HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 5th September, 2014

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 5th September, 2014, at 10.00 am	Ask for:	**Lizzy Adam**
Council Chamber, Sessions House, County Hall, Maidstone	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 (Pages 5 - 16)	
4.	Medway NHS Foundation Trust: Update (Pages 17 - 50)	10.05
5.	CQC Inspection Report - East Kent Hospitals University NHS Foundation Trust (Written Update) (Pages 51 - 56)	10.45
6.	East Kent Outpatients Services (Pages 57 - 64)	10.50
7.	SECAmb - Future of Emergency Operation Centres (Pages 65 - 82)	11.30
8.	Patient Transport Services (Written Update) (Pages 83 - 92)	12.15
9.	NHS England: General Practice and the development of services (Pages 93 - 110)	14.00
10.	Date of next programmed meeting – Friday 10 October 2014 at 10:00 am	

Proposed items:

- Child and Adolescent Mental Health Services (CAMHS)
- West Kent Primary Care: Urgent and Emergency Provision
- Dermatology Redesign: North and West Kent
- CQC Inspection: East Kent Hospitals University Foundation Trust

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

28 August 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, 18 July 2014.

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

ALSO PRESENT: Mr S Inett, Mr M Ridgwell, Dr M Parks, Mr A H T Bowles and Mr T Gates

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

UNRESTRICTED ITEMS

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

(3) Mr Chris Hoare declared an interest as his son was being assessed for a statement and his wife was pregnant and receiving prenatal care from Maidstone and Tunbridge Wells NHS Trust.

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

52. Minutes - 6 June 2014
(Item 3)

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

(a) Minute Number 43 - Community Care Review: NHS Ashford CCG & NHS Canterbury & Coastal CCG. The CCGs were asked to provide an update on the design of the community hubs. The paper was being drafted and would be circulated to Members informally.

(b) Minute Number 44 - East Kent Outpatients Services: Consultation Update. The draft Minutes for this item had been circulated to EKHUFT

Board and NHS Canterbury & Coastal CCG Governing Body in advance of their decision-making meetings.

(c) Minute Number 48 - Kent Community Health NHS Trust: Community Dental Services (Written Update). KCHT was asked to produce a briefing note to clarify the percentage of local patients who were seen at the Deal Clinic and the commissioner's view on the changes to community dental services. The briefing note was circulated to Members on 9 July 2014.

(d) Minute Number 49 - Child and Adolescent Mental Health Services (Written Update). Michael Ridgwell was asked to co-ordinate a joint response and update on performance across the four CAMHS tiers in Kent. The paper was being drafted and would be circulated to Members informally in the week beginning 21 July 2014.

(e) Minute Number 50 – Date of the next meeting. Following a request by a Member, Mr Gough was asked to include 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 his report to the Committee in July 2014.

(2) The Scrutiny Research Officer requested that Minute 45 be amended to the Queen Elizabeth The Queen Mother Hospital.

(3) RESOLVED that, subject to the amendment in paragraph (2) above, the Minutes of the Meeting held on 6 June 2014 are correctly recorded and that they be signed by the Chairman.

53. Kent Health & Wellbeing Board: Update and Strategy
(Item 4)

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

- The 2015 Challenge Declaration - NHS Confederation
- The Initial Health & Wellbeing Strategy
- The Refreshed Health & Wellbeing Strategy
- Communication and Engagement Plan
- Local Health and Wellbeing Boards
- The complexity of the Kent landscape
- Integration Pioneer programme
- Better Care Fund

(2) At the 6 June meeting, a Member of the Committee 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 Mr Gough's presentation. Mr Gough gave an overview of the local Health and Wellbeing Boards in Kent. He explained that there was a distinctive set up in Kent with seven CCGs running across 12 local

authority boundaries and three health economies. He highlighted the proposed merger between NHS Ashford CCG and NHS Canterbury & Coastal CCG.

(3) Mr Gough explained that there was a developing relationship between the Kent Health and Wellbeing Board and the local Health and Wellbeing Boards. There was a mandate for local Health and Wellbeing Boards to look at national issues or particular areas such as falls and develop local strategies. The Kent Fire & Rescue Service presented to the Kent Health and Wellbeing Board in July about their contribution to health and wellbeing of Kent which would be taken forward by local boards.

(4) Mr Gough explained that Local Health and Wellbeing Board were key stakeholders in the development of the refreshed strategy. As part of the communication and engagement plan, the local Health and Wellbeing Boards would be engaging with their local populations and reporting back to Kent Health and Wellbeing Board in November 2014. A number of local Health and Wellbeing Boards inputted into the Better Care Fund and reviewed local commissioning plans. Local Health and Wellbeing Boards had mixed economies with Chairs ranging from KCC Cabinet Members, District Council Leaders and CCG Chairs.

(5) The Chairman invited Mr Bowles, a guest of the Committee, to speak. As the Chair of the Swale Health and Wellbeing Board, he raised concerns about financial and staffing pressures on the borough council to facilitate the local Health and Wellbeing Board in particular attendance at additional meetings and leading on public consultation. Mr Gough acknowledged the difficulties Swale faced in covering two CCG areas. He explained that he did not expect borough and districts to lead on consultations. It was for the CCGs to consult on their commissioning plans and the communication and engagement for the refreshed Health and Wellbeing Strategy was being led by KCC.

(6) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A Member raised a concern about the ownership and redesign of NHS estate. Mr Gough explained that NHS estate was owned by NHS Property Services. It would be a significant player in reconfiguration as it could match and mirror changes to services. Mr Ridgwell commented that there was a large amount of NHS estate available to utilise with the redesign of services.

(7) A number of comments were made about ‘hospitals without walls’ and community services. Mr Gough explained that ‘hospital without walls’ was the concept of acute services coming out into the community enabling patients to have a shorter stay in hospital and receiving care in the most appropriate location such as at home or in a community setting. He highlighted Simon Stevens’, Chief Executive of NHS England, support of community hospitals. He noted that the KCC Accommodation Strategy was looking to establish community capacity and ensuring the correct mix of accommodation was available.

(8) A specific question was asked about the Assurance Framework’s fit with the Better Care Fund. Mr Gough explained that the Assurance Framework had been developed over the last year with elements of the Better Care Fund

being anticipated and incorporated. The Assurance Framework fitted well with six Better Care Fund indicators. He noted the Better Care Fund's greater focus on reducing hospital admission.

(9) A Member enquired about devolved budgets. Mr Gough explained that CCGs were responsible for their own budget. Social care budgets would be moving towards the CCG structure and there was a desire to bring the public health funding closer to the local CCG areas. He acknowledged that some public health services would continue to be commissioned county wide. He stated that he would be happy to discuss the issue further with the Member.

(10) A Member highlighted SEN funding and provision. Mr Gough explained that there was a large special school capacity in Kent. There were huge pressures on autism, speech & language and behavioural & emotional services. KCC had invested heavily in reducing out of county placements and had developed six new primary schools with specialised units in areas of need. There would be further integration between KCC as the education authority and the health service with the introduction of the Children and Families Act.

(11) A number of comments were made about CAMHS, statistical variances in the report and the utilisation of libraries and gateways. Mr Gough explained that The Rt Hon Greg Clark MP had suggested the countywide target for improvements to CAMHS. Mr Gough stated that he would need to check the differences in the statistics and would provide additional information on the utilisation of libraries and gateways.

(12) RESOLVED 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.

54. Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy
(Item 5)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust), Avey Bhatia (Chief Nurse, Maidstone and Tunbridge Wells NHS Trust) and Jayne Black (Director of Strategy & Transformation, Maidstone and Tunbridge Wells NHS Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee and asked them to introduce the item. Mr Douglas began by giving an overview of the developing five-year strategy.

(2) Mr Douglas stated that the biggest challenge for the clinical strategy was financial viability. The Trust was required to make an annual 5% cost improvement programme consistently over five years which was a quarter of current income. The Trust employed 5,500 staff which accounted for 80% of cost. The Trust was focusing on efficiency and a reduction of in non-elective activity to achieve financial viability. This would enable them to create capacity

and deliver elective or full price non-elective care to a wider population. The Trust only received 30% of the tariff for emergency activity in excess of emergency activity in 2009 which cost the Trust £9 million each year.

(3) He explained that the seven key drivers for change were identified:

1. Quality issues to ensure sustainable clinical services such as the proposed development of the first hyper acute stroke unit in Kent by the Trust;
2. Major financial challenges over the next five years;
3. NHS West Kent CCG's funding gap of £60 million by 2018/19;
4. Predicted increases in demand for emergency non-elective services as the population gets older and lives longer;
5. Changes in technology to improve quality and efficiency;
6. Workforce deficiencies;
7. National recommendations including Sir Bruce Keogh's recommendations to introduce seven day working and two levels of hospital emergency department: Emergency Centres and Major Emergency Centres. The Trust would like to establish one of two/three Major Emergency Centres identified for Kent.

(4) He informed the Committee that a Clinical Strategy Group had been established which identified the four major work streams required to develop the strategy: emergency care; centres of excellence; seven day working; and integration & collaboration.

(5) He |highlighted the key messages from the strategy. The Trust needed to improve efficiency and productivity within the next two years including a reduction in the length of stay to below the national average. The Trust planned to redesign emergency pathways to achieve a reduction in non-elective activity and release 50% of capacity for other services. The Trust was aligning to West Kent's five year commissioning strategy and engaging with local partners.

(6) He stated that engagement with local partners included the Trust's work with the Queen Victoria Hospital NHS Foundation Trust to establish a major hub at Maidstone Hospital. The Trust was working with Brighton and Sussex University Hospitals NHS Trust and High Weald Lewes Havens CCG to look at providing additional services at the Tunbridge Wells Hospital. The Trust was also in discussions with Medway NHS Foundation Trust to move some elective care to the Trust. It had developed strategic links with EKHUFT through the Kent Pathology Partnership.

(7) He confirmed that the Trust was continuing to develop the clinical strategy. Work planned for July – September included the development of implementation plans, a new model of care for stroke services and plans for a paediatric A&E at Tunbridge Wells Hospital.

(8) Members of the Committee then proceeded to ask a series of questions and made a number of comments. Mr Pearman thanked the guests for facilitating a visit to the Tunbridge Wells Hospital in March 2014 with Mr Crowther. He wanted to acknowledge the enthusiasm and professionalism of the staff he had met. He believed that the implementation of the strategy was dependent on front end delivery and was confident that this would be achieved by the

staff. Mr Douglas thanked Mr Pearman for the compliment and highlighted the work of the Trust's staff. The Trust ranked fifth out of 90 Trusts in the NHS Trust Development Authority's Patient Experience Survey which was testament to the staff.

(9) A comment was made about pathway management for patients with multiple long term conditions. Mr Douglas acknowledged the need for the Trust to work closely with GPs and community services to provide pathway management. GPs required additional infrastructure from organisations such as acute trusts to support the co-ordination of patients with multiple long term conditions. Mr Ridgwell reminded the Committee that a paper on the strategic development of GP services would be brought to the September meeting.

(10) In response to a specific question on the PFI initiative at the Tunbridge Wells Hospital and the cost of individual rooms, Mr Douglas explained that PFI was the only option to build a new hospital as the hospital at the old site was unsustainable. An option appraisal had been carried out by the Department of Health and the Treasury, using a Public Sector Comparator, which was supportive of the PFI initiative. It was explained that whilst a single room cost more as there was a larger area to clean with an en suite bathroom, nursing costs had remained the same. All new hospitals had a significant number of single rooms which patients responded well too.

(11) A question was asked about traffic congestion in Tunbridge Wells and its impact on the Hospital. Mr Douglas explained that ambulance timings had not been affected by congestion; they were able to get through the traffic. He noted that staff and patients were impacted by traffic congestion. The old site, the Kent & Sussex Hospital, was located in the centre of Tunbridge Wells which was significantly impacted by congestion. Mr Douglas expressed concerns about the impact on the hospital with the construction of dual lanes on the A21 from Tonbridge to Pembury.

(12) A number of comments were expressed about the CQC inspection at Maidstone and the involvement of the Trust in the Maidstone's Borough Council's Local Plan. Mr Douglas stated that he was disappointed by some of the comments made by the CQC particularly in regards to 24 hour consultant paediatrician cover at Maidstone Hospital. The comment by the CQC was made despite knowing that the paediatric service had moved to Tunbridge Wells and the Trust had closely followed the guidance set out by the Royal College of Paediatricians. Following the CQC inspection, the Trust had reviewed the paediatric pathway and was looking to introduce a paediatric A&E in Tunbridge Wells Hospital. Mr Douglas acknowledged that the Trust needed to take a more active role in the community. He explained that he had responded to the Bluebell Wood planning application as there had been a desire by staff for the wood to remain next to the hospital. He stated that he felt that the Trust was not treated as a partner by the Borough Councils despite being one of the largest local employers which generated economic growth.

(13) RESOLVED that the guests be thanked for their attendance and their contributions, and that there be on-going engagement with HOSC as plans are

developed with a return visit to a meeting of the Committee at the appropriate time.

55. CQC Inspection Report and Royal College of Surgeons Report: Maidstone Hospital
(Item 6)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust), Avey Bhatia (Chief Nurse, Maidstone and Tunbridge Wells NHS Trust) and Jayne Black (Director of Strategy & Transformation, Maidstone and Tunbridge Wells NHS Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee and asked them to introduce the item. Ms Bhatia began by giving an overview of the three CQC inspections, which had taken place since November 2013. The inspections took place unannounced in November 2013 at the Tunbridge Wells Hospital, in February 2014 at Maidstone Hospital and in April 2014, which looked at safeguarding in North and West Kent. The Trust believed that the Royal College of Surgeons report was the trigger for the CQC inspections.

(2) Ms Bhatia stated that the main theme of the inspections was the provision of paediatric services. A concern highlighted in the Maidstone Hospital inspection was the shortage of paediatric-trained nurses in A&E which was a national issue. The Trust was reviewing the emergency care pathways for children to enable a separate emergency paediatric and adult pathway at both sites. The Trust was exploring the option of a dedicated paediatric A&E department at Tunbridge Wells Hospital.

(3) Ms Bhatia explained that other issues identified in the inspection report, including governance, had been developed into a 20-point action plan with the CQC to deliver improvements. The improvement plan was updated monthly and shared with the CQC. The Trust was expecting a re-inspection towards the end of the year under the new model of inspection to assess compliance with CQC standards.

(4) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A specific question was asked about the recruitment of paediatric-trained A&E nurses. Ms Bhatia explained that paediatric-trained A&E nurses wanted to work in dedicated paediatric emergency department rather than in a mixed model. Ms Bhatia stated that when the model changed to a dedicated emergency paediatric unit, the Trust would be able to recruit. The CQC had become prescriptive about the recruitment of paediatric-trained A&E nurses to all Trusts. Mr Douglas explained that Tunbridge Wells had a fully staffed paediatric unit with paediatricians and paediatric nurses, which received good shortlists when jobs were advertised. A rotation of staffing between the proposed emergency paediatric department and paediatric unit at Tunbridge Wells was being considered.

(5) Mr Angell thanked the guests for facilitating a visit to Maidstone Hospital with Miss Harrison in November 2013. He explained that he had recently met with the Trust's Finance Director who had stated that a high proportion of patients at both sites had dementia and he enquired about dementia training for staff. Ms Bhatia explained that there was lots of training for staff on dementia. Engaging with family members and carers was essential as they knew the needs of the patients. The Trust had introduced the 'This Is Me' booklet, a nationally developed booklet to record key information on memory, mobility and other factors to ensure that the right care was provided for the individual patient. The Trust had a Lead Nurse in Dementia Care. A Dementia Café and Ward had been developed at Tunbridge Wells Hospital and the Activities Co-ordinators at Maidstone Hospital had been key to moving patients out of beds into other areas of the hospital to interact. The Trust had a paper published in the Nursing Times about the Trust's work on dementia. Mr Inett referred to a report on the range of dementia services provided in the community which was presented to the Kent Health and Wellbeing Board in July 2014.

(6) Dr Sigston was invited to provide a brief overview of the Royal College of Surgeons report. The Trust Board was proactive in commissioning the Royal College of Surgeons (RCS) report in response to unexpected deaths following upper gastrointestinal cancer surgery in 2012/13. The Trust commissioned the report in April 2013 and the report was delivered by the RCS in December 2014. In line with the RCS recommendations, the Trust was working with St Thomas' Hospital in London to provide upper gastro intestinal cancer surgery. He stated that only a small minority of patients required this type or surgery.

(7) A Member enquired about the employment status and management of the consultants mention in the RCS report. Dr Sigston confirmed that the three gastro-intestinal surgeons continued to work for the Trust but no longer carried out complex cancer resection surgery. Dr Sigston explained that the document used to manage doctors, 'Maintaining High Professional Standards in the Modern NHS', was not fit for purpose and made it difficult to manage doctors.

