HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 10th October, 2014

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 10th October, 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 - 14)	
4.	Child and Adolescent Mental Health Services (CAMHS) - Tiers 1, 2 & 3 (Pages 15 - 66)	10.05
5.	West Kent: Out of Hours Services Re-procurement (Pages 67 - 114)	11.00
6.	North and West Kent: Dermatology Redesign (Pages 115 - 160)	11.30
7.	CQC Inspection Report - East Kent Hospitals University NHS Foundation Trust (Pages 161 - 184)	12.00
8.	Date of next programmed meeting – Friday 28 November 2014 at 10:00 am	12.45

Proposed items:

- CCG Merger: Ashford and Canterbury & Coastal
- Patient Transport Services
- Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy and Stroke Services
- South Kent Coast CCG: Integrated Care Organisations

9.	North Kent: Emergency and Urgent Care Review and Redesign (Long Term) (Pages 185 - 196)	14.00

Motion to exclude Press and Public

That, under Section 100A of the Local Government Act 1972, the press and public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act.

10.	North Kent: Emergency and Urgent Care Review and Redesign (Short Term) (Pages 197 - 222)	14.45

**Timings are approximate*

Peter Sass
Head of Democratic Services
(01622) 694002

2 October 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, 5 September 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 G Lymer, Mr C R Pearman, Cllr P Beresford, Cllr R Davison, Cllr M Lyons and Cllr Mrs A Blackmore (Substitute for Cllr J Burden)

ALSO PRESENT: Cllr J Burden, Mr A H T Bowles, Mr T Gates, Mr S Inett, Dr J Allingham and Dr M Parks

IN ATTENDANCE: Mr T Godfrey (Policy Manager (Health)), Miss L Adam (Scrutiny Research Officer), Mr A Scott-Clark (Interim Director of Public Health) and Ms D Fitch (Democratic Services Manager (Council))

UNRESTRICTED ITEMS

60. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 2)

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

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

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

61. Minutes
(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 had been asked to provide an update on the design of the community hubs. An update email was circulated to Members on 20 August. A paper was being drafted and would be circulated to Members after public events in September.

(b) Minute Number 49 - Child and Adolescent Mental Health Services (Written Update). Michael Ridgwell (NHS England (Kent and Medway Area Team)) had co-ordinated a joint response and update on performance across the four CAMHS tiers in Kent. The response was circulated to Members on 24 July.

(c) Minute Number 53 - Kent Health & Wellbeing Board: Update and Strategy. In response to a question about statistical variances in the report and the utilisation of libraries and gateways, 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. Responses were circulated to Members on 1 and 3 September.

(d) Item 58 - Future of Services at Dover Medical Practice. A 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. Responses from NHS England (Kent and Medway Area Team) were circulated to Members on 24 July and 15 August.

(2) The Scrutiny Research Officer requested that the following sentence be added to Minute 53: Mr Roger Gough (Cabinet Member for Education and Health Reform, Kent County Council) and Mr Tristan Godfrey (Policy Manager (Health), Kent County Council) were in attendance for this item.

(3) Mr Hoare requested that the following sentence be added to Minute 53: A Member made a comment about the number of people in Kent who could be potentially affected by the Assisted Dying Bill. Mr Gough stated that he was unable to provide a definitive answer as the Bill was going through its parliamentary passage.

(4) RESOLVED that, subject to the amendment in paragraph (2) and (3) above, the Minutes of the Meeting held on 18 July 2014 are correctly recorded and that they be signed by the Chairman.

62. Medway NHS Foundation Trust: Update
(Item 4)

Dr Phillip Barnes (Acting Chief Executive, Medway NHS Foundation Trust), Patricia Davies (Accountable Officer, NHS Swale CCG), Fiona Armstrong (Clinical Chair, NHS Swale CCG) and Gillian Wells (Governing Body Independent Lay Member, NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Barnes began by giving an overview of the last 15 months. As a Trust investigated by the Keogh Mortality Review, the Trust was inspected in June 2013. A Quality Improvement Plan (QIP) was developed in response to the inspection report and had been worked through by the Trust and external stakeholders. A re-inspection took place in April 2014 and the inspection report was published on 8 July. The Trust was rated as inadequate with particular concerns about emergency and surgical services.

(2) Dr Barnes highlighted a number of themes from the report including leadership instability; over the last 18 months there had been 32 different board members. It was announced that the Council of Governors had appointed Shena Winning as the new Chairman of the Trust on Thursday 4 September. Interviews for a substantive Chief Executive would take place at the end of October. A new management structure will be introduced which would include

a Chief Operating Officer. The Trust was receiving best practice guidance and support from University Hospitals Birmingham NHS Foundation Trust with its management and governance structure. The Trust had produced a very detailed action plan in response to the CQC inspection report. The action plan detailed proposals to improve staff engagement and ownership; and surgical leadership with seven day working for consultants.

(3) It was reported that a further unannounced inspection of the emergency department by the CQC took place in August. In response to the inspection, the Trust had implemented a support team to challenge and hold the emergency department to account; changed the front of house assessment process; and made improvements to discharge as part of seven day working. The Trust had also received advice and guidance from Homerton University Hospital NHS Foundation Trust in Hackney.

(4) The Chairman invited Ms Davies to speak. Ms Davies explained that NHS Swale CCG's concerns were with the speed and pace of delivery at the Trust. The CCG was working very closely with the Trust, Monitor, CQC, NHS England, NHS Medway CCG and wider CCGs to make improvements and reduce pressure on the Trust. NHS Swale CCG had released additional funds to extend the Integrated Discharge Team, provided nursing and quality support and expanded psychiatric liaison. She stated that NHS Swale CCG was using its commissioner levers to engender change; Monitor the regulator for NHS Foundation Trusts had the jurisdiction to enforce regulatory measures.

(5) The Chairman invited Mr Bowles, a local Member, to speak. He thanked Dr Barnes for his openness at the meeting with HOSC and at a briefing with Swale Borough Council.

(6) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A question was asked about the completion of actions in the Trust's Improvement Plan which had been marked as commenced. It was explained that any actions which had not been completed were incorporated into the CQC Action Plan. One of the areas which had been commenced was the development of an estates strategy for the Medway site. This would include the construction of buildings fit for purpose and efficient working which would require a minimum of two years to acquire loan funding. Dr Barnes provided an update on serious incident training; a central team of investigators had been embedded within each of the clinical directorates.

(7) Concerns were expressed about the Trust's ability to make a change. Dr Barnes acknowledged that the Trust had previously lacked calibration and had not worked with outside partners sufficiently. He stated that the Trust had moved from a culture of denial; whilst the Trust had a world class neonatal unit, there were many areas which required improvements. The CQC rated the Trust good for caring which gave assurance to patients and staff.

(8) A number of comments were made about the monitoring of lower levels of the action plan; jeopardy of the Trust and board members; and staff morale. Dr Barnes stated that the Trust's most recent submission to the CQC contained both Trust level actions and detailed actions for each clinical divisions which

would be adjusted accordingly if not delivered. It was explained that jeopardy would be dependent on the level of failure. If there was ultimate failure, every staff member would be at risk of losing their job. The Trust's use of Schwarz Rounds was highlighted as a method to boost morale. Sessions for staff from all disciplines were available to discuss difficult emotional and social issues arising from patient care.

(9) In response to a specific question about the Listening into Action methodology, it was explained that it had been discontinued by the Trust as it had not been effective. The methodology brought together a group of staff who would be given a local problem and work towards an outcome for the Trust to implement. For a number of Trusts who had pioneered the methodology, it had been an effective way of engaging staff.

(10) A number of Members raised concerns about the CQC and the new acute regulatory model. Mr Angell stated that he had attended the Quality Summit and was impressed with Trust's response to CQC inspection report at the Summit.

(11) RESOLVED 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 and submit a two monthly report to the Committee.

63. CQC Inspection Report - East Kent Hospitals University NHS Foundation Trust (Written Update)
(Item 5)

Stuart Bain (Chief Executive, East Kent Hospitals University NHS Foundation Trust), Julia Bournes (Head of Outpatients, East Kent Hospitals University NHS Foundation Trust) and Mary Tunbridge (Divisional Director for Clinical Support Services, East Kent Hospitals University NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Bain began by expressing his disappointment with the CQC inspection report. He recognised that a number of improvements were required and were being addressed including engagement with staff, capacity, outpatient services and the quality of estate. He highlighted the caring nature of staff which was praised in the inspection report; in addition to the excellent mortality rates and clinical outcomes delivered by the Trust. Mr Bain welcomed the opportunity to share and discuss the action plan with the Committee on 10 October.

(2) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member welcomed the opportunity to discuss the Trust's action plan at the October meeting. He stated that he was not surprised with the CQC's findings from the anecdotal experiences of his constituents. He had concerns about the number of qualified staff but recognised their caring and compassionate nature.

(3) A Member enquired if the Trust would receive any additional money as a result of being placed into special measures. It was explained that the Trust would not receive any additional money. Monitor would appoint an external Improvement Director and buddy Trust who would provide guidance and

support in areas of weakness by the end of September. The Trust would be subject to enhanced monitoring each month to check the progress of the action plan.

(4) Cllr Lyons, a Governor of East Kent Hospitals University NHS Foundation Trust, informed the Committee that the Governors of the Trust had written a report to Monitor and the Health Service Journal with their concerns about the CQC inspection report. He stated that the Governors were united and supportive of the Trust.

(5) The Chairman invited Mr Bowles, a local Member, to speak. He thanked the Committee for putting this item on the Agenda and the guests for attending at short notice. Mr Bowles enquired if the Monitor appointed Improvement Director would be available to speak with the Committee. Mr Bain explained that the Terms of Reference for the Improvement Director were decided by Monitor; he stated he would feedback the comments to Monitor.

(6) RESOLVED 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.

64. East Kent Outpatients Services
(Item 6)

Stuart Bain (Chief Executive, East Kent Hospitals University NHS Foundation Trust), Julia Bournes (Head of Outpatients, East Kent Hospitals University NHS Foundation Trust), Mary Tunbridge (Divisional Director for Clinical Support Services, East Kent Hospitals University NHS Foundation Trust) and Simon Perks (Accountable Officer, NHS Canterbury & Coastal CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Tunbridge began by giving an update on East Kent Outpatients Consultation. The outcome of the consultation was discussed at the East Kent Hospitals University NHS Foundation Trust (EKHUFT) Board in June 2014 and NHS Canterbury & Coastal CCG Governing Body in July 2014. Both the Board and Governing Body agreed to implement the new outpatient strategy at their respective meetings.

(2) Following the decision to implement the strategy, mobilisation of the strategy had commenced. A number of developments were outlined including the opening of the new Dover Hospital in March 2015 and the implementation of extended working days and Saturday clinics. Further engagement would be undertaken through NHS Canterbury & Coastal CCG's proposed community networks.

(3) The Chairman invited Mr Gates and Mr Bowles, local Members, to speak. Mr Gates highlighted a letter circulated to the Committee by Save Faversham Hospitals which asked the Committee to recommend that the decision be deferred until the town Community Networks were in place and local health needs had been identified.

(4) Mr Bowles stated he disagreed with decision to implement the outpatient strategy. He raised concerns about the centralisation of services and the Trust's decision to subsidise public transport.

(5) Mr Bain responded to the comments made by the local Members. He stated that facilities were poor at the 15 outpatients' sites. The delivery of services at six fit for purpose sites would increase capacity with extended opening hours and Saturday clinics. It would also enable patients to receive their assessment, diagnostic tests and treatment plan on the same day at a one stop clinic. He stated that Kent was a challenging area to serve with its rural populations; some patients would face difficulty in reaching services wherever they were located. 80% of patients would access outpatients' services in a car either by driving themselves or being driven by a relative or carer. The Trust had been in detailed negotiations with Stagecoach to subsidise £450,000 of public transport to improve access.

(6) Miss Harrison reminded Members that she had attended the two option appraisals for the North Kent site on behalf of the Committee. She stated that the process was extremely fair with no bias in favour or against a particular site.

(7) Dr Eddy enquired about the transfer of outpatient services from Deal Hospital to Buckland Hospital. It was explained that acute services would move after the opening of Buckland Hospital in March 2015. The services would transfer as quickly as possible. The Scrutiny Research Officer agreed to arrange a meeting with Dr Eddy and NHS South Kent Coast CCG to discuss the future of services at Deal Hospital.

(8) RESOLVED 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.

65. SECAmb - Future of Emergency Operation Centres

(Item 7)

Geoff Catling (Programme Director, Estates, SECAmb), Sue Skelton (Deputy Director of Operations, SECAmb), Chris Stamp (Senior Operations Manager (Kent), SECAmb), Janine Compton (Head of Communications, SECAmb) and Patricia Davies (Accountable Officer, NHS Swale CCG) were in attendance for this item.

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

- The future of the Emergency Operations Centres (EOC)
- Drivers for reconfiguration
- Proposals for reconfiguration
- Preferred option – Two Emergency Operations Centres
- Initial Engagement Plan

(2) Ms Davies explained that NHS Swale CCG was the host commissioner of ambulance services on behalf of 22 CCGs and the resident population of 4.6 million people in Kent; Medway; Surrey; East and West Sussex; Brighton and Hove; and North East Hampshire. She stated that the CCG welcomed the SECAmb review of operational arrangements and the engagement that they were undertaking.

(3) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about collaboration with other emergency services. Mr Catling explained that SECAmb had been working closely with Surrey County Council on a project which looked at the collaboration of emergency services. Their research had found that in Surrey, only 0.9% of SECAmb responses were attended by another emergency service and 0.16% with both Fire & Rescue and Police. SECAmb were looking at the benefits of collaboration with Kent Fire & Rescue and Kent Police.

(4) A question was asked about the two options which were not chosen: the retention of three EOCs and the implementation of one large central EOC. Ms Compton explained that it would be expensive to retain three EOCs and they would be unable to expand due to limited space. It was stated that one EOC would not be resilient in the event of system failure. Under the proposed two EOC configuration, Mr Catling confirmed that both sites would be located on different parts of the BT Super Highway and National Grid which would make the EOCs super-resilient. Ms Skelton explained that in the event of system failure at one EOC, the other would be able to respond immediately.

(5) In response to a specific question about establishing a Centre of Excellence, it was explained that the EOC was already a Centre of Excellence. Under the proposals, there would be one Emergency Operations Centre which would operate over two locations in state of the art buildings. Clinical outcomes for patients and training for staff would be the same at each site. It was highlighted that staff at EOCs were highly trained and the Trust wanted to retain as many skilled staff as possible. If the Trust moved to one EOC, it was stated that this could affect some highly skilled staff.

(6) RESOLVED 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.

66. Patient Transport Services (Written Update)
(Item 8)

(1) The Committee received a report from NHS West Kent CCG which provided an update on the performance of the Patient Transport Services contract held by NSL Kent.

(2) RESOLVED that the report be noted and that CCG colleagues be invited to attend the November meeting of the Committee.

(3) The meeting adjourned until 13.30.

67. NHS England: General Practice and the development of services
(Item 9)

Stephen Ingram (Head of Primary Care, Kent & Medway Area Team, NHS England), Dr Mike Parks (Medical Secretary, Kent LMC) and Dr John Allingham (Medical Secretary, Kent LMC) were in attendance for this item.

(1) The meeting reconvened at 13.30. The Chairman welcomed the guests to the Committee. Members of the Committee then proceeded to ask a number of questions and made a number of comments.

(2) A Member enquired about the challenges of general practice. Mr Ingram explained that the role of the GP had changed with multi factorial challenges which included running a business; maintaining professional accreditation; complying with regulations; involvement with CCGs in addition to providing services to patients.

(3) A question was asked about succession planning. Mr Ingram stated it was extremely difficult to replace GPs on a like-for-like basis. Health Education England had set a target for 50% of all medical students to become GPs but this was not producing GPs as quickly as they were required. Dr Parks stated that the Kent LMC was actively discussing the fragility of the service and the importance of succession planning with practices.

(4) Mr Ingram and Dr Parks stressed the importance of the wider primary care team in managing GP workload. The use of nurse practitioners to deliver care for long term conditions; accreditation for community pharmacists and nurse practitioners to independently prescribe; and the introduction of physician associates, science graduates who complete two years of intense training, to support GPs in the diagnosis and management of patients were discussed.

(5) Dr Parks explained that Health Education Kent, Surrey and Sussex had identified recruitment to primary care as a key issue for the Deanery in particular the shortage of nurses in primary care. Dr Parks acknowledged that nurses in training had little experience of primary care. The Deanery was establishing community networks to provide mentoring and training for nurses in order to make it easier for them to move from acute to community roles.

(6) A number of comments were made about holistic care and GPs directly employed by the NHS. Dr Parks explained that GPs were generalists and closest to providing holistic care. He stated that the average consultation time had increased to 12 minutes. The Royal College of General Practitioners was campaigning for 15 – 20 minutes consultations as patients were attending with multiple problems. As part of a holistic approach, multiple problems could be assessed over a number of consultations with the most important being dealt with first. Mr Ingram stated than in his experience GPs directly employed by the NHS had not worked well.

(7) In response to a specific question about sustainability, Mr Ingram explained that the current model of general practice was not sustainable. Proposals for a new model of general practice included the introduction of place based services whereby an integrated team including GPs could provide health and

social care for their local populations. He stated that CCGs were developing community hubs, based around a clustering of GP practices and a local population, which could provide a wide range of services. He explained that there was a move away from single-handed GPs holding contracts as the challenges were more significant than those in a partnership or a company. Mr Ingram expressed concerns about the overinvestment in buildings rather than services. In Kent there were 260 practices which operated out of 400 buildings. The Local Area Team had concerns about the state and condition of 30 – 50 buildings in Kent and Medway.

(8) A question was asked about the attractiveness of being a GP. Dr Parks explained that General Practice was no longer attractive to medical students. A number of reasons were highlighted including long working hours, rising patient expectations, workforce pressures, partnership working, funding and increased regulation. This was leading to stress and burnout of experienced GPs. Dr Allingham added that with the feminisation of the workforce, many female GPs wanted to be salaried and work child friendly hours rather than take on the responsibility of a partnership. The average age for GPs to leave the profession was 35 – 39 for women and 55 – 59 for men, it was explained that many female GPs did not return to work after having children. Dr Allingham stated that he had recently met with 30 – 40 trainee GPs in Kent; only one trainee GP wanted to become a partner, 7 – 8 trainee GPs were leaving general practice and the remainder were going to practice abroad, become a salaried or locum GP. He stressed the importance of highlighting the interesting nature of the job to medical students such as unexpected and challenging problems brought by patients and new developments such as the Prime Minister's Challenge Fund.

(9) In response to a specific question about the difficulties faced by GPs returning to practice after a period of absence, it was explained that GPs had to undertake a refresher examination and scheme in which they worked full time in a training practice under the supervision of a trainer. GPs had to pay for the examination and often had to pay the training practice for supervision. Once a GP had completed the scheme, the trainer can write to NHS England Local Area Team to say the GP can rejoin the local performers' list. A Member requested examples of difficulties faced by GPs returning to practice. Representatives from the Kent LMC stated that they would be able to provide this.

(10) Mr Inett informed the Committee about a project, being undertaken by Healthwatch Kent, to look at patients' experiences of primary care in Kent. He explained that the CCGs had been approached and enquired if NHS England could input into the project. Mr Ingram stated that he would be happy to discuss the project with Healthwatch Kent.

(11) The Chairman asked the Committee for expressions of interest to join a working group, led by Mr Angell, to meet with Professor Tavabie (Interim Dean Director, Health Education Kent, Surrey & Sussex). Dr Eddy and Mr Chard indicated their interest. It was suggested that Mr Ingram, Dr Allingham and Dr Parks be given the option to attend.

(12) A Member thanked Mr Ingram for the paper which gave a national overview of general practice. The Member requested a Kent focused paper when the item returned to the Committee in six months. Mr Ingram stated that he would be happy to provide more detailed information on Kent which could be broken down by CCG area. He suggested that the Committee could look at one or two CCGs in detail and ask CCG representatives to also attend in six months.

(13) Mr Ingram gave an example of a unique feature of Kent; the county had the highest percentage of nationally negotiated General Medical Services (GMS) contracts in the UK. It was explained that the Local Area Team had little power over this type of contract. NHS England's preference for new contracts was Alternative Provider of Medical Services (APMS) contract as it was the only contract which met the requirements of procurement law. Kent LMC representatives stated their preference for nationally negotiated GMS contracts.

(14) RESOLVED that the report be noted and that NHS England (Kent and Medway Area Team) take note of the comments made by Members during the meeting and be invited to attend a meeting of the committee in six months.

68. Date of next programmed meeting – Friday 10 October 2014 at 10:00 am
(Item 10)

(1) The Chairman confirmed that CAMHS Tiers 1, 2 & 3 would return to the Committee on 10 October 2014.

(2) A number of Members raised concerns about the CQC and their inspection regime. A Member enquired if there was a strategic overview of quality issues in Kent. Mr Inett noted that a joint report on quality issues by Healthwatch Kent and Roger Gough would be taken to the Health and Wellbeing Board on Wednesday 17 September. Mr Godfrey confirmed that there was a HOSC section in the report which gave examples of the Committee's consideration of quality issues. It was agreed the Scrutiny Research Officer would circulate the paper to the Committee when the Agenda was published on Tuesday 9 September.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 10 October 2014

Subject: Child and Adolescent Mental Health Services (CAMHS) – Tiers 1, 2 & 3

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

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

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1. Introduction

(a) The Health Overview and Scrutiny Committee considered reports on Child and Adolescent Mental Health Services (CAMHS) in Kent on 31 January 2014, 11 April 2014 and 6 June 2014.

