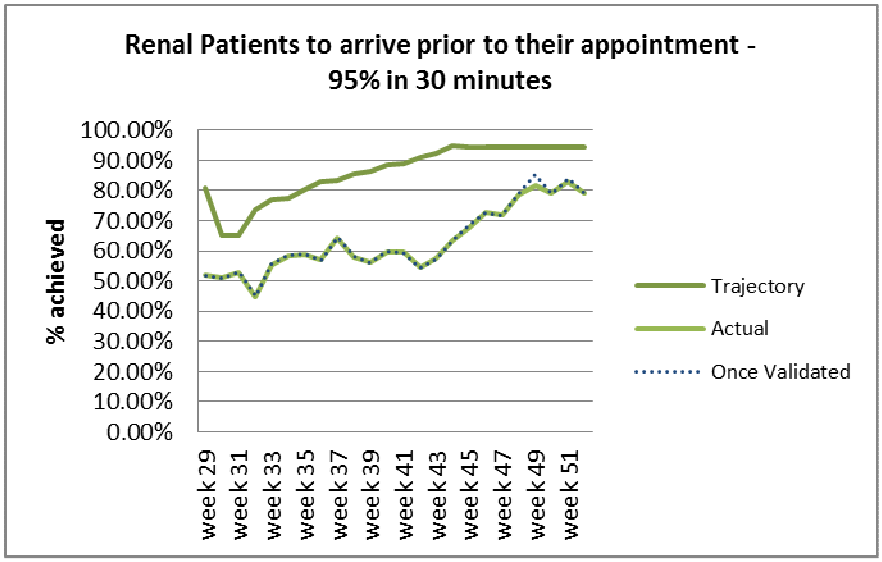
- Timeliness of taking patients into an outpatient appointment,



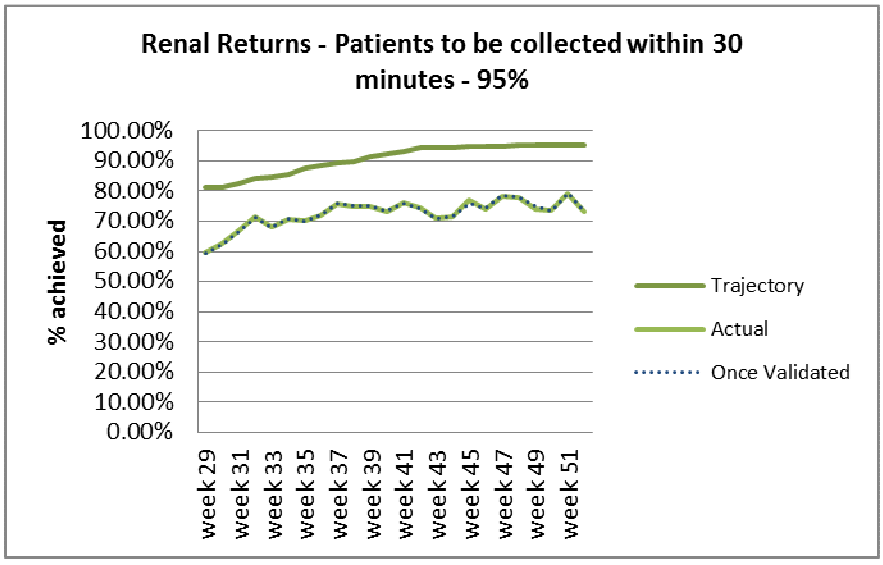
- Timeliness of collecting patients from an outpatient appointment



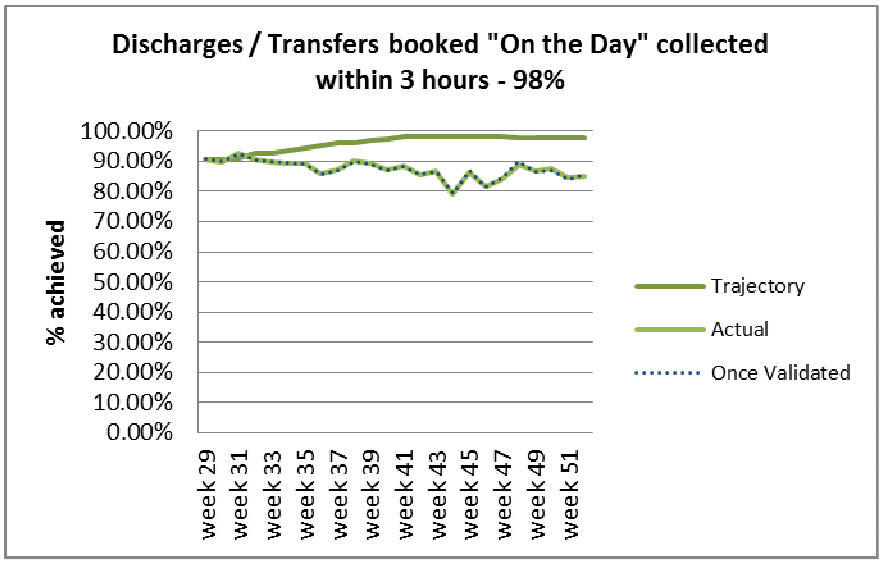
- Timeliness in bringing renal patients in for treatment