(8) In response to a question from a Member, Dr Sigston explained that under guidance, issued by the General Medical Council and the Royal College of Nursing, a competent child was able to give consent and request that information remained confidential regardless of their age.

(9) Mr Douglas confirmed that that, the Trust was not aware of the qualifications and backgrounds of the inspectors carrying out unannounced inspections. The Trust was able to make comments on the draft report. He stressed that the Trust was committed to work with the CQC to make improvements to services and develop a good relationship with them.

(10) RESOLVED 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 December.

56. Patient Transport Services
(Item 7)

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

(1) The Chairman welcomed Mr Ayres to the Committee and asked him to introduce the item. Mr Ayres began by updating the Committee on NSL's performance. He explained that although there had been an improvement in the transport of renal patients, the rest of the service's performance had flat lined for three months.

(2) Mr Ayres explained that the contract with NSL was a standard NHS contract; the contract was for three years with two twelve-month extension periods. There were two clauses for early termination: a no fault termination by either party to terminate the contract early with a twelve month notice period or termination by one of the parties, with immediate effect, if the contract had been breached including the persistent and repetitive breach of a quality requirement. Although the CCG believed that NSL had breached the quality requirement; if this route was pursued by the CCG, it was likely that there would be a legal challenge by NSL to determine a breach.

(3) Mr Ayres confirmed that the CCG was reviewing the contract with procurement experts. As a large and significant contract, it would need to be re-procured with an advert in the European Journal. It would be a full procurement lasting a minimum of 12 – 15 months and a maximum of 18 months. This would mean that the earliest the contract would be re-procured was nine months before the contract expired.

(4) Mr Ayres stated that the CCG would be in a position to talk publically about the future of the contract by September following discussions with NSL and the acute trusts. There were no providers who would be able to deliver the Kent and Medway contract immediately. NSL was now the biggest Patient Transport Services (PTS provider) in the country. It had grown from a small to large company in five years. Mr Ayres raised concerns about the rapid growth of the company and local leadership. Mr Ayres noted that the specification would be revised in advance of procurement at which time the CCG would ask the Committee if it views the changes as a substantial variation of service.

(5) Members of the Committee then proceeded to ask a series of questions and made a number of comments. A Member raised a concern about the quality of the contract. Mr Ayres explained that in the first three – six months there was a range of problems with the quality of the contract; these had been remedied and resolved by December 2013. For the last six months, there was no explanation for NSL's performance; the road networks, geography, staff and vehicles did not hinder performance.

(6) A specific question was asked about the achievability of the contract. Mr Ayres explained that the CCG had looked at targets set, by other CCGs, for PTS providers; the targets for NSL were reasonable and achievable. It was difficult to compare NSL to the service before; targets were not centrally measured as a number of different providers were contracted to provide services.

(7) A number of questions were asked about alternative providers. It was explained that there was a significant range of providers who wanted to bid for the contract. Whilst NSL had a large number of contracts, it was explained it did not have a monopoly over PTS contracts; a number of PTS contracts were held by local ambulance trusts. Mr Ayres stated that nationally PTS commissioners were struggling with ambulance and private sector providers.

(8) A Member enquired about the use of penalty clauses and the logistical movement of patients. Mr Ayres explained that there were one or two penalty clauses in the contract; the CCG was looking to change penalty clauses when PTS was re-procured. Evidence had shown that penalties did not drive performance or change behaviour. A Member made reference to the efficient operation of freight companies to transport goods and produce. Mr Ayres stated that although PTS patients could not be treated as freight he acknowledged that managing logistics to enable the correct utilisation of vehicles and staff was key to provision.

(9) A number of comments were made about a reduction in funding for PTS and the difficulty in accessing patients' properties. Mr Ayres explained that eligibility for PTS was set nationally and had to be provided despite any cost pressures. Patients who were eligible for PTS were not able to use alternative transport; difficulty in accessing properties was part of a PTS provider's role through its talented and committed staff.

(10) RESOLVED that Mr Ayres 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 that he be invited to attend a meeting of the Committee in September.

57. Faversham Minor Injuries Unit

(Item 8)

Bill Miller (Chief Operating Officer, NHS Ashford CCG & NHS Canterbury & Coastal CCG), Andrew Bowles (Leader of Swale Borough Council and KCC Member for Swale East) and Tom Gates (KCC Member for Faversham) were in attendance for this item.

(1) The Chairman welcomed Mr Miller to the Committee and asked him to introduce the item. Mr Miller began by outlining the key points in the NHS Canterbury & Coastal CCG paper. Since discussions with HOSC in November 2013, the CCG had worked with the local community through a steering group to explore alternative ways of delivering services at the Minor Injuries Unit (MIU). The recommendations of the steering group were supported by the CCG at its governing body meeting in June. The CCG was in discussions with providers to deliver the new service specification. The specification included direct access x-ray to enable more patients to be seen and treated which was more attractive to providers. The CCG was grateful for the support of the local community and the current provider IC24. The new service would commence in April 2015.

(2) The Chairman invited the local Members, Mr Bowles and Mr Gates, to speak. Mr Bowles explained that the local community was pleased with the outcome. He hoped that a provider would be found to deliver the services. He was grateful to the CCG for listening but expressed concern about how close the MIU had been to shutting. He thanked the Committee for their intervention and sincere support. In addition, he thanked the Cabinet Member for Community Safety and Health at Swale Borough Council and the Mayor of Faversham.

(3) Mr Gates thanked the Committee, Chairman and staff for keeping him informed and updated. He was grateful to the Committee for their hard work in preventing the MIU's closure. He supported the new specification but enquired if the x-ray activity could be increased in the future.

(4) Mr Miller responded to the comments made by local Members. He explained that in Faversham a community network had been developed with local people and the CCG. The network had stimulated discussion and enabled future services to be planned collaboratively with the local community. The CCG was hoping to develop similar networks across the Ashford and Canterbury & Coastal areas. In regards to the extension of x-ray services in the future, it was explained that additional services would be dependent on demand from patients.

(5) A Member highlighted the positive impact the Committee had. The importance of communication with the local community was stressed. A comment was made about contract specification; CCGs were encouraged to ask KCC if they required assistance with contract writing and monitoring.

(6) Mr Inett was invited to speak about the report submitted by Healthwatch Kent. He explained that Healthwatch had powers to conduct 'Enter and View' visits. Healthwatch Kent had attended the steering group meetings and wanted to gain additional insight by visiting the MIU. The visit was conducted on Saturday 31 May during the MIU's busiest time. The staff had been very welcoming and it was a positive experience. Minor recommendations were made and were fed into the steering group's specification in particular raising awareness of the unit and the services it covered. Mr Miller confirmed that greater communication and awareness of the unit was key for the new service specification.

(7) RESOLVED that Mr Miller be thanked for his attendance at the meeting, and that the CCG be requested to take note of the comments made by Members during the meeting and that the Committee is kept informed with progress.

58. Future of Services at Dover Medical Practice
(Item 9)

(1) The Committee received a report from NHS England (Kent and Medway) regarding the future of services at Dover Medical Practice. The paper set out two options available to NHS England to ensure the continued provision of local GP services to patients which requested the Committee to confirm its views on each of the options.

(2) A Member noted that the Committee had been informed that the provider, Concordia Health Limited, had also requested that their contract at The Broadway, Broadstairs be terminated early.

(3) Another Member asked for clarification regarding the status of Dover Medical Practice as one of 13 practices in Dover and Folkestone to pilot extended and more flexible access to GP services as part of the Prime Minister's Challenge Fund.

(4) A number of comments were made about the sustainability of GP services in Kent. Mr Ridgwell explained that sustainability of primary care was a national issue. Dr Parks stated that there were an increasing number of practices that had requested their contract be terminated early. Also General Practice had become unattractive to providers, junior doctors and medical students. Dr Parks was concerned about the capacity for patients to register with an alternative local GP practice.

(5) A Member made a comment about the use of interpreters at GP consultations and asked whether patients should be encouraged to bring someone with them to interpret. Mr Ridgwell explained that it was not always appropriate for a family member to attend and interpret due to the personal nature of the matters to be discussed. He confirmed that interpreting services were available at all GP practices and the cost was funded by NHS England.

(6) RESOLVED that the report be noted, NHS England (Kent and Medway Area Team) take note of the comments made during the meeting and it be noted that there would be a wider discussion on General Practice and the development of services at the next meeting.

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

(1) The Chairman confirmed that Patient Transport Services would return to the Committee in September 2014.

(2) A Member requested fewer items on the next Agenda to allow time for discussions on General Practice and the development of services.

Item 4: Medway NHS Foundation Trust: Update

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 September 2014

Subject: Medway NHS Foundation Trust: Update

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

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

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1. Introduction

(a) Medway NHS Foundation Trust has attended the Health Overview and Scrutiny Committee on two occasions (6 September 2013 and 7 March 2014) following the publication of Professor Sir Bruce Keogh KBE's review into the quality of care and treatment provided by 14 hospital trusts in July 2013.

(b) At the end of the discussion on 7 March 2014, the Committee agreed the following recommendation:

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

2. Keogh Review

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

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

deviations away from regular practice' (NHS England 2013a; NHS England 2013b; NHS England 2013c).

(c) Medway NHS Foundation Trust was selected for the review due to a HSMR above the expected level for the last two years (a score of 115 for financial year 2011 and 112 for financial year 2012). A score greater than 100 indicates that a hospital's mortality rate exceeds the expected value (NHS England 2013d).

(d) In July 2013, 11 of the 14 Trusts including Medway NHS Foundation Trust were put into 'special measures'. Special measures was a new regime introduced following the Keogh Review in 2013. It involves action and scrutiny by three organisations: the Care Quality Commission (CQC), Monitor (for NHS Foundation Trusts) and the NHS Trust Development Authority (TDA) (for NHS Trusts) (CQC 2014).

3. Monitor

(a) The NHS TDA and Monitor put in place support packages for the 11 trusts in special measures.

(b) The support package provided by Monitor for Medway NHS Foundation Trust included:

- the appointment of an improvement director to the trust to provide challenge and support to board members on the delivery of the Keogh action plan;
- the appointment of an interim Chair and Chief Executive in February 2014 to strengthen the Trust's leadership;
- A buddying arrangement with East Kent Hospitals University NHS Foundation Trust to support Medway in improving its quality reporting systems (CQC 2014).

4. CQC

(a) Professor Sir Mike Richards, the Chief Inspector of Hospitals, prioritised full inspections of the 14 trusts that were in the Keogh Review (including the 11 trusts in special measures) under CQC's new inspection model for acute hospitals (CQC 2014).

(b) The inspections took place between mid-March and early May 2014. A wide range of quantitative and qualitative information was gathered before the inspections. The inspections were undertaken by a team comprising of clinicians, Experts by Experience and CQC inspectors. Eight core services were inspected, with each being assessed against the five key questions. A rating was given to each service for each of the five questions on a four-point scale (outstanding, good, requires improvement or inadequate). An overall rating for the 11 trusts were given (CQC 2014).

(c) The CQC inspected Medway NHS Foundation Trust in April/May 2014. The Trust was rated inadequate overall. The ratings awarded for the five key questions were:

Safe?	Inadequate
Effective?	Requires improvement
Caring?	Good
Responsive?	Inadequate
Well-led?	Inadequate

(d) Following the CQC's inspections, the Chief Inspector of Hospitals made recommendations about special measures for the 11 trusts to Monitor and the NHS TDA. The Chief Inspector of Hospitals concluded that significant progress had been made at 10 of the 11 trusts. Two had made exceptional progress and were rated 'good' overall. A further three had made good progress but required further improvements; it was recommended that they should exit special measures with ongoing support. Five trusts were recommended a further period in special measures, with an inspection in six months to ensure that they are continuing to make progress (CQC 2014).

(e) Medway NHS Foundation Trust was the only Trust found to have failed in making significant overall progress. It was recommended that the Trust remains in special measures. The reasons for this recommendation were given:

- Significant improvements had been made in the maternity services, but overall there has been little or no progression the quality and safety of care;
- Multiple inadequate CQC ratings;
- Unstable leadership throughout the past year;
- Poorly defined vision/strategy;
- Very poor alignment or engagement of clinicians (CQC 2014).

5. Recent Developments

(a) Monitor and CQC are now considering what urgent action should be taken to ensure the quality of care, provided to the local population in Medway, improves as rapidly as possible (CQC 2014).

(b) At the Trust's Board Meeting on 26 June 2014 it was announced that Phillip Barnes, Medical Director, would be taking over as the Trust's acting chief executive until further notice. The Board was informed that the interim Chief Executive, Nigel Beverley, had other commitments that precluded a continuation of his contract after its original end date (Medway NHS Foundation Trust 2014).

(c) A partnership project with University Hospitals Birmingham NHS Foundation Trust (UHB) was also announced. UHB is a large teaching hospital in Birmingham that treats nearly 900,000 patients a year, employs over 8,500 staff and has a reputation for clinical excellence,

training and innovation. UHB is providing management support and helping develop the Trust's improvement plans over a 12-week period which started in July 2014 (Medway NHS Foundation Trust 2014).

6. Recommendation

RECOMMENDED that guests be thanked for their attendance at the meeting, 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 in six months.

Background Documents

CQC (2014) *'Special Measures: One Year On (05/08/2014)*', http://www.cqc.org.uk/content/special-measures-one-year

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (07/03/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27666

Medway NHS Foundation Trust (2014) *'News Release 26 June 2014 (27/06/2014)*', http://www.medway.nhs.uk/news-and-events/latest-news/news-release-26-june-2014/

NHS England (2013a) *'Professor Sir Bruce Keogh to investigate hospital outliers (06/02/2013)*', http://www.england.nhs.uk/2013/02/06/sir-bruce-keogh/

NHS England (2013b) '*Sir Bruce Keogh announces final list of outliers (11/02/2013),*' http://www.england.nhs.uk/2013/02/11/final-outliers/

NHS England (2013c) *'Rapid Responsive Review Report for Risk Summit - Medway NHS Foundation Trust (01/06/2013)*', http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/Medway%20NHS%20Foundation%20Trust%20RRR%20report.pdf

NHS England (2013d) *'Medway NHS Foundation Trust: Keogh Review Data Pack (09/08/2013)*', http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/130709-keogh-review-medway-data-packs.pdf

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The Quality Improvement Plan Update

1. Introduction

The Trust's Quality Improvement Plan was written in June 2013 in response to the findings and recommendations of the Rapid Review Team that visited in May 2013.
The Plan is being monitored internally on a monthly basis by the Quality Committee and externally by the Local NHS England Area Team via a Sub Committee of their Quality Surveillance Committee. Monitor also report progress monthly directly to the Secretary of State.

This report updates on the:
- Quality Improvement Plan
- NHS Choices Special Measure Report.

2. The Quality Improvement Plan

The Quality Improvement Plan (QIP) (Appendix One) is attached. The achievement of the Improvement Plan remains a binding agreement with Monitor as an undertaking on the Trusts licence. The plan is over 95% complete or on track to deliver.

The Deputy Director of Multi Professional Training and Education started on the 21st July 2014. The introduction of multidisciplinary education – supported by the new deputy director post – will include joint training in the important day to day issues that were described in the Keogh action plan.

The Interim medical assessment unit proposals have been agreed, with planned opening at the end of September 2014. Works for the paediatric ED are to commence at the beginning August 2014.
The Trust continues to promote Friends and Family across the ward areas. Maternity have gone back to using postcards for ladies to offer feedback instead of texting and ED have some extra support from the Governance team to help staff understand the feedback. They are working with Healthcare Communications to help improve response rates.

As part of special measures the Trust are obliged to submit an update to NHS choices on the Quality Improvement Plan, monthly – by the 11th of the month. A copy of the August update is attached (Appendix Two). The Quality Assurance Committee (QAC) is asked to sign of this update

prior to submission to Monitor and the Trust's Improvement Director. However, from September, the dates for the QAC meetings will not enable sign off for the documents to meet this deadline. It is suggested that the QIP and NHS Choices Upload document is circulated to the QAC members for comment / approval via email the week before the 11th.

From September we are required to change the report template and content:

Approach to be adopted

The updated action plan should incorporate:

(a) Any outstanding items from the current action plan (carry forward); and

(b) Any material additional actions required as a result of the re-inspection reports/CQC recommendations.

If appropriate, we may wish to consider grouping items under the "summary of main concerns" column by main CQC domain headings (e.g. safe, effective, caring, responsive and well led) in order to be more overtly aligned to the CQC re-inspection regime/outputs.

At this point (i.e. for September and going forward) it is suggested it would be appropriate for someone involved in the new CQC action plan to lead on this report.