(b) On 11 April 2014 the Committee considered updates provided by NHS West Kent CCG and Sussex Partnership NHS Foundation Trust. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) this Committee continues to be concerned for the CAMHS service in Kent and recommends that the commissioning of this service is investigated by KCC and West Kent CCG.

  (b) West Kent CCG be asked to give due regard to the recent KCC Select Committee on Commissioning.

  (c) West Kent CCG and Sussex Partnership colleagues be invited to the Committee meeting in 6 months' time and the CCG submit two monthly update reports to the HOSC.

(c) On 6 June 2014 the Committee considered a letter from the Secretary of State for Health. At the conclusion of this item, the Committee agreed the following recommendation:

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

(d) A joint response and update on performance across the four CAMHS tiers in Kent was circulated to Members on 24 July.

2. CAMHS – Tier System

(a) Mental health services for children and young people in England are organised in a four tier system (NHS England 2014). The tiers are described below:

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

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

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

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

3. Recommendation

RECOMMENDED that the 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 be invited to submit a progress report to the Committee within six months.

Background Documents

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (31/01/2014)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=27048

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (11/04/2014)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=27877

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (06/06/2014)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5397&Ver=4

NHS England (2014) *'Child and adolescent mental health services (CAMHS) (26/06/14)'*, http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Pages/about-childrens-mental-health-services.aspx

Contact Details

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By: Andrew Ireland, Corporate Director, Social Care Health and Well-being

To: Health Overview and Scrutiny Committee

Date: 10th October 2014

Subject: Emotional Well-being Services for Children and Young People

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Summary: On behalf of the Health Overview and Scrutiny Committee, the Chairman has requested some supplementary information to the CAMHS report from SPFT and West Kent Clinical Commissioning Group.

This report describes the emotional well-being services (tiers one and two) in Kent and Kent County Council's role in the commissioning and development of emotional well-being and mental health services in Kent.

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1. Background

1.1 The Ofsted review in 2010 found that the outcomes for children and young people in care were inadequate, which led KCC and partners to review all provision including mental health and emotional well-being and establish a framework for early intervention and prevention services. At that time there was disparity across the county with lots of small contracts delivering services that were not appropriately procured, without a quality framework or parity of access. This led KCC to work with partners as part of the Improvement programme to design a suite of services which were complementary and provided a range of services across tiers (or levels) of need. There have been improvements since this time, which Ofsted has recognised. However the service providers and partners continue to realise that there is still work to do to ensure sustainability for the future.

1.2 In July 2011, Kent County Council Cabinet Members and NHS Kent & Medway agreed to align funding in order to jointly commission new emotional well-being and mental health services for children and young people. This decision was made in response to significant evidence identifying the need to establish a more integrated system that would enable interventions to be delivered to children and young people in a more targeted and timely fashion.

1.3 It was agreed that the new services would take the form of an emotional well-being service delivering support within community settings (Tier 2), alongside a 'Community Child Adolescent Mental Health Service (CAMHS)' model comprising targeted (Tier 2) and specialist (Tier 3) mental health services. Each element of service would be aligned to ensure clear pathways for children and young people between the different tiers. Within this model it was also agreed that there would be a distinct offer for Children in Care (CIC) that could provide additional targeted support to foster carers and the professional network where there were mental health concerns about a child

or young person in care. KCC aligned funding into the CAMHS model to specifically support this aspect of provision for Kent Children in Care.

1.4 KCC led the procurement of the emotional well-being service and the NHS led the procurement of the CAMHS service. The emotional well-being service was specifically designed to meet need where mental health services end. Both contracts were awarded in September 2012 for a period of three years. Both contracts are subject to regular performance monitoring.

1.5 KCC and NHS commissioning and clinical/operational staff worked together to develop the specifications for both services.

1.6 Since then the Division of Early Help and Preventative Services (within KCC's Education and Young People's Services Directorate) has been established to provide integrated support for children, young people and families who are at risk of having poor outcomes.

1.7 Emotional well-being and mental health services are currently commissioned at four levels:

Tier 1 – support delivered within universal settings i.e. GPs, schools, youth clubs etc.
Tier 2 – targeted support e.g. accessed through referral including self-referral
Tier 3 – specialist support for complex needs
Tier 4 – specialist support for acute needs

See Appendix 1 for information about tiers of services.

2. KCC's role in developing emotional well-being services

2.1 Emotional well-being, like mental health, is everybody's business. As part of the 0-25 Transformation Portfolio, the Early Help and Preventative Services Division is in the process of establishing a new offer to support opportunities for children, young people and families that will assist them in achieving positive outcomes and reduce the demand on specialist children's services.

2.2 Four key priorities have been established for early help and preventative services which shape the work of the Division. These are:

- Safety - keeping vulnerable and disadvantaged children and young people safe without the need of specialist services, providing support earlier so that their needs do not escalate.
- Health – reducing health inequalities to ensure that we improve physical and mental health outcomes, helping young people avoid substance misuse and risky behaviours,
- Participation and Achievement – ensuring children participate in education and achieve good outcomes,

- Resilience – helping children and families to be resilient and overcome barriers, promoting good emotional and mental health and able to make informed choices.

3. Current emotional well-being services

3.1 Referrals to Specialist Children's Services

Last year KCC had 14,304 referrals to Specialist Children's Services (SCS). Of these 69% went on to an assessment and were related to domestic abuse, emotional well-being or neglect, and 31% did not meet the criteria for a SCS assessment and should be signposted to Tier 1 services.

3.2 Externally Contracted services

KCC are the lead commissioner for the Young Healthy Minds (YHM) service which operates alongside the Tier 2 element of CAMHS. The provider of YHM supports and provides a service to 1,500 children and young people a year. See Appendix 2 for further performance information.

In addition to YHM which is specifically focused on emotional well-being issues, all other external services contracted to provide early help are expected promote emotional well-being as part of their work. Monitoring information suggests that approximately 60% of the issues these organisations address are related to emotional health.

3.3 Children's Centres

Children's centres are universal settings that provide a range of support to children aged 0-5 and their families, many of which contribute to emotional well-being. Examples include antenatal and postnatal support groups, healthy lifestyle programmes, peer group support programmes around issues such as breastfeeding and infant care, and access to targeted parenting programmes.

3.3 Schools

Schools also commission a range of emotional well-being support services, which are purchased at an individual school-level and responds to the needs of children and young people within the school community.

4. Finance

4.1 The Children's Commissioning Unit is currently responsible for services with an annual budget of £5.8m for early help and preventative services, of which £800,000 is for YHM. These services address the wider context of children, young people and families' emotional well-being. In addition, Public Health support wider community initiatives such as health visiting and Healthy Lifestyles which positively impact upon outcomes for Kent's children and young people.

5. Emotional Well-being Strategy

5.1 As a response to the disparate and unconnected range of provision, services and commissioning arrangements which was identified by HOSC in early 2014, a partnership response has been galvanised as a proactive attempt to fundamentally improve the whole emotional well-being response in Kent.

5.2 In April 2014, the Children's Health & Well-being Board approved the establishment of a Task and Finish Group with the remit of leading a multi-agency Emotional Well-being Summit (July 2014). The aim of the group was to set the strategic direction for future delivery of emotional well-being services, including mental health. Following the summit the group is overseeing the development a multi-agency emotional well-being strategy.

5.3 The draft strategy, provisionally entitled 'The Way Ahead', has been developed at pace by partners on the Task and Finish Group, guided by the findings of consultation exercises with children, young people and families as well as views expressed at the Emotional Well-being Summit.

5.4 The Strategy sits beneath the Kent Joint Health and Well-being Strategy, and forms a key part of the response to two of its overarching outcomes: to ensure that 'every child has the best start in life' and that 'people with mental health issues are supported to live well'. *The Way Ahead* has adopted a complementary approach, and sets out a framework of four key outcomes (with promoting emotional well-being as a fifth overarching outcome, to be delivered across each level of need). The document is currently being developed to adopt the same visual format, emphasising the relationship between the two strategies.

5.5 The framework of outcomes within the strategy is as follows:

Outcome 1: Early Help: Children, young people and young adults have improved emotional resilience and where necessary, receive early support to prevent problems getting worse.

Outcome 2: Access: Children, young people and young adults who need additional help receive timely, accessible and effective support.

Outcome 3: Whole-family approaches: Children, young people and young adults receive support that recognises and strengthens their wider family relationships

Outcome 4: Recovery and Transition: Children, young people and young adults are prepared for and experience positive transitions between services (including transition to adult services) and at the end of interventions.

5.5 Promoting emotional well-being is envisaged as a 'golden thread' running each of these four outcomes, and influencing activity at each level of need.

5.6 Part 2 of the strategy will be a Delivery Plan. This is currently in development. This will inform future KCC and CCG commissioning intentions. It will be taken to the Children's Health and Well-being Board for consideration in February 2015, with the aim of implementation beginning at the start of 2015/16.

6. Future commissioning plans

6.1 Contracts for existing commissioned services from Tiers 2-4 (delivered by Young Healthy Minds, Sussex Partnership Foundation Trust and South London and Maudsley NHS Trust) are all due to end in October 2015, with option to extend for up to two years. Decisions will need to be taken within the next few months to determine what actions should be taken in relation to the future of these arrangements. Any decision will be informed by the Emotional Well-being Strategy and forthcoming Delivery Plan. This will be considered by the Children's Health & Well-being Board.

7. Recommendation

Members are asked to

(i) NOTE the content of the report.

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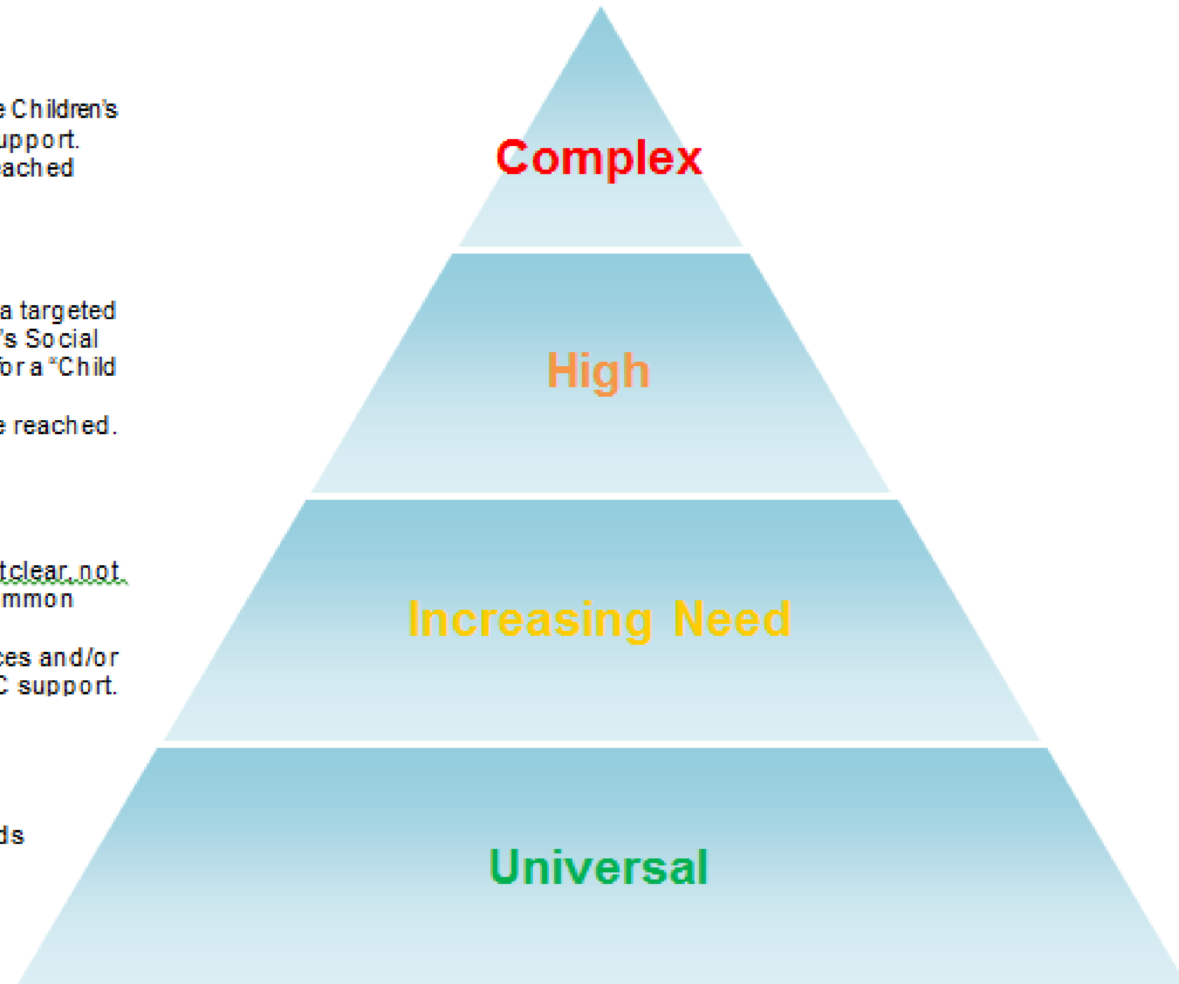
Appendix 1 – Tiers of services

Tier 4
Acute needs requiring urgent, intensive Children's Social Services / Care statutory support.
Threshold for child protection reached

Tier 3
High level complex needs requiring a targeted integrated response from Children's Social Services / Care. This is the threshold for a "Child in Need".
Threshold for child protection may be reached.

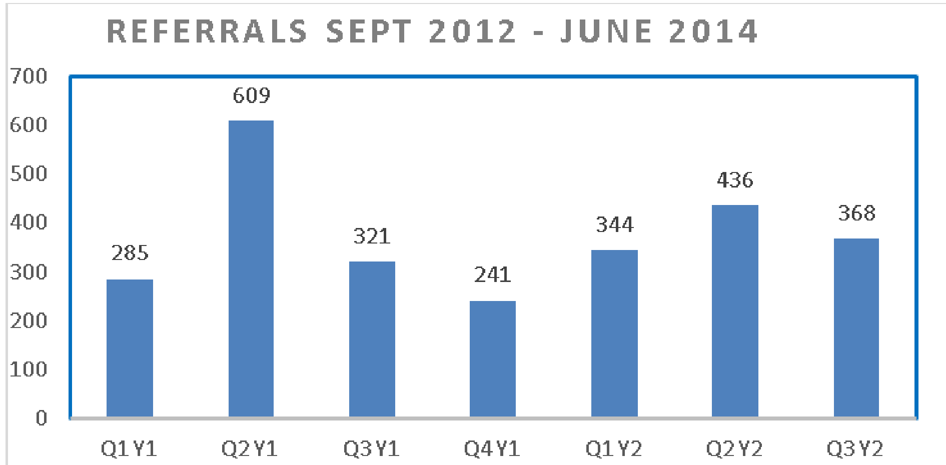
Tier 2
Targeted early intervention. Needs not clear, not known or not being met. Use Common Assessment (CAF).
Response is universal support services and/or targeted preventative services and TAC support.

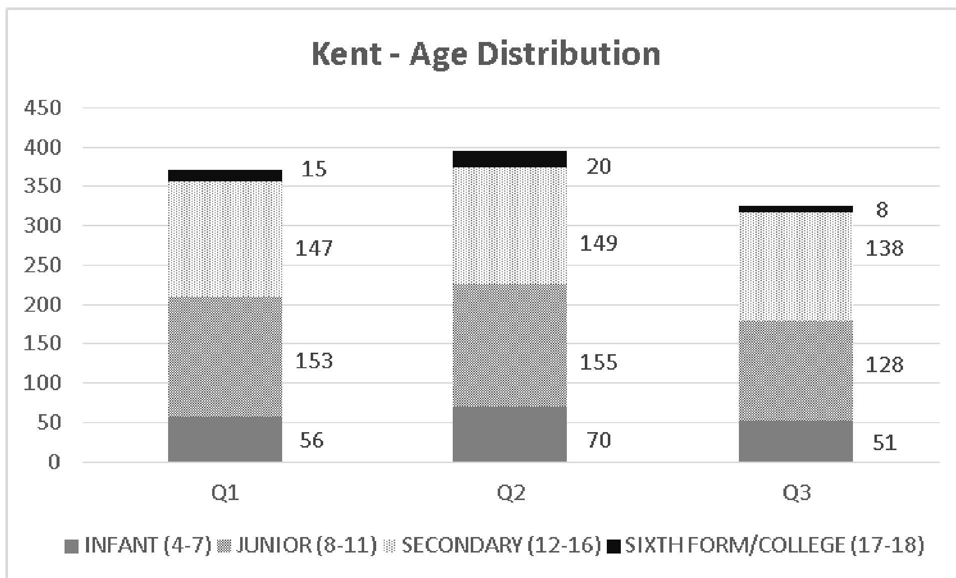
Tier 1
No identified additional needs
No identified risks
CAF not required



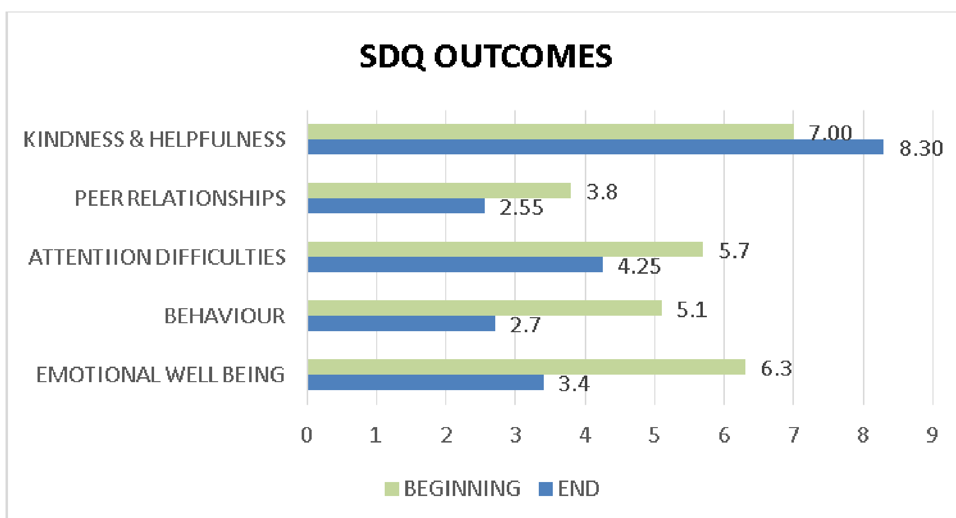
Performance data from Young Health Minds

Appendix 2





The highest incidence of age is 10 (38), followed by 9 (37) then 12 (35) and 15 (35). Primary and Secondary needs are fairly evenly distributed. In East Kent there are marginally more secondary pupils (51%) but in South Kent there are significantly more primary pupils (63%).



The Strengths and Difficulties Questionnaire is used as an outcome indicator.
With the exception of Kindness and Helpfulness which is positive if it ends higher, all other scores show **improvement if they are lower**. The blue represents the end in all but Kindness and Helpfulness where green is the beginning and shows improvement if blue is higher.

NHS
West Kent
Clinical Commissioning Group

Child and Adolescent Mental Health Services

Patient focused,
providing quality,
improving outcomes

SEPTEMBER 2014

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) UPDATE

SUMMARY

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

RECOMMENDATIONS

The HOSC is asked to:

Note the report and comment.

1. Background

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

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

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

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

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

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

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

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

- Tier 4 (specialised mental health) services were retendered the year before (2010/2011) and are commissioned by NHS England. The main Tier 4 CAMHS provider for Kent is South London and Maudsley NHS Foundation Trust (SLaM), although Kent residents have access any tier 4 bed commissioned by NHS England. The SLaM contract is managed by the London Area Team on behalf of NHS England.

2. Current national picture

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

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

- Following publication of the Health Select Committee inquiry into children's mental health and emotional wellbeing services, including CAMHS, NHS England have commissioned 50 new Tier 4 beds across England. Prior to this exercise in recognition of the bed shortage, providers with immediate capacity were supported to increase bed numbers on a short-term basis, whilst awaiting the findings of the Tier 4 National CAMHS review. In the Kent area, Cygnet opened an additional temporary eight Tier 4 CAMHs beds. The beds can be accessed by all areas in England and are not ring-fenced for use just by individuals from Kent and Medway.

- On 10th July 2014 NHS England published a report on the provision of CAMHS Tier 4 services. In response to the findings, NHS England will urgently:

    - Increase general CAMHS specialised beds for young patients – there will be up to 50 additional permanent beds commissioned;
    - Recruit 10 – 20 new case managers working across the country responsible for ensuring that young people received appropriate levels of care; and
    - Improve the way people move in and out of specialised care, with consistent criteria for admission and discharge, based on best practice.

- A longer term strategic review of Camhs services will now be carried out as part of NHS England's wider work on specialised services.

3. Sussex Partnership Foundation Trust (SPFT) contract performance

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

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

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

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

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

- Until recently, there had been a rise in the number of complaints from parents and MPs, together with interest from local media. This has reduced.

- The Kent Health Overview and Scrutiny Committee have requested two monthly reports on progress and Camhs will be on the October 2014 agenda.

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

- There was no identified Section 136 suite available for young people under 18 in Kent.