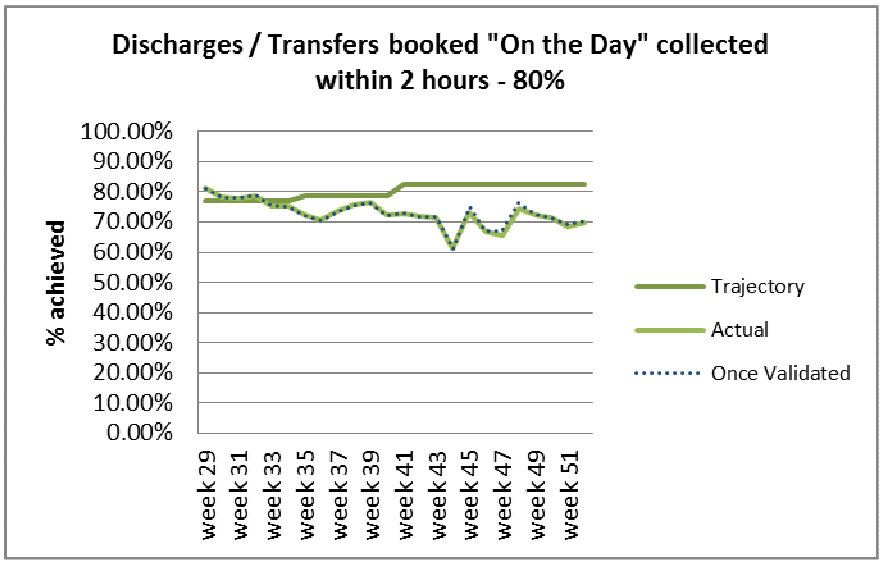


- Timeliness in collecting renal patients from treatment



- Timeliness of collecting patients discharged from hospital (2 indicators)





The above graphs show weekly un-validated data up to mid-June, validated to end May. Week 51 is the end of June (the contract started in week one July 2013). The end of May is week 47; the end of April is week 42

A review of the actions NSL has taken to improve performance is undertaken monthly. At the end of May it was clear that NSL had made many of the changes needed. Day to day variations in performance were continuing to narrow and the number of extreme incidents was reducing.

However, validated data for the month of May has now been analysed and, whilst it shows some improved performance on transport of Renal patients, overall performance in May did not make significant progress.

Reviewing complaints and NSL collected patient experience data shows that, where NSL collect on time, patient satisfaction is high. Concerns focus almost solely on failure to collect or deliver on time.

On 19th, 20th and 21st March the Care Quality (CQC) visited and inspected the NSL services in Kent and Medway. The draft report is still with NSL to be checked for factual accuracy. As soon as it has been finalised by CQC and published, the CCGs will review the results and consider what action the commissioners need to take. The report will be shared with HOSC when available.

NSL is required to meet the requirements of the six key indicators by the end of June 2014. Validated June data is being reviewed by the commissioners in July.

Commissioners and hospitals are meeting in July to discuss the position and, as previously reported to HOSC, failure to meet these targets will lead to further action being taken by the commissioners.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 18 July 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.

(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.*

(d) On 11 April 2014 the Committee considered an update provided by NHS Canterbury and Coastal CCG. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that its guests be thanked for their attendance and contributions to the meeting along with their answers to the Committee's questions, and that they return to the Committee within three months to give an update on the consultation and final outcome of the steering group review before a final decision is made by the CCG governing body.*

2. Recommendation

RECOMMENDED that CCG colleagues be thanked for their attendance at the meeting, and that the CCG Governing Body be requested to take note of the comments made by Members during the meeting and that they be invited to present a report to the Committee once the final decision has been made.

Background Documents

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (29/11/2013)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=26458

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (31/01/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5394&Ver=4

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (11/04/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27879

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NHS
Canterbury and Coastal
Clinical Commissioning Group

Faversham Minor Injuries Unit
Briefing Paper

Background

1. Members will recall that the Faversham Minor Injuries Unit (MIU) service was put out to tender during 2013 by NHS Canterbury and Coastal Clinical Commissioning Group (CCG).The outcome of the procurement process was unsuccessful as only one bid was received, and which was not acceptable financially. Without a new service provider the MIU was due to close at the end of the contract with the current provider on 31 March 2014.

2. The matter was discussed at length at the November 2013 Health Overview and Scrutiny Committee (HOSC). Committee members raised concerns about the commissioning process and the impact of changes to the current specification including MIU X-ray. The CCG was asked to set aside the decision to close the service on 31 March 2014 to allow time for a new procurement exercise to be undertaken after taking advice and with full consultation with the people of Faversham and their democratically elected representatives.

3. The CCG accepted the request and arranged to keep the MIU open whilst a review was carried out to consider a number of aspects of the procurement and potential alternative service models, including:

    - How the specification for the service tendered was developed
    - The procurement process the CCG used to try to find a new provider
    - The feasibility and impact of including MIU X-ray services.

4. This report sets out how the CCG has taken forward its review, the outcomes to date, and recommendations for the next steps.

Steering Group

5. To help support the review, the CCG established a local Steering Group comprising representatives from the local community, patients, The Friends of Faversham Cottage Hospital and Community Health Centres, Faversham GPs, Faversham Town Council, Swale Borough Council, Kent County Council, Healthwatch and the CCG. Meetings have been well attended and chaired by the Chairman of the Friends and Town Mayor.

6. It was agreed each area of the review would involve members from the steering group and a report produced. This report would be presented to the Health Overview and Scrutiny Committee (HOSC) and used to help decide on the next steps.

7. The steering group has met on three occasions. To date the group has:

   (i) Received clarification from the CCG that the proposed service specification in the 2013 tender was in keeping with the East Kent strategy for Minor Injury Units. However the steering group felt that the CCG should allow some flexibility in order to investigate variations around the strategy if these had the potential to ensure the long-term viability of a minor injuries service in Faversham.

   (ii) Agreed that the CCG had followed the correct process for procurement but that the scale of changes to the current service model itself (inclusion of MIU X-ray facilities, exclusion of minor illness and treatment services and funding at national tariff per attendance, rather than the current block contract) were ambitious and had led to providers being concerned about financlal viability and unwilling to tender for the service.