3. Conclusion

The Quality Improvement Plan is being implemented with 95% of milestones delivered or on track to be delivered.

The remaining themes from the Quality Improvement Plan will be incorporated into the Trust's action plan in response to the Trust's recent CQC inspection.
This strategy incorporates the outstanding actions within the QIP and builds on the initial recommendations within the Keogh report.

Medway NHS
NHS Foundation Trust

The Medway NHS Foundation Trust

Review into the Quality of Care and Treatment
July 2013

Quality Improvement Plan in Response to the Review Recommendations

Tracy Rouse, Project Director – Patient Safety

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1. The NHS England Review

1.1 Introduction

NHS England has undertaken a review of 14 Trusts that have been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). MFT was identified as one of these Trusts.

The Rapid Review Team visited the Trust on the 9th and 10th of May with an unannounced visit on the 17th May. Terms of reference for this review can be found on www.nhs.choices.

On the 3rd June 2013, a risk summit took place with the Rapid Review Team, NHS England, the Trust and our stakeholders. The high priority actions from the review were discussed and it was agreed that these would form the core of the Trusts improvement plan. The themes arising from the review and subsequent actions incorporated in this improvement plan can easily be cross referenced to the Trust's annual strategic plan. Furthermore, plans are in place to re-engage stakeholders in the development of the longer term strategic direction of the organisation in the autumn. At the heart of the Trust's long term vision is pursuit of the highest quality of care and standards for patients, within a clinically and financially sustainable organisation.

This report demonstrates what is currently underway and planned in relation to the high priority actions identifying leads and timescales. Supporting strategic and operational plans will be developed locally to ensure achievement. The work streams will be embedded in our workforce and business plans and will be core to our clinical strategy.

1.2 High Priority Actions

The rapid review identified 6 high priority areas:	
1	Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients
2	Review of staffing and skill mix to ensure safe care and improve the patient experience
3	Redesign of unscheduled care and critical care pathways and facilities
4	Improved senior clinical assessment and timely investigations
5	Need to galvanise the good work that is already going on in Wards and adopt and spread good practice
6	Improve public reputation

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2. Improvement Plans

1.		Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG Status
1.1	The Trust urgently needs a single visible strategy and action plan based on a recognised patient safety improvement model and underpinned by systematic staff training and roll out	The Trust Board will endorse this Improvement Plan at its Board meeting on 25th June 2013. Work on the revised strategy will take place over the next two months with an update at the Trust Board meeting on 5th September 2013. The new Quality Strategy which will incorporate patient safety as part of the 'Darzi' quality model: safety, effectiveness and patient experience will be presented in its final form to the Trust Board on 24th September 2013 by the new Medical Director and Chief Nurse. It will articulate a clear and compelling vision for patient safety and continuous improvement, building on the patient safety key driver framework (endorsed by the Mortality Working Party on 24th May 2013 and reflecting national learning from AQuA[1] and Don Berwick Report August 2013). The framework also incorporates the key priorities identified at the Listening Into Action[2], patient safety event (6th March 2013). Work on the implementation of the key drivers and improving outcomes has commenced and is progressing well. *Ongoing support from MWP will be required*	MD (CN)	25th June 2013 5th Sept 2013 24th Sept 2013		Completed Completed

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[1] AQuA. The Advancing Quality Alliance. It is an informatics observatory providing benchmarked intelligence and evidence based best practice

[2] Listening Into Action is an accredited national programme to actively engage staff

1.		Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG Status
		The delivery of the Quality Strategy will be underpinned by a comprehensive training programme. The 'NHS Change Model' provides a framework for developing the capabilities of individuals and teams (within the organisation and across the system) in service improvement techniques. NHS IQ has been invited to lead a board master class, followed by systematic roll out throughout the organisation, including clinical leads and multi disciplinary teams. The process will commence this summer and rollout will be completed to essential staff by 30th June 2014. *External support is required from NHS Improving Quality Working with NHS IQ*	DODC	Rollout to be completed by 30th June 2014		Completed
		It will be complemented by the introduction of dedicated MDT Schwartz rounds to encourage multi professional reflection and learning. This will commence by 31st October 2013 and rollout over a six month period.	MD	Complete – Rounds introduced April 2014.		Completed
		A dedicated Programme Management Office, including a Programme Director Patient Safety, project manager, data analyst and co-ordinator is being developed to spearhead this work. *The Trust has asked for NHS England support to set this up*	CEO	Complete by 31st July 2013		Completed

1.		Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG Status
		The new Director of Organisational Development & Communications has developed an OD framework (for consideration by the Workforce sub Committee of the Trust Board on 17th June 2013 prior to formal ratification by the Trust Board on 25th June 2013). The framework aligns the vision, values and strategic objectives of the organisation to 5 priority areas for delivery as follows: • Capacity (people) • Capability • Culture and people experience • Contribution linked to recognition • Communications, engagement and brand	DODC	25th June 2013		Completed
		The capability plan incorporates all learning and development, which is required to deliver the annual plan, including this Improvement plan. It includes essential training, continuous professional development, leadership and management development.	DODC	Launch by 31st July 2013		Completed
1.2	Accountability needs to be threaded through the organisation, via the clinical directorates, to embed responsibility for patient safety and experience at every level of the Trust	The new Director of Organisational Development & Communications has developed a leadership and management development framework, which forms Appendix 1 and is linked to the OD framework. It illustrates the accountability and underpinning knowledge and expectations of all staff, at every level, in respect of the vision, values and strategic objectives of the organisation – including patient safety, outcomes and experience. It will be launched by 31st July 2013 as part of the 5 priority areas for action (see section 1.1 above) and the	DODC	Launch by 31st July 2013		Completed

1.		Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG Status
		implementation of a new style appraisal to underpin the implementation of the Agenda for Change Agreement (initially for all leaders operating at band 8 and above, or equivalent, including Consultants).				
		The Trust is undertaking a corporate governance review to ensure terms of reference and membership of board sub committees (including their role in providing adequate scrutiny, and performance management arrangements are clear, particularly in relation to patient safety, outcomes and experience. This will include the Boards role in defining strategy and gaining assurance. This will take place in July and August 2013 and report to the Board on 5th September 2013. The revised corporate committee structure will inform the Quality Strategy	DGS Update: With change in Executive roles this will be DODC from next version.	Complete by 5th Sept 2013		Completed
		The Medical Director and the Chief Nurse remain responsible for presenting evidence to comply with the Monitor Quality Governance Framework.	MD / CN	Complete by 30th Sept 2013		Completed
		The Director of Operations, supported by the new Director of Strategy and Governance will introduce "new style" monthly directorate performance reviews by 31st July 2013. These reviews will enable the executive team to review the performance of clinical directorates using a balanced score card approach including: patient safety, outcomes and experience, workforce, finance and service development, activity and efficiency. This will be developed to include external benchmark information to drive an improvement culture.	DOp DOp	Complete by 31st July 2013 Complete by 30th Sept 2013		Completed Completed

1.		Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG Status
1.3	The Trust must ensure learning from serious incidents and complaints is disseminated in a timely manner and that actions to prevent a recurrence are implemented	The Medical Director will continue to develop the SI process which will include : • A critical multi –disciplinary review meeting within 48 hours of all involved • Confirmation of immediate action taken at Directorate level • A multi-disciplinary peer review through the Patient Safety Committee to share learning and improve clinical outcomes • A Presentation at the grand round • An audit to close the loop and confirm the learning and action has been embedded • Improved Root Cause Analysis Training to apply an evidenced based approach to RCA and ensure that the right improvements are in place This process has been implemented and is being reported monthly via the Patient Safety Committee to the Quality Committee and externally to the CCG Clinical Quality Review Group. The Board will receive a monthly report on the analysis of serious incidents. To include key themes and actions arising.	MD MD	Commenced From 30th July 2013	1/5/14: External RCA training completed. Newly trained staff are now undertaking all SI investigations. There will be improved emphasis on human factors and rigor in identification of root cause. A grand round is planned for June 2014 Grand Round took place on 20th June.	Green Completed
		The Chief Nurse will continue to present regular reports on complaints to the Patient Safety Committee and Patient Safety Forum, identifying themes, learning and actions to prevent recurrence. The learning and outcomes of these reviews will be reported to the CCG Clinical quality Review Group. The Board will receive a report quarterly illustrating key themes arising from patient complaints and actions that have been taken.	CN CN	Ongoing From 24th Sept 2013		Completed Completed

2.		Review of staffing and skill mix to ensure safe care and improve the patient experience. : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
2.1	Holistic medical staffing review and recruitment strategy needs immediate attention. Reducing the level of locum usage for consultants provides a suggested starting point for this work.	The new OD framework set out in 1.1 above includes a capacity plan, which will align the acuity of patients with the workforce – both in terms of numbers of staff by staff group and the skill mix. This will build on the existing medical, nursing and midwifery workforce reviews. HEE has committed to supporting the Trust with the development of a long term workforce plan – maximising opportunities for introducing new roles and ways of working to address 7 Day Services as well as national skill shortage areas and hard pressed specialities.	DODC (CN/MD)	25th June 2013 31st Dec 2013		Completed Completed
		A Rapid Recruitment Program is in place to fill existing medical and nursing vacancies with high calibre candidates. The vacancy factor is currently at 8.7%, with a target of 7% during 2013/14, which will be monitored by the Workforce Committee on a monthly basis.	DODC	Commenced Monthly reporting from 17th June 2013		Completed
		All locum medical staff will receive high quality local induction	DOp	Commenced		Completed

2.		Review of staffing and skill mix to ensure safe care and improve the patient experience. : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
		The Clinical Training Programme has been extended to enable multi disciplinary teams to learn together and adopt the best clinical standards in relation to : • Care planning • Handover • Safe patient transfers internally and externally • Implement SBAR[3] and NEWS[4]	CN	Commenced April 2013	Appointed Deputy Director of Multi professional Training and Education, start date was the 21st July 2014.	Amber
		The HE KSS action plan is being implemented to strengthen the clinical supervision and teaching of junior medical staff. In addition, two experienced consultants have been identified to provide pastoral support to supplement the formal clinical tutor roles. This will complement listening exercises such as the Big conversation with junior staff on the 20 June 2013.	MD	This is now business as usual and being monitored by the local academic board		Completed
		The Trust is working with HE KSS to explore options for a new Director of Medical Education. This includes consideration in partnership with the Dean of a joint post, GP / Physician who will lead the development of education and training of junior doctors for the future.	MD	By 30th Sept 2013		Completed

[3] SBAR (Situation, Background, Assessment and Recommendations) It is an structured pneumonic escalation model that staff use when escalating a deteriorating patient

[4] NEWS National Early warning System. Vital signs scoring system that triggers a deteriorating patient. Linked to an escalation protocol

3.		Redesign of unscheduled care and critical care pathways and facilities : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
3.1	Urgent review of the design and layout of the emergency department, admission and critical care areas to be incorporated in an estate strategy. Partnership working with health and social care providers will be important to the success of this	The Trust has been working with the Emergency Care Intensive Support Team (ECIST) to establish a Medway Emergency Flow Programme Board, which will oversee the review of emergency pathways, ensuring year-round stability (preparing for challenging winter periods in 2013/14 and beyond). It is likely that these pathways lend themselves to the greatest improvement. The terms of reference for the board are as follows : - Oversee the Trusts goal to achieve the 95% wait for A&E and • Improve patient safety by reducing delays in assessment areas • Increase patient experience and satisfaction • oversee the Trust goal to reduce bed occupancy to below 90% and - Ensure safe care is delivered in the right environment • Achieve better patient flow • Reduce transfers in the patient journey - Implement the Enhanced Quality Programmes of Care - Develop a set of metrics to support and monitor the implementation and outcomes of the programme This programme will build on best practice from other sites facilitated by ECIST and in collaboration with HEE KSS. *It will need support from Medway CCG and NHS England 's local area team.*	CN	Commenced	1/6/14: Emergency Flow Action Plan being further developed led by Interim Director of Operations Flow is one of the five key Board priorities led by the COO. Reported by "flash report" weekly to Trust Board and formally monthly.	Amber

3.		Redesign of unscheduled care and critical care pathways and facilities : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
		The Trust is in the process of appointing an Associate Director of Estates to develop an estates strategy for the Medway site. The short term priority is to lead the internal redesign of the emergency department to maximise space for emergency patient flow and to relocate the MDU and emergency assessment areas. The medium term priority is to redesign services into vacated clinical areas (currently occupied by KMPT and MCH). Longer term it is proposed to establish a new purpose built Emergency Department. *It will need support from NHS England and external project management and Capital funding support.*	DGS	Commenced	An internal solution for the medical assessment unit is being developed by internal ward moves. Update: Interim medical assessment unit proposals agreed, with planned opening end of Sept. 14. A business case for the redevelopment of ED was approved by the Trust Board at the end of June 2014, subject to successful funding. Update: Works for paediatric ED to commence beginning August 14.	Amber
		In preparation for winter 2013, the Trust will scope and procure additional modular capacity to create decant space and enable reconfiguration (linked to the ECIST and estates work underway).	DOp	By 30th Sept 2013		Completed

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3.		Redesign of unscheduled care and critical care pathways and facilities : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
		Through the CCG Urgent Care Board the Trust will work in partnership with stakeholders and ECIST to understand the demand on the emergency pathways and review • the provision of out of hospital care • adequate commissioning of emergency pathways • adequate commissioning of out of hours care The Trust will need support from the CCG / NHS England / ECIST.	DOp	From 27th June 2013	1/6/14: Work continues through the executive programme board.	Amber

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4.		Improved senior clinical assessment and timely investigations: URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
4.1	Ensure appropriate consultant cover for acute medicine and medical HDU at night and weekends	An urgent review of consultant cover on medical HDU has been carried out to ensure appropriate cover and timely review. It has been agreed to implement daily consultant ward rounds 7 days a week. *The Trust will require support from Health Education Kent Surrey Sussex*	MD	30th June 2013		Completed
		As part of the capacity planning work to support the ECIST programme and the move to seven days services, senior clinical decision makers are currently timetabled 'at the front door' from 8am to midnight.	MD	Completed		Completed
		The timescale on the implementation of RAT[5] is planned to allow the full engagement of the consultant team in designing and agreeing the change required in working practices. This will be implemented throughout July.	MD	Complete by 31st July 2013		Completed

[5] RAT : Rapid Assessment and Treatment AT typically involves the early assessment of 'majors' patients in ED, by a team led by a senior doctor, with the initiation of investigations and/or treatment. The approach consciously removes 'triage' and initial junior medical assessment from the pathway. Instead, the first doctor a patient sees is one who is able to make a competent initial assessment, define a care plan and make a decision whether the patient requires admission or referral to an in-taking specialist team. Nurses and junior doctors in the RAT team then implement the first stages of the care plan

4.	Improved senior clinical assessment and timely investigations: URGENT					
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
4.2	Review care provided in the Admission and Discharge Lounge	As an interim measure, the Chief Nurse has converted the Admission and Discharge Lounge to a ward with a Head of Nursing overseeing clinical quality and undertaking a daily review of all patients. The ward is adequately equipped and established to function as a ward.	DOp	Completed		Completed
		However, the Trust is committed to revert to a fully functioning ADL through the ECIST work programme.	DOp	Achieve by 1st Aug 2013		Completed
4.3	Develop a clear universally known activation protocol for escalating a response to deteriorating patients. This should be standardised across the whole hospital.	The Medical Director and Interim Director of Nursing will re-launch a standardised activation protocol for the deteriorating patient. This will form part of the personalised and team objectives of all clinical staff and monitored and reviewed daily through the normal line management process. *The Trust will require support from the Health Foundation / HE KSS*	MD / CN	By 30th June 2013 Revised date of early August 2013.		Completed
		The Trust has established a weekly multi-disciplinary mortality review. The outcomes from this review go back immediately to the originating consultant and team. The process is led by the Deputy Medical Director.	MD	Commenced in April 2013.		Completed

4.		Improved senior clinical assessment and timely investigations: URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
		The key themes and actions arising from this process will be reported to Board monthly	MD	30th July 2013		Completed
		An electronic database is being developed so learning can be collated and acted upon through the Trusts audit programme and patient safety committee structure.	MD	Complete by 31st July 2013		Completed
		The Trust has implemented the CHKS Q Lab programme via the audit programme. Q lab is a continuous improvement process that provides the Board with the assurance that the performance across the directorates is within expected ranges. CHKS meets with directorate on a quarterly basis to review aspects of care and treatment that may be driving variation. The issues are debated and actions agreed. This is an iterative process and the outcomes are will included in the audit committee board report	MD	Commenced		Completed