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

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

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

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

- There was a temporary agreement with SLaM to use their Section 136 suite at the Bethlem Royal Hospital in London whilst commissioners locally developed a local S136 solution.

- A Kent 136 place of safety is now in place, based in Dartford. This is a delivered through an agreement between KMPT and SPFT. This solution has been welcomed by Kent Police through the Strategic Police Partnership Board.

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

5. Progress to date

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

- SPFT has cleared the backlog from 1/4/13 and has prioritised assessing children to enable them to be treated in clinical order.

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

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

- A performance notice was served on SPFT by NHS West Kent CCG as the co-ordinating commissioner in February 2015. The trust produced a recovery plan to deliver rapid improvements to ensure compliance with contract standards for waiting times for routine referrals (4-6 weeks from referral to assessment and 8-10 weeks from referral to commencement of treatment). Since February performance has been regularly monitored on a weekly basis to ensure compliance. The actions have seen full achievement of contract key performance indicators by the end of August 2014. The CCG is now assured that the current contract performance regime can end. SPFT are putting forward new plans to ensure sustainability.

- Dr Steve Beaumont, NHS West Kent CCG's Chief Nurse, has met with SPFT to agree a quality dashboard and a process for reporting serious incidents. This dashboard is now part of the monthly contract performance regime.

- NHS West Kent CCG has agreed with KCC and the Health and Wellbeing Board to jointly review commissioning arrangements for CAMHS with a view to bringing the commissioning of Tier 1 to 4 services into an integrated approach. This will help resolve some of the problems created by the current fragmented commissioning process. This review will also consider issues of transition and the interface with education and other agencies. A stakeholder summit in July 2014 launched the strategic review, including plans for the development of a children's emotional health and wellbeing strategy.

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

6. Current position

- Weekly performance monitoring and feeding the information back to the frontline teams has helped to establish process, structure and workforce data capture that previously caused concern and impacted on the trust's ability to keep partners informed.

- The impact of the additional focus since February can be seen clearly in the July trend graphs with a significant decrease waits for assessments and treatments offered, now back to contract targets. However, demand for the service continues to rise.

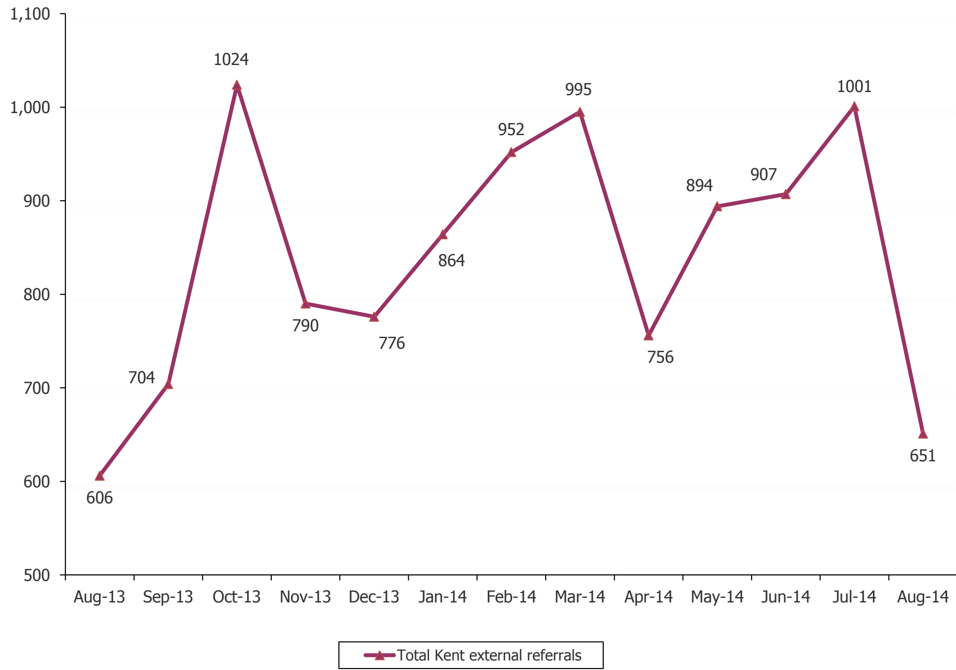
- The numbers waiting for treatment has significantly reduced. All new referrals will now be treated within target time, and work continues to clear the long wait backlog. The small remainder of treatment waits will be cleared by December 2014. The target of 8 to 10 weeks wait from referral to treatment has been difficult to achieve for all as the current figure is impacted by a number of long wait patients skewing the average figure as the data recording process is from referral to treatment.

- A peer review of the performance plan and the current model of service has been undertaken by Oxford Health CAMHS, this was a required action from the Jan 2014 HOSC, findings will be available end of October 2014.
- Quality and serious incidents data is now part of the monthly performance regime. This has provided improved assurance.
- Recent performance data from SPFT is continuing to show clear improvements to waiting times.

Summary of achievement against business continuity plan

		Plan	Actual (Feb-Aug)	Variance
↑	Referrals received	5100	6153	1053
↑	Sign-posted to other services	1172	1382	210
↑	Emergency referrals	537	610	73
↑	Choice appointments offered	4020	5014	994
↓	Total contacts	42095	39110	(2985)
↑	Total discharges	6001	7246	1245
↓	Total caseload	8408	8314	(94)
↓	Waiting-list to assessment Aug-14	601	563	(38)
↓	Waiting-list to treatment Aug-14	440	323	(117)

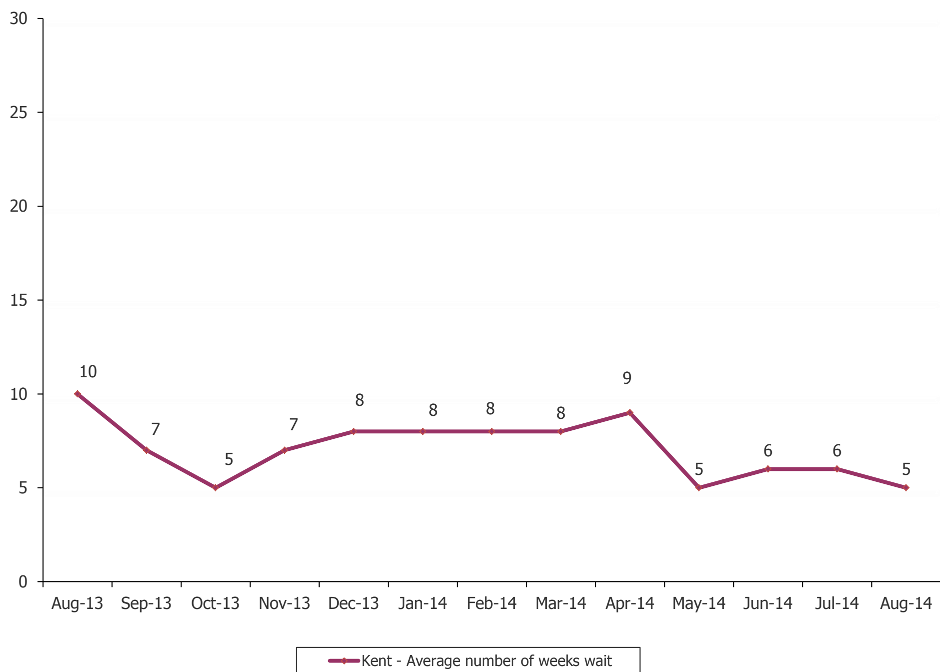
Number of referrals (Kent-wide) July 13 - July 2014 ↓



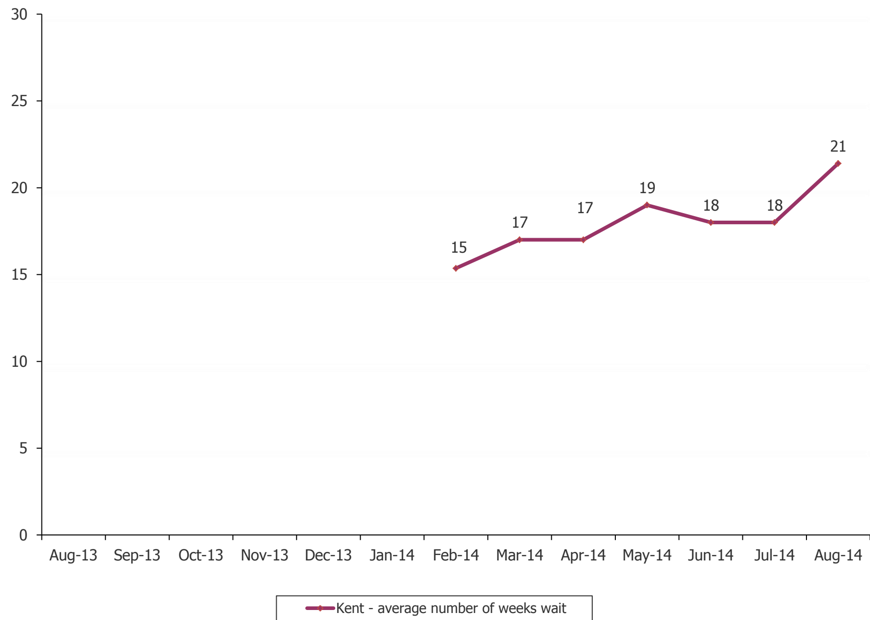
Numbers waiting for Assessment (Kent Wide) July 13-July14 ↓

Numbers waiting for treatment Kent-Wide July 13-July14

Average weeks waiting for routine assessment from referral Kent-Wide July 13–July 14



Average weeks waiting for Treatment from Referral



- SPFT will continue to produce weekly situation reports for its teams and the CCG, which are continue galvanise further action and provide reassurance that the achievements of the recovery plan continue to be progressed.

- A contract refresh for 2014/15 has been completed to capture the required performance improvements, this has included for the first time a contract CQUIN to improve transition arrangements between children's and adult services.

- Vacancy levels at SPFT continue to fall.

- Meetings have been held across the CCG's to examine 'pinch points' in the system and develop action plans to alleviate immediate pressures whilst the strategic review commences.

- The new Section 136 arrangements are progressing, activity has decreased following an early spike when the new service commenced. Further developments and increase in provision are planned linked to the mental health crisis care concordat requirements.

- The July whole system emotional and wellbeing summit and the September Children's Health and Wellbeing Board has agreed to the development of new children and young people's emotional and wellbeing strategy and the development of a new model of service across all tiers of activity by December 2014.

- The new agreed children's and young people emotional and wellbeing model will be embedded in new contract arrangements post Aug 2015, this is when the current SPFT, SLAM and young healthy minds contracts end.

List of background documents

DH NHS Outcomes Framework

No Health Without Mental Health 2011

Draft Kent and Medway Emotional Wellbeing and CAMHS Strategy 2012

Kent Health and Wellbeing Strategy 2012

Health and Social Care Act 2012

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CHILDREN ADOLESCENT MENTAL HEALTH SERVICE REPORT

August 2014

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What is Healthwatch Kent?

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

What we do?

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

Our Mission Statement

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

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

Our Values

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

Background

Healthwatch Kent has heard concerns from members of the public, voluntary organisations and health professionals from all over Kent about the Children Adolescent Mental Health Service (CAMHS).

At Healthwatch Kent we heard these concerns and wanted to investigate further to identify some of the issues and make recommendations for the future. We also wanted to clarify that some of the plans around improvements to the service we being made and if they were being experienced by the patients and their families.

Healthwatch Kent commissioned Activmob to undertake a 'shallow dive' engagement project to better understand the concerns that have been raised. The issues raised related to diagnosis, access, engagement, waiting times, quality of service amongst others.

Kent is currently undertaking a review of the delivery of CAMHS services. Healthwatch Kent are seeking to add value to this review by ensuring the public voice is fully heard and by understanding the reality of the service by speaking to people who are accessing it.

The services are being reviewed due to experiences from Kent residents that the service is not performing well and the fact that data has not been released from CAHMS.

It is important to note, that this report reflects only what patients and their families told us. There are many aspects of the CAMHS service that are not mentioned in this report such as provision within schools.

Our Objectives

The objectives of the review were :

- To talk to patients, their families and carers, as well as staff and stakeholders, to understand the reality faced by people using the CAMHS service

- To assist and add value to the current review of the service that is already underway by ensuring the public voice is fully heard. We do not want to reinvent the wheel

Our Approach

We undertook a combination of desk research and talking to people.

There are already many reports relating to the performance of the CAMHS service which we have reviewed.

We've also spoken to families, patients and professionals either face to face or over the phone using our Topic Guide (appendix 3) to develop an up-to-date picture of the current issues and concerns around the service in Kent

Key stakeholders were identified primarily from within local carer groups and the community using the Healthwatch website and newsletter to make people aware of the study and to invite people to participate.

In depth face-to-face conversations were had with 15 individuals, 2 carers groups and a further 15 -20 people were involved either over the phone or via email. The Topic Guide was used to stimulate and guide the conversations. As the study progressed, further families and their children made contact in order to share their experiences. Interviews were carried out throughout May and June.

The aim of the engagement was to ensure families and others who would not normally be spoken to be included to capture their experiences. Insights were also gathered in relation to routes of access into the service (GP's, schools) and their effectiveness.

Context:

To enable the reader to fully understand the issues as presented in this report it is necessary to provide information related to the history of CAHMS in addition to the legislative framework within which it is set. Significant information related to this section is listed in the appendices for further and more in depth reading.

What is CAMHS?

Children and Adolescent Mental Health Services (CAMHS) provide a range of services for children and young people 0-18.

The services are commissioned and provided at four levels:

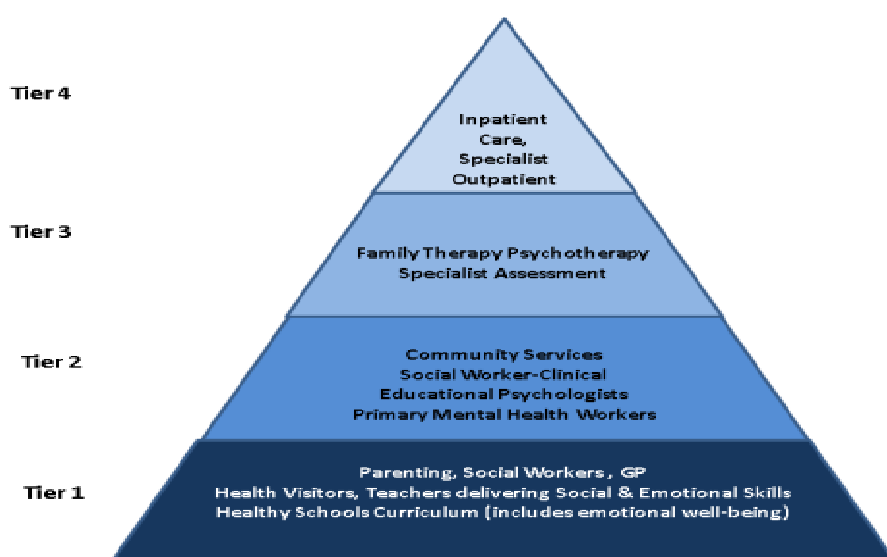
Tier 1 – support delivered through non specialist primary care workers such as GPs, health visitors, school nurses, teachers etc. This level could include an issue often picked up at school. For example when a child has low self esteem and the school will look to see how to boost their confidence.

These services are provided by Healthy Young Minds and is commissioned by Kent County Council.

Tier 2 – targeted support delivered through Sussex Partnership Foundation Trust (SPFT). West Kent Clinical Commissioning Group co-ordinates the commissioning of this service on behalf of all the CCGs in Kent & Medway.

Tier 3 – specialist support delivered through Sussex Partnership Foundation Trust (SPFT). West Kent Clinical Commissioning Group co-ordinates the commissioning of this service on behalf of all the CCGs in Kent & Medway.

Tier 4 – specialised mental health services commissioned by NHS England. The current provider is South London & Maudsley NHS Foundation Trust (SLaM). They provide both day and inpatient services plus some highly specialised outpatient services to treat severe and complex mental health issues in children and young people.



A brief timeline of CAMHS policy in England can be found in appendix 1 of this document.

Legislation;

There are several pieces of legislation that have a direct impact on the rights and responsibilities of children, young people, their parents/carers and service providers involved with the CAMHS service, most notably;

Parental Responsibility is defined by the Children Act 1989 as being all the rights, duties, powers and responsibility that a parent of a child has in relation to the child and his or her property. It includes rights and duties with regard to education, choice of religion, administration of a child's property, choice of residence and choice of medical care. It is important to

note that all the provisions of the Children Act 1989 are subject to the guiding principle of the child's best interests.

The Mental Capacity Act 2005 gives protection to anyone over the age of 16 who may lack capacity to make a specific decision. Up to the age of 16, the Children Act 1989 applies, giving the right to make decisions to those with parental responsibilities.

There is no lower age range for The Mental Health Act 1983 (amended 2007), which provides for detention in acute hospital for the treatment and care of a 'mental disorder of the mind or brain'. The MHA also provides for detention by the police (section 136) under specific circumstances*

The Human Rights Act says that all children and young people under the age of 18 have certain rights. The Convention is separated into 54 "articles", or sections. The rights in the treaty include the right to education, the right to play, the right to health and the right to respect for privacy and family life.

The Children Act 1989 (amended 2004 'Every Child Matters') brought into being the Common Assessment Framework (CAF) a tool to help practitioners working with children, young people and families to assess children and young people's additional needs for earlier, and more effective services, and develop a common understanding of those needs and how to work together to meet them.

CAMHS in Kent

There has been much in the local and national media attention about the CAMHS service and it is beyond doubt that there is recognition that there are national issues with the CAMHS service including high demand, limited capacity and a complicated service.

The provision of Tire 2 and Tier 3 have been the subject of particular scrutiny in Kent, with concerns focussed on the length of wait for assessment and treatment. In March Sussex Partnership Foundation Trust (SPFT) published a report detailing the progress made since taking on the contract.[1] Length of waiting lists have been a long-standing criticism of Kent CAMHS, with reports of 18-month-long waits for assessments. Average waiting times - as well as numbers waiting for assessment - have come down, year on year (Dec 2012 - Dec 2013), in Dartford and Gravesham, Maidstone, Tunbridge Wells, Medway, and Swale. It has increased in Ashford, Canterbury, Dover, Shepway and Thanet.[2] The contract standard is 4-6 weeks wait from referral to assessment, and 8-10 weeks from referral to treatment.

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[1] SPST CAMHS Update, March 2014: date accessed: 14th June 2014
[2] *Ibid*, page 4.

When SPFT took over the Tier 2 & 3 provision in Sept 2012, they inherited long waiting lists from the previous contract holders, with the majority of problems faced in West Kent. This has led to considerable delays for assessment and treatment. Addressing the waiting list problems has largely been tackled by restructuring the team structure which in turn has led to high levels of staff vacancies which compounded the problem of waiting times. Dartford and Gravesham has clearly presented a particularly difficult case and SPFT have employed temporary staff through agencies. Overall, SPFT report that they have made 'good progress' in their overall recruitment drive.

In March The 'open caseload' was said to stand at 10,077, with many young people 'inherited by the service' being continuing to be reviewed annually.[3] It was clear that the number of young people waiting for assessment was far greater than anticipated through the tender process.[4] The challenges facing SPFT and Kent CAMHS this year were presented by Jo Scott (SPFT Programme Director for Kent CAMHS) and put to the Health Overview and Scrutiny Committee (HOSC) in April 2014:[5] She outlined the following areas:

Introducing a Common Assessment Framework (CAF) across the county - whilst this is intended to make access to higher tier services (tier 2 upwards) easier, some families are said to feel as though they are being 'pushed back on' by more paperwork.

Out of hours and inpatient admissions - SPFT have put in place an out of hours service, which they state accounts for 10% of service activity. Jo Scott stated that they hugely underestimated the number of out of hours emergencies - having predicted 120 in a year and exceeding that number after four months. There is a national issue around the lack of beds for inpatient admissions. NHS England are reviewing the situation.

Review of team structure and service organisation - this undertaking has led to high levels of vacancies in certain key positions, 'which compounded the problems clearing waiting lists'. There has also been an introduction of computerised systems where, in parts of Kent, only manual records had previously existed. Although some vacancies do still exist, the number has been reduced.

Section 136 of the Mental Health Act - a strategic partnership group has been set up between Kent Police and mental health service providers, but there is concern amongst local MPs, parents and the media that children are being left to wait in A&E. At the time of Jo's report there was no 'place of safety' in Kent for Section 316 detainees with children needing to be transported to the designated place of safety at Bethlem Hospital in London.[6] **This is now in place** in Dartford through an agreement between SPFT and Kent & Medway Social Partnership Trust.

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[3] *Ibid,* page 6.
[4] West Kent Clinical Commissioning Group - CAMHS Update, 11th April 2014.
[5] http://connect.kent.public-i.tv/site/player/text.php?a=130293&m=flash - date accessed: 14th June 2014.
[6]SPST CAMHS Update, March 2014.

Criticism of the SPFT record in Kent was put to HOSC in the same meeting. Tunbridge Wells MP, Greg Clark, was sceptical of significant improvements to waiting times, but was also critical of the communications systems in place for CAMHS in Kent, with contact numbers missing from websites. Staff shortages and poor levels of treatment were also highlighted, with an over-reliance on just one psychiatric nurse (and unqualified counsellors working in her absence) offered as one example.

There was also a frustration that children were being allowed to reach crisis point, thus requiring higher-tier services. There is concern that not enough is being done to support schools and parents in the recognition of lower-tier mental health problems. HOSC requested to see reports every other month on progress.