   (iii) Developed and reviewed a total of eight potential scenarios for a service model, including the addition of GP referral direct access Xrays to increase the potential viability of on-site X-ray facilities.

   (iv) Requested that a small working group be established from the steering group membership to further investigate the scenarios offering greatest potential.

8. Based on the available data the working group used the scenarios to develop an incremental approach to modelling MIU activity and financials including and excluding MIU X-ray and GP direct access X-ray for four time-bands:

   - Monday to Friday: 8.00am – 6.30pm (Coreservice)
   - Saturday and Sunday: 8.00am – 6.30 pm
   - Monday to Friday: 6.30pm – 8pm
   - Saturday and Sunday : 6.30pm – 8pm

9. The steering group considered the working group's findings and recommendations. They were satisfied that the information was as realistic as possible in relation to estimated numbers accessing the service - at least in the intial period. There is significant scope for further MIU activity shift of ME13 residents back to Faversham, in particular from Canterbury, but there is an acceptance that any shift of activity would not be immediate.

   The steering group was however satisfied that, whilst activity shift away from other sites cannot be accurately determined at this stage, due to the tariff system, any shift

back from Kent and Canterbury A&E would be a positive financially and in the right strategic direction for the CCG.

10. From the activity and financial modelling the steering group supported a hybrid option based on an integrated service providing :
    (i) Monday to Friday 8.00am – 6.30pm MIU, MIU X-ray, GP direct access X-ray
    (ii) Monday to Friday 6.30pm – 8pm MIU Only
    (iii) Saturday and Sunday 8.00am – 8pm MIU Only

Next Steps:

11. On 4 June the CCG governing body considered a briefing paper, presented by two members of the public, from the steering group. The governing body supported the following recommendations:

- That the CCG should commence a new procurement process for an MIU in Faversham.
- That the specification should :
    - require the provider to:
        - operate a minor injury service from 8.00am to 8pm seven days per week
        - provide minor injury X-ray at least from 8.00am to 6.30pm, Monday to Friday
        - provide direct access X-ray at least from 8.00am to 6.30pm, Monday to Friday
        - undertake a strong awareness raising, advertising and ongoing promotional campaign along with improved signage to encourage local people to use the Faversham service instead of going elsewhere
        - work with the CCG, and be involved in the local co-production of community networks , to ensure that the MIU evolves in line with the CCG strategic direction and local service developments.
    - Encourage cost reductions from sharing of staffing costs from providers offering services which are integrated with other on-site services, with these savings helping to cross subsidise non-core opening hours.
    - Include provision for appropriate risk sharing including pump-priming and transitional support from the CCG to allow time for service change, if supported by a full business case submitted to the governing body at a later date.
    - Include continued provision in the short term for minor illness and treatment services, as currently provided, to allow time for services and service users to change.
    - Be for an initial three years, extendable to five by agreement, with regular reviews.

- That the existing contract with IC24 is therefore extended until April 2015 to allow time for the procurement process to be completed.

- That project resource is put in place, managerially responsible to the CCG, but with accountabliity to the steering group and involving and working with the working group.

- That early discussions will take place with potential providers to provide information and develop greater confidence in the market so that providers will be interested in delivering the service we want.

- That the MIU steering group, supported by the working group, should continue as the co-production group for the local community network in line with the CCG five year strategic plan. As part of this, the group should work towards ensuring a full seven day 8am-8pm service for the Faversham MIU, in line with East Kent MIU strategy and allied to extended working for general practice.

12. As a consequence, a project resource has been allocated to this project, contract extention has been verbally agreed and initial discussions with potential providers has commenced.

    An indication of the timetable to procure the new service is as follows:

- Approach potential providers July/September 2014

- Agree model and award contract October/ November 2014

- New service commences April 2015

ENDS

ENTER AND VIEW VISIT REPORT

FAVERSHAM MINOR INJURIES UNIT

About Healthwatch Kent

Healthwatch gives people a powerful voice locally and nationally. In Kent, Healthwatch works to help people get the best out of their local health and social care services. Whether it's improving them today or helping to shape them for tomorrow. Local Healthwatch is all about local voices being able to influence the delivery and design of local services. Not just people who use them, but anyone who might need to in future.

What is Healthwatch Kent?

Healthwatch Kent was established in April 2013 as the new independent community champion created to gather and represent the views of our community. Healthwatch plays a role at both national and local level and makes sure that the views of the public and people who use services are taken into account.

Healthwatch Kent took over the role of Kent Local Involvement Network (LINk) and also represents the views of people who use services, carers and the public to the people who commission plan and provide services.. Healthwatch provides a signposting service for people who are unsure where to go for help. Healthwatch can also report concerns about the quality of health care to Healthwatch England, and the Care Quality Commission take action.

Our Mission Statement

Our mission is to raise the public's voice to improve the quality of local health and social care services in Kent. We listen to you about your experiences of health and social care

services and take your voice to the people who commission health and social care services in Kent.

Our FREE Information and Signposting service can help you navigate Kent's complicated health and social care system to ensure you can find and access the services that are available for you. Call us on 0808 801 0102 or email info@healthwatchkent.co.

Our Values

- Volunteer led (5 staff, 60 volunteers)
- Information and Intelligence based
- Support and Guidance
- Two way communications
- Partnerships and relationships – achieve more in partnership than alone
- Honest, accountable and transparent

Enter & View

In order to enable Healthwatch Kent to gather the information it needs about services, there are times when it is appropriate for trained Healthwatch Volunteers to see and hear for themselves how those services are provided. That is why the Government has introduced duties on certain commissioners and providers of health and social care services (with some exceptions) to allow authorised Healthwatch representatives to enter premises that service providers own or control to observe the nature and quality of those services.