5.		The Trust should develop a strategy and action plan to create a culture that welcomes improvement, galvanises the good work that is already going on in some wards and adopts and rapidly spreads good practice : HIGH PRIORITY				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
5.1	The Trust should develop a strategy and action plan to create a culture that welcomes improvement, galvanises the good work that is already going on in some wards and adopts and rapidly spreads good practice	The OD framework referenced in 1.1 includes a Culture and People Experience Plan. It is due for consideration by the Workforce sub Committee of the Trust Board on 17 June 2013 prior to formal ratification by the Trust Board on 25 June 2013. The plan will embed a culture which is consistent with the Trust values and behaviours including the learning from patient feedback and the Francis Enquiry. It will Improve the working experience of staff through actively listening and responding to staff feedback and improve staff engagement across the organisation and within multi disciplinary teams. It will develop a consistent approach to change management which maximises opportunities to involve and support staff throughout the change process. Key actions include:	DODC	Commenced		Completed
		• Adoption of the 'NHS Change Model' providing a framework for developing the capabilities of individuals and teams (within the organisation and across the system) in service improvement techniques		By 31st March 2014		Completed
		• Develop staff and leaders in assertiveness techniques, handling challenging people and situations		By 30th Sept 2013		Completed

5.		The Trust should develop a strategy and action plan to create a culture that welcomes improvement, galvanises the good work that is already going on in some wards and adopts and rapidly spreads good practice : HIGH PRIORITY				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
		• Encourage the identification and treatment of "cause(s) not effect(s)" of culture		Commenced		Completed
		• Promote the "speaking up campaign" - voicing and reporting concerns and closing the feedback loop		By 30th June 2013		Completed
		• Launch the board visibility and assurance programme ("Director of the week" - Pairings with wards/ clinical areas, "Back to the Floor" programmes)		Completed		Completed
		• Introduce monthly Pulse surveys to provide regular feedback on staff experience by June 2013				Completed
		• Maintain existing IWL and WOW recognition schemes		Completed		Completed
		• The Trust will continue to use the Listening into Action methodology. The Trust has signed up to move into the second phase of implementation and become a 'Beacon' site. This phase commences in September 2013		Sept 2013		Completed
		The Trust is planning to pilot a Clinician Led Quality improvement Team to drive clinical improvement and rapidly spread good practice. As part of the pilot, a software platform 'Crowdicity' has been procured to provide an electronic means for staff to share good practice, innovate and problem solve.	CEO	By 31st July 2013		Completed

6.		Improve public reputation: HIGH PRIORITY				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
6.1	The Trust should improve the methods and frequency with which it engages with the public and as a starting point extend its staff Big Conversation work to the public.	An annual communications and engagement plan has been developed which identifies Executive relationship leads for all stakeholders, including the public, members and governors. The plan is due for consideration and ratification by the Trust Board on 25th June 2013 and where possible will be aligned to national publication timelines and the Trust annual plan. The new communications officer role has been created to focus on good news stories for publication and to improve public relations in a sustained manner.	DODC	25th June 2013		Completed
		Continued promotion and improvement of Friends and Family feedback.	CN	Commenced	Maternity have gone back to using postcards for ladies to offer feedback instead of texting and ED have extra support from the Governance team to help staff understand the feedback. They are working with Healthcare Communications to help improve response rates.	Amber

6.		Improve public reputation: HIGH PRIORITY				
	Recommended Action	Trust Response	Lead Director	Timescale	Update	RAG
		Plans are in place to build on the Friends and Family test with a patient electronic feedback APP. This will provide instant feedback to wards and clinical areas.	CN	By 30th Sept 2013		Completed
		Promote the PALs service as an effective advocate for patients.	CN	By 31st July 2013		Completed

RAG Status:

Green On track to deliver on time. Or has delivered but remains in the action plan for review at a later stage

Amber Timescale on delivery has slipped but there are clear plans or mitigation in place and / or there is a reliance on stakeholder support that has not yet been agreed

Red Timescale has slipped with no clear plans or mitigations

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FT Keogh Plans

Medway NHS Foundation Trust

August 2014

KEY
Delivered
On Track to deliver
Some issues – narrative disclosure
Not on track to deliver

Medway - Our improvement plan & our progress

What are we doing?

- The Trust was one of 14 trusts selected for the Keogh Review, due to higher than expected hospital standardised mortality ratio (HSMR). There were 6 recommendations arising from the Keogh review in June 2013 which, when implemented, will improve the quality of our services by ensuring we have the right staff in the right place at the right time, with an organisational focus on patient safety and improving patient experience, to deliver the Trust's vision of "Better Care Together" and its values: caring, listening, learning and respecting. It will require investment to improve facilities and pathways for a better patient experience, particularly in A&E.
- The review recommended the following:
    - Pace and clarity of focus at Board level for improving the overall safety and experience of patients, underpinned by an accountability framework and staff training.
    - Staffing and skill mix review to ensure safe care and an improved patient experience.
    - A redesign of unscheduled care and critical care pathways and facilities, to improve the patient experience and clinical outcomes in critical care and A&E.
    - Improved senior clinical assessment and timely investigations, to ensure patients are properly assessed by senior doctors and nurses and are managed appropriately, with escalation of deteriorating patients to senior doctors.
    - Galvanising the good work that is already going on in Wards and adopting and spreading good practice, to create a culture that welcomes improvement and innovation, facilitated by the Listening into Action methodology, including Big Conversations.
    - An improved public reputation, in particular through greater engagement of the membership and in collaboration with local health and social care organisations, working together as a whole system.
- This 'plan & progress' document shows our plan for making these improvements and demonstrates how we're progressing against the plan. This document builds on the 'Key findings and action plan following risk summit' document which we agreed immediately after the review was published http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx.
- This summary plan sets out short and medium term improvements on the issues identified and we envisage the trust improvement plans going beyond Keogh deadline dates to ensure that when the Chief Inspector of Hospitals' Team inspects the trust, that it is prepared for the new style CQC inspection. The Trust is in the process of developing a longer-term Quality Strategy (Transforming Medway), to maintain progress and ensure that the actions lead to measurable improvements in the quality and safety of care for patients.
- While we take forward our plans to address the Keogh recommendations, the Trust is in 'special measures'. More information about special measures can be found at http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/Special-measures-FAQs.pdf.
- Oversight and improvement arrangements have been put in place to support changes required.
- There will be regular updates on NHS Choices and subsequent longer term actions may be included as part of a continuous process of improvement.

Medway - Our improvement plan & our progress

Who is responsible?

- Our actions to address the Keogh recommendations have been agreed by the Trust Board
- Our Acting Chief Executive/Medical Director, Phillip Barnes is ultimately responsible for implementing actions in this document. Another key board members is Steve Hams, Chief Nurse, and together they provide the executive leadership for quality, patient safety and patient experience. Our Interim Chairman is Christopher Langley
- Jonathan Guppy has been appointed by Monitor as an Improvement Director and is helping us to implement our actions by offering challenge and undertaking regulatory responsibilities.
- Ultimately, our success in implementing the recommendations of the Keogh plan will be assessed by the Chief Inspector of Hospitals who re-inspected our Trust on the 23rd, 24th, 25th of April. A report will be issued in due course
- If you have any questions about how we're doing, contact the Medical Director by email at Medical.Director@medway.nhs.uk or if you want to contact Jonathan Guppy, as an external expert, you can reach Jonathan by email at enquiries@monitor.gov.uk.

How we will communicate our progress to you

- We will update this progress report on the first day of every month while we are in special measures.
- Updates on our progress will be given at our Board meetings, with papers published on our website, and regular members engagement events, which will be held in collaboration with our local health and social care partners. The next planned members events are: Think AKI! Improving Acute Kidney Injury Care – this will take place on the 6th August at 6.30pm in the Postgraduate Building, an Update on ED improvement plans - 21 August at 6.30pm and The Annual Members' Meeting will be taking place on 18 September 2014 at 6.30pm in the restaurant.
- These events form part of our existing Trust Communications Plan and we will be using the full range of established communications channels to keep our local communities updated on our progress, including: updates in the public section of our Board meetings, updates at our Council of Governors meetings, regular briefings by our Chair to local MPs, regular updates to local Health Overview and Scrutiny Committees from the Chief Executive, regular updates to GPs, progress communicated on our website and intranet and regular communication to our members, such as through the members' newsletter.

Christopher Langley, Chairman

Phillip Barnes, Acting Chief Executive and Medical Director

Medway - Our improvement plan (1)

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Progress
Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients	• Dedicated team to lead delivery of plan. • New organisational development framework and management development framework. • Monthly updated balanced scorecard reviews. • Develop Serious Incidents process. • Corporate governance review. • New Quality Strategy and Quality Governance Framework self-assessment for presentation to the board by the new Medical Director and Chief Nurse. • Complaints related feedback on themes and trends. • Service improvement training to deliver the new quality strategy	• July 2013 • July 2013 • July 2013 • July 2013 • Sept 2013 • Sept 2013 • Sept 2013 • Roll out completed by June 2014	NHS Improving Quality. Mortality Working Party. NHS England. External management consultant to review Quality Governance Framework self-assessment.	ON TRACK TO DELIVER • Complete – team in place and significant progress made in delivering the plan. • Complete – frameworks in place and aligned to appraisals. • Complete –monthly reviews in place to challenge and improve performance, including quality metrics. • Complete– process and training plan in place. External RCA training completed. Newly trained staff are now undertaking SI investigations. There will be improved emphasis on human factors and rigor in identification of root cause. A grand round is being held in June 2014 • Completed 24/09/13. • Complete – approved by Board and action plan being implemented. Transforming Medway approved by Board on 7/1/14 • Completed – quarterly reports provided to Board. • Completed– 40 members of staff currently undertaking the training. Projects that they are undertaking include: reducing dispensing errors, working with the community to ensure appropriate admission and discharge of frail elderly patients, aligning clinical audit to quality improvements.
Review of staffing and skill mix to ensure safe care and improve the patient experience	• Clinical Training Programme extended to all multidisciplinary team members. • Rapid recruitment plan to fill medical, nursing and midwifery vacancies, with monthly reporting. • All locum medical staff to receive high quality local induction. • Develop action plan to strengthen clinical supervision and training of junior doctors. • Develop a Capacity Plan to align workforce with acuity. • Explore options with partners and appoint a new director of medical education.	• From Apr 2013 • From June 2013 • Commenced • Commenced • From June 2013 • Sept 2013	Health Education Kent Surrey Sussex Leadership Academy. Clinical Commissioning Group / NHS England.	ON TRACK TO DELIVER • Ongoing: Successfully appointed a Deputy Director of Multi professional Education. Her role will include developing multidisciplinary clinical training programmes on safety critical processes. • Completed - Vacancy factor from 8.7% to 6.34%. Process is now embedded • Complete and audit underway • Complete College tutor and two deputies have been appointed by the Deanery. Weekly teaching has been moved at trainees request to rotate daily through the year. Monthly half day M&M and audit meetings have commenced. This is now business as usual and being monitored by the local academic board • A draft 5 year workforce planning model report has been developed and presented to the Trust for consideration. On completion of this extensive review, Dr Pat Oakley presented the Trust's draft Strategic Workforce Plan on 7th May 2014. • Complete – GP and Consultant appointed to job share role.

Medway - Our improvement plan (2)

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Progress
Redesign of unscheduled care and critical care pathways and facilities	• Redesign plan with advice and support from Emergency Care Intensive Support Team. • Appoint interim associate director of estates to develop an estates strategy for the Trust. • Whole-system partnership working to address demand on emergency pathways. • Procure modular capacity for winter 2013.	• Commenced • Commenced • From June 2013 • Sept 2013	Clinical Commissioning Group / NHS England. Emergency Care Intensive Support Team.	SOME ISSUES Ongoing – plan being implemented. Continued work with ECIST to rework acute medical services and establish an new emergency pathway. •Ongoing – Estates strategy in development. This involves a full redesign and extension of our current emergency department and the development of a larger emergency assessment unit. •Ongoing – Whole system working remains complex. A system wide Urgent Care Board has been established to improve care. The Trust is fully engaged in whole health economy working looking at long term solutions •Complete – POD procured to enable reconfiguration of emergency services.
Improved senior clinician assessment and timely investigations	• Review of consultant cover on medical High Dependency Unit and implement consultant ward rounds 7 days a week. • Senior decision makers from 8am to midnight everyday 'at the front door' in A&E • Implementation of Rapid Assessment and Treatment system (STAR). • Plan to re-launch an activation protocol for deteriorating patients. • Weekly multi-disciplinary mortality review, reported to the Board monthly. • Electronic database launched to share learning (Qlikview)	• June 2013 • Commenced • July 2013 • June 2013 • July 2013 • July 2013	CHKS. NHS Improving Quality.	DELIVERED •Complete – Consultant ward rounds have been implemented 7 days a week. •Complete – Implemented. •Complete – STAR in place to enable a competent, initial assessment leading to a defined care plan and a timely admission decision •Complete – Standardised protocol launched deteriorating patients, with use monitored via staff objectives. •Complete– In line with best practice we are starting a new mortality review process using the Global trigger Tool (GTT) in March 14 •Complete – database developed. Further work underway to strengthen processes to share and respond to learning.
Galvanise the good work already going on in wards and adopt and spread good practice	• Develop a Culture and People Experience Plan. • Pilot a clinician led quality improvement team and introduce a software platform to share good practice. • Beacon site for 'Listening into Action' methodology • Adoption of NHS Change model.	• From June 2013 • July 2013 • Sept 2013 • Adopt by Mar 2014	NHS Improving Quality.	DELIVERED •Complete – plan in place and currently being implemented to embed a culture consistent with the Trust's values and vision. •Complete – team in place. Social media platform launched to enable staff to share good practice, innovate and problem solve. •Complete – signed up to second phase which is linked to improvement plan priorities. •Complete – Board event in September to develop the capability of individuals in service improvement techniques.

DRAFT

Medway - Our improvement plan (3)

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Progress
Improve methods and frequency of engaging with the public in order to improve public reputation	• Board commitment to develop an annual communications and engagement plan. • Promote PALs as an effective advocate for patients. • Patient electronic feedback app to build on the Friends and Family Test.	• June 2013 • July 2013 • Sept 2013		ON TRACK TO DELIVER •Complete – Approved by Board in Sept 13 and team strengthened in 2013. Further work underway to ensure engagement for emerging initiatives. •Complete– Actions identified from peer review, including improvements to the website and information leaflets. •On track – Friends and Family test response rate have improved although our scores are still in the bottom quintile of comparable medium sized NHS Trusts. •Despite delivery of this plan, recent events have inevitably resulted in no improvement in public reputation. A clear focus on improving performance will improve our public reputation. •During 2013/14 the communications team has expanded and appointed experienced senior resource.

Medway – How our progress is being monitored and supported

Oversight and improvement action	Timescale	Action owner	Progress
Trust has sought external assurance on its elevated mortality (working group and peer review) and commissioned assistance from the Emergency Care Intensive Support Team (ECIST).	Working group commenced Nov 2012 ECIST Phase 1 May 2012 ECIST Phase 2 May 2013	Trust CE/Monitor	ON TRACK TO DELIVER ECIST continue to support Trust.
Changes to leadership will improve governance arrangements and pace of change: New executive team appointed since September 2012 – Director of Finance, Director of Strategy & Infrastructure, Director of Organisational Development and Communications, Chief Nurse and Medical Director. Four new Non Executive Director appointments were formally ratified at the Council of Governor meeting in November 2013 and include Mrs Shena Winning, Caroline Becher, Andrew Burnett and Tony Moore. In February 2014 a new interim Director of Operations, Chairman and Chief Executive were appointed	Implemented	Trust	DELIVERED
Monthly accountability meeting with Monitor to track delivery of action plan.	Aug 2013 to July 2014	Trust CE/Monitor	ON TRACK TO DELIVER
Working with a range of partners, who are providing support on a variety of areas, including mortality levels and service quality. These partners include Public Health and the Emergency Care Intensive Support Team.	On-going from Nov 2012	Trust CE	ON TRACK TO DELIVER
Appointment of Improvement Director	September 2013	Monitor	ON TRACK TO DELIVER
Meetings of the Trust Board Quality sub-committee will review evidence about how the Trust's plan is improving our services in line with the Keogh recommendations. Updates will be presented at each public Board session.	Sept 2013 to July 2014	Trust Chair	ON TRACK TO DELIVER
Trust reporting to the public about how our trust is improving via established stakeholder meetings and communications channels, as well as at public Board sessions.	Monthly	Trust CE	ON TRACK TO DELIVER
Monitor requires the trust to implement a quality improvement plan and to undertake an external quality governance review to look at how the trust is performing, provide assurance it is operating effectively and identify further opportunities for improvement.	Sept 2013	Trust/Monitor	SOME ISSUES KPMG appointed. Review complete and action plan developed.
Local economy level consideration of whether the trust is delivering its action plan and improvements in quality of services by a Quality Surveillance Group (QSG) composed of NHS England Area Team, Clinical Commissioning Groups, Monitor, Trust Development Authority, Care Quality Commission, Local Authority and Healthwatch.	Sept 2013 to July 2014	Quality Surveillance Group	ON TRACK TO DELIVER

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Item 5: CQC Inspection Report: East Kent Hospitals University NHS Foundation Trust

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 September 2014

Subject: CQC Inspection Report: CQC Inspection Report: East Kent Hospitals University NHS Foundation Trust

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by East Kent Hospitals University NHS Foundation Trust

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

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

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1. Introduction

(a) The 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 (CQC 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 (CQC 2014).