In addition, Children's and Adolescents' Mental Health Services (CAMHS) are currently the focus of a national inquiry led by the House of Commons Health Select Committee. See Appendix 2 for further detail.

We met with the commissioners of the CAMHS service, West Kent Clinical Commissioning Group, in July 2014 to discuss our initial findings. At that point they had served a Performance Notice on SPFT. This requires the Trust to produce a recovery plan and deliver rapid improvements particularly around waiting time. They anticipated the contract to meeting waiting time targets by August 2014.

In addition West Kent CCG have agreed with Kent County Council and the Kent Health & Well Being Board to jointly review commissioning arrangements for CAMHS. The aim is to integrate the commissioning of all four Tiers to prevent the current gaps in provision. A summit was arranged for July 2014 to discuss the strategic review. Unfortunately Healthwatch Kent were not invited.

At the same time (July 2014), NHS England published a report on the provision of Tier 4 CAMHS services. At a national level, they have pledged the following:

- To commission up to 50 additional beds across the country (we understand that a 8 additional beds have been secured in Cygnet in Sevenoaks but these are not guaranteed for Kent based patients).
- To recruit up to 20 new case managers across the country
- To improve the way people move in and out of Tier 4 care with consistent criteria for admission and discharge.

What People Told Us

The key themes from our conversations with patients and their families were:

Waiting times/access

Most parents/carers were very critical of the delay in access to services and the impact this has on the mental health of the young person involved.

"*What starts out as a tier 1 or 2 is a tier 4 by the time you are seen*".

The experiences of GP support and understanding is not consistent, some GPs have an interest and some knowledge around mental health and where this is the case, referrals are seen to be made sooner and progress more quickly, in other cases GP's assumption that an eating disorder may be a lifestyle choice or that the symptoms may be because the young person is '*growing up or being a teenager*' indicates that GP education and understanding regarding mental health is inconsistent.

The assumption that a referral automatically generates an appointment also causes a sense of frustration and anxiety as parents/carers report that a referral may be followed by a phone call rather than an appointment six weeks later and attempts to chase can result in the response that '*we have children with a greater need*'.

There is a sense that entering the service requires a level of skill and understanding of the system and how this should be done, as an example, understanding the 'code' or 'label' which generates a higher place on the waiting list is important as this code or label determines when your child may be seen '*putting OCD first, and anorexia second will put you lower down on the list*'. Some parents report that they have to be referred several times and '*it's a fight to see anyone*', particularly if the young person has multiple needs.

Specialists are seen as important in understanding the condition; however the understanding is that there are not enough hours of specialism available as many work part time. Some parents reported that they felt that they were offered alternatives such as parenting classes as a delaying tactic. Some parents felt that there is a significant gap given that Asperger's conditions are not supported via CAMHS.

Diagnosis

Once in the system, parents/carers find the process of diagnosis confusing and in some cases unhelpful. There is little if any support pre diagnosis, particularly once the young person is on a waiting list. Parents/carers and their children are left to manage symptoms and behaviours themselves

which can often mean deterioration in mental health, the only option for some is a visit to A&E or to call the police.

Until very recently Kent did not have a designated ‘place of safety’ for young people detained by the police under section 136 of the Mental Health Act. Young people would be taken to the designated place of safety at the Bethlem Hospital in London. **This has recently been put in place**.

Long waiting lists of up to 18 months for a specialist may result in the initial diagnosis being overturned with the prospect of another long wait for an alternative specialist. In addition there is an understanding that young people must ‘*fit in with the diagnostic tool’* and be considered serious enough to warrant help, a checklist for diagnosis can mean that you are not seen ‘ *my daughter was not seen as severe because she was still having periods’.*

Pathway and journey

From beginning to end, all the parents/carers we spoke to relayed a series of confusing, frustrating and complex experiences regarding the journey through CAHMS, one stating; ‘*this is a secret world designed to stop people accessing it’*.

Most parent/carers found navigating the system difficult and confusing. There is very little information regarding who delivers what part of the service. Most online information is out of date or missing, there is no clarity as to who the delivery partners are; where they are based and who works for them or what the pathway through the service may look like for those who use it.

Most found it difficult to build relationships with service providers and workers; a high turnover of staff was cited as one of the most frustrating elements as young people are encouraged to open up and talk about themselves, but when they do this, by the next visit the person has left ‘*my daughter says she doesn’t want to talk with anyone else because as soon as she gets to know someone and trust them, they move on.*’

The lack of a holistic approach to the young person and the insights that can be provided by parents/carers being dismissed was seen as a major issue in relation to the service. Some parents/carers felt that ‘*you get nothing from the hospital, but they want to know everything about you’* was an attitude reflected through the system. Perceptions are that it is secretive service, designed to be confusing and ‘all powerful’, effectively it is ‘*CAHMS or nothing’*.

Experiences

Parents/carers reported that experiences may differ depending on the age of the child. In general those children who entered the system prior to

school age had a better experience than those entering later. Those transitioning from primary to secondary school and from young person to adult services also seemed to have service issues, parents reported that there was a lack of willingness to take responsibility through the transition and it was someone else's problem, parents questioning '*is there a gap- are children being missed*?'

There is no clear understanding regarding a county wide offer, parents are left to question '*what a standard offer looks like*?' as there is no information available to indicate this. There is a perception that it is a '*lottery of where you live and if you have a good school, GP, Service'*.

Parents report a lack of engagement with CAHMS and in one case the CAHMS worker not attending a care meeting at which every other person was present.

On entering hospital the system appears to become even more 'secretive' with little or no information being provided to parents, in some cases parents are not allowed to visit and one parent reported that ' *when you have your child home for a break, you have to keep a book or detail of what they have done, you get nothing from the hospital'*; another '*they won't tell you anything when they are in hospital, or let you see where they sleep…..what they might be doing with their day. We had never had a night apart until that day'*. Parents also report that the Mental Health Act is confusing and feel it has been used as a weapon in some cases.

There is a sense that professionals need to better balance professionalism with compassion; they need to learn how to communicate with young people on their level. They are perceived as arrogant and unwilling to involve parents/carers in the diagnosis and care of the young person, they '*don't recognise the fact that they are your children and you know them'*.

Parents and carers are '*made to feel that they are in the wrong and have caused the issue, they never work with you to understand how you can help, what you can do…..I'm with my daughter most of the time, surely that makes sense?*'

As a parent/carer there is a perception that you have to fight every step of the way to get what is needed, there is very little support available to parents/carers and there seems to be no mechanism for the patients voice to be heard, leading to the belief that there is a lack of accountability of the service providers and a lack of voice for the service users.

Family support/Involvement

Parents and carers recognise the importance of family and social networks to the child or young person in relation to treatment and recovery; they wish to know how they can best use these resources and what they can do

to help their child recover and prevent further isolation. There are very few resources available to them to enable them to confidently do this. Support groups are very few, leading to parents establishing their own in many cases, which is often a huge relief for others as they find '*comfort in other parents*'. However, support groups are in some cases being attended by private clinicians who are recruiting patients into the private sector, creating a divide between those who can afford to pay privately and those who cannot. Training in mental health is non-existent or only available to those who have the knowledge and resources to find it and pay themselves.

The hospital environment is also difficult to navigate and understand and creates a 'false' family environment. Parents/carers respect the fact that children and young people should be consulted around their treatment and care, however often these conversations are happening without the parents present, allowing the child/young person to have the responsibility but parents have to pick up the pieces when things go wrong. The hospital environment seems secretive and the mechanisms used such as the Mental Health Act are confusing and can be used as a 'weapon'.

Another concern relates to where the child or young person can go when they are very unwell, Kent does not have a secure unit for children and young people who are a serious risk to themselves or others.

Key Conclusions – the future

What we want/Gaps

The people we spoke to were very clear what they wanted to see. They are;

- A single point of contact, with someone who knows their child/young person and their history and with whom they can build trust.
- A clear universal offer that is proportionate to need, well documented, described and explained with a clear pathway, which is transparent on time frames and mechanisms to challenge.
- A patient/family voice, that can inform services, help identify gaps and improve the quality of services, which will also help to inform support and training for parents/carers and professionals.
- To be inclusive and compassionate- service and staff, which is open and honest, has a common sense approach, is based on a best practice holistic model and provides a clear pathway to diagnosis and care, with professionals who are committed, attend meetings and involve parents and carers fully in the process.
- There needs to be a specialist secure in patient service based in Kent (Tier 4)

Since the concerns were raised in the Health Overview & Scrutiny Committee, it is clear that commissioners and providers have worked at pace to improve the service, in particular waiting times for assessment and treatment.
This progress is to be commended and it is the intention of Healthwatch Kent to support ongoing input from patients, carers and young people to consolidate these improvements and to build on them.

Our Recommendations

Short to medium term (remainder of current contracts):

- The commissioners and the providers for all four tiers should confirm with Healthwatch Kent how they will respond to the needs highlighted by patients and families for:
    - A single point of access and appropriate, simple referral system
    - A clear service offer and pathway, described in a user friendly way and made easily accessible to anyone requiring services
    - A mechanism for patients, families and young people to continue to inform service delivery and development
    - Increase understanding in staff at all levels of the mental health needs of young people and the need for a compassionate and holistic way of working
    - The provision of a specialist secure accommodation in Kent
- Commissioners and Providers for Tier 2 and 3 should confirm how they will continue to be transparent regarding the work on waiting times. Waiting times should also continue to be closely monitored with other partners such as HOSC
- NHS England should confirm how they will respond to the need for consistent awareness from GPs about mental health issues in children and adolescents to ensure a more consistent service amongst GPs and quicker referrals
- Healthwatch Kent acknowledge that much of the feedback we received was about Tier 2 and 3. Discussions would be welcomed about the role Healthwatch Kent can play in working with commissioners and providers to look in more detail at other elements of the CAMHS service.

Longer Term

- Commissioners should confirm with Healthwatch Kent how they will involve patients, the public and Healthwatch Kent in the redesign of the entire CAMHS service

Our Next Steps

- Healthwatch Kent will continue to monitor and review the experience of patients and their families.

- Healthwatch Kent will consider the option of undertaking a follow up review to check on progress.

- Healthwatch Kent will share the findings of this report with the mental health community and the wider Kent public.

- The report will be shared as part of our role on the Kent Health & Well Being Boards, the seven local Health & Well Being Boards and the Health Overview & Scrutiny Committee

- Healthwatch Kent and service users to be involved in any discussions and plans around improvements to the service.

Acknowledgements

Healthwatch Kent would like to thank:
The individuals and their families who took the time to share their experiences and helped find further families to participate in our research

And professionals for their assistance, expertise and insight

Appendix 1- A brief timeline of CAMHS policy in England;

In 1995, two key documents, A Handbook on Child and Adolescent Mental Health and Together We Stand, paved the way for the development of CAMHS within a four-tiered framework for planning, commissioning and delivery. 1998 saw the start of the 24 CAMHS Innovation Projects (learning from those was published in 2002). The Crime and Disorder Act led to the establishment of youth offending teams with the core aim of preventing offending. 1999 saw the advent of Sure Start local programmes and the National Healthy Schools Programme. In 2000 the NHS Plan Implementation Programme included a requirement that health and local authorities work together to produce a local CAMHS strategy.

In 2003, Every Child Matters set out the core framework for reform of children's services, including Children's Trust arrangements and the five outcomes (being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic wellbeing) with the 2004 Children Act giving statutory force to these. The Behaviour and Attendance Strategy and the advent of Behaviour and Education Support Teams encouraged schools to adopt whole-school approaches and integrated work on mental health and wellbeing.

In 2004 the National Service Framework for Children, Young People and Maternity Services (NSF) set out a 10-year strategy with 11 specific standards with the mental health and psychological wellbeing of children and young people being standard 9

In 2008, the first Children's Plan was published; the first Targeted Mental Health in Schools (TaMHS) pathfinders were established and the Child Health Promotion Programme was published. In November of the same year the CAMHS Review (an independent review which made a number of recommendations for action at national, regional and local levels) was published.

2009 saw the publication of New Horizons, which set out a vision for improving the mental health of the whole population across the age range.

2010 saw the publication by the National Advisory Council for Children's Mental Health and Psychological Wellbeing (established as part of the recommendations of the CAMHS Review) of its One Year On report.

In April 2010 the age-appropriate environment duty under S131A of the Mental Health Act (1983) took effect placing new responsibilities on NHS Trust Boards providing in-patient adult mental health services.

The Government published a mental health strategy in February 2011 - No Health Without Mental Health: a Cross-Government Outcomes Strategy for People of All Ages (see appendix)

The Government gave a commitment to expand the People's Improving Access to Psychological Therapies IAPT programme to children and young people in their Talking therapies: a four-year plan of action. This expansion was formally launched in October 2011 with Government committing £32 million to children and young people's IAPTs.

The Government consulted on the proposed suicide prevention strategy. This strategy builds on previous strategies and they suggest 6 areas for action with action 2 being; Tailor approaches to improve mental health in specific groups – this includes children and young people.

The Me and My Schools project was commissioned as the national evaluation of the Targeted Mental Health in Schools (TaMHS) project. The aim of the project was to look at how schools can help children and young people with mental health problems. The final evaluation report was published in November 2011 (see appendix).

In 2012 the Secretary of State for Health launched the development of a Children and Young People's Health Outcomes Strategy by establishing a forum, which was tasked with:

Identifying health outcomes that matter most for children and young people
Consider how well these are supported by the NHS and Public Health Outcomes Frameworks, and make recommendations
Set out the contributions that each part of the new health system needs to make in order that these health outcomes are achieved

The Children and Young People's Health Outcomes Forum reported back to government in 2012, and produced an overarching report, and a sub-group report on mental health (see appendix).

No Health Without Mental Health: Implementation Framework This Implementation framework was developed jointly by the Department of Health, the NHS Confederation's Mental Health Network, Mind, Rethink Mental Illness, Turning Point and The Centre for Mental Health. The aim of the document is to assist local organizations with the implementation of the Mental Health Strategy.

In 2013 the Government have responded to the Children and Young People's Health Outcomes Forum report and will:

Launch a pledge, which will commit Government to do everything they can to improve the health of children and young people.
Set up a Children and Young People's Health Outcomes Board, which will be led by the Chief Medical Officer (CMO)
Set-up a new Children and Young People's Health Outcomes Forum to provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work.

Appendix 2 - The National Picture -House of Commons - Health Select Committee

Children's and Adolescents' Mental Health Services (CAMHS) are currently the focus of an inquiry led by the House of Commons Health Select Committee. The investigation will centre on the following themes:

The current state of CAMHS, including service provision across all four tiers; access and availability; funding and commissioning; and quality;
Trends in children's and adolescent mental health, including the impact of bullying and of digital culture;
Data and information on children's and adolescent mental health and CAMHS;
Preventative action and public mental health, including multiagency working;
Concerns relating to specific areas of CAMHS provision, including perinatal and infant mental health; urgent and out-of-hours care; the use of Section 136 detention for under-18s; suicide prevention strategies; and the transition to adult mental health services.[7]

At the time of writing, early evidence to the Committee has asserted that CAMHS is 'a service under siege', facing 'significant reductions in resources' at a time of 'rising demand'.[8]

A tough economic climate is believed to have exacerbated pre-existing problems, with children from poorer backgrounds more likely to require such services, and research from mental health charities, such as Young Minds, suggesting widespread inequality and spending cuts to early intervention services.[9]

With regards to early intervention, also highlighted is a basic lack of understanding of children's mental health among doctors and within schools – as well as a funding cuts to third sector partnerships - forcing an upward pressure upon higher-tier services. As a consequence, thresholds for accepted referrals are pushed higher, leaving families to face long waits and a battle to access services.

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[7] http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cmh-2014/ - date accessed: 8th June 2014
[8] House of Commons Health Select Committee, Oral Evidence Session 01/04/2014
[9] http://www.youngminds.org.uk/about/our_campaigns/cuts_to_camhs_services - date accessed: 8th June 2014

Appendix 3 – Topic Guide

TOPIC GUIDE- CAHMS

Introduction check list

- Introduce ActivMob and Healthwatch Kent
- Briefing sheet (to cover, rationale, objectives, who is being involved and why, outcomes)
- Clarify reasoning and use of the project and this conversation- anon
- How will the discussion be structured- Based around the theme 'the carer voice'
- Consent form

TOPIC and PROMPTS	NOTES
About you/your group (to set the scene and get to know them) *Areas covered/live in.* *How long have you met/often? Do you go to any groups?* *Service user/carer/other?* *How long have you been (caring for someone) accessing the CAHMS services ? Where? Types/Tiers? For?*	
Understanding your journey so far: Accessing CAHMS Thinking about the first time/ or the last time you needed to access the CAHMS service: What was the process/journey like? *What happened?* *How long did it take?* *Where did you go first?* *Was it easy/hard? Where were some of the hurdles/barriers?* *Was it good/bad experience-How did you feel during this process?* *What was the outcome?* *Did it meet your needs?* *What role did GP's/schools etc play in this?*	
Now thinking about some of the issues and examples you have raised, we would like to understand further your experiences around: Diagnosis *How easy/hard has it been to get a diagnosis?* *How important is this?* *Dual diagnosis- what impact does this have?* *What are the barriers?* Family support and Involvement	

How involved are you in the care? *Does involvement/input vary depending on treatment/area/diagnosis?* *How involved would you want to be?* *How does it make you feel?* *Why is it important?* *What training/support is available for you? Does it include the whole family?* *What else would you want?* *Issues/barriers/positive experiences?* The care pathway Understand more in-depth experiences of the service: Do you feel that you always understand what is happening? Are things clear enough or could it be clearer? Like what and how?	
General Discussion *On other topics that may have come up:* *Understand the issue, why, what happened, what would they want to happen etc* *Thinking about the remit of the project- is there anything else you would like to add?*	

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23rd September 2014

Mr S Inett
Chief Executive
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Dear Steve

Thank you for the recent report Healthwatch Kent: Child and Adolescent Mental Health Service report. This service is now called 'Children and Young People's Service' [ChYPS] although in this response it will be referred to as CAMHS.

Firstly, thank you for completing this important piece of work. In this area of practice the Kent and Medway system as a whole is undertaking a wide and far reaching service redesign with the aim of improving provision for children and adolescents experiencing a mental health issue. The experiences and observations of children and young people in this report will help us in our efforts.

NHS West Kent Clinical Commissioning Group, in its role as the coordinating commissioner for Tier 2 and Tier 3 health provision across Kent and Medway, is able to respond to each of your recommendations. However, it is important to note that some of the issues raised in the report relate to other parts of the emotional health and wellbeing system for children and young people in Kent and Medway. This includes local authority led provision therefore I will be sharing my response with key stakeholders. My responses to each of the recommendations are set out below:

The commissioners and the providers for all four tiers should confirm with Healthwatch Kent how they will respond to the needs highlighted by patients and families for:

1) A single point of access and appropriate, simple referral form

Following a multi-agency summit in July 2014, a programme of activity has now commenced to improve current provision; this is being overseen by the Children's Health and Wellbeing Board. The approach is to develop a new Children's Emotional and Wellbeing Strategy sitting underneath the Kent Health and Wellbeing Strategy. This will be based on four key principles: early help, access whole family approaches, recovery, and transition.

A new service model will follow for all tiers to support service improvement under these headings. The new service model will be embedded in new contract arrangements from August 2015. Evidence highlights that there is a problem with the current referral system, West Kent CCG is working with partners across the system to improve the current arrangements, although we are yet to fully develop the new service model, it is likely to have a single point of access triage system.

2) A clear service offer and pathway, described in a user friendly way and made accessible to anyone requiring services

As part of the development of the draft Children's Emotional and Wellbeing Strategy, an extensive consultation was undertaken with young people, young adults and parents/carers, with further group discussions facilitated by youth workers across Kent. They told us that they want a service offer that is easy to access and understand. This will be a key element of the emerging new model of service.

3) A mechanism for patients, families and young people to continue to inform service delivery and development

We recognise that on-going engagement with patients, families and young people will be essential as the model is developed and to improve services going forward. There are currently mechanisms in use, for example, patient participation groups, but these need to be more visible so that young people's voices are heard and inform future commissioning and service delivery arrangements.

4) Increase understanding in staff at all levels of the mental health needs of young people and the need for a compassionate and holistic way of working

There is an acknowledgement that more needs to be done, particularly in universal services, about promoting good emotional wellbeing and enabling staff to respond to young people in a compassionate and holistic way at the earliest opportunity, whatever their role.

We at NHS West Kent CCG, along with the other CCGs, are aiming to deliver the mental health Parity of Esteem requirement through the Strategic Commissioning Plans. In doing

so, we will reduce health inequalities and raise awareness of mental health and the impact on physical health conditions.

Organisations that provide health and social care locally all have workforce plans that increase the understanding of mental health. Workforce plans are monitored through the current contractual arrangements. CCGs oversee a complaints process in partnership with the provider and ensure responses are received in an appropriate time-frame. Complaints are monitored by CCGs through regular performance meetings with the provider.

5) The provision of specialist secure accommodation in Kent

The South London and Maudesley Trust provides Tier 4 inpatient provision at The Woodland Unit in Staplehurst, Kent. This is not a secure unit but offers a holistic 'secure' provision, meeting complex needs. Kent CAMHS patients can access all specialised Tier 4 CAMHS beds nationally, depending on need and bed availability. Kent presently uses the Woodland Unit in Staplehurst, Kent for access to Tier 4 CAMHS beds but it should be noted that NHS England does not commission specialised services for geographical areas and Kent people can access all specialised beds, regardless of the area. However, we note that patients will prefer access to services nearer to home.