Healthwatch Enter and Views are not part of a formal inspection process, neither are they any form of audit. Rather, they are a way for Healthwatch Kent to gain a better understanding of local health and social care services by seeing them in operation. Healthwatch Enter and View Authorised Representatives are not required to have any prior in-depth knowledge about a service before they Enter and View it. Their role is simply to observe the service, talk to service users and staff if appropriate, and make comments

and recommendations based on their subjective observations and impressions in the form of a report.

This Enter and View Report is aimed at outlining what they saw and making any suitable suggestions for improvement to the service concerned. The reports may also make recommendations for commissioners, regulators or for Healthwatch to explore particular issues in more detail. Unless stated otherwise, the visits are not designed to pursue the rectification of issues previously identified by other regulatory agencies. Any serious issues that are identified during a Healthwatch Enter and View visit are referred to the service provider and appropriate regulatory agencies for their rectification.

Legislation allows 'Enter and View' activity to be undertaken with regard to the following organisations or persons:

- NHS Trusts
- NHS Foundation Trusts
- Local Authorities
- a person providing primary medical services (e.g. GPs)
- a person providing primary dental services (i.e. dentists)
- a person providing primary ophthalmic services (i.e. opticians)
- a person providing pharmaceutical services (e.g. community pharmacists)
- a person who owns or controls premises where ophthalmic and pharmaceutical services are provided
- Bodies or institutions which are contracted by Local Authorities or the NHS to provide health or care services (e.g. adult social care homes and day-care centres).

Key Benefits of Enter & View

To encourage, support, recommend and influence service improvement – by:

- Capturing and reflecting the views of service users who often go unheard, e.g. care home residents
- Offering service users an independent, trusted party (lay person) with whom they feel comfortable sharing experiences
- Engaging carers and relatives
- Identifying and sharing 'best practice', e.g. activities that work well

- Keeping ‘quality of life’ matters firmly on the agenda
- Encouraging providers to engage with local Healthwatch as a ‘critical friend’, outside of formal inspection
- Gathering evidence at the point of service delivery, to add to a wider understanding of how services are delivered to local people
- Supporting the local Healthwatch remit to help ensure that the views and feedback from service users and carers play an integral part in local commissioning
- Spreading-the-word about local Healthwatch.

Details of the Visit

Name and address of premises visited	Faversham Minor Injuries Unit
Name of service provider	IC24
Purpose of the premises / service	Minor Injuries
Lead contact	Duty Nurse :Sandra Bigwood Receptionist: Tamsyn Webb
Date and time of visit	31st May 2014
Authorised representatives undertaking the visit	Jim Hancock – Team Leader Hilary Clayden
Healthwatch Support Team	Lillian Ndawula

Purpose of the visit

Healthwatch Kent is part of the Steering Group which is discussing the future of Faversham Minor Injuries Unit. As part of our work within the Steering Group we wanted to visit the Unit and talk to patients about how they use the service. Our findings will be used to help inform our discussions within the Steering Group.

How the visit was conducted?

This was an announced visit with the Provider being given 2 weeks notice. The Healthwatch volunteers reported to reception and then talked to patients and their families in the waiting room. The team also met with and spoke to Sandra Bigwood, the nurse in charge that day. Prior to the visit, Healthwatch staff had visited the Unit and spoken with the Nurse about the logistics of the visit to ensure we didn’t interrupt the service.

Background Information

Faversham MIU is situated at Faversham Cottage Hospital in the borough of Swale and is part of the outpatient services offered by East Kent Hospital University Foundation Trust (EKHUFT). It shares the same building as the Bank Street Health centre. It is open from 8am till 8pm seven days and week and provides treatment and advice for people with minor injuries and illnesses.

This visit was a response to the proposed closure of the Minor injuries unit which met great resistance from the public; especially the people of Faversham. The proposal by the Canterbury &Coastal Clinical Commissioning Group was to close the Faversham MIU and move all services to Estuary View in Whitstable. However, by the time the visit was conducted, Canterbury and Coastal Clinical Commissioning Group had agreed to start a new procurement process following recommendations from the Faversham MIU Steering Group of which Healthwatch Kent is a part. During this time, the contract with IC24 who provide the service, had been extended until March 2015.

The visit was conducted on a Saturday when the GP surgeries were closed following advice from the staff. This ensured that everyone in the waiting area was there to visit the MIU and not GP service which shares the same waiting area.

The report relates only to a specific visit (a point in time) and the report is not representative of all service users (only those who contributed within the restricted time available)

Our Findings

We were very warmly welcomed by staff. The visit lasted for 2 hours. During this time we spoke to eleven patients. This comprised seven adults and four children. Their ages ranged from 2.5 years to 85 years old.

All patients were from the local area (ME13 Faversham).

Reasons for attending:

Six of the patients were seeking help for an illness, four for an injury and one for

treatment.
All were aware that their GP practice was not available on the day (Saturday).
One patient seeking treatment was referred to the unit by her GP to continue with the daily injection prescribed as the GP practise was closed.

How they travelled to the MIU?
Eight of the patients had travelled in their own car and three had walked to the unit.

Frequency of use:
Seven of the patients had previously attended the unit,
Two were attending for the first time, and two did not respond to this question.

Waiting times:
The majority (seven) of the patients had waited less than thirty minutes, three had been waiting for between thirty and sixty minutes and one did not respond.

Quality of service received:
The majority of patients were satisfied with the quality of service they received on that day. Six (54%) of the patients stated that they were very happy with the information provided to them, Six (54%) felt that their privacy and confidentiality had been respected and Six (54%) said that they had been involved in decisions made about them. Nine patients (82%) said that they were very likely to recommend the unit to friends and family

Four patients did not respond to these questions.