(d) Eight key service areas are inspected, along with others where necessary. The service areas are (CQC 2014):

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 (CQC 2014).

(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 (CQC 2014):

- 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 (CQC 2014):

- Outstanding
- Good
- Requiring improvement
- Inadequate

(h) The CQC, through the Chief Inspector of Hospitals, will normally recommend that a trust is placed in special measures when an NHS trust or foundation trust is rated 'inadequate' in the well led domain (where there are concerns that the organisation's leadership is unable to make sufficient improvements in a reasonable timeframe without extra support) and 'inadequate' in one or more of the other domains (safe, caring, responsive and effective) (Monitor 2014).

(i) When NHS Trust Development Authority (TDA) or Monitor receives a recommendation from the Chief Inspector to place an NHS trust or foundation trust in special measures, NHS TDA or Monitor will consider the evidence that CQC provides to them alongside other relevant evidence. On the basis of the full range of information, NHS TDA or Monitor will make a decision whether the trust or foundation trust will be placed in special measures. An NHS trust or foundation trust will not

enter special measures until NHS TDA or Monitor formally makes that decision (Monitor 2014).

(j) NHS TDA or Monitor may also place a trust or foundation trust into special measures without receiving a recommendation from the Chief Inspector, based on its own evidence. In these circumstances, NHS TDA or Monitor will seek advice from CQC (Monitor 2014).

2. Recommendation

RECOMMENDED that the report be noted, the Trust take note of the comments made by Members during the meeting and be invited to attend the October meeting of the Committee.

Background Documents

CQC (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

Monitor (2014) *'A guide to special measures (06/05/2014)'*,
http://www.cqc.org.uk/sites/default/files/special_measures_guide.pdf

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East Kent Hospitals University NHS
NHS Foundation Trust

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Chairman
Health Overview and Scrutiny Committee
Kent County Council

Our Ref: SB/AF/jc

27 August 2014

From the Chief Executive: Stuart Bain

Dear Chair

East Kent Hospitals University NHS Foundation Trust: CQC Inspection Report

Thank you for the invitation to attend the Health Overview and Scrutiny Committee on 10 October to give an update on the CQC Action Plan which I can confirm I am able to attend.

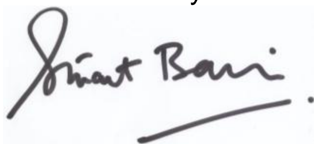
I am pleased that the report praises the caring nature of the hospital staff saying and this was reflected at all three hospitals: the William Harvey Hospital in Ashford, the Queen Elizabeth The Queen Mother Hospital in Margate and the Kent and Canterbury Hospital in Canterbury; the report also rated our critical care services as good.

However the report also contained many criticisms of the Trust for example the report concluded that there were insufficient numbers of appropriately trained staff across all three hospitals that staff engagement was poor and that patients experienced of long waiting times for appointments. In addition it required the Trust to make improvements to its environment.

Many of the areas of concern had been presented to the CQC Inspection Team at the beginning of the inspection with our plans to address them; such as, the £2.9m investment in staffing and the investment in improving outpatients.

Since the receipt of the report we have been engaging with staff to actively involve them in the development of the action plan which has to be submitted to the CQC by 23 September. We will also be setting up meetings with our key stakeholders, such as the CCGs, as some of the actions to improve services, such as A&E waiting times and access to follow-up appointments, require their support and influence. I am hopeful that the CQC will have had time to review and accept the action plan in time for us to share it with you at the meeting.

Yours sincerely



Stuart Bain
Chief Executive

Putting patients first

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 September 2014

Subject: East Kent Outpatients Services

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

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

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1. Introduction

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

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

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

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

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

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

(e) On 11 April 2014 the Committee considered a further written update provided by East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED that the report be noted and the Chairman to write to EKUHFT to clarify the concerns raised regarding the redeployment of non-clinical staff prior to the independent analysis of the consultation.*

(f) Miss A Harrison was invited to observe the option re-appraisal for the North Kent Coastal site on 22 April and 29 May. The re-appraisal was held following new information and comments received during the consultation and to incorporate additional information which had been requested by members of the public.

(g) Dr M Eddy and Mr A Crowther visited Victoria Memorial Hospital in Deal on 29 April with representatives from NHS South Kent Coast 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.

(h) Representatives of the Trust attended the Committee on 6 June 2014 to present the findings of the consultation and provide an update on the option appraisals for the North Kent site. At the conclusion of this item, the Committee agreed the following recommendation:

- *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.

2. Recommendation

RECOMMENDED that the Trust be thanked for their attendance at the meeting and the update provided on the progress of the Board's plans for Outpatient Services in Kent and that they be invited to submit a progress report to the Committee within six months.

Background Documents

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (07/06/2013)*',
https://democracy.kent.gov.uk/mgAi.aspx?ID=25151

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (11/10/2013)*',
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5075&Ver=4

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (11/04/2014)*',
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5396&Ver=4

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (06/06/2014)*',
https://democracy.kent.gov.uk/mgAi.aspx?ID=27887

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East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group

Progress report on the Outpatient Consultation in east Kent Kent Health Overview and Scrutiny Committee

September 2014

1. Introduction

In November 2013 the Out-Patient Clinical Strategy (OPCS) Full Business Case was endorsed by the East Kent Hospitals University Foundation Trust (EKHUFT) Board. The OPCS subsequently went to Public Consultation from Dec 2013 to March 2014. The NHS Canterbury and Coastal Clinical Commissioning Group (C&C CCG) partnered EKHUFT in the consultation process.

The outcome of the consultation was discussed at the EKHUFT Board in June 2014 and C&C CCG Governing body in early July, following engagement with the Kent Health and Overview Scrutiny Committee (HOSC). The final decision on the outcome of the consultation was based on an independent analysis of the process, undertaken by the University of Kent, which was commissioned by Kent and Medway Commissioning Support (KMCS).

In reaching its unanimous decision to implement the new outpatients strategy EKHUFT took into account a wide range of factors including the proposals having support from the CCGs and the intent of NHS C&C CCG to develop community networks that will enable the appropriate delivery of GP/Community led outpatient services in settings beyond the 6 site model being adopted by EKHUFT.

The implementation of the community networks will be aligned, where appropriate to the changes to EKHUFT'S acute outpatient services and the CCG, in conjunction with KCC, has commenced a broad programme of engagement with multiple stakeholders to ensure we take in to account our local population's health and social care needs when planning and developing each of the networks.

The networks will be designed to deliver a variety of joined up health, social care and voluntary sector services to local communities, with GP's at the heart of co-ordinating a range of integrated services as close to peoples' homes as possible with the aim of reducing the need for acute hospital interventions as appropriate.

2. Background

The Trust currently operates a comprehensive range of outpatient (OP) services from its three acute sites at the William Harvey Hospital in Ashford (WHH), Kent and Canterbury Hospital, Canterbury (KCH) and The Queen Elizabeth the Queen Mother Hospital, Margate (QEQMH). In addition to these three acute sites, the Trust also provides a range of outpatient and diagnostic services from the Royal Victoria Hospital Folkestone (RVH) and Buckland Hospital Dover (BHD), both of which the Trust owns.

The Trust also delivers outpatient services from a number of community hospital sites which include Faversham Hospital (FH), Whitstable and Tankerton Hospital (W&T), Queen Victoria Memorial Hospital in Herne Bay (QVMH) and Victoria Hospital in Deal (VHD). These sites are not in the ownership of the Trust. On these sites, the Trust is a sub-tenant of the Kent Community Health Services Trust, which is itself a tenant of NHS Property Services.

Finally, in addition to the above sites, the Trust has local agreements to deliver a range of "specialty specific" outpatient services throughout the local area in facilities owned by other organisations (other Trusts' properties and at GP surgeries). These specialty specific outpatient services include dermatology, paediatrics, obstetrics and midwifery services, renal, therapy clinics and neurological nurse-led clinics.

3. Next steps

Following the Board decisions mobilisation of the strategy has now commenced. Notice has been given to NHS Property Services and the Kent Community Trust to allow for withdrawal of clinics from Faversham Health Centre, Whitstable and Tankerton Hospital and Herne Bay Hospital.

It is anticipated that the enablement works to deliver safe services from the Estuary View facility will be complete by December 2014. A wider range of services will be available on the north Kent coast in this new facility and the one stop clinics will be expanded. Activity will triple for the local population and there will be an opportunity for wider development as part of the CCG community network programme.

The new Dover hospital will open in March 2015. A wider range of outpatient services will be offered and one stop clinics expanded. The hospital will have an imaging unit, a pharmacy, child health centre, women's health centre, a therapy unit and Minor injury unit with expanded ambulatory care. The renal unit will have an additional station allowing for 4 additional chronic renal patients to receive their treatment locally as demand grows. Activity at the Dover hospital will double for the local population. The acute clinics currently held at Deal hospital will transfer to the new Dover hospital in line with an earlier Consultation held by the Eastern and Coastal Kent Primary Care Trust (PCT). Community child health, midwifery and anticoagulation clinics will remain at Deal hospital with the radiology service which supports the minor injury unit.

The extended working day and Saturday clinics are being planned by the Trust to ensure clinicians are scheduled to offer clinics on all sites as discussed previously. The support infrastructure for diagnostic tests is being coordinated to ensure one stop clinics can be offered where clinically appropriate.

Plans to improve the current outpatient departments on the main hospital site are being developed to ensure accommodation is fit for purpose and in line with the clinical strategy key principles previously presented. Architects have been employed to work up options for each of the three main sites although at the Kent and Canterbury work has commenced on a new clinic area with a procedure suite which will be open this September.

4. Conclusion

EKHUFT are delighted to be able to take forward their vision for an improved outpatient service and are enthusiastic about working with the CCGs to support their vision for a community network model.

EKHUFT would like to thank the HOSC for their support in the process and success of the outpatient strategy plan which is now leading the work on improving services for the local population.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 September 2014

Subject: SECAmb - Future of Emergency Operation Centres

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

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

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1. Introduction

(a) The South East Coast NHS Ambulance Service NHS Foundation Trust (SECAmb) was formed on 1 July 2006 through the merger of Trusts in Kent, Surrey and Sussex. SECAmb achieved Foundation Trust status on 1 March 2011 - one of the first ambulance service NHS foundation trusts.

(b) SECAmb provides ambulance services to a population of over 4.6 million across 3,600 square miles in Kent, Medway, Surrey, East and West Sussex, Brighton and Hove and North East Hampshire. SECAmb responds to 999 calls and provides the NHS 111 service in Kent, Surrey and Sussex. It also provides non-emergency patient transport services in Surrey and Sussex (SECAmb 2014a).

(c) The three Emergency Dispatch Centres (EDCs) at Coxheath, Lewes and Banstead received 862,466 emergency calls in 2013/14 (SECAmb 2014b).

(d) Response times for 999 calls are set nationally and apply to all ambulance services in England and Wales. 999 calls which are received are assessed and categorised as follows (SECAmb 2014b; SECAmb 2014c):

1. Category A calls are made up of two sub categories: Red 1 & Red 2. Red 1 calls are life threatening conditions where the speed of response may be critical in saving life or improving the outcome for the patient e.g. heart attack, trauma, serious bleeding. Red 2 calls are serious but not the most life threatening. The performance standard for Category A calls is that 75% of all Category A calls should be reached within 8 minutes of the call being made. If the first response is not a fully-crewed ambulance then an ambulance should arrive within 19 minutes.

2. Category C calls are for conditions where the patient has been assessed as not having an immediately life threatening condition

but does require an assessment by an ambulance clinician or transport to hospital. The performance standard is agreed locally; the patient should receive an emergency response in 30 or 60 minutes depending on the clinical need.

3. Urgent calls can only be requested by a doctor or a midwife. The standard is to get 95% of patients to the hospital within 15 minutes of the time specified by the doctor when booking the ambulance.

4. Hear & Treat calls are for conditions assessed as not requiring an ambulance service response, but could more appropriately be assessed or treated by an alternative healthcare provider. The performance standard is agreed locally; where an ambulance service clinician provides advice, a call back should be made within two hours of the original 999 call depending on clinical requirement.

2. Current Developments

(a) SECAmb is currently developing its service and organisation in a number of different ways. The following are brief descriptions and definitions of some of them (SECAmb 2014a):

1. Make Ready Centres - SECAmb have implemented five Make Ready Centres in Ashford, Chertsey, Hastings, Paddock Wood, Thanet and Worthing where vehicles are regularly deep-cleaned, restocked and checked for mechanical faults. The Trust is looking to develop a further seven centres across the SECAmb region by 2016.

2. Community First Responders (CFRs) – SECAmb have introduced CFRs who are volunteers trained to respond to emergency calls. Responders are based within their local communities and attend the scene of an emergency to provide vital lifesaving first aid before the arrival of an ambulance, increasing the patient's chance of survival. In 2013/14 SECAmb established 104 new Public Access Defibrillator (PAD) sites as well as recruiting and training 193 new CFRs; there are now 957 CRFs in total.

3. Specialist Paramedics (PPs and CCPs) - SECAmb have continued to develop Specialist Paramedics - Paramedic Practitioners (PPs) and Critical Care Paramedics (CCPs).

   Paramedic Practitioners (PPs) are paramedics who have undergone additional training to equip them with greater patient assessment and management skills, enabling them to diagnosis a wide range of conditions and treat many minor illnesses and injuries. PP desks have been established at the EOC which has reduced the number of patients requiring conveyance, with incidents dealt with by the PP desk achieving a conveyance rate of only 20%.

Critical Care Paramedics (CCPs) are paramedics who have undergone additional training to work in the critical care environment, both in pre-hospital setting and by undertaking Intensive Care transfers between hospitals. SECAmb have 129 PPs and 39 CCPs plus a further six in training.

3. Potential Substantial Variation of Service

(a) It is for the Committee to determine if this service change constitutes a substantial variation of service.

(b) Where the HOSC deems a proposed service change as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the relevant health commissioner or provider.

(c) Where the HOSC determines a proposed change of service to be substantial, a timetable for consideration of the change will need to be agreed between the HOSC and SECAmb after the meeting. The timetable shall include the proposed date that the SECAmb intends to make a decision as to whether to proceed with the proposal and the date by which the HOSC will provide any comments on the proposal.

4. Recommendation

If the proposed service change is *not substantial:*

RECOMMENDED that guests be thanked for their attendance at the meeting, 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 in three months.

If the proposed service change is *substantial*:

RECOMMENDED that the Committee determined that the proposed service change constituted a substantial variation of service, that guests be thanked for their attendance at the meeting, 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 in three months.

Background Documents

SECAmb (2014a) *'South East Coast Ambulance Service NHS Foundation Trust Quality Account and Quality Report 2013/14 (02/07/2014)'*, http://www.secamb.nhs.uk/about_us/our_performance/quality_account.aspx

SECAmb (2014b) *'Response time targets: call prioritisation (01/04/2014)'*, http://www.secamb.nhs.uk/about_us/our_performance/response_time_targets.aspx

SECAmb (2014c) *'Call categories (01/04/2014)*',
http://www.secamb.nhs.uk/our_services/calling_999/call_categories.aspx

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South East Coast Ambulance Service NHS
NHS Foundation Trust

SECAmb Emergency Operations Centre (EOC) Reconfiguration Project

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

The future of our EOCs

- Our vision – "Putting patients first, to match international excellence through our culture of innovation"
- We want to be able to provide the best possible 999 service to the area served by your HOSC – consistently achieve a performance standard of answering 95% of our calls within five seconds & build on and expand the clinical capacity within our EOCs
- To achieve this we need to ensure we can develop the right environment to manage growing demand and the changing clinical complexities of patient needs.

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

The future of our EOCs contd.