Where more specialised types of CAMHS beds are required, Kent patients can access a full range of services across the county. These include Medium and Low Secure provision, Psychiatric Intensive Care Units, Eating Disorder and Deaf services. Given the small numbers of people needing such services, they will not be provided in all Area Team localities. NHS England commissions a range of CAMHS services that are accessible to all Kent CAHMS patients and, given the highly specialist nature of secure CAMHS provision, would not seek to have an additional secure unit in Kent.

Commissioners and providers for Tier 2 and 3 should confirm how they will continue to be transparent regarding the work on waiting times. Waiting times should also continue to be closely monitored with other partners such as HOSC

Following the concerns regarding waiting times raised at January HOSC, a detailed performance regime was implemented to reduce the numbers and the length of time young people were waiting for an assessment and treatment. Within Sussex Partnership NHS Foundation Trust, waiting times are now in line with contract requirements and the current weekly performance monitoring regime can now end. As a result of this weekly monitoring, we have more indepth knowledge and detail about the waits issue. The level of understanding of the reasons behind waits has also improved; this has helped inform the thinking and details of the emerging new model of service.

Waits will continue to be monitored through the monthly performance monitoring regime that includes wider system stakeholders such as KCC. The position on waits will always be available for scrutiny, for example via the Health and Overview Scrutiny Committee, as this is a vital measure of performance.

NHS England should confirm how they will respond to the need for consistent awareness from GPs about mental health issues in children and adolescents to ensure a more consistent service amongst GPs and quicker referrals

The new NHS Clinical Commissioning Group arrangements meant that CCGs and KCC now have more opportunities to have close links with GPs. We are working with them to further develop the Common Assessment Framework (CAF) referral process. This includes information being shared with GPs both verbally and through publications about how to refer and also information and support on raising awareness about children's mental health.

KCC colleagues also collect referral information, this supports targeted work with those GP practices where the quality of referrals needs to improve. NHS West Kent CCG also requests information from Sussex Partnership NHS Foundation Trust on the quality and number of referrals. This means a targeted approach can be applied across the system.

Healthwatch Kent acknowledges that much of the feedback received was about Tier 2 and 3. Discussions would be welcomed about the role Healthwatch Kent can play in working with commissioners and providers to look in more detail at other elements of the CAMHS service

NHS West Kent CCG welcomes a further role for Healthwatch in looking in more detail at other elements of the CAMHS service. Stakeholders' contribution have been vitally important as we have gone through the journey this year of Tier 2 and 3 service improvement and building plans for a strategic children's emotional and wellbeing offer. Through the Children's Emotional and Wellbeing Task and Finish Group there may be a role for Healthwatch in examining other elements of the service, with findings being fed into the on-going service developments. If agreeable, this can be taken forward at a further meeting.

Commissioners should confirm with Healthwatch Kent how they will involve patients, the public and Healthwatch Kent in the redesign of the entire CAMHS service

NHS West Kent CCG can confirm that patients and carers will be involved fully in the planned redesign of the whole CAMHS service. This will be through the ongoing consultation and engagement exercise, including having young people on working groups involved in the process. Progress will be communicated through the Children's Health and Wellbeing Board and the Kent Health and Wellbeing Board, where Healthwatch Kent is a member. NHS West Kent CCG is happy to attend any Healthwatch Kent public meetings to share information and progress.

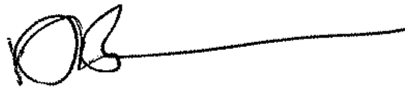
NHS England has set up a number of Clinical Reference Groups (CRGs), including a CAHMS CRG, which is responsible for the development of service specifications which set out the standards and quality requirements of services. Service users and carers are members of these groups.

In addition, NHS England supports the need for co-commissioning of CAMHS services and supports commissioners working collaboratively on pathways of care. NHS England and

Kent CCGs welcome this approach and have been working together to develop integrated pathways of care.

I hope this information provides assurance on the steps the whole system is taking to respond to Healthwatch Kent's recommendations and improve provision for children and young people's emotional wellbeing in Kent. I welcome further engagement with Healthwatch Kent going forward and we will continue to use your feedback to develop further service improvement.

Yours sincerely



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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 10 October 2014

Subject: West Kent: Out of Hours Services Re-procurement

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

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

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1. Introduction

(a) NHS West Kent CCG has asked that the attached report be presented to the Committee.

(b) In recent years, there have been moves to integrate primary care with urgent and emergency care. In November 2013, NHS England highlighted the following case studies of best practice (NHS England 2013).

(c) County Durham and Darlington NHS Foundation Trust

GPs in Durham and Darlington work a seven day week to make sure people can get an appointment locally at weekends. The region's 31 practices open at the weekends so patients are able to call and book routine appointments with a GP, but are also able to go to their local surgery for urgent, but not emergency, treatment.

All practices take any patients who need treatment, not just those on their own lists, with the local NHS 111 service making appointments for all practices. This initiative has been driven by local doctors, nurses and other healthcare professionals.

(d) Guy's and St Thomas' NHS Foundation Trust

The home ward and Enhanced Rapid Response service provided by the Trust has helped more than 1,200 local residents in Lambeth and Southwark to be treated at home rather than in hospital between January 2012 and November 2013.

Launched as pilot schemes, both services have been extended to support patients in all parts of the two local boroughs with a range of chronic diseases including diabetes, heart disease and severe breathing problems.

Nurses, physiotherapists, social workers and GPs work together to provide patients with the care they need to stay out of hospital and in

their own homes. Patients can be referred to the service by their GP or hospital doctor.

(e) South Tees NHS Trust

A virtual ward has been set up for patients in Middlesbrough so that they can receive care in their own homes instead of hospital. As well as benefits to the patient, such as receiving care and treatment in their own home and reduced risk of infection from seasonal flu or norovirus, the virtual ward also frees up inpatient beds and visits to A&E. The South Tees Hospital in Middlesbrough also set up a 30 bed winter ward to meet the expected increase in patients over the 2013/14 winter period, investing an extra £650,000 in doctors and nurses.

(f) Oxford Health NHS Foundation Trust

The Emergency Multidisciplinary Unit (EMU) run by the Trust aims to deliver an acute care pathway for frail older patients that does not rely on bed-based care yet can still provide appropriate medical, nursing and therapist treatments within an individually tailored care plan as close to the patient’s home as possible. It delivers an innovative service to the community by changing pathways of care focussing on patients’ needs for rapidly responsive and local services by changing the culture of ‘silo-working’ among healthcare professionals to a more integrated approach supported by technological innovation.

A comprehensive assessment (supported by point of care diagnostics for laboratory tests and basic imaging) enables acute medical diagnosis and treatment with on-going care to support patients and carers during episodes of acute illness without acute hospital admission. It has a dedicated ambulance and driver to ensure rapid transfer to and from EMU and the team on the unit consists of nurses, health care assistants, physiotherapists, occupational therapists, social workers and the medical team contains elderly care physicians and general practitioners.

A key aim of the unit is to allow patients to stay safely at home in a familiar and secure environment during acute illness by providing care that is high quality in terms of medical decision making, monitoring and appropriate therapeutic interventions coupled with therapist assessment and intervention. A pool of five beds is available for short term use (<72 hours) for patients who are not suitable for ambulatory care but continuity of the clinical team is maintained by using these beds rather than transfer to the large acute hospital. There is also the availability of the ‘hospital at home’ nursing team who can support the EMU in delivering therapeutic interventions in patients’ homes.

(2) Integration in Kent

(a) On September 2014, Members of the County Council considered Health and Social Care Integration in Kent. The following case studies were given to illustrate some of the work being carried out across Kent to integrate primary care with urgent and emergency care (Kent County Council 2014).

(b) NHS Dartford, Gravesham and Swanley CCG - Integrated Discharge Team

The Integrated Discharge Team (IDT) is an initiative commissioned by NHS Dartford, Gravesham and Swanley CCG and includes the Kent Community Health NHS Trust, Darent Valley Hospital, KCC, IC24 (out of hours GP service) and the Kent and Medway NHS and Social Care Partnership Trust (mental health trust).

It is designed to ensure that patients receive the most appropriate treatment delivered by the most relevant health care worker in the most appropriate setting, all the time. This will help avoid admissions, ensure patients are managed to reduce their length of stay and enable those who are medically stable to leave hospital as early as possible. The IDT brings together nurses, doctors, therapists, pharmacists, case managers and mental health specialists working across hospital and community settings.

Since its inception there has been:

- A decreasing trend in emergency admissions seen from December 2013 to February 2014.
- A reduction in the number of patients having to wait more than four hours in A&E since January 2014.
- An improvement, since November 2013, of timely access to specialist mental health assessments out of hours from 20% to 48%.

On average over 50% of patients have been discharged going home with an enablement service since January. So far no one receiving a service through the IDT has been placed in residential care.

(c) NHS West Kent CCG - Enhanced Rapid Response Service

This service targets people aged 75 and over and includes clinical treatment, rehabilitation and support, whilst linking with re-ablement programmes, and focusing on supporting people to stabilise from an acute event, regain their independence and helping them safely to remain at home.

Key to the success of the service is the collaborative working between Health, Social Care and Ambulance Services and by providing a fast response to patients who need assistance unexpectedly.

Since November 2013 the service has seen well over 4000 patients. The majority of interventions enable unnecessary admissions to hospital to be avoided and support safe but earlier discharge from hospital. Case reviews are demonstrating that the scheme is enabling patients with more complex needs to remain at home due to improved decision making via a multidisciplinary team of medical practitioners, paramedics and clinicians.

(d) NHS Ashford CCG and NHS Canterbury & Coastal CCG - Health and Social Care Coordinators

This service has been enhanced in 2014 to provide extended availability including co-locating with acute hospital services at weekends. The Health and Social Care Co-ordinators:

- Help coordinate activity with Multi-Disciplinary Teams and between GPs and community services;
- Have had over 2300 contacts with patients resulting in 700 A&E attendances and140 admissions being avoided.;
- Have produced cost savings to the local health economy estimated at over £200,000.

(e) NHS South Kent Coast CCG - Prime Minister's Challenge Fund

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.

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.

This will enable patients to book appointments at any of the 13 practices from 08.00 to 20.00, seven days a week. Outside of core practice hours (08.00-18.30) 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.

South Kent Coast is also in the process of developing an Integrated Care Organisation. This is designed to work with all relevant partners to establish the most appropriate form of organisation to deliver a comprehensive and holistic service to ensure patients receive high quality care outside of hospital whenever this is the best option for the patient.

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 NHS West Kent CCG after the meeting. The timetable shall include the proposed date that the NHS West Kent CCG 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 submit a report to the Committee in six months.

If the proposed service change is *substantial*:

RECOMMENDED that the proposed service change constitutes 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

Kent County Council (2014) *'Agenda, County Council (18/09/2014)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=113&MId=5524&Ver=4

NHS England (2013) *'Winter Pressures – Media Briefing Note (01/11/2013)'*, http://www.england.nhs.uk/wp-content/uploads/2013/11/150mill-ease-wntr-pres.pdf

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NHS
West Kent
Clinical Commissioning Group

Re-procurement of the West Kent Out-of-Hours service

Patient focused,
providing quality,
improving outcomes

1. Purpose of the report and summary of key issues

This report outlines the process for the re-procurement of primary care services that delivers urgent and emergency care. The key issues and actions for note are:

- Part of the new model of primary care defined by mapping the future will include redesigning the traditional out-of-hours service so that it becomes an integral part of new primary care rather than a separate element.
- In order to comply with NHS financial regulations and competition rules, NHS West Kent CCG is required to re-tender West Kent out-of-hours provision.
- NHS West Kent CCG currently commission three core primary care services that deliver urgent and emergency care. They are an out-of-hours service, an enhanced rapid response service, and GPs working in A&E to see and treat primary care type patients.
- The CCG proposes to combine these services into one contract in order to improve integration and reduce fragmentation. This will enable us to treat patients with the best care in the best place in the fastest time.
- The main focus is on provision at A&E as the aim is to provide services to patients in a way that matches people's behaviour. West Kent is seeing a year on year increase in the numbers of A&E attendances with the majority of activity between 9.00am – 7.00pm. It may therefore be the case that there will no longer be out of hours bases in Tonbridge, Sevenoaks or Cranbrook, though the provider of the new service will need to demonstrate they can meet all the needs of the West Kent resident population.
- A service specification has now been drafted for consideration

2. Current Service Provision

NHS West Kent CCG currently commissions three core primary care services that deliver urgent and emergency care. These are an out-of-hours GP service, an enhanced rapid response service to support people with acute medical conditions in the community and GPs working in A&E to see and treat primary care type patients.

The current contract for out-of-hours is provided by IC24. The service has bases at Maidstone A&E department, Tonbridge Cottage Hospital, Cranbrook Community Health Centre and Sevenoaks Minor Injuries Unit. These centres are open between 6.30pm – 9.00am on any day from Monday to Thursday and between 6.30pm on Friday and 8.00am on the following Monday (so open throughout the weekend) and also between 6.30pm the night before bank holidays until 8.00 am on the next working day. In 2013/14 a total of 41,486 patients accessed out-of-hours services, in West Kent, with approximately 40 per cent of patients receiving telephone advice, 50 per cent being treated at the out-of-hours treatment centres and 10 per cent treated at home.

Kent Community Health NHS Trust (KCHT) is currently commissioned to pilot an enhanced rapid response service (ERRS). The enhanced rapid response supports people (particularly those who are frail and elderly) who have acute medical conditions which can be treated safely and effectively in the community. Patients are admitted into a virtual ward following clinical assessment within two to four hours of referral and the service is available 24/7.

The enhanced rapid response service is an integrated service being delivered by the community and acute trusts and the workforce includes consultants, medics, enhanced practitioners and therapists. There are robust pathways with A&E, GPs, community nurses, community hospitals, social services, the mental health trust, out of hours, the ambulance service and voluntary sector including hospices and the dementia crisis service. From November 2013 to July 2014, they received a total of 3,774 referrals. The care provided by the ERRS team meant that these patients could be treated and remain at home, with a range of conditions that would normally result in a hospital admission. These include cellulitis, urinary tract infections and COPD.

The GPs in A&E see and treat patients who are assessed as appropriate to be seen by primary care. These are patients arriving in the A&E department by their own efforts who are assessed by the A&E triage nurse as suitable to be seen by the GP in A&E. The GPs also advise patients on alternative, more appropriate services (particularly primary care) that they could have contacted and how they can be accessed.

The contract for West Kent out-of-hours provision is coming to an end. In order to comply with NHS financial regulations and competition rules, NHS West Kent CCG is required to re-tender West Kent out-of-hours provision.

3. NHS West Kent CCG Strategic Direction

A key aspiration of the NHS West Kent CCG Strategy, Mapping the Future, is to develop a new model of primary care. Part of that new model will include redesigning the traditional out-of-hours service so that it becomes an integral part of new primary care rather than a separate element. The aspiration is that they will take on a wider range of functions supporting GP practices and will include supporting the provision of in-hours urgent care, incorporated within GMS and PMS contracts. This will include multidisciplinary teams providing urgent care flexibly, for patients who require urgent or emergency care, such as primary care type patients who attend A&E.

The CCG are working towards delivering a network of integrated services that are able to treat patients in their own home or normal place of residence, preventing unnecessary hospital attendances. This includes working towards hospital at home and virtual ward models of care, in order to treat a greater number of acutely unwell and ambulatory care patients in the community.

The CCG's Clinical Strategy Group (CSG) carried out a detailed review to scope out the future model of out-of-hours provision for West Kent. The CSG wanted to consider which model is the most appropriate for urgent care services in West Kent. A comprehensive data pack was collated to help inform and guide the decision making process. The pack included information on: local need and

population changes, strategic drivers, finance, activity, performance and service and procurement options. The following options were considered:

- **Option 1:** A re-commissioning of out-of-hours services as per the current service specification i.e. more of the same with no additional services.
- **Option 2:** Commissioning a service that continues to focus on out-of-hours provision but which encompasses a much broader provision of types of care available
- **Option 3:** Commissioning a service that provides 24/7 urgent care. This service will move away from the traditional approach of providing in hours and out of hours provision separately and will provide urgent care services 24/7 through a range of schemes
- **Option 4:** Decommissioning current OOHs provision with an expectation that the activity will be managed elsewhere in the system

The CSG agreed that out-of-hours procurement should take place over two phases. For phase one the following was recommended:

- Procuring service model option 2: commissioning a service that continues to focus on out-of-hours provision but which encompasses a much broader provision of types of care available.
- For the next two years the broader provision of care will be contained to just the inclusion of an enhanced rapid response service and GPs triaging and treating primary care type patients attending A&E. These are patients who present directly to A&E and are not triaged by NHS 111
- To procure the services within one contract in order to improve integration and reduce fragmentation. This simplification of the system will improve efficiencies as well as helping to ensure patients access the right treatment in the right place
- The out-of-hours provider will need to have the IT solutions to enable access to shared care plans.

It is recommended that this service would be contracted for two years, 2015 - 2017, allowing the CCG more time for the development of phase two in which the CCG will procure a more complex and comprehensive urgent care service through a process of competitive dialogue that would engage all the key providers locally.

4. Evidence Base for the Revised Model

The entire urgent care needs of the population cannot be delivered within the same framework and resources as emergency care. It is not appropriate for accident and emergency to be regarded as the place to treat ‘anything and everything’ or for the emergency department to be the place people default to. It is, however, unreasonable to expect patients to determine whether their symptoms reflect serious illness or more minor conditions.

The growing body of evidence that primary and community teams should be physically co-located within the emergency department to bridge the gap between hospital and primary and social care and to support vulnerable patients is persuasive. The teams co-located within emergency departments should include primary care practitioners, community teams, social workers and mental health professionals[1]. Co-location enables patients to be streamed following a triage assessment. This also enables collaborative working including sharing of diagnostic facilities; reduces duplication of administrative tasks; and permits patients to be easily re-triaged should further assessment require so[2].

Evidence suggests that General Practice provides urgent care more cost effectively than A&E, where cases are appropriate to primary care. General Practice continues to deal with most of the urgent care activity during usual opening hours. There is little room, however, to increase activity in primary care, and it is currently not configured to tackle the activity out-of-hours. It has been proven, however, that effective reorganisation of primary care out-of-hours services can result in the numbers of referrals to A&E reducing and an increase in the use of out-of-hours[3].

The urgent care system is complex and often disorganised with systems that are difficult for people to understand. This can lead to fragmentation of service provision, impacting on quality of care and efficiency of the system as a whole. Healthcare organisations should be seen as conglomerates of smaller systems, a microsystem, and not coherent monolithic organisations[4]. Microsystems are defined as small, functional, multidisciplinary front line units that provide the majority of healthcare to patients[5]. There is a growing body of evidence for the effectiveness of microsystems as an approach to improve healthcare and the integration of services[6]. Excellent services are attainable in microsystems that understand what really matters to a patient and family and have the capacity to provide services to meet the patient's needs[7].

Critical to the success of a model where you have integrated primary care units within A&E units, is ensuring that services are clearly defined locally. Clear boundaries between primary care, MIUs and A&E need to be defined locally for patients[8]. In addition, commissioning a primary care assessment unit in A&E should be strategically aligned to the reorganisation of local out-of-hours services and community services that provide reactive, urgent care provision to the local community [*ibid.*].