Additional Comments:

- Professional service, delighted with treatment.
- Happy with everything
- Fantastic service, ease and speed of access, good follow up, should not close
- Older people may find it difficult to deal with the questions asked at reception

Which service would they most likely use if the MIU closed?
Six of the patients (54%) knew of the proposal to transfer the services to Estuary View

Medical Centre, four (36%) did not know and one did not respond.

When asked which service they were most likely to use if the MIU was to close, five said they would see a GP if available, one would use A & E, two would use Estuary View and three did not respond

Other comments

- Depending on what the problem is, GP then 111, not Estuary View, Canterbury nearer, ease of access.
- GP would be first choice, Whitstable next. Has a car so no problem with getting to A & E.
- Fantastic service, ease and speed of access, good follow up, should not close
- Would favour a walk in centre instead of M.I.U.
- Probably 111 if no GP is available, sad to see it shut, good to know it is here.
- Thinks it should not close as it is easy to access. Has been before for injury and treatment for children's asthma.
- Patient had an appointment for treatment (injection), normally see GP for this but closed at weekends and arrangements made to have it here.
- There seems to be a tendency for GPs within the building to send patients needing routine follow up treatments like wound dressing to the MIU.

Our Observations:

The signage for the MIU is very poor. There are no signs for people driving to the Unit, there is only one sign at the door which is by a car park. Within the building there little signage for the MIU, although there are plenty of signs for other services within the building. It is not clear for patients where they should register for the MIU.

The reception area is not wheelchair friendly. The desk is approximately 42 inches high which makes it difficult for any wheelchair users to freely speak to members of staff or to write/sign anything if needed.

Our Conclusions:

The unit is clearly popular and is well run with a high level of satisfaction from patients. People are returning to the service and user numbers are healthy. Although signage is

poor, the Unit is very accessible on foot for the people of Faversham. It was clear from our discussions that this MIU unit is an important service that meets a need for a local easily accessible unit, which can provide cost and medically effective treatment for both illnesses and minor injuries especially when no GP is available.

Recommendations:

- Better signage for people looking for the Unit, especially for those coming by road
- Improved signage within the building to ensure people know where to go
- Information should be clearly available which states what the MIU offers patients (many patients were presenting with illness rather than minor injuries)
- The reception counter needs to be lowered to enable everyone better access to the reception and to discuss and answer any questions comfortably
- If the MIU service was to be moved, it needs to be accessible for the local community

Acknowledgements

Healthwatch Kent would like to thank:

- the staff at Faversham Minor Injuries Unit, particularly Sandra Bigwood
- IC24, particularly Gilly Carliell and Mary Kitcher
- Our Healthwatch volunteers, Jim Hancock, Hilary Clayden and Jim Richards

for their assistance in planning this visit and preparing this report.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 18 July 2014

Subject: Future of Services at Dover Medical Practice

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the NHS England Kent and Medway Area Team.

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) Primary medical services in England are provided by GPs under contracts with NHS England (before April 2013 the contracts were with primary care trusts (PCTs), which have now been abolished). The mechanism by which funding is allocated to GP practices is complicated, and there are a number of different contracting methods. In addition about a quarter of GPs in England (around 9,000 of the nearly 36,000 GPs in England) are salaried direct employees of NHS organisations (House of Commons Library 2014).

(b) The majority of GP services are contracted using the nationally negotiated core GP contract: the General Medical Services (GMS) contract. There are also locally negotiated contracts, including the Personal Medical Services (PMS) and Alternative Provider Medical Service (APMS) contracts. PMS is designed to allow GPs to offer a wider range of services responding to local need. APMS contracts allow the commissioning of additional primary care services from the independent sector (House of Commons Library 2014).

(c) Additional services can also be commissioned through locally negotiated contracts either by NHS England or local Clinical Commissioning Groups (CCGs). NHS England can commission enhanced services including out-of-hours care. CCGs can commission other services—such as minor surgery—from general practices in their area, directly or on behalf of other local providers. The Quality Outcomes Framework (QOF) provides additional funding based on the quality of patient care (House of Commons Library 2014).

2. General Medical Services contract

(a) Under the General Medical Services (GMS) contract, introduced in 2004, practices get an amount, known as the global sum, allocated according to a needs-based formula (taking into account levels of deprivation, age and health status of patients) adjusted for geographic differences in cost (House of Commons Library 2014).

(b) Practices also receive a Minimum Practice Income Guarantee (MPIG) that ensures the global sum is no lower than it would have been under the previous contract. As part of the GP contract settlement in 2013, the Department of Health decided to phase out MPIG top-up payments over a seven-year period, starting in the financial year 2014/15. This is intended to distribute resources more equitably between practices (House of Commons Library 2014).

(c) The GMS contract is negotiated between the British Medical Association (BMA) General Practitioners Committee and NHS Employers, on behalf of the Government. GMS contracts were held by 55% of practices in 2012 (The King's Fund 2014).

3. Personal Medical Services contract

(a) Personal Medical Services (PMS) contracts are a locally-agreed alternative to the General Medical Service (GMS) contract. Introduced under the National Health Service (Primary Care) Act 1997, it is only in recent years that the number of practices choosing PMS has grown rapidly; over 40% of all GP practices in 2012 had PMS contracts (The King's Fund 2014).

(b) Unlike GMS contracts, they are negotiated between NHS England (PCTs before April 2013) and the practice. They are not subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the BMA (House of Commons Library 2014).

(c) NHS England initiated a national review of PMS contracts in June 2013 in response to concerns some practices were paid significantly more than others for similar work. NHS England has asked NHS Employers to manage a project to collect data from NHS England Area Teams on all PMS contracts in England. This information will enable NHS England to work with Area Teams to consider how far PMS expenditure (in so far as it exceeds the equivalent expenditure on GMS services) is effectively paying for 'core' primary care services (House of Commons Library 2014).