- Approximately 400 staff currently employed in our EOCs.
- Currently manage 2,400 emergency calls a day (850,000 a year).
- Demand has grown by 25% since 2007 and is forecast to grow by 5% year-on-year.
- Mixture of increasing number of calls, complexity of patient need, and length of call; we are now able to provide more clinical advice over the phone

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

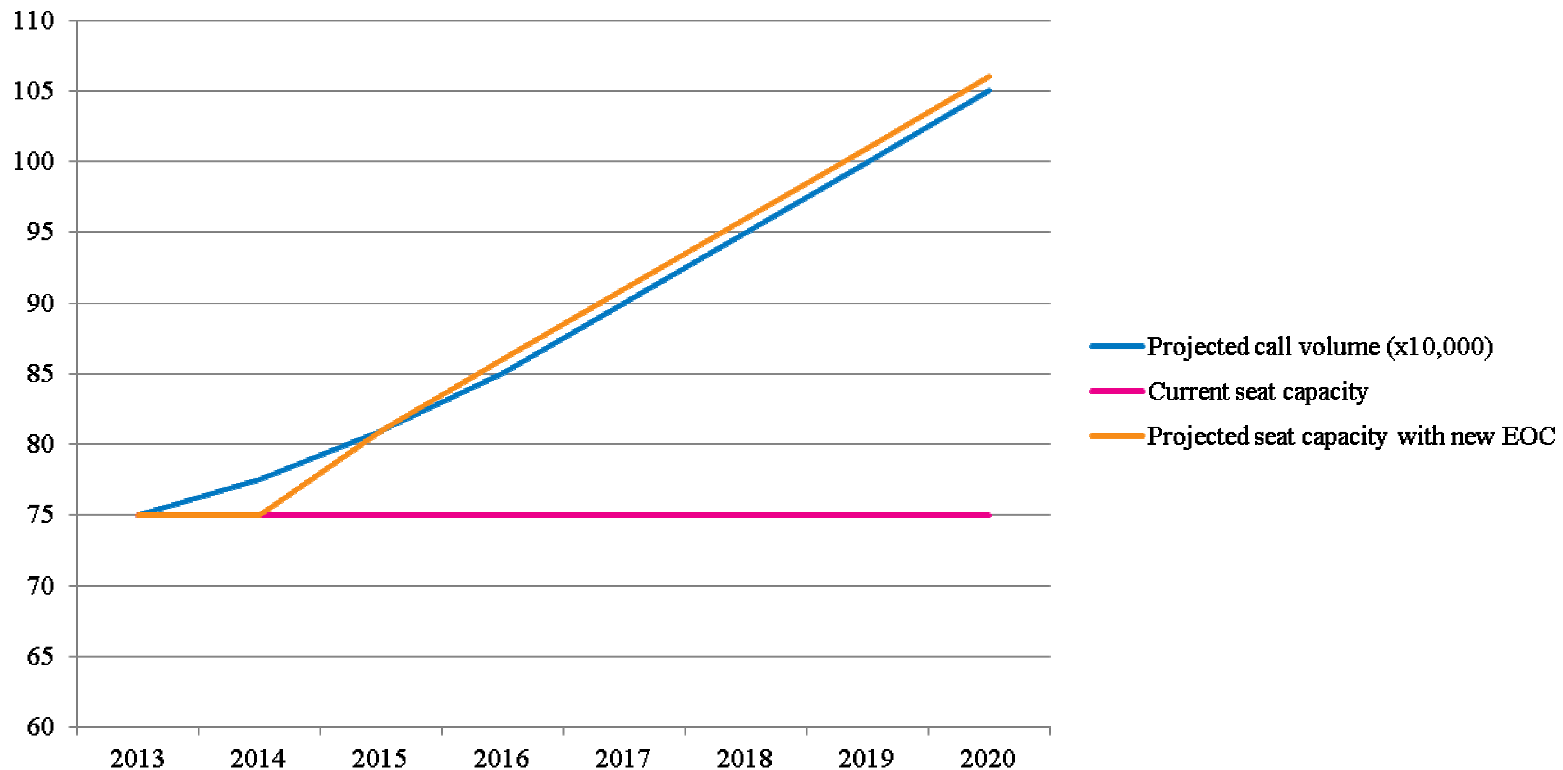
Drivers for Change

- EOC capacity
- Condition of current estate
- Increased resilience
- Lewes Regional Office and EOC lease break clause – February 2017

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Current EOCs have now reached capacity



Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Our proposals

- Our strategic planning includes, therefore, a new configuration of our current EOCs.
- Three options were looked at and the likely impact each would have on the service was assessed:
  - Three EOCs (remain as we are)
  - One large central EOC
  - Two EOCs (chosen option)

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Two EOC configuration

- Moving to a two EOC model was found to be the most practical out of the three options.
- A two EOC configuration will enable us to:
  - Manage up to 1.5 million 999 and urgent calls a year by 2028 (based on 5% annual increase)
  - Meet growing demand for ‘Hear & Treat’ service – providing the right clinical support over the phone
  - Improve resilience of service by providing capacity for additional facilities at either site in event of system failure and greater sharing of workload at peak hours

Your service, your call

Two EOC configuration cont…

- Better retention, recruitment, working practices, culture and management with two 'balanced' EOCs
- Equip staff with a better working environment to ensure they have the right tools to meet the needs of patients
- Increase range of services by allowing greater emphasis on new technologies and expertise

Two EOC configuration - summary

- Represents significant investment in development of EOCs
- Likely timescales – to be in place by late 2016/early 2017
- No planned redundancies – about increasing staff numbers, not decreasing
- Potential locations not yet agreed – optimum would be Kent and North Sussex/Surrey border

South East Coast Ambulance Service NHS
NHS Foundation Trust

Reasons for engagement

- Following legal advice and previous discussions with the HOSCs, we believe that statutory consultation is not required for reconfiguration of EOCs, as there is no change to the way patients access or receive services provided by the Trust.
- However, we are keen to deliver very best engagement with elected representatives, patient and public advisory groups, and with staff.
- Therefore, we are seeking your views and advice on how best to engage with these audiences.
- We also recognise that some issues may have to be handled sensitively when it comes to relocation and reconfiguration.

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Commissioner view

- The number and location of Emergency Operations Centres is at the discretion of SECAmb (the provider)
- SECAmb must ensure they:
  - Meet performance standards across their area of responsibility (Kent and Medway, Surrey and Sussex)
  - Manage operational capacity in a way which supports the delivery of a safe and effective emergency ambulance service, engaging with local healthcare systems
  - Provide an appropriate level of resilience, and ability to meet their nationally specified emergency response requirements.
- Commissioners welcome the SECAmb review of operational arrangements and the engagement that they are undertaking.

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Initial engagement plan

- Initial meetings with HOSCs/IHAG
- Launch of public engagement with announcement at Trust Board 25 September 2014
- Follow-up meetings with HASCs/HOSCs/Trust patient groups
- Workshops for EOC staff
- Meetings with CCGs/GPs/elected representatives

Your service, your call

Initial engagement plan cont…

- Distribution of engagement literature to public including local public and patient groups
- Media announcements at key milestones
- Dedicated section on the Trust's website.
- Dedicated internal comms programme including intranet, regular updates and FAQs, linked to workforce/HR plan

South East Coast Ambulance Service NHS
NHS Foundation Trust

Questions/suggestions?

Your service, your call

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 September 2014

Subject: Patient Transport Services (PTS)

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

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

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

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1. Introduction

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

- *Non-emergency patient transport services, known as PTS, are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients' medical needs (Department of Health 2007).*

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

- 1 February 2013
- 11 October 2013
- 31 January 2014
- 11 April 2014
- 18 July 2014

(c) At the end of the discussion on 18 July 2014, the Committee agreed the following recommendation:

- *RESOLVED that Mr Ayres 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 that he be invited to attend a meeting of the Committee in September.*

(d) Consideration of this item has changed from a verbal to a written briefing. It is proposed that this item returns to the Committee in November 2014.

2. CQC Inspection

(a) The Care Quality Commission carried out an unannounced inspection on 19, 20 and 21 March to check improvements had been made since the last inspection in November 2013. The inspection report was published on 23 July 2014.

(b) The inspection team visited the head office, hospitals where the service was provided, local depots and spoke with the management of the service and staff. The inspection team also spoke with patients who used the service and the commissioner NHS West Kent CCG.

(c) The CQC found that improvements had been made and many people were now experiencing a better service but there were still further improvements needed, in order to ensure people received a reliable consistent service.

(d) The CQC inspected five essential standards to check that action had been taken. NSL Kent was found to be non-compliant with three of these standards:

- Care and welfare of people who use services
- Requirements relating to workers
- Supporting workers

(e) NSL Kent was asked to produce a report for the CQC by 16 August 2014 which sets out the actions it will take to meet the standards. CQC inspectors will return unannounced in due course to check whether the required improvements have been made (CQC 2014).

3. Recommendation

RECOMMENDED that the report be noted and that CCG colleagues be invited to attend the November meeting of the Committee.

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

Care Quality Commission (2014) '*CQC Inspection Report - NSL Kent (23/07/2014)*', http://www.cqc.org.uk/location/1-793656098/inspection-report/1-7936560982014-07-23

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

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (18/07/2014)'*
https://democracy.kent.gov.uk/mgAi.aspx?ID=29193

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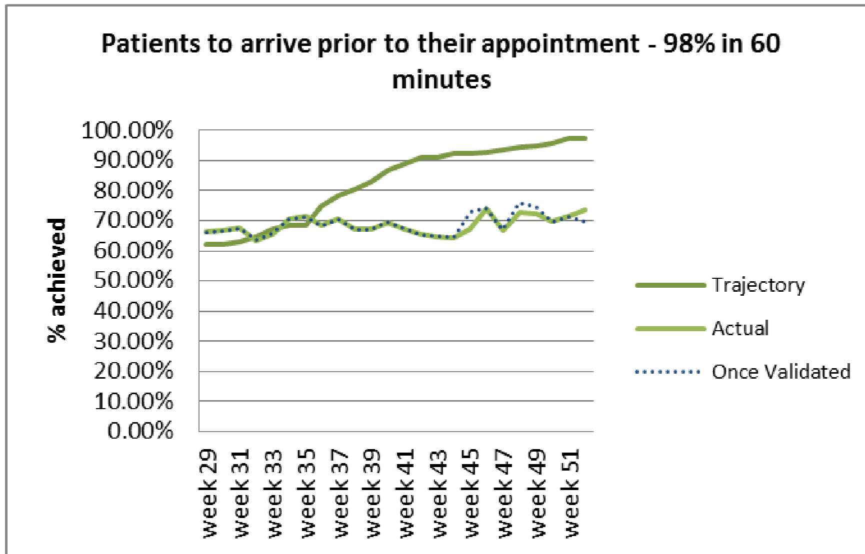
Patient Transport Services Contract

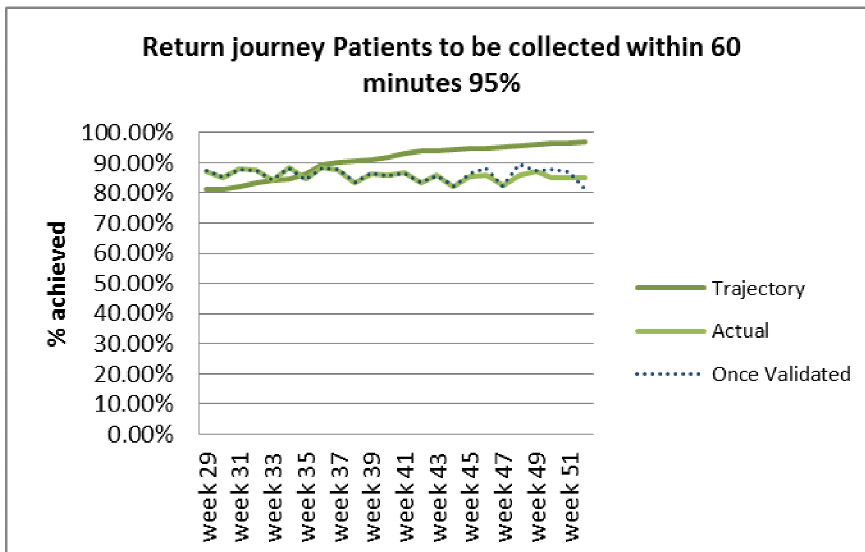
Update to Kent HOSC – 5 Sept 2014

This short report updates HOSC on performance of the PTS contract since the July update.
The CCG continues to discuss performance with NSL (the PTS service provider) on a weekly basis.
Attention remains focused on the six key indicators:

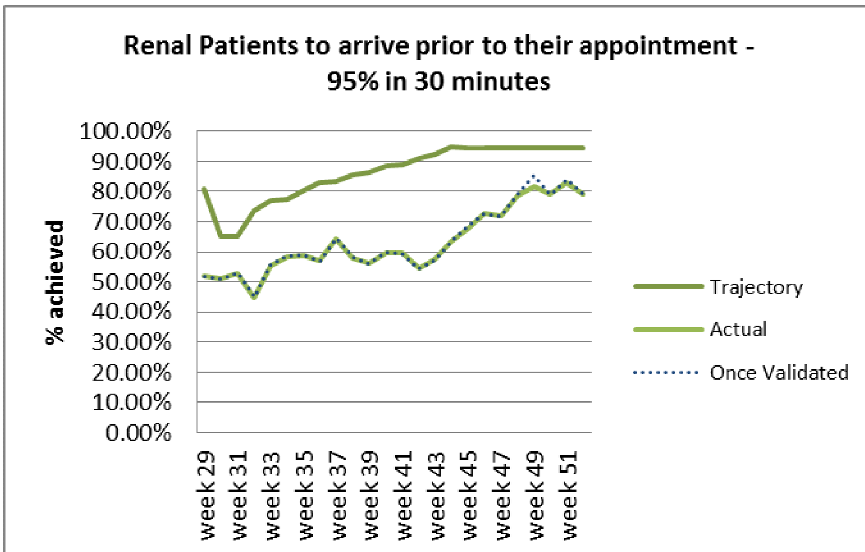
- Timeliness of taking patients into an outpatient appointment,



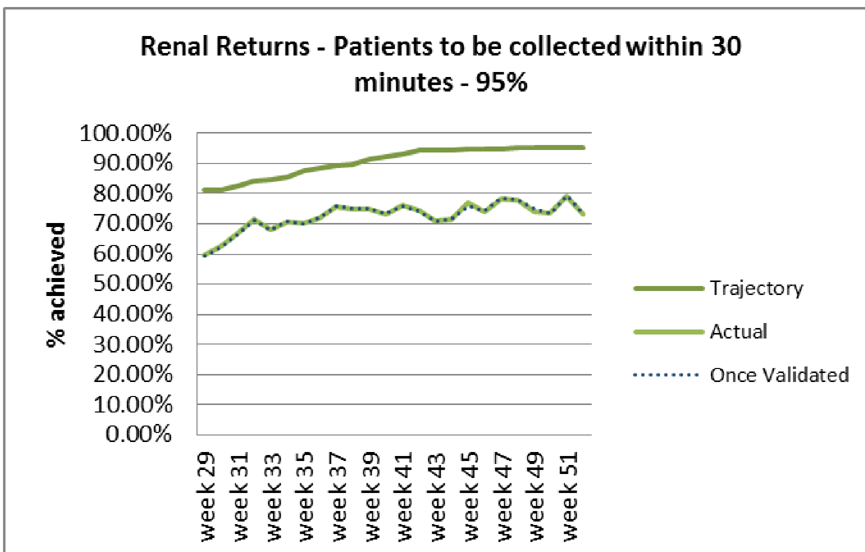
- Timeliness of collecting patients from an outpatient appointment



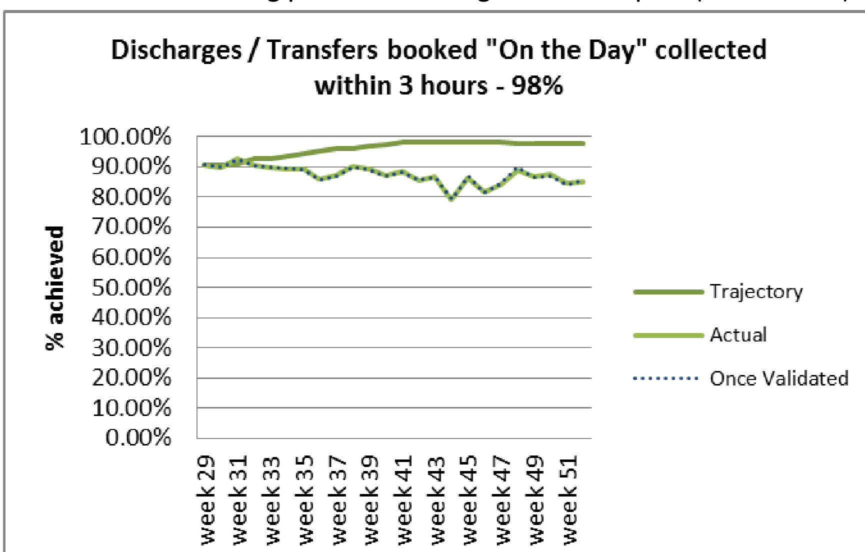
- Timeliness in bringing renal patients in for treatment

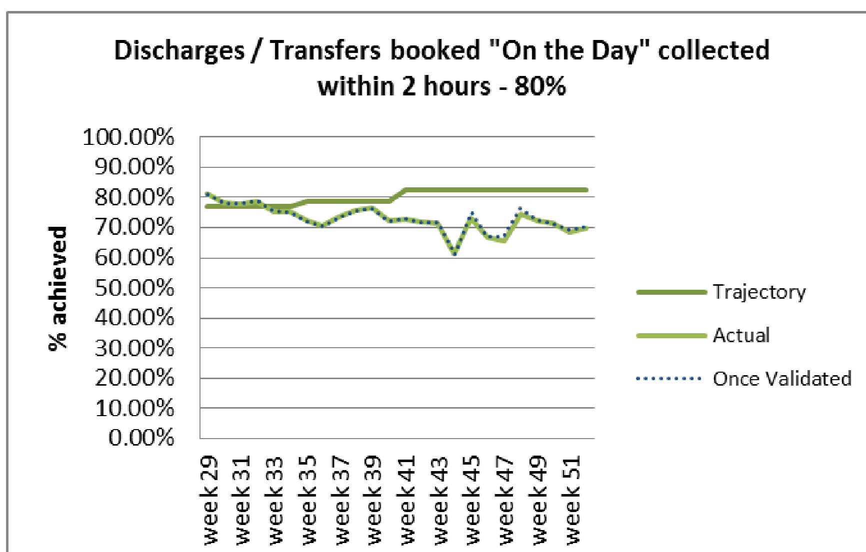


- Timeliness in collecting renal patients from treatment



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





The above graphs show weekly data up to mid-June. 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, data for the month of June has been analysed and, whilst it shows some improved performance on transport of Renal patients, overall performance in June 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.