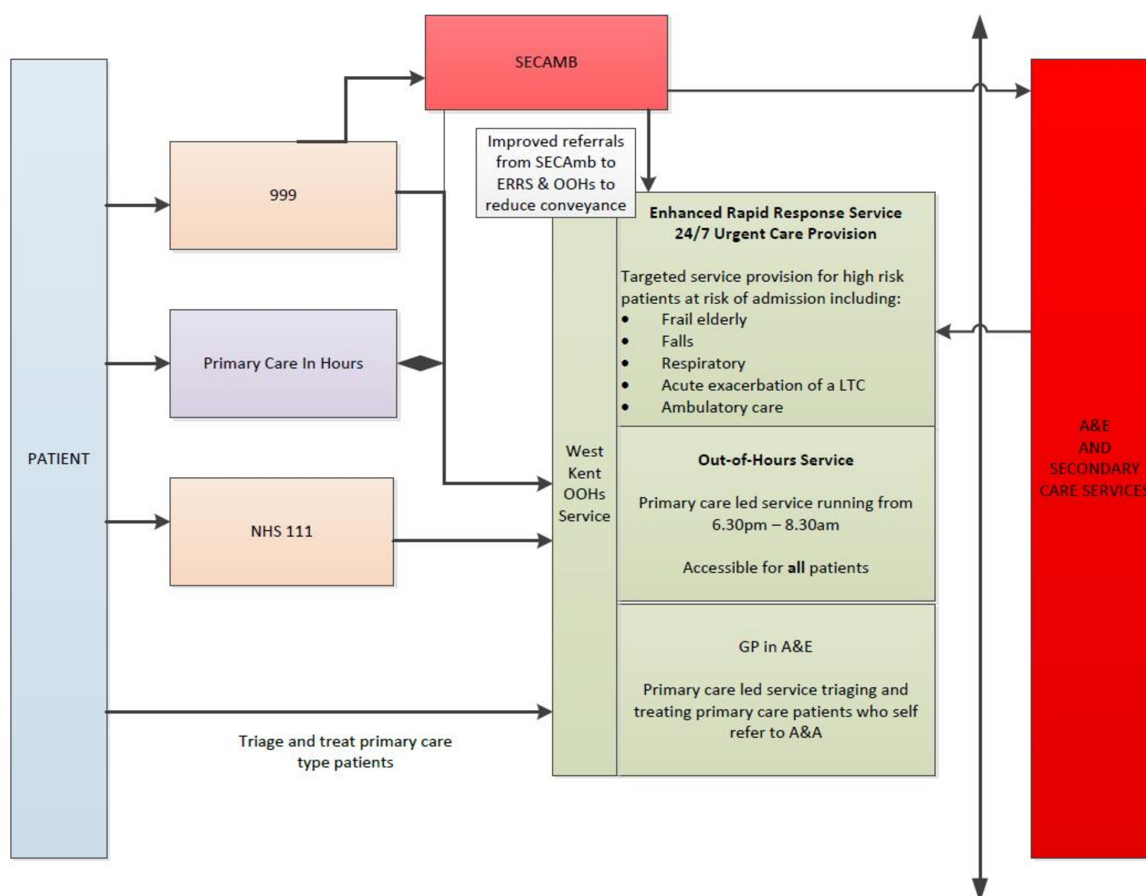
Patients attending A&E departments with minor illnesses, which were assessed by GPs as capable of being managed in a general practice setting, make up approximately 10 – 30 per cent of the average caseload of a UK A&E department[9]. There is a growing body of evidence that a true see and treat model within A&E, delivered by primary care practitioners, can impact on waiting times and reduce

[1] The college of Emergency Medicine (2014) Acute and emergency care: prescribing the remedy
2 NHS England (2013) The Keogh Urgent and Emergency Care Review – end of stage 1 engagement report. www.nhs.uk/NHSEgnaldn/keogh-review/Documents/UECR/Ph1Report.FV.pdf
[3] Van Uden C.J., Crebolder H.F. (2004) Does setting up out of hours primary care co-operatives outside of a hospital reduce demand for emergency care
[4] Mohr. J.J (2004) Integrating patient safety into the clinical microsystem. Quality and Safety in Healthcare
[5] Batalden, P.B. (2003) Microsystems in health care: part 9 : developing small units to attain peak performance. Joint Commission Journal on Quality and Safety
[6] Wasson, J.H (2003) Microsystems in health care: part 4: planning patient centred care. Joint Commission Journal on Quality and Safety
7 Williams., I. (2009) Clinical microsystems in the NHS: a sustainable method for improvement? Journal of Health Organization and Management
[8] Sanders J. (2000) A review of health professional attitudes and patient perceptions on inappropriate A&E attendances. The implications for current minor injury service provision in England and Wales
[9] Primary Care Foundation, DH (2010) Primary care and emergency departments

emergency admissions and diagnostics [*ibid.*]. There is also some evidence that it can result in a shift of emergency consultations from secondary to primary care[10].

Primary care can play a key role in changing culture communication and treatment within A&E. Primary care practitioners are seen to enhance emergency departments by bringing vital skills and expertise to a multi-disciplinary team, though it is important that there is a clear recognition of the skills of each group of clinicians and mutual respect[11].

5. West Kent Urgent Care Model 2015 - 2017



6. Scope of the integrated primary care urgent and emergency care service

A service specification has now been drafted, for review and sign off. The service will deliver both urgent primary care and hospital at home services for West Kent residents, through the integration of out-of-hours provision, the GPs in A&E and the enhanced rapid response service. The CCG is of the view that at this time there is no substantial alteration to current service provision, as all components of the new procurement are currently in place.

[10] Kool RB, Homberg DJ, Kamphuis HC. Towards integration of general practitioner posts and A&E departments: a case study of two integrated emergency posts in the Netherlands

[11] Kool RB, Homberg DJ, Kamphuis HC. Towards integration of general practitioner posts and A&E departments: a case study of two integrated emergency posts in the Netherlands

The team delivering the service must be multidisciplinary, in order to meet the requirements and needs of patients for both a primary care service and a hospital at home service. The service will be contracted to provide out-of-hours primary care medical services; based at primary care medical assessment units, co-located within the two A&E units in West Kent. The provider may wish to identify further community settings, for out-of-hours treatment centres, as deemed appropriate, to ensure all the needs of the West Kent population are met.

It should be noted, however, that the main focus is on provision at A&E as the aim is to provide services to patients in a way that matches people's behaviour. West Kent is seeing a year on year increase in the numbers of A&E attendances with the majority of activity between 9.00am – 7.00pm. It may, therefore, be the case that there will no longer be out of hours bases in Tonbridge, Sevenoaks or Cranbrook, though the provider of the new service will need to demonstrate they can meet all the needs of the West Kent resident population.

7. Benefits to patients

The primary care medical service element will not solely focus on out-of-hours provision but must extend to normal working in order to triage and treat primary care patients attending A&E both in-hours and out-of-hours. This will help patients with primary care treatable conditions get the right care whatever time they attend A&E and will support patient flows through the hospital during its busiest periods.

All patients who are assessed as potentially needing a hospital admission will be further assessed for suitability for the hospital at home service. These may be patients who are triaged and assessed through the primary care medical assessment units or by a health professional, triaging a patient within their own home, who refers on to the hospital at home service.

The service will also work closely with MTW's discharge teams and primary care teams to facilitate early discharge of patients, providing a step down service for patients who are assessed as being medical fit.

There must be leadership and oversight from a specialist acute physician, in order to assess and agree treatment and care plans, and provide ongoing monitoring as appropriate, for those patients who are deemed suitable for the hospital at home service. This is critical to ensure appropriate clinical governance, patient safety and quality of care is maintained within a virtual ward model of care.

The provider must ensure all appropriate support and resources are in place, including nursing and therapeutic services and prescribing, to provide the appropriate level of care for patients within the primary care medical assessment units and within the community.

Each of the services currently commissioned that the CCG is looking to integrate and commission under one contract, already clearly demonstrates good patient outcomes. Moving to a single contract will further strengthen those outcomes plus, as outlined above, it will improve integration between out-of-hours care and the enhanced rapid response service, improving outcomes for patients.

Integration of the services and co-location within the acute setting will ensure the service is built on best practice. This will direct patients to the right care, first time, reducing repetition of assessment, delays to care and unnecessary duplication of effort. This will result in the following benefits for patients

- Patients are helped to navigate the health system and directed to the service that is best able to give them the help they need, as close to home as possible
- Services built around the patient through improved integration of services across primary, community and secondary care services. This will enable us to treat patients with the best care in the best place in the fastest time
- Improved care for elderly patients with multiple health conditions who will undergoing investigation by multidisciplinary teams, not necessarily within the setting of the emergency department
- Access to specialists teams when appropriate
- Improved patient and carer satisfaction due to increased admission avoidance
- Reduction in unnecessary diagnostics

8. Procurement Process & Timelines

The CCG is in the process of giving notice to all three services currently delivering primary care urgent and emergency services. Their contracts will cease in June 2015, giving the CCG nine months to complete the procurement and mobilisation of the new service. There is a small project group overseeing the process, made up of a number of local GPs, KMCS and the CCG Urgent Care team. The project group is set up to oversee the procurement process including overseeing the following workstreams:

- Development of the service specification and required patient outcomes
- Consultation with CCG members
- Equality impact assessment
- Agreeing the financial scope of the service
- Development and delivery of a patient engagement strategy
- Development and delivery of a market engagement strategy
- Review of premises, workforce and IT
- Procurement and tender process
- Mobilisation of the new service

The CCG is currently working to the following timetable for the procurement.

The CCG is currently in the process of consulting with its members on the draft specification. Following clinical engagement the CCG will also look to engage with patients and local stakeholders, including the Local Authority Districts, Kent Health Overview and Scrutiny Committee and local Providers. The feedback received from primary care, patients and other stakeholders will be used to further develop a service specification we believe will meet the urgent care needs of West Kent, with its increasing ageing population and numbers of patients suffering from multiple long term conditions.

9. Questions for Health Overview and Scrutiny Committee

- Is the CCG consulting widely enough and is there more we could be doing?
- Does HOSC believe this to be a substantial change to current service provision requiring formal public consultation?

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SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement
Optional headings 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Primary Care Urgent Care Service
Commissioner Lead	Mark Atkinson
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

The White Paper 'Equity and Excellence: Liberating the NHS'[1] has the driver to improve health outcomes. This is supported by greater accountability to the public and strengthened regulation. Specifically, commissioners are tasked to develop a coherent 24/7 urgent care service that makes sense to patients when they have to make choices about their care. The Department of Health review of urgent care lists some expectations of patients in healthcare. Services should:

- Be quick.
- Be simple to access.
- Put patients in control.
- Support patients to prevent ill health.
- Be available close to or in patients' own homes.
- Ensure patients feel that the advice received will keep them safe.

To facilitate this, a new single telephone number, NHS 111, has been introduced which will improve the quality, efficiency and coherence of urgent care services. This means that any future development of primary care urgent medical services will need to fit within this model of care.

The commissioner must develop coherent 24/7 urgent care services, supported by

[1] DH (2010) Liberating the NHS https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

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the NHS 111 single telephone number, which helps patients to access the right services in the right place, at the right time, from the right care professional. The Health and Social Care Act builds on this and highlights the need for a more integrated approach so that patients have a seamless experience of health and social care. The emphasis is on creating a simple system that guides patients to the right place to receive care. The evidence base to support the national context is as follows:

- The Operating Framework for the NHS in England 2014/15
- The Health and Social Care Act 2012
- Department of Health - Liberating the NHS, 2010
- Healthcare Commission - Not just a matter of time: A review of urgent & emergency services in England, 2008
- Department of Health - Taking Healthcare to the patient, 2005
- Primary Care Foundation - Urgent Care a practical guide to transforming same-day care in general practice, 2009
- Primary Care Foundation - Benchmarking GP Out of Hours service, 2010
- Primary Care Foundation – review of urgent care centres, 2010
- College of Emergency Medicine – The Way Ahead, 2008
- The Direction of Travel for Urgent Care: A Discussion Document; DH; 2006
- Department of Health - Urgent Care, Direction of travel, Consultation document, 2005
- GP Patient Satisfaction Survey - conducted by MORI annually
- A Guide to Patient and Public Involvement in Urgent Care

The entire urgent care needs of the population cannot be delivered within the same framework and resources as emergency care. It is not appropriate for accident and emergency to be regarded as 'anything and everything' or for the emergency department to be 'everyone's default. It is unreasonable to expect patients to determine whether their symptoms reflect serious illness or more minor conditions.

Evidence suggests that General Practice provide urgent care more cost effectively, where cases are appropriate to primary care and General Practice continues to deal with most of the urgent care activity during usual opening hours. There is little room, however, to increase activity in primary care, and it is currently not configured to tackle the activity out-of-hours. It has been proven, however, that effective reorganisation of primary care out-of-hours services can result in the numbers of referrals to A&E reducing and an increase in the use of out-of-hours[2].

The growing body of evidence that primary and community teams should be physical co-located within the emergency department to bridge the gap between hospital and primary and social care and to support vulnerable patients is

[2] Van Uden C.J., Crebolder H.F. (2004) Does setting up out of hours primary care co-operatives outside of a hospital reduce demand for emergency care

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persuasive. The teams co-located within emergency departments should include primary care practitioners, community teams, social workers and mental health professionals[3]. Co-location enables patients to be streamed following a triage assessment. This also enables collaborative working including sharing of diagnostic facilities, reduces duplication of administrative tasks and permits patients to be easily re-triaged should further assessment require so[4].

The urgent care system is complex and often disorganised with opaque systems to their users. This can lead to fragmentation of service provision, impacting on quality of care and efficiency of the system as a whole. Healthcare organisations should be seen as conglomerates of smaller systems, a microsystem, and not coherent monolithic organisations[5]. Microsystems are defined as small, functional, multidisciplinary front line units that provide the majority of healthcare to patients[6]. There is a growing body of evidence for the effectiveness of microsystems as an approach to improve healthcare and the integration of services[7] Excellent services are attainable in microsystems that understand what really matters to a patient and family and have the capacity to provide services to meet the patient's needs[8].

Critical to the success of a model where you have integrated primary care units within A&E units, is ensuring that services are clearly defined locally. Clear boundaries between primary care, MIUs and A&E need to be defined locally for patients[9]. In addition commissioning a primary care assessment unit in A&E should be strategically aligned to the reorganisation of local out-of-hours services and community services that provide reactive, urgent care provision to the local community [*ibid.*].

Patients attending A&E departments with minor illnesses, which were assessed by GPs as capable of being managed in a general practice setting, make up approximately 10 – 30% of the average caseload of a UK A&E department[10]. There is a growing body of evidence that a true see and treat model within A&E, delivered by primary care practitioners, can impact on waiting times and reduce emergency admissions and diagnostics [*ibid.*]. There is also some evidence that it can result in a shift of emergency consultations from secondary to primary care[11].

Primary care can play a key role in changing culture communication and treatment within A&E. Primary care practitioners are seen to enhance emergency departments by bringing vital skills and expertise to a multi-disciplinary team, though it is

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[3] The college of Emergency Medicine (2014) Acute and emergency care: prescribing the remedy

4 NHS England (2013) The Keogh Urgent and Emergency Care Review – end of stage 1 engagement report. www.nhs.uk/NHSEgnaldn/keogh-review/Documents/UECR/Ph1Report.FV.pdf

[5] Mohr. J.J (2004) Integrating patient safety into the clinical microsystem. Quality and Safety in Healthcare

[6] Batalden, P.B. (2003) Microsystems in health care: part 9 : developing small units to attain peak performance. Joint Commission Journal on Quality and Safety

[7] Wasson, J.H (2003) Microsystems in health care: part 4: planning patient centred care. Joint Commission Journal on Quality and Safety

8 Williams., I. (2009) Clinical microsystems in the NHS: a sustainable method for improvement? Journal of Health Organization and Management

[9] Sanders J. (2000) A review of health professional attitudes and patient perceptions on inappropriate A&E attendances. The implications for current minor injury service provision in England and Wales

[10] Primary Care Foundation, DH (2010) Primary care and emergency departments

[11] Kool RB, Homberg DJ, Kamphuis HC. Towards integration of general practitioner posts and A&E departments: a case study of two integrated emergency posts in the Netherlands

important that there is a clear recognition of the skills of each group of clinicians and mutual respect[12].

1.2 Local Needs in West Kent

West Kent CCG has a registered population is 466,000, 31% of the total Kent registered practice population[13]. The CCG has 63 practices and covers the resident population from the local districts of Maidstone, Tonbridge & Malling, Tunbridge Wells, majority of Sevenoaks (except Swanley ward which is covered by the Dartford Gravesham and Swanley CCG) and two wards within the local district of Ashford. There is also a very small part of the population of the T&M District Council catchment historically serviced by practices located in Medway and which are aligned to Medway CCG.

Although the age profile of the population is broadly similar to that of Kent and Medway as a whole West Kent has a:

- Slightly larger proportion of 35 to 54 year olds and smaller proportion of 20-29 year olds.
- 7% of the population of the four districts is of black and ethnic minority origin.
- The percentage of the BME population is higher in those of working age compared to the 0 to 15 age group and those who have retired.

Over the next twenty years the overall population of the four local authorities is expected to increase. Using resident populations for the districts of Maidstone, Sevenoaks, Tonbridge and Malling and Tonbridge Wells, the following changes are predicted:

- The under-five population will remain fairly constant with an increase of less than 4% over 20 years.
- The population aged 5-19 will increase by just over 12.5% across that period
- The population of 65+ is set to increase by 57.3% from 2011 to 2031 increasing from 88,300 to 138,900 and within this the population of 85+ group is predicted to increase by 127.3% during the same period, 12,100 to 27,500.

This increase has important implications for health and care delivery from both a financial and activity perspective. For example, over 65s are:

- 18 times more likely to suffer long term heart/circulatory problems
- 20 times more likely to suffer with eye conditions
- More likely to be high users of services

1.3 The local urgent care system

Hospitals are struggling to cope with increasing pressure on urgent and emergency care services. West Kent is seeing a year on year increase in the numbers of A&E attendances. The majority of activity is between 9.00am – 7.00pm, in line with national trends. At Maidstone Hospital 64% of A&E attendances are classified as minors. This is slightly less at Tunbridge Wells Hospital (40%). Over the last year,

[12] Kool RB, Homberg DJ, Kamphuis HC. Towards integration of general practitioner posts and A&E departments: a case study of two integrated emergency posts in the Netherlands

[13] Working together to Keep Kent Healthy: Joint Strategic Needs Assessment. http://www.kmpho.nhs.uk/jsna/

however, there has been a 15% increase in the numbers of minors attending A&E with the majority of the increase in activity at Tunbridge Wells. For the 75 and overs there has been a gradual increase in the number of A&E attendances with no apparent seasonality.

Local analysis shows that there are three groups where A&E attendance is disproportionately high: the under 5s, 20-24 years and >80yrs. Conversion rates from A&E attendance to admission appears to gradually increase with increasing age. 70% of the above 85 year age group attending A&E are likely to be admitted.

Though overall numbers of emergency admissions have remained static there is a year on year increase in the number of emergency admissions for the over 75s and a significant increase in the numbers of short stay non-elective admissions.

Data from the Hospital Episodes Statistics shows that the proportion of people aged 65+ and over who are admitted to their hospital from their own home and discharged to residential and nursing care is relatively high for Kent (and the Home Counties generally) compared to other parts of the country, suggesting that this is an area where improvement is needed.

A significant proportion of all acute hospital activity is related to ambulatory care sensitive conditions (ACS). Structure use of pathways for ambulatory care sensitive conditions, commissioned by West Kent CCG, has reduced long stay emergency admissions by shifting activity to same day care.

Our data clearly shows that the largest proportion of urgent care activity is related to older people with health and social care needs linked to dementia, falls and perhaps end of life. This cohort will be complex, have multiple morbidities requiring an integrated health and social approach which can be successful depending on a whole systems transformational change towards an integrated care team approach using risk stratification and patient empowerment methods through self-care and self-management.

The roll out of NHS 111 has led to some incidents of poor patient experience and unnecessary A&E attendances during early implementation and consistent positive patient experience of ambulance services and confusion surrounding other areas of urgent and emergency care services may have contributed to an increased use of the emergency (999) number and ambulances services by patients with non-urgent healthcare needs.

The national and local trend for 999 calls is on the increase, but in West Kent this is not resulting in an increase in the numbers of patients conveyed to hospital, during in-hours periods. There is, however, an increase in the numbers of patients who are conveyed to hospital out-of-hours. In 2013/14 a total of 41,486 patients accessed out-of-hours services with approximately 40% of patients receiving telephone advice, 50% were treated at the out-of-hours treatment centres and 10% were treated at home.

1.4 West Kent CCG Strategic Aims for 2015 - 2020

West Kent CCG has established six strategic aims which tackle the key priorities for the West Kent Health economy. These aims are to secure:

- A thriving local NHS provider landscape for the West Kent population which delivers safe and high quality urgent and non-urgent care.

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- Improved patient and carer experience for End of Life Care.
- Improved and integrated health and social care packages for the elderly population.
- Supported and enhanced healthcare provided by General Practice
- Engaged and empowered patients who are able to manage their own health and make informed decisions
- Improved Value for Money and outcomes for Mental Health conditions including dementia

A key aspiration of the West Kent CCG Strategy, Mapping the Future, is to develop a new model of primary care. Part of that new model will include redesigning the traditional out-of-hours service so that it becomes an integral part of new primary care rather than a separate element. The aspiration is that they will take on a wider range of functions supporting GP practices and will include supporting the provision of in-hours urgent care, incorporated within GMS and PMS contracts. This will include multidisciplinary teams providing urgent care flexibly, for patients who require urgent or emergency care, such as see and treating primary care type patients who attend A&E.

We are working towards delivering a network of integrated services that are able to treat patients in their own home, preventing unnecessary hospital attendances. This includes working towards hospital at home & virtual ward models of care, in order to treat a greater number of acutely unwell and ambulatory care patients in the community.

Under this strategic focus the key deliverables and areas for particular focus relevant to the delivery of a primary care urgent medical service are:

1. Supporting the wider introduction of NHS 111 locally in a way that does not result in increased A&E attendance
2. An emphasis on making best use of an integrated intermediate care service that provides a rapid health and social care response to support people at home
3. To work more closely with Maidstone and Tunbridge Wells NHS Trust as the main provider of acute care to deliver the four hour access target and early supported discharge
4. Developing pathways to reduce A&E attendances/emergency admissions and tariff based spend while supporting the CCG's priority areas
5. Develop more community services to avoid a transfer to hospital based care
6. Working with the ambulance service to care for more people in the community, decreasing conveyances to hospital

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

	Improvement Area	Indicator

Domain 3	Helping people to recover from episodes of ill-health or following injury	Emergency admissions for acute hospitalization that should not require admission
		Proportion of people who recover from Trauma
Domain 4	Ensuring people have a positive experience of care	Patient experiences of A&E services

2.2 Local defined outcomes[14]

1. Reduction of A&E attendances and emergency admissions
2. Delivering high quality, safe and clinical sustainable services which meet required standards of care and are safe 24/7
3. Increase use of alternative services to ensure a continued focus on prevention and self-care
4. Ensuring patients receive the right advice at the right time and place
5. Connecting urgent care services together more efficiently to reduce a fragmented and complex system

See section 6 for monitoring requirements and key performance indicators

3. Scope

The service will provide an integrated service, delivering both urgent primary care and hospital at home services for West Kent residents. The team delivering the service must be multidisciplinary, in order to meet the requirements and needs of patients for both a primary care service and a hospital at home service. The service will function as a microsystem providing the majority of care for the following cohort of patients: (See section 3.8 for full acceptance criteria)

- Patients who may be at risk of a hospital admission and can be treated within their own home or at alternative community based facilities (e.g. community hospitals.
- Patients who have a primary care need and are referred directly by NHS 111
- Patients who attend A&E with a primary care need

The service must provide out-of-hours primary care medical services; based at primary care medical assessment units, co-located within the two A&E units in West Kent. The provider may wish to identify further community settings, for out-of-hours treatment centres, as deemed appropriate, to ensure all the needs of the West Kent population are met.