4. Alternative Provider Medical Services contract

(a) Under Alternative Provider Medical Services (APMS) contracts, NHS England are able to locally negotiate contracts for primary medical services with commercial providers, voluntary sector providers, mutual

sector providers, social enterprises, public service bodies, GMS and PMS practices (through a separate APMS contract) and NHS Trusts and NHS Foundation Trusts. 2.2% of GP practices in 2012 had APMS contracts. (Department of Health 2010; The King's Fund 2014).

(b) APMS can be used to provide essential services, additional services where GMS/PMS practices opt out, enhanced services, out-of-hours services or any one element or combination of these services (Department of Health 2010).

(c) The Dover Medical Practice is managed by the medical group Concordia Health Limited, which is contracted by NHS England to provide care to patients at the surgery under an Alternative Provider Medical Services (APMS) contract.

5. Prime Minister's Challenge Fund

(a) In October 2013, the Prime Minister announced the £50 million Challenge Fund to improve access to general practice and test innovative ways of delivering GP services. NHS England invited GP practices to submit their 'expressions of interest' to be one of the pilots (NHS England 2014a).

(b) Invicta Health, a community interest company, owned by more than 40 GP practices in East Kent was selected as a pilot and awarded £1,894,267. The pilot brings together 13 practices, in Dover and Folkestone, and will offer extended and more flexible access to services for 94,940 patients, backed by enhanced community care and specialist services for people with mental health needs. Patients will be able to book appointments at any of the 13 practices from 8am to 8pm, seven days a week. Outside of core practice hours (8am-6.30pm) patients can access urgent home visits and if required, short-term residential facilities in the community, to avoid hospital admissions. For patients with urgent mental health needs, this pilot is also introducing a new rapid assessment service delivered by a primary care mental health specialist, either at a patient's home or at their GP (NHS England 2014b; NHS England South 2014).

(c) Dover Medical Practice was selected as one of the 13 practices to pilot extended and more flexible access to GP services.

6. Recommendation

RECOMMENDED that the report be noted and that NHS England (Kent and Medway Area Team) take note of the comments made by Members during the meeting and be invited to submit a written update in three months.

Background Documents

Department of Health (2010) '*Alternative Providers of Medical Services (APMS) (05/03/2010)'*, http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/APMS/index.htm

House of Commons Library (2014) '*General Practice in England (06/06/2014)'*, http://www.parliament.uk/briefing-papers/SN06906/general-practice-in-england

NHS England (2014a) '*Prime Minister's Challenge Fund (14/04/2014)'*, http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/

NHS England (2014b) '*About the PM Challenge Fund Pilots (14/04/2014)'*, http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/pm-about/

NHS England South (2014) '*Folkestone and Dover GPs awarded £1.89 million to improve access for patients (16/04/2014)'*, http://www.england.nhs.uk/south/2014/04/16/dover-pmfund/

The King's Fund (2014) '*Commissioning and funding general practice: Making the case for family care networks (19/02/2014)'*, http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/commissioning-and-funding-general-practice-kingsfund-feb14.pdf

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Paper for the Kent Health Overview and Scrutiny Committee (HOSC) from NHS England (Kent and Medway)

Future of services at Dover Medical Practice, Dover Health Centre, Maison Dieu Road, Dover, CT16 1RH

1. Background

The Dover Medical Practice is managed by the medical group Concordia Health Limited, which is contracted by NHS England to provide care to patients at the surgery under an Alternative Provider Medical Services (APMS) contract. The contract commenced on 1 December 2011 for a period of five years.

Concordia Health recently informed NHS England that they would not be able to guarantee the continued provision of services to patients at Dover Medical Practice for the duration of their contract and therefore requested that the contract be brought to an end on 30 November. Having given careful consideration to this request, and in order to ensure sustainable arrangements for the future care of patients registered at the surgery, NHS England agreed to Concordia Health's request.

2. Practice Profile

Dover Medical Practice is located on the ground floor of the Dover Health Centre, a multi-purpose healthcare facility within central Dover. The building is owned and managed by NHS Property Services Limited.

As at April 2014, the practice had 3,712 registered patients.

The surgery treats a range of different patients from across the local community. A significant proportion of patients registered at the practice do not have English as their first language and some patients do not speak English. A breakdown of patient demographics at the practice is shown at **Appendix 1**.

GP practices which have the capacity to treat more patients are required to accept new patients who live within their local catchment area. Practices also have discretion about whether to accept any patients who do not fall within their surgery boundary.

The catchment area for Dover Medical Practice is shown at **Appendix 2** as attached. **Appendix 3** then shows the geographic spread of patients registered at the practice.

3. Context

The APMS contract includes some nationally agreed core elements. This includes provision for either the provider, or the commissioner of the service (in this case NHS England) to end the contract early providing the required notice period of at least six months is served.

After Concordia Health gave notice of its intention to end its contract with NHS England for the provision of services at Dover Medical Centre, both parties agreed to an end date of 30 November 2014 in order to meet the requirements of the contract and allow sufficient time for alternative arrangements to be made for the care of patients registered at the practice.

4. Options

NHS England wrote to all patients registered at the practice and other local stakeholders on 18 June 2014, to seek their views on the two options available to NHS England to ensure the continued provision of local GP services to patients.

Further information about these two options and the potential implications of each option are detailed below.

4.1 Option 1: Ask patients to register with an alternative local GP practice

This option would allow the practice to close once the current contract ends on 30 November 2014 and for arrangements to be put in place to support patients to register with an alternative local GP surgery of their choice (providing they live within the boundary of their chosen GP practice).