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

CQC Report

CQC inspected the PTS service in November 2013 and published their findings in January 2014; they inspected the service again in March 2014 and finally published this second report on 29th July. West Kent CCG has raised concerns with CQC about the delay in publishing the second report as the findings are now four month out of date.

The report recognised that significant improvements have been made since the initial CQC visit in November 2013 acknowledged that they had received lots of positive comments from staff and patients during the inspection.

The first report issued following the November visit found that NSL have failed to meet 4 out of the 5 standards inspected. In two of the areas Enforcement Actions were taken (warning notices issued); in the other two areas Enforcement Actions were not taken, but CQC advised NSL that action was needed.

The second report following the March visit found the actions required by the warning notices had been taken and that improvement had been made in all areas. However, the level of improvement was not sufficient and NSL was still failing to meet 3 out of 5 standards. The impact of the failures was deemed by CQC to be minor and no enforcement actions were taken.

NSL have now tackled two of the three areas (recruitment and training). The key remaining issue relates to getting patient to and from hospital on time. These are the same concerns we are tackling through the contract and which are documented above.

Next Steps

Commissioners and NHS Trusts have met, and continue to meet to discuss the next steps. The following paragraphs set out the contractual background for consideration of future options:

Current contractual options

The contract is a standard NHS contract that runs for three years from July 2013 – July 2016. There is an option in the contract to extend it by 2 periods of 12 months. At this point in time we are assuming that we do not plan to extend the contract and should be planning to re-procure by July 2016 at the latest.

Under the contract there are four options that the CCGs can take:

- Work with the provider to improve services but take no contractual action. Let the contract run until the end of its three year duration.

- Serve a performance notice and require a formal recovery plan

- Serve a no fault termination notice (General Clause 17.1) and re-procure the service early. This clause requires the commissioner to serve a minimum of 12 months' notice. There is no contractual basis for the provider to challenge this action.

- Serve a termination notice for provider default (general clause 17.8) and re-procure the service early. The clause enables the commissioner to terminate with immediate effect. The contract specifies the circumstances when this can be done and the commissioner would have to justify such action against these circumstances. The Provider can legally challenge this action. Given the reputational impact on NSL of termination by us on this basis, it is very likely that NSL would legally challenge our actions. This would at best delay our ability to re-procure, at worst derail it.

Procurement timetable

Kent and Medway Commissioning Support Service working with NHS Commercial Solutions (a professional procurement support service within the NHS) has looked at potential timelines for any re-procurement and the advice is as per the table below:

Activity	Optimistic (Days)	Likely (Days)	Optimistic (Completion Date)	Likely (Completion Date)
Issue resolution and agreement of specification	90	180	September 2014	December 2014
Governing Body approval of re-procurement	30	60	October 2014	February 2015

Procurement planning	35	45	November 2014	March 2015
Issue ITT/PQQ	40	45	December 2014	May 2015
Evaluation of bids	60	80	February 2015	July 2015
Award recommendation	15	15	March2015	August 2015
Governing body approval of contract award	30	60	May 2015	October 2015
Contract mobilisation	150	150	October 2015	March 2016
Total days	450	635		

Assuming we are able to move rapidly this shows the earliest we could see a new provider in place is October 2015. This means we will go through next winter with the current provider.
If we were to let the contract run to July 2016, we would still need to commence work on re-procurement by October 2014.

Future service options

The current service is procured by CCGs as a Kent and Medway wide single service. A re-procured service need not be configured the same way. Some other options are:

- Separate services commissioned for each Trust,
- Pre-booked journeys (mainly outpatients and renal) and on the day bookings (mainly discharge and rapid access clinics) commissioned separately,
- CCGs delegate commissioning responsibility to trust to commission their own service,
- Trusts provide their own services.

The CCG has started to work with Trusts to agree the appropriate service model and specification to be commissioned. This work will need to be completed before commencing procurement

Other issues

NSL are one of the largest PTS providers nationally and any action taken locally may have national impact and would need to be discussed with NHS England.

Actions/Next steps

The following are the actions/next steps are being taken.

- CCGs and Trusts continue to work with NSL to resolve current issues and improve the service.
- As a working assumption, CCGs plan on the basis that CCGs will not be extending the contract and will need to re-procure by July 2016 at the latest.
- CCGs commence working with trusts to decide on the future service options and produce an updated service specification that can be issued for the re-procurement. This will need to be agreed by CCG Governing bodies and shared/discussed with OSCs.

- Formal public consultation may be needed if the specification changes significantly from that of the current service. If consultation is needed it will extend the timeline.

- CCGs start now to prepare for re-procurement. This may give CCGs the option of terminating the contract early and having a new provider in place for winter 2015. Any decision to terminate early will need to be made by October 2014 and will require the Commissioner to give the provider a minimum of 12 months' notice.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 September 2014

Subject: NHS England: General Practice and the development of services

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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 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).

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.

(c) The pilot will enable patients 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).

6. Primary Care Co-Commissioning

(a) On 1 May 2014 Simon Stevens, Chief Executive of NHS England, announced a new option for local Clinical Commissioning Groups (CCGs) to co-commission primary care in partnership with NHS England (NHS England 2014c).

(b) CCGs were asked to submit their expressions of interest (EOI) to NHS England by 20 June 2014, indicating the form that the CCG would like co-commissioning to take and how they would like it to evolve. 183 of the 211 CCGs submitted an EOI. 49 out of the 50 CCGs in the South Region submitted an EOI.

(c) Three categories of interest emerged:
- Category A: greater CCG involvement in influencing commissioning decisions made by NHS England area teams;
- Category B: joint commissioning arrangements; and,
- Category C: delegated commissioning arrangements.

(d) On receipt of the EOIs, Local Area Teams undertook a desktop exercise to assess the state of readiness of each CCG's proposal.

(e) A different approval and governance process is required for each of the three categories of interest in primary care co-commissioning. Details of the governance framework, the criteria and process for approving delegated budgets and commissioning responsibilities will be brought to the September NHS England Board Meeting for approval (NHS England 2014c).

7. Special Measures for GP Practices

(a) On Thursday 14 August the Care Quality Commission (CQC) announced plans to introduce special measures for GP practices from October 2014. This will coincide with the introduction of ratings for GP practices. Practices will be rated on the five key questions (safe, effective, caring, responsive and well-led) and six population groups (older people, long term conditions, mothers babies and children, working age, people living in vulnerable circumstances including people with a learning disability and people experiencing poor mental health, including dementia) (CQC 2014a; CQC 2014b).

(b) Under the proposals, GP practices rated as inadequate for one or more of the five key questions or six population groups will be given six months to improve. Practices that fail to make improvements will be put into special measures, after which they will be given a further six months to meet the required standards. At the end of their period in special measures, if the CQC still judge them to be inadequate, their CQC registration will be cancelled and their contract with NHS England will be terminated. In some cases, when poor care is putting patients at risk or that a practice is not capable of improving on its own, the CQC will put the practice straight into special measures (CQC 2014a; CQC 2014b).

(c) The CQC is working closely with NHS England to pilot special measures, in close consultation with the General Medical Council and the Royal College of GPs as the new approach is developed. NHS England is starting work with the Royal College of General Practitioners to develop a pilot programme of intensive peer support to practices that are placed in special measures (CQC 2014a; CQC 2014b).

(d) The proposals bring GP practices into line with the other sectors regulated by the CQC. Special measures for acute hospitals were adopted last year following the Keogh Review which identified significant problems relating to quality, safety and leadership in 14 Trusts. The CQC has also announced the special measures regime will be introduced across the adult social care sector from April 2015 (CQC 2014a; CQC 2014b).

8. 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 that they be invited to attend a meeting of the Committee in six months.

Background Documents

CQC (2014a) *'Special measures to target failing GP practices (13/08/2014)*', http://www.cqc.org.uk/content/special-measures-target-failing-gp-practices

CQC (2014b) '*CQC's proposals for special measures for GP practices (14/08/2014)*', http://www.cqc.org.uk/content/cqcs-proposals-special-measures-gp-practices

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 (2014c) '*Item 7 - Primary Care Co-Commissioning, NHS England Board Paper (03/07/2014)*', http://www.england.nhs.uk/wp-content/uploads/2014/06/item7-board-0714.pdf

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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NHS England

Transforming general practice within Kent and Medway; the challenge

Briefing for Kent Health Overview and Scrutiny Committee for presentation at a meeting on 5 September 2014

1. Summary

This paper sets out a summary of the key challenges currently facing general practice and the need to transform the way that GP services are delivered in order to address these growing challenges and to ensure the future delivery of good quality, local care to patients in a sustainable way.

A national report published by NHS England earlier this year summarised the overarching issues facing general practice across the country, many of which are equally applicable to Kent and Medway. These challenges include:

- an ageing population and an increasing number of patients with complex care. needs and multiple long-term conditions, who require more intensive support from GP services.
- increasing pressure on NHS financial resources.
- dissatisfaction amongst patients about the ability to access GP appointments and rising patient expectations about this.
- variation in the quality and performance of local services and health inequalities.
- growing reports of workforce pressures, including recruitment and retention problems.

The national report published by NHS England, Improving General Practice - A Call to Action, describes some of the work that is taking place at a national level to develop GP services fit for the future.

In addition to the work that is continuing to take place to determine what national incentives and actions might be necessary to support the transformation of GP services, within Kent and Medway we are also considering what action might be required locally in order to meet the specific needs of our local communities.

This paper sets out the potential implications of the challenges currently facing local GP services and considers how services might need to develop and change in order to meet the priority of providing good quality, accessible care to all local patients, both now and for future generations.

To help put this in context the next section of the paper provides a brief overview of the current contracting arrangements for GP services.

2. GP contracts

Across Kent and Medway, NHS England holds 260 individual contracts with GP practices. Each contract allows the provider to deliver primary medical services to its patient list.

There are 3 different type of contract held with GP practices. These are:

General Medical Services (GMS) contract: GMS contracts are nationally negotiated. These contracts run in-perpetuity and provide the contractor with considerable flexibilities in terms of being able to take on new GPs as partners to the contract. This allows GMS contracts to be handed on from one GP or group of GPs to another without this requiring the agreement of NHS England as the commissioner (subject to the individuals concerned meeting certain conditions as set out in the national GMS regulations). GMS contracts can only be terminated by the commissioner should there grounds to do so (i.e. fundamental concerns regarding patient safety). GMS contracts cannot be held by public limited companies (PLCs).

Personal Medical Services (PMS) contracts: These are locally negotiated contracts between NHS England and local practices which give local flexibility compared to the nationally-negotiated GMS contract by allowing the opportunity for variation in pricing and the range of services that may be provided by a GP practice.

32 practices across Kent and Medway hold this form of contract (1 of which is in Medway). PMS contracts cannot be held by PLCs.

Alternative Provider of Medical Services (APMS) contract: APMS contracts vary from GMS and PMS contracts in two key ways. Firstly they can be held by any form of entity (including PLCs, local GPs and third sector organisations). Secondly they are for a fixed-term period. 14 practices across Kent and Medway currently hold APMS contracts, five of which are in Medway.

It is important to note the following two points:

a) GP practices that hold GMS and PMS contracts have considerable influence over determining the service model and the configuration of GP practices across a local population. This is because they can decide who they might take on as GP partners, who they pass their contract onto and at what point in time, or whether, they wish to resign their contract. Should they wish to resign their contract then they need provide only a limited period of notice (six months for a GP partnership, three months for a sole practitioner contractor).

b) When NHS England is considering awarding a new contract for GP services it is now always likely to be in the form of an APMS contract. This is because APMS is the only contract platform available that meets the requirements of procurement law and its underpinning principles (in terms of being open and non-discriminatory). This is because both GMS and PMS contracts are seen as being “closed” contracts as they cannot be held by certain types of organisational entity and because they effectively run in-perpetuity and are not therefore subject to subsequent market-testing. The existing GMS, PMS and APMS contracts that NHS England hold with various local GP providers were inherited by the organisation when it came in to being in April 2013.

3. Current challenges facing general practice in Kent and Medway

3.1 Demographic change and epidemiology

The populations of both England and Kent and Medway are increasing in size and increasing in age. This change in our demography has a significant epidemiological dimension as an increasing number of people are now living into their 80s and 90s.

By 2021, there is expected to be an overall increase of 5.4% in the total Kent and Medway population. However, the number of people in the area aged over 65 years is expected to increase by 25.5 per cent during this period, while the number of those aged 85 years and above is expected to rise by 34.1 per cent.

The relevance of this demographic change to general practice is that it means that many more of us are, and will be, living for longer with multiple and complex long-term conditions.

These changes are already having a significant impact upon GP practices and GPs. Nationally it has been estimated that there has been a 95 per cent growth in the consultation rate for people aged 85-89 in the ten years up to 2008/09.

GP practices across Kent and Medway will therefore need to be prepared and equipped for the rising demand on local services as a result of the ageing population.

3.2 Public expectations

Changes in the age and health profile of the population are also matched by changes in patient expectations. The most recent GP Patient Survey showed that nationally, although 76% of patients still rated their overall experience of making an appointment with a GP as good, there have been further reductions in overall satisfaction with access to GP services, both for in-hours and out-of-hours services.

Improving patient access to services is therefore a key factor that will need to be addressed in transforming primary care services.

In this respect a group of practices within Kent and Medway were amongst 20 pilot schemes awarded support from the Prime Minister’s Challenge Fund earlier this year to pilot a range of options to make GP services more accessible to patients. Practices within Folkestone and Dover will benefit from £1.89 million of support with which to improve access to care for almost 95,000 patients and have come together to pilot various initiatives aimed at achieving this, including:

- extended opening hours from 8am to 8pm, seven days a week
- an urgent home visit service outside of core practice hours (8am-6.30pm)
- enhanced community care with short-term residential facilities in the community to avoid hospital admissions
- and for patients with urgent mental health needs, a new rapid assessment service delivered by a primary care mental health specialist, either at a patient’s home or at their GP practice.

NHS England will use the learning from this and other pilot schemes across the country as we seek to develop new models for the future provision of primary care which will improve access to services and ensure the highest quality care for patients.

3.3 Workforce

Changes in the GP workforce are one of the biggest single drivers to the changes that we are now witnessing in terms of the potential future configuration of general practice services (alongside the impact of an ageing population and the changing health needs associated with this). There are several important strands to this, which are all interconnected. While the narrative below highlights some of the key issues, a more comprehensive summary can be found in a report published by the Centre for Workforce Intelligence in July 2014. A copy of the report is available on their website and was commissioned by the Department of Health and Health Education England (which is the organisation within the health service with overall responsibly for providing system wide leadership and oversight of workforce planning, education and training).