The primary care medical service element will not solely focus on out-of-hours provision but must extend to normal working in order to triage and treat primary care patients attending A&E both in-hours and out-of-hours. This will help support patient

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flows through the hospital during its busiest periods.

All patients who are assessed as potentially needing a hospital admission will be further assessed for suitability for the hospital at home service. This may be patients who are triaged and assessed through the primary care medical assessment units or by a health professional, triaging a patient within their own home, who refers on to the hospital at home service.

The service must also work closely with MTW's discharge teams & primary care teams to facilitate early discharge of patients, providing a step down service for patients who are assessed as being medical fit.

There must be leadership and oversight from a specialist acute physician, in order to assess and agree treatment and care plans, and provide ongoing monitoring as appropriate, for those patients who are deemed suitable for the hospital at home service. This is critical to ensure appropriate clinical governance, patient safety and quality of care is maintained within a virtual ward model of care.

The provider must ensure all appropriate support and resources are in place, including nursing and therapeutic services and prescribing, to provide the appropriate level of care for patients within the primary care medical assessment units and within the community.

3.1 Aims and objectives of service

- To provide a safe/high quality patient friendly primary care urgent care service for the registered, unregistered and resident population of West Kent.
- To encourage and facilitate providers to work together to deliver care that is centred around patients, responsive, safe, resilient, and fit for purpose to ensure patients receive the right care, in the right place, at the right time.
- To ensure a smooth and apparently seamless handover of care between provider organisations
- To ensure that whenever appropriate patients are safely cared for within the community so integration with practices and other primary and community services is critical.
- Involve patients and carers in the development, implementation and evaluation of care/treatment plans, which are appropriate shared with other relevant providers
- Have a planned outcome of maximising independence and enable users of the service to resume living at home independently wherever possible. Service users should be assisted with relearning independence techniques with personal care which may include assistance and retraining in washing, dressing, using the toilet, food preparation, essential shopping and the taking of medication
- To support the delivery of the vision and objectives of the CCG through the individual interactions with patients.

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3.1.1 Specifically this means providing a service that:

- The service is clinically safe and is subject to the appropriate clinical governance of the employing organisation
- Provides prompt and convenient fully integrated primary and community care
- Provides an excellent patient service
- Manage conditions not requiring an acute hospital admission, examples of which include urinary tract infections, cellulitis, administration of drug using nebulisers, intravenous therapies, oxygen therapy.
- Undertake diagnostic tests as indicated, interpret and implement an appropriate management plan including appropriate treatment, remote or direct monitoring, urgent bloods, radiology, ECGs
- Gives value for money, bearing in mind the benefits of reducing usage of other services such as secondary care
- Is sustainable, attracting and retaining good competent primary care and community clinicians with local knowledge and also fosters local clinical engagement
- Meets the quality requirements for urgent care services together with other relevant standards, recommendations and good practice guidelines
- Makes use of clinical records to provide good care to patients and ensure that the record of each contact is complete and made available to other health professionals (See Section 4 for IM&T requirements)
- Works collaboratively and in the interests of the whole health system, for example to ensure that patients are provided with the most clinically appropriate pathway for their condition so that any impact on A&E attendance, admissions and pressure on GP in-hours services, is appropriate and justified.
- Makes imaginative use of technology to support the service aims whilst providing a robust framework and strong business continuity backup
- Is actively managed in a way that involves patients, practices, staff, commissioner and other stakeholders in developing the service

3.2 Service description/care pathway

- To ensure a GP is available to be involved in the assessment of patients at the primary care assessment units, and to carry out home visits at all times.
- The primary care assessment units, though co-located within the A&E departments and will work closely alongside the emergency department teams, they will need to operate independently and will not be part of the hospital system in order to effectively filter primary care type patients away from A&E
- The expectation is this will be a GP lead service. This is a minimum

requirement and it will not be deemed safe to operate the service without the physical availability of GPs to carry out this task.

- Face to face consultation &/or home visits must be undertaken by suitably trained and experienced staff. This should be a GP, unless the clinical indications are such that another suitably qualified health professional will be able to provide the care needed, e.g. blocked catheter, dressing required, etc. Where appropriate consultations and home visits can be carried out by a nurse practitioner, paramedic or therapist.
- Provide telephone advice as part of the definitive clinical management of calls, ideally in such a way that this is provided as a seamless part of the call-handling service provided by the NHS 111 provider, through integration and coordination. Telephone advice should only be given when clinically appropriate following the appropriate procedures
- Enable the "primary care" stream of patients to be seen more appropriately within A&E, improving patient experience by avoiding unnecessary admissions/diagnostic tests, providing additional capacity within A & E, and providing training/influencing of acute doctors
- Provide rapid response 24/7 (including weekends) to people who would otherwise face unnecessary admission to acute in-patient care or unnecessary prolonged hospital stays, long term residential care, or continuing NHS in-patient care;
- To facilitate timely discharge from A&E, an acute or community hospital back to their own home or where appropriate discharge to the Romney ward
- Provide support to GP services by assessing and treating people, who require primary care services out-of-hours or meet the hospital at home criteria, in their own homes which includes Residential and Nursing Care, Extra Care Housing and Day Care Services.
- Deliver therapeutic medical and nursing input in a cohort of patients in the patient's usual place of residence instead of the current arrangements of delivering the same in a secondary care setting
- Prescribe medicines as required in accordance with legislation and in line with the local formulary and any national or local guidelines. Where appropriate medicines are to be provided and/or administered to patients
- The service will at all times maintain a contemporaneous record of all consultations documenting clearly any changes in management and the reason for such changes. The provider will be asked to report on this so that the commissioner can review the accuracy of the initial clinical determination and work with NHS 111 to review their outcomes.
- Maintain and share as appropriate good quality clinical records with adequate coding to support analysis, reporting and service improvement and to maintain details about each encounter with each patient to provide a full record of the service provided
- Maintain facilities, equipment, vehicles communication and information technology systems etc. to support the service

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- Provide, train and manage appropriately skilled clinical staff and support staff to cover such areas as driving despatch and response to calls
- Prepare and maintain suitable resilience and contingency plans and train staff in their use to provide a resilient service that can respond to system outages, facilities being inaccessible, major incidents and surges in demand
- Establish relationships and ways of working to facilitate clinicians from the primary are assessment units and the hospital at home service to integrate packages of care around the needs of individual patients drawing in other specialist, primary, community or social care services.
- Operational integration with services to ensure seamless patient flows. This should include integration with NHS 111, A&E and SECAmb.
- Support individual unregistered patients to help them to register with a practice.
- Meet statutory, regulatory and good practice requirements that are relevant including in respect of governance, safeguarding children and vulnerable adults, the mental capacity act, health and safety, accessibility and those in the health and social care act or recommended by such bodies as the department of health, care quality commission etc.
- Provide the commissioner with assurance that in light of the Francis report, services developed are based on quality, effectiveness and patient safety and that it is recognised rigorous monitoring arrangements will need to be in place to monitor compliance.
- Promote the service in an appropriate manner that ensures all patient groups have access to helpful and informative information using different mediums of communication
- Be proactive in managing all aspects of public and patient relations

3.2.1 Assessment

- The service will complete a comprehensive assessment within an appropriate timescale for all patients referred into and accepted onto the service.
- Acute management will be undertaken, either within the primary care assessment unit or at the patients usual place of residence, by support team – virtual and direct (physician, senior & junior nursing, physio, OT, social worker, HCA etc)
- For patients being treated by the hospital at home service initial and all on-going assessments will be completed in consultation with the patient, the patients family and social services
- The referral will be returned to the patients GP if suitable for management by primary care.
- If an assessment deems the patient is unsuitable at the point of referral or at a later stage e.g. due to a change in need advice, support and alternative arrangements will be made. A re-assessment will take place within 24 hours with a view to securing more suitable care. This should, be facilitated within

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48 hours

- When a person has been assessed as requiring long term care, it is imperative that they are appropriately referred to ensure the service user receives the most appropriate care, by the right person in the right place at the earliest opportunity.

3.2.2 Care Planning

- Where appropriate patients accepted will have a personalised care plan in place, completed to local standards. This care plan will be developed in full consultation with the patient and the patient's family. Care plans for patients in care homes and residential homes will be completed in consultation with the staff of that home
- All care plans will be documented in case notes and retained at the patients' location. Care plans will be holistic in their approach and will be shared with other relevant care professionals
- The provider will put in place systems and processes to ensure quality standards for the completion of care plans are met. The provider's standards will align with national standards and policies and any key changes in these during the life of the contract.

3.2.3 Discharge planning

- Discharge planning shall commence from the date of the referral and shall be person-centred and flexible, to meet the needs of the patient. The patient and/or carer shall be consulted regarding the discharge plan and the potential date for discharge shall be identified and communicated as appropriate.
- Discharge planning will form an integral part of the patients programme and the service will provide acute case management until the patient is clinically stable and safe to be discharged to Primary care and/ or social services.. The team will ensure referrals are made to the required community services as early as possible ensuring continuity of care/rehabilitation
- Following discharge from the service appropriate information, advice, guidance and sign posting will be provided to the patient and their carer, and robust handovers will be undertaken with other care professionals
- The team will complete and send a discharge summary report within a week to the GP and other agencies where appropriate

3.2.4 The provider must:

- Ensure that the patient understands the outcome of their assessment and are kept informed of any related follow-up actions.
- Provide suitably equipped vehicles for home visits. Vehicles must be equipped with up-to-date communications and navigation aids and comply with relevant legislation.
- Ensure the GP/suitably qualified clinician has access to secure mobile devices to record their consultation and view notes where appropriate, which

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should be done as soon after visiting the patient as possible.

- Have in place a clear system of recording to facilitate the GP/suitably qualified clinician being aware of previous requests for a home visit and any treatment provided to ensure continuity of care.
- Clinicians should be provided with a system that makes it easy for them to record full details of the consultation (at the treatment centre or at a patient's home) onto the system in a suitably secure way. The provider should take responsibility to check that coding, clinical notes, referral information etc. is reliable and complete
- Have in place escalation procedures for patients who have been seen twice or more in the same 48 hours (unplanned) to review presenting symptoms and consider whether alternative management is required.
- Have in place escalation procedures for patients who are repeat and frequent callers to review presenting symptoms and consider whether alternative management is required.
- Ensure that protocols and processes are in place to ensure the health and safety of the visiting member of staff is secured.
- Prioritise all calls in terms of clinical urgency and response and comply with the timeframes as set out in National Quality Requirements below.

3.3 Service elements

3.3.1. Telephone consultations

The provider will complete telephone clinical consultations for patients received/referred from NHS 111.

Once the patient details/referral is received from NHS 111, the clock will start in terms of commencement of the definitive clinical management process. The referral will give an indication of the urgency of the response which out-of-hours clinicians must respond to within the specified timeframe.

The out-of-hours GP is expected to complete the telephone clinical consultation with appropriate advice, arrangement of a face to face consultation or arrangement of a home visit. The GP will clarify any points or gaps in information with the patient by telephone and will review the urgency of the presenting medical need to determine the most appropriate outcome.

During the completion of the telephone clinical consultation the GP must ensure the patient understands the outcome of their assessment and are kept informed of any related follow-up actions. The GP will determine the urgency of the consultation and make an appointment linked to this assessment. Patients must be told the time of their face to face appointment and be given details of how to get to the out-of-hours treatment centre.

The GP may present the following options to the patient:

- Offer advice about the presenting need, reassure the patient and discharge them from out-of-hours care.

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- Offer advice to the patient, if the presenting symptoms do not need urgent medical intervention, and direct the patient to contact the in-hours GP service.
- Direct the patient to a local pharmacy, taking note of opening days and times and being aware of pharmacies with extended or 100 hour per week opening.
- Make a referral to district nursing or other community services including on-call palliative care services.
- Arrange an appointment for the patient to be seen for a face to face consultation.
- Arrange for a home visit

The expectation is that GPs will work from a primary care assessment unit and be an active part of the range of clinical responses to patients. Care must be taken to link any previous calls by maintenance of an electronic record summarising all calls. This is to ensure there is continuity of care and, if the initial contact has not resolved the patient's presenting condition/concerns, for further action to reduce the risk of exacerbation of the patient's condition.

3.3.2 Face to face consultations (Primary Care Home visits)

The provider will provide an out-of-hours home visiting service to all patients where the 111 completion of the telephone clinical consultation has determined that this visit is required. The provider will offer assessment, diagnosis, treatment or treatment plan, make arrangements for onward referral, follow-up or discharge and prescribe/dispense medicines as required.

Circumstances that will lead to a patient receiving a home visit will be determined by the provider's protocols, which must be agreed with the commissioner, as well as the clinical judgement of the clinician involved with the case. For all patients who request a home visit as opposed to a consultation at an out-of-hours designated treatment centre where the decision is made by the GP/suitably qualified clinician not to visit, the reason not to visit must be recorded.

Patients who have an immediate need to be seen by a GP are:

- Patients in the late stages of a terminal illness.
- Patients who are housebound and/or bed bound'.
- The frail, elderly or vulnerable
- Patients for whom an immediate car journey could lead to an unnecessary deterioration in their condition or unacceptable discomfort, or whose condition precludes travelling.
- Parents alone with young children, whose circumstances preclude travelling, for example two or more other siblings cannot be left home alone while parent accompanies child for treatment or requires treatment themselves

Patients who are suitable for the hospital at home service, particularly frail elderly, will be assessed and a treatment and care plan agreed in order to prevent

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inappropriate admission and investigations.

3.3.3 Face to face consultations (Primary Care Assessment Units / OOHs treatment centres)

The Provider will offer face to face consultation conducted by an appropriately trained clinician according to the assessed patient's needs.

The Provider will offer face to face consultation that will include: assessment, diagnosis, treatment or treatment plan, or make arrangements for onward referral, follow-up or discharge and prescribing of medicines as required

The consultation will take place at a designated treatment centre or (where, in the light of the patient's medical condition and social circumstances (for example being 'housebound'), it would not be reasonable to expect them to travel) can take place at the patient's home location

Patients will be seen promptly based at the booked appointment time, but recognising the need to prioritise those patients that are more acutely ill or where there is a requirement for urgency

The provider should make use of a suitable system so that the status of each patient can be viewed, appointments, arrival and patient contacts are recorded and the queues and processes can be managed. This detail forms part of the record of care and should be part of or linked to the clinical record of the episode of care

The provider must ensure there is a multidisciplinary team working within the primary care assessment units which should have input from primary care (GPs), nursing, mental health and social care.

The team must be able to link back to their respective organisations in order to enable effective 'rapid access' dispositions to their respective organisations for patients if and where there is a need, in order to manage patient care competently.

The team will be required to liaise with and work alongside other health and social care services in order to: draw in specialist expertise as required; improve efficiencies; as well as preventing duplication of staffing and skills. This will require staff to have a robust knowledge of the range of locally commissioned services.

The Provider must:

- Ensure receptionists, telephone and other non-medical staff who are providing a service to patients have access to adequate medical supervision, by at least a nurse.
- Prioritise all calls in terms of clinical urgency and response, and comply with the timeframes as set out in National Quality Requirements.

3.3.4 Face to face consultations – (patients triaged from A&E)

The Provider's clinicians will operate a see and treat service, delivered to those patients that are assessed as appropriate to be seen as part of a primary care stream of patients:

- Patients arriving in the A&E by their own efforts will be assessed and triaged

by a triage nurse.

- Using an agreed list of conditions, the triage nurse will identify those patients that are suitable to be seen by the clinician in the primary care assessment unit.
- Patients who are suitable for the hospital at home service, particularly frail elderly, will be assessed and a treatment and care plan agreed in order to prevent inappropriate admission and investigations.
- The clinicians will advise patients on alternative/more appropriate service (particularly primary care) that they could have contacted and how they can be accessed.
- The discharge report to the patient's GP practice will highlight where there has been a "primary care attendance" to the A&E.
- Where a patient requires additional follow-up or referral to another specialty the clinicians in the primary care assessment unit will work with A&E and other clinicians as appropriate to explore alternative pathways to admission.

3.3.5 Hospital at Home

Provide responsive support to patients in crisis through the provision of short-term, clinical care and acute rehab, with on-going assessment and, where needed, referral for longer term treatment or community support

Provide medical, nursing and social input to patients at home during an exacerbation of a long term condition, or during a period of illness or loss of function that does not require an acute admission;

Provide support and expertise post-surgical intervention or acute hospital stay for people who are medically stable but have a short term reduced level of independence than that prior to admission

A senior nurse practitioner/physician will undertake the initial assessment in the community within 2 hours. Bloods will be taken where required. The care plan will be discussed and agreed with physician for treatment, monitoring frequency and reablement. Consultant physician in most cases will be involved virtually but may need to undertake a face to face assessment. Patients on the Hospital at Home caseload will be discussed by the lead physician at least once a day.

3.3.6 Medical capabilities of the urgent primary care and hospital at home service

These are the suggested medical capabilities which the service should have, but are not limited to those stated below;

- Appropriately trained General Practitioners
- Senior clinical nurses (Band 7 or 8) or paramedics with clinical skills to physically assess acutely unwell patients that meet the service criteria.
- Acute physician/geriatrician support who will discuss and agree on management and monitoring plan for each case. This support could be mostly virtual but based on their risk and clinical assessment should be able

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to provide a face to face assessment in a minority of cases. This support should be available 24 hours and should be both treatment initiation and continued management.

- Skills to meet internal clinical governance and risk management standards.
- Prescribing and drug dispensing capability including SBOT (short burst oxygen therapy) and nebulizer therapy and anticipatory prescribing
- Short-term virtual monitoring systems like tele-health. IT capabilities for transmission of photographs (eg leg cellulitis)
- Advanced skills in the diagnosis and treatment of complex health conditions including acute confusion and dementia
- Treat diagnosed conditions not requiring an acute hospital admission for example urinary tract infection, cellulitis, administration of nebulisers, oxygen therapy
- Administer intravenous therapy for a diagnosed cause (antibiotics, iron and fluids) and cannulation
- Undertake diagnostic tests, interpret and implement an appropriate treatment plan including remote or direct monitoring, routine blood tests, urgent bloods, radiology access, ECGs
- Provide short term rehabilitation and reablement services including occupational therapy and physiotherapy
- Effective symptom control and pain management including syringe drivers
- Successfully support patients to have a good death in their usual place of residence
- Assess and manage falls
- Provide self-management techniques in the patient's own home
- Provide patients with responsive and timely access to equipment to promote independence or assist in their care, including using assistive technology appropriately and show demonstrable benefit to patient outcomes.
- Provide short term input for the following (and refer to the LTC community nursing service where longer term care is required);
    - Continence care
    - Insulin therapy
    - Wound management
    - Venepuncture and cannulation
    - Alternative feeding

There must also be;

- Access to in-house or subcontracted support services like OT, physiotherapy etc
- Nursing and HCA support for continued care and monitoring
- Robust team working between the support services, the acute Physician and primary care practitioners with virtual and real MDTs, case reviews and

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3.4 Access

The single point of access for patients will be through NHS 111 or self-referral via A&E. NHS 111 service will undertake the initial clinical assessment of the patient and determine the outcome of that process.

3.4.1 The provider must:

- Establish a single point of access for health professionals, where the health professional referring to the service can make a clinician to clinician referral.
- Manage the timings of the availability of telephone and face to face consultation that reflects demand, clinical appropriateness and service efficiency.

3.4.2 For the primary care assessment unit the following hours of operation will apply:

- the period beginning at 12 noon on any day from Monday to Thursday and ending at 8 am on the following day;
- the period between 12 noon on Friday and 8 am on the following Monday; and
- Good Friday, Christmas Day and Bank Holidays;

3.4.3 For additional out-of-hours treatment centres based within alternative community settings the following hours of operation will apply

- the period beginning at 6.30pm on any day from Monday to Thursday and ending at 8 am on the following day;
- the period between 6.30pm on Friday and 8 am on the following Monday; and
- Good Friday, Christmas Day and Bank Holidays;

3.4.4 The hospital at home service will operate as a 24/7 service and only health professionals can refer to this service. Patients will not be able to self-refer

3.4.5 The service will meet local needs for West Kent, be easily accessible for patients, particularly those who are vulnerable and/or disadvantaged. Access must be simple, consistent and provided to meet the needs of all patients, including those who are vulnerable, have special needs, whose first language is not English, and who have impaired hearing (as per the National Quality Requirements). Facilities must be accessible to patients with mobility problems or physical disabilities. The service must also demonstrate its equity in terms of access for culture, gender, age, sexuality, faith and ethnicity

3.5 Management of referrals

3.5.1 The provider must:

- Receive details of callers from the NHS 111 call-handling service where definitive clinical management or a face to face visit is required and respond

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appropriately

- Receive calls from other services and health professionals (such as the ambulance service or district nursing when they are on site with a patient for whom:
    - immediate transport to hospital is not appropriate,
    - the health professional wishes to arrange care during the out of hours period,
    - the health professional wishes their patient to be assessed for hospital at home.