4.1.1 Implications for patients

If this option were taken, patients registered at Dover Medical Centre would be provided with a list of alternative local GP practices to help them choose a new GP surgery. Information provided to patients would include addresses and contact details for other local practices, as well as the distance in miles from Dover Medical Practice for each alternative local surgery. Patients would also be advised that they could find additional information about alternative local practices and how close they live to them on the NHS Choices website at www.nhs.uk.

Alternatively, are also able to call the Kent Primary Care Agency to find out which local GP surgeries are in their area and the relevant contact details would be made available to patients if this option was taken.

Under the terms of the nationally agreed core contract for the provision of GP services, GP practices can accept new patients if their list of patients is 'open' (eg if they have capacity to treat more patients). Practices must accept new patients who live within their practice boundary if they have an 'open' list, but can also accept patients who live outside the surgery catchment area should they wish to do so.

As at 7 July 2014, all GP practices in the Dover area have open lists and can therefore accept new patients.

NHS England is aware that some concerns have been raised locally about whether other local practices would provide translation services to patients who do not speak English, a number of whom are currently registered at Dover Medical Centre.

Under the nationally agreed GP contract, GP surgeries cannot refuse to register patients on the grounds of an applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. Practices cannot therefore refuse a registration request on the basis that a patient has need of an interpreter.

We are investigating concerns that some practices in Dover are not providing access to an interpreting service for patients.

It is important that all local practices meet the needs of patients and their local communities and we are working to raise awareness of the importance of interpreting services (which are

funded by NHS England) amongst local surgeries. We will take appropriate action if it is found that practices are not meeting the needs of patients.

NHS England will continue to work to ensure that the needs of all patients registered at Dover Medical Practice including any vulnerable patients, can continue to be met after 30 November.

4.1.2 Implications for other local GP practices

The CT16 postcode, where the majority of patients registered with Dover Medical Practice live, is covered by a range of alternative local GP practices in the town. These are:

- Pencester Health (also located within Dover Health Centre)
- Pencester Surgery (on Pencester Road)
- St James' Surgery (on Harold Street)
- Buckland Medical Centre (at Brookfield Place)
- The High Street Surgery (on the High Street) and Branch (in Whitfield)
- Peter Street Surgery (on Peter Street)
- White Cliffs Medical Centre (on Folkestone Road)

In addition a number of patients to the north of the boundary would be covered by the Lydden Surgery (on Canterbury Road).

Discussions have taken place with these practices regarding their ability to accept new patients should NHS England need to ask patients to register with an alternative local surgery. The discussions with the practices have included reference to levels of patient access, staff numbers and building capacity for each of their surgeries in order to seek assurance about their ability to welcome new patients.

This has included initial discussions with Pencester Health given the surgery shares the same building as the Dover Medical Practice. The assumption therefore is that most patients would seek to register with this surgery first as an alternative to Dover Medical Practice. The discussions with Pencester Health have included consideration of their ability to take on a large number of patients from Dover Medical Practice and the potential to reconfigure their accommodation within Dover Health Centre and to increase the number of clinical and administrative staff at the surgery to manage this. We are currently awaiting further information from Pencester Health about this and discussions with other local practices are also ongoing.

It is acknowledged that a proportion of the patients registered at Dover Medical Practice are perceived by other local practices as having greater needs than other patients, particularly in relation to interpreting services and learning disabilities.

However information available from Concordia Health and staff currently working at Dover Medical Practice shows that appointments where an interpreter is required to support patient care do not impact upon access to appointments for other patients. Data provided by Concordia Health shows that on average 6.8% of appointments per week require an interpreter to be available, but all appointments are able to be managed within the standard ten minute timeframe for patient consultations (although longer appointment slots can be booked where clinically necessary).

As confirmed above, we have been made aware of concerns that some Dover practices are not providing patients with access to interpreting services or are referring them on to the Dover Medical Practice, advising that they are not able to register patients who need interpretation services. These concerns will be investigated fully and action taken where necessary to ensure no patients is being discriminated against.

4.1.3 Implications for other services provided at Dover Health Centre

The essential provision of other services within Dover Health Centre will remain unchanged regardless of the decision that NHS England makes regarding the future care of patients registered at Dover Medical Practice.

As noted above, there is the potential to reconfigure use of the rooms within the health centre pending further discussions with Pencester Health about their ability to register patients from Dover Medical Centre if needed. However this would have no detrimental impact on other services provided in the building.

NHS Property Services will also work with the local NHS to agree a new use for the space should discussions with Pencester Health not progress; however the space would remain for NHS use.

4.2 Option 2: Identify a new provider to deliver GP services to Dover Medical Practice's patients from the existing premises

4.2.1. Implications for patients registered at Dover Medical Practice

If this option were chosen, patients registered with Dover Medical Practice would continue to access GP services from the existing premises of Dover Health Centre. Patients would not be required to re-register with an alternative local practice; however they would retain the right to do so if they so wished.

4.2.2 Implications for other local practices

Whilst patients would retain the right to register at an alternative GP surgery, local practices would be unlikely to see a significant increase in registration requests if the Dover Medical Practice remained at Dover Health Centre, with an open list.

4.2.3 Implications for other services provided at Dover Health Centre

As noted above, the provision of other services in Dover Health Centre will remain unchanged regardless of the decision that NHS England makes regarding the future care of patients registered at Dover Medical Practice.

5. Engagement

NHS England is continuing its engagement process with patients and local stakeholders on the above options in order to determine how best to ensure ongoing care for patients currently registered at Dover Medical Practice.