The Centre for Workforce Intelligence concluded in their review of the GP workforce that the current level of GPs being trained is inadequate and likely to lead to a major workforce demand-supply imbalance by 2020. The key findings from this review were:

- Growth in the GP workforce has not kept pace with the increase in medical consultants or population growth. According to the report, nationally the number of GPs rose by 23 per cent on a whole time equivalent (WTE) basis between 1995 and 2013. By contrast the number of consultants in other medical specialties doubled over the same period. On a per capita basis, the number of GPs per 100,000 population in England has actually fallen to 59.6 GPs. It is expected that the GP per capita ratio will only return to its peak of 61.5 GPs per 100,000 population by 2015.
- Boosting the number of GP trainees is proving difficult
- The GP workforce is getting younger and more females are entering general practice. The review concludes that a larger number of GPs will be needed to ensure the appropriate WTE workforce is in place , as a higher proportion of women work less than full-time hours for some periods of their GP career.
- There is significant geographical variation in the distribution of GPs.
- The review concluded that simply increasing the number of GPs will not necessarily lead to a more equal distribution of doctors.
- The GP role has become broader and more complex
- General practice activity and workload has increased substantially for GPs and other practice staff
- Available evidence suggests the GP workforce is under considerable stain and current levels of activity may not be sustainable in the face of rising demand for services

Across Kent and Medway there are a number of GPs working either as GP partners or as single handed GPs who hold contracts with NHS England and who are likely to retire within the next three to five years. Defining the precise number is very difficult as it is a matter for the individual GP to determine when they will retire and cease working. This uncertainty creates difficulty in planning for service change.

The Centre for Workforce Intelligence report highlights that one of the former PCTs within Kent was one of only 11 former primary care trusts (from an overall total of 151) where more than 35 per cent of local GPs were aged over 55. The Seventh National GP Worklife Survey (Institute of Population Health, University of Manchester, 2013) also found that 54.1 per cent of GPs aged 50 or over expected to cease providing direct patient care within five years, which the British Medical Association (BMA) claim is driven by low levels of job satisfaction and high levels of stress (as opposed to pay).

Given the ageing GP workforce one of the challenges that needs to be addressed is whether the number of new GPs coming through the system will be sufficient to maintain existing service levels and the rising demand for GP care.

Alongside this, an increasing number of the new generation of GPs who are entering the profession are often seeking different types of fulfilment in their careers compared to their predecessors. A number of younger GPs are now choosing to work abroad particularly in the first years following their registration as doctors, while others favour the flexibility that working as a locum provides. Some decide to follow a portfolio career which entering in to a GP partnership arrangement does not allow for. A significant number of younger GPs are therefore no longer attracted to the prospect of becoming a partner within a practice; favouring working as either salaried GPs or as a locum instead.

In this respect, partnership working comes with considerable responsibilities and obligations. As a partner to a practice you effectively become jointly responsible for the management of the practice and the risks and benefits associated with this. For many GPs this involves making a long-term commitment to the practice and the community that their surgery serves. We are now seeing many GP practices experiencing difficulty in recruiting to partnership vacancies and they are instead having to backfill with locum GPs or appoint GPs on a salaried basis.

As we develop plans for the future of services, NHS England (Kent and Medway) will be working closely alongside local colleagues at Health Education England to identify the approaches we can take locally to address the workforce challenge effectively.

3.4 Professional accountability

All GPs are now subject to professional revalidation, which is the process by which GPs demonstrate to the General Medical Council (GMC) that they are up to date, fit to practice and are complying with the relevant professional standards. GPs must be revalidated in order to maintain their license to practice. A GPs revalidation takes place every five years and is based upon an evaluation of their practice (through annual appraisal) during this time.

The processes of appraisal and revalidation are important in terms of providing safeguards about a GPs fitness to practice. However this process does place a significant responsibility upon individual GPs in order that they can demonstrate they meet the required standards.

3.5 Regulation

GP practices must now be registered with the Care Quality Commission (CQC) and have to meet the regulator’s “essential” standards for delivering general practice services.   The CQC is responsible for monitoring, inspecting and regulating GP practices to ensure that services are meeting the relevant quality standards.

GP practices need to ensure their registration with the CQC is in place in order to operate legally. To do this they need to ensure both their premises and services are of an acceptable standard and will stand up to scrutiny, in the form of an announced or unannounced visit by a CQC inspection team.

In August, the CQC announced that is planning to introduce a system of special measures for GP practices from October 2014. This means that GP practices that provide inadequate care will be given deadlines for improvement or could potentially face closure. NHS England's area teams will be working together with the CQC to support a timely and coordinated response with regards to any GP practices that are providing inadequate care and who are placed into "special measures". This will ensure that any such practices do not continue to provide inadequate care to patients.

As HOSC members will be aware, the clinical leadership at the Lakeside Medical Practice in Sittingbourne recently changed following a CQC report published in June, which raised serious concerns about the services that were previously provided to patients at the practice under the former sole practitioner GP contractor.

3.6 Viability of local practices

NHS England provides funding to local GP practices to cover the cost of providing core services to patients. GP practices are nonetheless managed by independent contractors who need to operate at a profit in order for their surgeries to be financially viable.

As confirmed above, general practice services in Kent and Medway are still largely provided by GPs working in partnership, or as sole practitioners under a General Medical Services (GMS) contract. These GPs draw a personal income from any profit margin generated by their practice. If profit margins are too low then a practice might struggle to recruit and retain GP partners and/or salaried GPs.

GP earnings have reduced in each of the last several years. This followed substantial increases in average earnings following the changes the GP contract in 2004.

The 2014 Review Body for Doctors and Dentist Remuneration highlighted that in 2011/12, average income for United Kingdom GPs was £103,000, with average expenses of £164,900. The expenses to earnings ratio increased slightly on year, from 60.9 per cent in 2010-11 to 61.6 per cent in 2011-12. This was because while average income decreased by 1.1 per cent between 2010-11 and 2011-12, average expenses increased by 1.5 per cent.

3.7 Involvement in clinical commissioning groups

Each GP practice is required to be a member of a clinical commissioning croup. This necessitates the practice becoming actively involved in the work of its CCG to support improvements to the overall health of the local population. This includes by inputting in to the development of new care pathways and services designed to ensure the effective management of patient care. GP practices will be supported by their CCG to understand their own referral patterns, their use of prescribing and how their patients use local accident and emergency (A&E) services and out-of-hours care as part of this work.

In May 2014, NHS England confirmed that it was inviting CCGs to express an interest in taking a greater role in the commissioning of local primary care services, in order to help support the integration of different health services and as part of efforts to achieve sustainable services in future years. NHS England has received expressions of interest from all local Kent and Medway CCGs in response to this invitation and work is now taking place alongside the CCGs to explore the potential for the effective co-commissioning of services further.

This could therefore also have a potential impact on the way that local GP services are developed over the coming years.

3.8 Parallel contracts and accountability

Previously GP practices sourced almost all of their contract income from one commissioner, under the single contract they held with their former primary care trust (PCT). Following the Health and Social Care Act 2012, GP practices now obtain funding and income from NHS England (as the commissioner of core GP services), from their local CCG (for services previously commissioned as Local Enhanced Service Schemes) and from their local authority public health team (for health improvement and health promotion services such as smoking cessation and sexual health).

GP practices therefore need to deliver services in accordance with the contracts they may now hold with three separate commissioners. This creates additional transactional work for practices and increased levels of monitoring and accountability which they need to be able to manage in order to provide the necessary assurances about the care they are delivering to patients.

4. Implications and Consequences

4.1 Vacancies and increased use of long-term locums

A number of GP practices across Kent and Medway have been and continue to experience difficulty in recruiting to partnership positions. A recent partnership opportunity at a successful and well respected practice in Maidstone attracted only two applicants, whereas 10 years ago a similar opportunity at the same practice attracted in excess of 50 applications. GP practices in the coastal areas of Kent appear to be experiencing the greatest difficulty in recruiting GPs to partnership positions and there are some practices where there have been substantive vacancies for prolonged periods.

As a consequence practices often make use of locum GPs to backfill for partnership vacancies and to ensure services continue to be provided. Locum GPs tend to be less popular with patients, many of whom prefer to see a GP they know and trust, and are expensive to engage by the practice.

4.2 Practice mergers

During the last 18 months several practices have decided to merge. This means that their respective contracts and patient lists are brought together and managed under one contract. We are also considering a further request from two practices in Faversham who wish to merge their contracts.

The merger of contracts is possible but does require the support and agreement of NHS England through the Kent and Medway Area Team. Each case is considered on its own merits and will take into account feedback to the practice from patient consultation, the benefits to the practice and to patients, while also being mindful of the potential for loss of patient choice and competition in an area if practices merge.

We anticipate further requests from practices to merge in the coming months and years**.**

4.3 Closure of branch surgeries

The Area Team has seen a small but noticeable increase in the number of applications it has received from practices to close their branch surgeries. In this respect 5 applications for branch surgery closure have been received since April 2013, three of which were approved.

These applications often to relate to branch surgeries that are located in poor accommodation and/or where the opening hours, range of services offered by the practice, and utilisation of the branch surgery by patients makes its continuation difficult to justify from the practice's viewpoint. A number of practices are finding it increasingly difficult to run branch surgeries unless these can support a sufficient number of patients and can provide a full range of services.

Each application is considered on its own merits and taking in to account local patient needs. Decisions about any proposed branch closures are also only taken following a period of consultation and engagement with patients, but it does appear that there may be a slow but steady move by practices away from maintaining small branch surgeries.

4.4 Requests to close practice lists

The Area Team is also seeing an increase in the number of practices that are enquiring about closing their lists to new patient registrations. Since April 2013 three practices have gone on to submit formal applications for list closure, none of which were approved.

These requests are considered carefully on a case-by-case basis. The practices that have applied to close their lists often cite patient safety issues and recruitment difficulties as the underlying reason for their applications.

4.5 Fewer smaller practices

Single-handed GPs who hold a contract to provide services at their surgeries could potentially find the challenges facing general practice more significant than those GP practices which are managed by GPs working in partnership, or by limited liability companies or PLCs. Partnerships and companies are arguably better placed to manage the responsibilities that come with holding a GP contract. This is because the workload associated with holding a contract for delivering GP services can be shared amongst a team of staff.

It is expected that the number of sole GP contractors will diminish over time. This will reflect how the system of general practice itself evolves and responds to the challenges that it is now faced with and because NHS England is less likely in the future to commission new contracts for relatively small patient lists, as these are no longer considered to be sustainable (except perhaps in remote rural communities). NHS England's general view is

that general practice is more likely to be able to successfully deliver high quality services that offer the best value for the taxpayer when operating at greater scale. It is however important that we ensure that all GP services continue to be responsive to the needs of their individual local patients.

4.6 Average GP practice list sizes are growing

Across England the average GP practice list size has grown by almost 20% between 2002 and 2014. In 2002 the average GP practice patient list size was 5,891. By the 1 January 2013 this had increased to 6,911 and by 1 January 2014 it stood at 7,052 patients.

On the one hand this is a reflection of demand for services, as the size of the population has grown. However it also reflects supply side issues too. There have been, relatively speaking, only a small number of new GP practices commissioned to provide services to patients (such as the walk-in centre contracts in Minster, Sheppey and at the White Horse Surgery in Northfleet) during this time, while some practices have also merged or closed.

We expect average patient list sizes to continue to grow, largely as a result of the way that general practice is responding to the challenges it faces. Many practices are taking steps to consolidate and come together through mergers with other local practices in recognition that operating at larger scale brings benefits in terms of operational resilience.

It is however interesting to note that alongside this change, the average number of patients managed by each whole time equivalent (WTE) GP is moving in the opposite direction. The average number of patients managed by each WTE GP reduced from 1,764 in 2010 to 1,569 in 2012, for example.

4.7 Redefining continuity of care

Some patients say that they value the care provided to them by their local family doctor and the continuity that this provides in terms of the care that they receive.

There will however be occasions when the care patients receive cannot be delivered by the same GP (including taking in to account any annual leave or part-time working arrangements for example).

The challenge for general practice therefore is to try and retain the best of the personalised service that patients value, while also providing patients with access to support from a greater range of health and social care professionals who are linked with practices and who can help meet patient needs in an integrated way. This includes for example the adoption of personalised care plans for the most vulnerable patients, or those who may have complex needs, in order to ensure they receive the best possible care that is tailored to their individual needs.

The Government announced an amendment to the GP contract at the end of last year, which places a responsibility upon GPs to co-ordinate care planning for frail and elderly patients in order to help avoid them being admitted to hospital unnecessarily.

4.8 Other contract terminations and procurement decisions

A contract with a GP practice may have to be ended for a number of reasons. These include:

- a decision by made the practice to end their contract
- the death of a single-handed GP who holds the contract for services at their practice (as recently occurred at the former Wyvill Surgery in Medway)
- the expiry of a fixed-term APMS contract, or
- a decision taken by NHS England to terminate a contract because of concerns it holds about the delivery of services to patients and/or management of the practice.

Under each of these scenarios, NHS England is then faced with an important commissioning decision with regards to how it will ensure patients will continue to be able to access GP services after the end of the contract under which their care is currently managed.

Commissioning decisions made by NHS England will always take in to account patient needs, but this paper gives an indication of some of the other factors we also need to take into account in such circumstances.

4.9 Emerging principles for the future commissioning of local GP services

As a result of feedback NHS England received as part of the Call to Action debate on the future of services, the organisation identified five areas where it believes GP services need to be improved in order to ensure the delivery of excellent services across the country, both now and in the future. These are:

Ambition 1: proactive, coordinated care: anticipating rather than reacting to need an being accountable for overseeing your care, particularly if you have a long-term condition.

Ambition 2: holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.

Ambition 3: fast, responsive access to care: giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.

Ambition 4: health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness - engaging differently with communities to improve health outcomes and reduce inequalities.

Ambition 5: consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety in order to reduce inequalities and achieve faster uptake of the latest knowledge about best practice.

These national priorities are also reflected in the local principles that NHS England (Kent and Medway) has begun to identify as being important to the future development of services in local communities). These include:

Kent and Medway emerging principles for the commissioning of GP services

Values	Principles
Equity and fairness	Health promotion and prevention are priorities and key to tackling health inequalities. Money should follow the patient.

	Commissioners and providers will be open and transparent in their dealings with the public and each other
Patient centred care	No decision will be taken about a patient without their involvement Care closer to home will be commissioned Services should be accessible and responsive to individual need Excellent information to patients and the public about health and primary health care services Patients to be treated as individuals and will be involved in decisions about their care with access to their clinical records Patients will be treated with respect Patient views are considered as part of the process of driving service improvements Continuity of care will be a priority
Choice	Excellent information to patients and the public about health and primary health care services There will be a range of services available
Sustainability	Reduced carbon footprint Services will be economically viable for the provider Services that are good will be built upon and learnt from in order to optimise potential. Workforce planning, training and education will be a priority Collaboration will be promoted including with the private sector, voluntary sector and local authorities
Value for money	Innovation and productivity Resources will be managed wisely Competition will be used to drive improvement and value Duplication will be reduced and eliminated wherever possible The commissioner will operate within available resources Money should be targeted on the patent facing services rather than on buildings

High quality	Evidence based services will be commissioned Minimum standards will be maintained The importance of continuity of care will be recognised and its role promoted An open and transparent culture will be embedded There will be a focus on coordinating care, especially for those patients who are at the greatest risk There should be senior clinical input at the front of the care pathway The number of times a patient is transferred between professionals or passed from organisation to organisation will be kept to a minimum There will be access to patient information for everyone that needs it Commissioner and providers will work to reduce variability/standardise the model

5. Conclusion

This paper has sought to brief the HOSC on the current challenges facing general practice and how it is responding and evolving to these challenges. In this respect we are witnessing some GP practices choosing to form larger practices as a result of contract resignations, mergers and we are also seeing some practices wish to consolidate the provision of services across fewer sites.

In order to address the various challenges outlined in this paper and to ensure sustainable services, a strategy for the future commissioning of local GP services is under development. NHS England and CCGs are consistently highlighting the importance of moving towards integrated primary care services, which places general practice at the heart of out-of-hospital care and where the GP holds the role of care navigator to ensure patients get the right care and treatment from a range of different service providers. We are working with CCGs and practices to identify how practices can work across local networks in order to be sustainable while delivering excellent care that drives improved outcomes for patients and communities. This strategic change model needs to work alongside individual practices as they continue to hold their own individual contract for GP services.

Our strategic approach will need to build upon the emerging national framework for primary care services which is being developed in order to ensure some national consistency in the provision of services where this is needed. It will also need to build upon NHS England's ongoing discussions with local CCGs about any future co-commissioning arrangements.

Our priority continues to be to ensure that all patients in Kent and Medway have access to a full range of good quality, local GP services. We will continue to keep HOSC members updated as these plans develop.