The following activities have been undertaken to date:

- **18 June 2014:** Letters sent to patients registered at Dover Medical Practice to seek their views on the two options available for the future of services

- **18 June 2014:** Letters sent to other local stakeholders seeking views on the two options (including other local GP practices, NHS South Kent Coast Clinical Commissioning Group, Kent HOSC, the Kent Health and Wellbeing Board, Kent Healthwatch, Dover Town Council, Charlie Elphicke MP and the Kent Local Medical Committee

- **25 June 2014:** NHS England held a meeting with the Dover Medical Practice Patient Participation Group to seek their views on the two options

- **Currently being arranged:** A meeting is also due to take place between NHS England, local GP practices, NHS South Kent Coast Clinical Commissioning Group and the Kent Local Medical Committee to help further determine the ability of other local surgeries to accept patients from Dover Medical Practice, if necessary.

The engagement process will conclude on 25 July 2014. NHS England will then consider all factors (including the views of patients and the local community) in reaching a decision about how to provide ongoing care for patients registered at the Dover Medical Practice.

In reaching this decision we will prioritise the need to achieve quality of care and improved health outcomes for local patients.

NHS England will update the Kent HOSC, patients registered at the practice and other local stakeholders once a decision has been made.

James Thallon
Medical Director

Appendix 1: Patient Demographics

The practice population is almost equally divided between male (49%) and female (51%) patients.

The percentage split by age range:

0-16yrs - 33%
16-30yrs - 21%
31-50yrs - 29%
51-70yrs - 13%
Over 70yrs - 4%

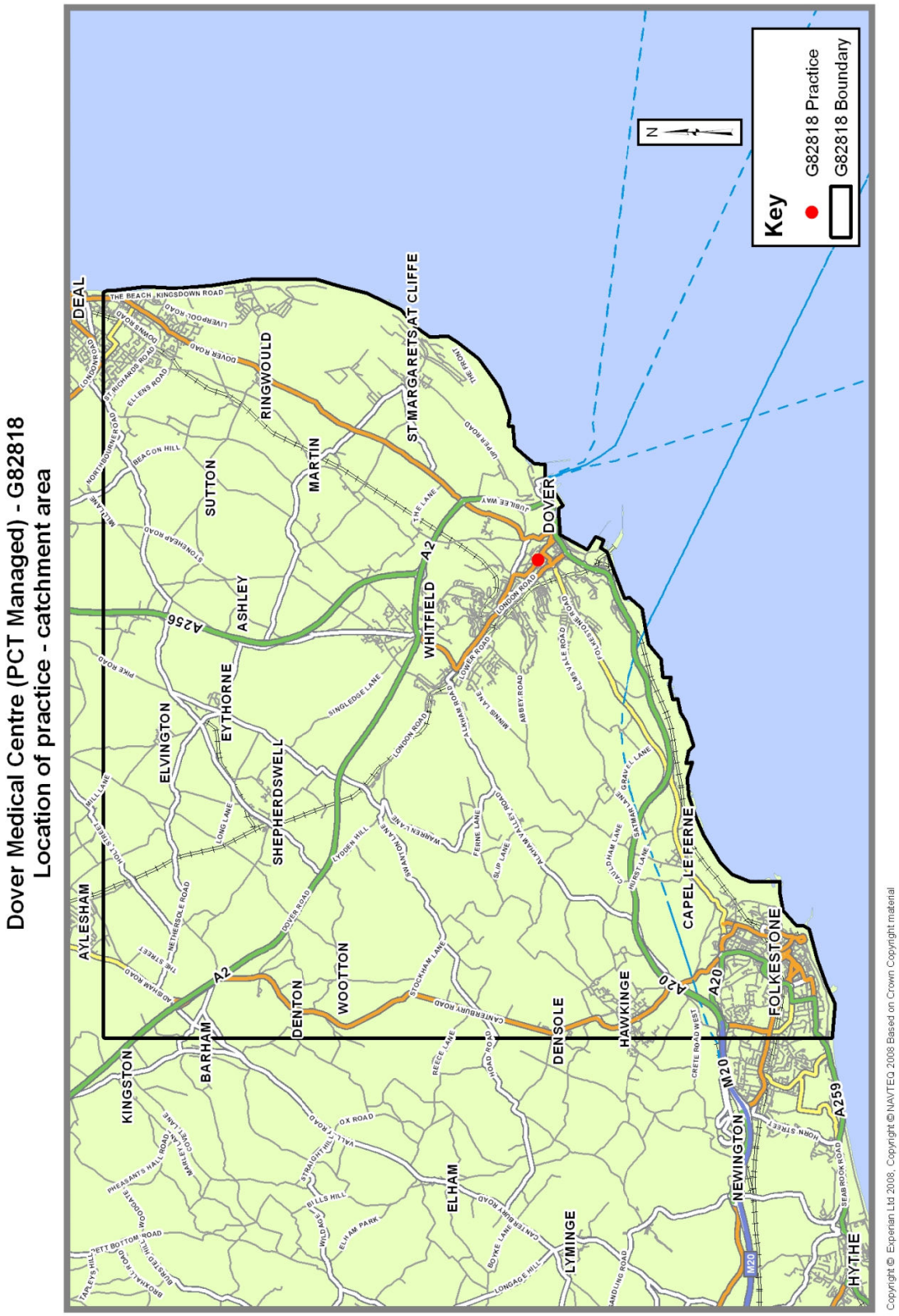
The practice has a number of groups of patients with particular needs, represented as a percentage of the practice population, as follows:

Patients who misuse alcohol - 7%
Drug abusers - 1.5%
Patients with a learning disability - 2%
Patients with a mental health condition - 4.5%

The ethnicity of the practice population is varied, mostly made up of ethnic minorities with a large Eastern European profile. The top five languages spoken amongst patients are:

English - 37%
Czech/Slovak - 27.2%
Nepali - 14%
Polish - 10%
Russian/Lithuanian - 7%

Appendix 2: Practice boundary



Appendix 3: Patient distribution