The provider will work towards greater integration of the service with the NHS 111 provider covering the call-handling so that most appointments and home visit can be arranged and confirmed efficiently and speedily for the patient. This requires direct booking by the NHS 111 service so that the majority of calls are closed with the patient knowing if and when they are to be seen face to face.

If the presenting clinical need requires a GP consultation, the 111 service will refer the patient to the out-of-hours service for a telephone assessment, a face to face visit either at an out-of-hours designated treatment centre or within the patient‘s own home, whichever is considered most appropriate. The pathway for patients between NHS 111 and out-of-hours will be in accordance with nationally determined protocols and will require agreement and sign-off through the NHS 111 Governance Board. A single telephone number will be required by the provider so that the NHS 111 Service, A&E, Urgent Care Centre, GP, ambulance and other interested professionals can make contact to update the service on an individual patient‘s progress.

The service must have clinically safe and effective systems for responding to calls already prioritised by the NHS 111 service which must comply with the National Quality Requirements

Referral protocols must be in place with NHS 111 providers, setting out the arrangements for passing data and transferring responsibility for the care of the patient. The aim is to maximise understanding within the receiving service and minimise the need for the caller to repeat details.

The Provider must develop arrangements with the NHS 111 service to facilitate the NHS 111 service making referrals for patients who require: to talk to a GP; a face to face consultation either at home or at the designated treatment centres.

If the NHS 111 service or other referring professionals were unable to complete the definitive assessment the service must:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient details being received from NHS 111, or from any other interested party such as the Ambulance Service or the patient‘s GP.
- Start definitive clinical assessment for all other patients within 60 minutes of the patient details being received either from NHS 111 or another referral point.

The Service must meet the response times of:

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- Emergency within 1 hour.
- Urgent within 2 hours.
- Less urgent within 6 hours.

3.5.2 Referrals to the hospital at home service

Response/contact will be within 2 hours of the referral being made if the need is medically urgent. However the response time must be one hour for acute urinary retention and Hypoglycaemia.

Referrals can be made through health and social care professionals in accordance with the eligibility criteria which would include GPs, SECAMB and 'Out of Hours' Service. The Provider will inform the patient's GP of the referral

Each accepted referral will have an allocated senior nurse practitioner who will remain with the service user/patient throughout the episode and will lead the review that will lead to discharge from the service (which may include reinstating previous packages of care)

Unregistered patients living in the area will access the service in the same way as registered patients. Following treatment, the provider must encourage unregistered patients who present at the service to register with a local practice by providing a list of relevant practices within an accessible geographical area encompassing the patient's postcode.

If the patient is not ordinarily resident in the UK there may be a charge for this service. The provider will have a system in place to support this process.

3.5.3 Referrals to the Ambulance Service

The provider will implement robust processes, protocols and systems to automatically transfer life threatening calls to 999 services and ensure that patients do not have to make a 999 call.

The provider needs to have in place arrangements with the ambulance service to make sure:

- There is support to an ambulance crew on request if the presenting case is deemed appropriate for primary care treatment/advice.
- The 999 crew will have the ability to refer and transfer to the Service, whenever this is clinically appropriate.
- The Provider must enable direct and easy referral from clinicians triaging or seeing patients to urgent ambulances.
- The Provider will have systems in place to receive referrals through alternate care pathways from Seacamb where clinically appropriate.

3.5.4 Transition time

Transition time is a 30 minute period immediately prior to or immediately after the out-of-hours service hours. The provider will make arrangements to ensure that these transitional times are covered and that the patients are either treated or signposted, or that their care is transferred appropriately within these transitional

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times.

The provider will ensure all referrals made between 1800h and 1830h are deemed appropriate for the service and are picked up and managed appropriately.

The provider will make arrangements to ensure that all patients referred between 0730h and 0800h have the episode of care completed and those episodes that remain open are transferred to the appropriate suitably qualified clinician.

3.5.5 Transfer of care

The provider will have a policy and protocol in place to outline the expectations of definitive clinical management and face to face consultations. A GP is the most appropriate professional to supervise this.

The provider will ensure that there is a robust system for the process of the transfer of care or onward referral that satisfies the following conditions:

- The patient is able to understand and navigate the system without unnecessary delays or further need for advice.
- Information on the patient's personal details and clinical assessment is transferred to other services, such as urgent care centres, walk-in centres, acute trusts, mental health services, social services and other such services as deemed appropriate. This must be in accordance with the CCG's enhanced discharge summary policy.
- The provider will ensure that the following information is transferred:
    - Patient personal details, include where appropriate details of carer, next of kin or authorised representatives
    - Time and day of completed clinical consultation either by phone or face to face
    - Details of the suitably qualified clinician who provided the patient's care.
    - Summary of medical history and where appropriate, examination and investigation.
    - Diagnosis (primary and secondary).
    - Treatment provided: Dose, route, frequency and amount.
    - Final disposition
- The provider will have a system in place to assure itself that the information transferred has been received

The provider will supply full clinical details of any telephone advice, face to face consultations or home consultations to the GP by 0800h on the next working day either by fax or electronically (as per National Quality Requirement 2)

3.6 Case Management and Patients with Special Needs

The Provider is expected to work with local GP practices to identify and meet the urgent needs of patients with long-term conditions, those receiving packages of continuing care, palliative care patients, frequent callers, and other patients with special needs.

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In order to achieve this, the provider will:

Make arrangements with GP practices and other services in order to set up registers of patients under special care/case management arrangements or other patients with special needs, highlighting monitoring arrangements, care plans and other clinically appropriate information following requirements set out in coordinate my care

Any child or adult safeguarding issues should be referred to the appropriate service and reported immediately in accordance with the commissioner's safeguarding procedures to the named leads for safeguarding and the GP informed immediately, or at the latest on the next working day.

Liaise with local community nursing services and therapy teams such as case management, early intervention teams, etc.

Ensure that contacts with any such patients are fed back to their GP (or appropriate service provider) electronically by 0800h the next day.

Work with the NHS 111 provider to ensure the delivery of Coordinate my Care as part of the London wide pilot of NHS 111.

3.6.1 End of Life Care

The provider will ensure its clinicians are familiar with and adhere as closely as is reasonably possible with the West Kent Care Pathway for palliative and end of life care. The Provider will make all necessary arrangements to work closely with the patient's GP practice and other relevant services to ensure that patient and their family are fully supported.

The Provider must:

- Work in partnership with local providers of end of life care to ensure that they have processes in place to access the most up-to-date information about vulnerable patients, their needs and preferences.
- Have systems in place to ensure that where possible the identified needs and expressed preferences of patients at the end of life, including preferred place of death are recorded and addressed.
- Patients at the end of life have access to timely and adequate medicine as agreed with the palliative care formulary and equipment, e.g. syringes drivers and catheters.
- Ensure all clinicians receive relevant training in end of life care to ensure patients are appropriately managed, within an agreed care pathway and where possible enabled to remain at home. The organisation must have systems in place and suitably qualified staff to undertake verification of death.
- Have a clear system of receiving and acting on information from patients' GPs, for example having a special case notes system and ensuring that it is used

3.6.2 Mental Health

The Provider will work closely with the local mental health trust and social services in offering appropriate clinical input to mental health assessment and referral for

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identified patients.

The arrangements for a patient with acute mental health needs being referred to the acute psychiatric services must be agreed between the provider and the local Mental Healthcare Trust prior to service commencement date.

3.7 Population covered

For the purposes of out of hours primary care the *Commissioning fact sheet for clinical commissioning groups*, NHS Commissioning Board, October 2012 states the following:

CCG's are responsible for commissioning *Out-of-hours primary medical services (for everyone present in your area), except where this responsibility has been retained by practices under the GP contract.*

This means therefore that the service is for the resident, registered and unregistered population of West Kent.

3.8 Any acceptance and exclusion criteria and thresholds

NHS 111 service will undertake the initial clinical assessment of the patient and determine the outcome of that process.

Acceptance criteria for patients triaged through the A&E primary care stream are that the patient has been triaged to minors and is presenting with one of agreed list of conditions for treatment in the "primary care stream". These include, though are not exclusive to:

- Dermatology
- ENT (except direct ENT referrals)
- Respiratory (this will include coughs, colds, hayfever, asthma, chest infections etc.)
- Gastro-intestinal (abdo pain, constipation, gastroenteritis etc.)
- Back pain (Non-traumatic)
- Limb/joint problems (Non-traumatic)
- Genito-urinary presentations.
- Ophthalmology (Non-traumatic)
- Headaches and dizziness
- Paediatrics (Non-traumatic)
- Gynaecology (not attending EGAU)

Exclusions (These patients should have been triaged to Majors)

- Grossly abnormal observations
- Potential for serious illness or injury

Acceptance criteria for patients referred to hospital at home service are that they are diagnosed with one or more of the agreed schedule of clinical conditions:

- Cellulitis not responding to oral antibiotics
- UTIs without sepsis but causing other morbidities like falls or acute

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confusion.

- Stable Community acquired pneumonia needing iv antibiotics/ hydration or monitoring (detail guidance to be further worked out)
- COPD and asthma exacerbation
- Acute heart failure (mild to moderate)
- Non fracture Falls
- Dementia crisis
- Acute confusion
- Gastroenteritis with mild to moderate dehydration
- Hypoglycaemia in patients on Insulin
- Frail Elderly with acute loss of self-independence or mobility due to any minor illness.
- Acute urinary retention (needs linking with urgent urology OPD slots and adhere to the Community catheter pathway)
- Palliative or end of life care with acute deterioration
- A person who is experiencing a sudden level of reduced mobility and ability to self-care.
- A person who is recovering from injury or surgery.
- A patient fit for discharge, but for the need to complete IV antibiotics.
- Patients who have lines and require a course of IV antibiotics (e.g. bronchiectasis).
- Patients with high level tube feeding needs beyond the scope of the regular community nursing team.

The above list of conditions may be expanded as the service develops.

3.9 Interdependence with other services/providers

The provider shall work jointly with existing services including Primary Care, SECAmb, Kent and Medway Partnership Trust, Maidstone and Tunbridge Wells NHS Trust, Kent Community Health Services, Kent County Council and the voluntary and community sector.

This will include working closely with paramedics, medics, LTC nurses, specialist nurses, community hospitals, social services reablement teams, the intermediate care team, the Romney ward, Health and Social care co-ordinators, the community falls service, the Carers Assessment and Support Service, community geriatricians, integrated multi-disciplinary teams, dementia and EOLC crisis services

Electronic discharge information shall be communicated by the Contractor to GPs within twenty four (24) hours

Pathways used by the contract shall include all sectors including the voluntary sector

The contractor shall develop strong links with social services in-hours and out-of-hours services in order to provide continuity of care to Patients with social care needs

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4. IT Requirements

The Health and Social Care Act 2012 is driving radical changes to way care is provided. To be able to achieve this, clinical providers are required to:

- Provide interoperability between their clinical systems and systems operated by other care providers. This includes, but is not limited to, GPs, clinical care providers, social care providers and cross-provider systems commissioned by the CCG. Such systems are expected to include access for patients / carers;
- Provide enhanced data to the CCG for, but not limited to, analysis of performance, care design and commissioning;
- Use any cross-provider systems that are necessarily commissioned by the CCG;
- Move to a fully paperless environment by 2018 (NHS England timescales) but make material progress towards this in 2014/15.

This applies to existing clinical systems, replacement clinical systems and any new clinical systems.

4.1 Further Detail of the Requirements

Definitions:

4.1.1 In the following paragraphs:

- 'Clinical systems' means the systems that are used by the provider to plan or provide patient care, upon which the provider creates / records / manipulates patient data. This does not include systems used by the provider to manage their business operations (e.g. finance systems);
- 'Interoperability' means interconnection of systems to exchange data, delivery of data in a usable format and possible modification of computer systems to create or make use of the data exchanged.

4.1.2 Requirements for interoperability:

- Providers are required to interconnect their clinical systems with other care providers in the health and social care system; the list of care providers will be defined by the CCG and will be added-to throughout the year;
- Providers are required to use interface approaches defined by the CCG; the interface approaches will use the standards being defined within health and social care where available (e.g. the Interoperability Toolkit definitions);
- The approaches will define all aspects of the interface including, but not limited to, the data to be transferred, the format of the data, the time for data transfer (including real-time), the availability of the data (in terms of hours in the day), the data transfer media / protocols, and the metadata;
- The interface definition may define which technologies should be used for the data transfer including, but not limited to, interface hardware, interface software, technologies for security, and data compression;

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- Interoperability may require the provider to make changes to existing clinical systems to increase the level of integration and usability of exchanged data;
- The exchange may include two-way transfer of data with the ability to update providers' systems by a patient / carer or user outside the provider;
- The data to be transferred will include both patient confidential data and data for secondary use;
- The transfer may be required to go via a third party who may also be used to pseudonymise or anonymise data that is for secondary use;
- Information Governance rules will apply at all times.

4.1.3 Requirements for maintaining interoperability

- Providers are required to maintain their interfaces within defined timescales to accommodate any changes within the wider health and social care system and to continue the delivery of data if the provider changes their own systems;
- Providers are required to test that their interfaces are 'fit for purpose' and ensure that the interfaces do not introduce any errors in the data;
- Providers are required to ensure continuity of availability of data through defined and regularly tested business continuity and disaster recovery arrangements;

4.1.4 Requirements for provision of enhanced data to the CCG:

- Providers are required to provide data to the CCG for, but not limited to, analysis of performance, care design and commissioning;
- The data required will be defined by the CCG and will include information required by the national health and social care bodies, and data required by the CCG;
- Providers may be required to capture and record additional data, not currently available today, that is deemed to be necessary for development of health and social care and meeting the needs of the Mapping the Future programme;
- The data definitions will define all aspects of the data including, but not limited to, the data to be transferred, the format of the data, the time for data transfer (including real-time), the availability of the data (in terms of hours in the day), the data transfer media/protocols, and the metadata;
- Providers are required to ensure that the data is 100% accurate, 100% complete and delivered to agreed timescales or in real-time;
- The data to be transferred will include both patient confidential data and data for secondary use;
- Providers may be required to pseudonymise or anonymise data that is for secondary use before exchange;
- The data may be required to be sent to a third party who may also be used to pseudonymise or anonymise data that is for secondary use;

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- Information Governance rules will apply at all times.

4.1.5 Requirement to use cross-provider systems that are necessarily commissioned by the CCG.

These include, but are not limited to, care plan management systems and continuing health care systems:

- The CCG will commission these systems where it is appropriate to do so;
- Providers are required to use these systems if they are involved in the care that the systems manage;
- The CCG will endeavour to interface such systems to providers' existing systems but this may not always be doable.
- Move to a fully paperless environment by 2018 (NHS England deadline). Achieving this requires providers to:
- Use electronic transfer for all data exchange with patients / carers, GPs, other providers and other stakeholders;
- Extend the reach of systems to devices for mobile staff so there is no need to carry paper documents and data is available / captured at the point of use;
- Implement security on mobile devices to meet Information Governance rules.

4.1.6 In 2014/15, providers are required to:

- Develop realistic plans for achieving this and share the plans with the CCG;
- Make material progress towards a paperless environment within the 2014/15 financial year so that the programme of work can be delivered in advance of 2018.

5. Applicable Service Standards

5.1 Applicable national standards (e.g. NICE)

5.1.1 The Provider must comply with:

- Care Quality Commission Standards
- Relevant pathways, NICE and National Standard Framework (NSF) guidance and ensure clinical audits take place
- The revised hygiene code, The Health and Social Care Act 2008, Code of Practice for the NHS on the prevention and control of healthcare associate infections and related guidance;
- Relevant standards to assure safeguarding of vulnerable adults
- Ensure all staff in contact with, or accessing data about, vulnerable adults have enhanced CRB checks
- Adhere to the Commissioner's procedures, protocols and guidance on Adult Protection
- Embed learning's from Serious Untoward Incidents into internal procedures

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and protocols

- Adhere to the requirements of the Mental Capacity Act 2005 (amended 2007)

5.1.2 The Provider must comply with the following regulations and legislation:

- Equal Pay Act 1970
- Sex Discrimination Act (as amended) 1975
- Race Relations Act 1976 (as amended by the Race Relations (Amendment) Act 2000
- Disability Discrimination Act 1995 (as amended) 2005
- Human Rights Act 1998
- Sex discrimination (Gender Reassignment) regulations 1999
- Employment Equality (Religion and Belief) regulations 2003
- Employment Equality (Sexual Orientation) regulations 2003
- Gender Recognition Act 2004
- Age Discrimination Regulations 2004, and
- Equality Act 2006 (Gender Equality Duty)

5.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

5.3 Applicable local standards

5.3.1 Staffing

- The Provider/s must have in place a detailed staffing plan that describes the staffing arrangements that will enable the delivery of the services for the duration of the contract.
- The Provider/s must ensure there is a staff conduct policy which covers inappropriate behaviour and customer care.
- The Provider/s must have an appropriate range of HR policies (including, but not limited to, policy for recruitment, performance, appraisal, disciplinary issues, staff grievances, alcohol and substance misuses, etc).
- The Provider/s must have appropriate Occupational Health procedures including, but not limited to, procedures to check that staff are fit to carry out all duties safely.
- The Provider/s must ensure all staff are aware of the procedure for reporting incidents.
- All staff must have a good standard of English in order to clearly communicate with attendees. This needs to be in line with current legislation and good practice.
- All staff must be trained in and adhere to the NHS Information Governance

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requirements.

- All staff with access to patients or patient related information must have a current CRB check (at an appropriate level as defined by the Home Office) which must be made available upon request to the Commissioner.
- Staff must also have an identified mentor who will support them in their role to ensure high quality services are provided

5.3.2 Training

All staff are provided with appropriate training to enable them to carry out their duties with due diligence. Training includes:

- Manual Handling
- Risk Assessment
- First aid
- Infection prevention and control
- Incident reporting and management
- Safeguarding
- Promoting independence

5.3.4 Communication

- Authorised Officers and contact points must be identified in the contract for Commissioner.
- The Provider/s staff must have a proactive, friendly, solution-focussed style of communication. A key objective is to have high-quality communication to discuss flexible and innovative approaches.
- The Provider/s must gain patient and staff feedback and demonstrate evidence of improvement in service in line with the feedback, surveys and complaints.
- The Provider/s must ensure that procedures exist for handling complaints in line with the Commissioner's complaints procedures.
- The Provider/s must inform the Commissioner of any Serious Incidents.
- The Provider/s must ensure the Commissioner is made aware of any actions that could impact on service delivery or publicity.
- The Commissioner will ensure the Provider/s is made aware of any actions that could impact on service delivery or publicity.

5.3.5 Management Structures

The Provider/s must ensure that there is an appropriate organisational structure to provide services to the levels specified in this Contract.

Contact details of the designated staff must be made available, i.e. names, titles, email addresses and telephone numbers. This shall be updated should this information change.

The Provider/s is expected to be proactive to ensure the organisation is a good place to work. This includes setting internal Key Performance Indicators and encouraging staff feedback through formal and informal feedback.

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5.3.6 Information Governance

The Provider/s must use an Information Technology solution which will deliver the Information and Security Management requirements of the contract

The Provider/s is responsible for:

- The provision and management of IM&T hardware and software. Systems should use the N3 network, utilising fast broadband, secure networking services which are interoperable with the Commissioners' and other stakeholders' systems.
- Ensuring that appropriate information management and governance systems and processes are in place to safeguard patient information and to comply with confidentiality and Data Protection laws/regulations and Confidentiality Codes of Practice and all other requirements as defined by Department of Health. This must be supported by appropriate training for all staff. All information must be secure in any form or media, such as paper or electronic system. Any exchange of personal/sensitive data must be via an appropriate secure method/process.
- Ensuring full detailed information is available for performance management, audits, prevention of fraud and investigation of any complaints.

All staff must respect the confidentiality of any information relating to the Commissioners, their staff or patients.

5.3.7 Sustainability and Carbon Management

The Provider/s must have a Sustainability policy which underpins their service design.

5.3.8 General Policies

- The Provider/s must comply with all current legislation and policies.
- The Provider/s must comply with all procedures related to all Serious Incidents and Patient Safety Incident reporting.
- The Commissioner requires the Provider's staff to operate a no smoking policy.
- The Provider/s must demonstrate that action has been taken to reduce patient / staff inequalities.
- The Provider/s must comply with Commissioner Safeguarding Children and Adults in Vulnerable Circumstances.
- The Provider/s must have an appropriate range of health and safety related policies including, but not limited to, health and safety, first aid, risk assessment/management and business continuity.

5.3.9 Marketing of this service

The provider/s will support the commissioners to advertise this service across West Kent

6. Applicable monitoring and quality requirements and CQUIN goals

6.1 Monitoring Requirements

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6.1.1 The CCG will collate and circulate performance information. Performance data will be provided to the Operational Group of the Urgent Care Board, which will be responsible for monitoring performance against the service specification.

6.1.2 It is expected that the provider will attend the Operational Group of the Urgent Care Board, when required, to update the group. It is expected that this will be no more than two times a year.

6.2 Applicable Key Performance Indicators

6.2.1 Robust and accurate monitoring information will be reported monthly as detailed below;

- Age
- Gender
- Ethnicity
- Disability
- GP and GP practice code
- Total number of referrals broken down by
    - Time, date and day of referral
    - Service stream (primary care: telephone, base or home visit & hospital at home)
    - Source of referral
    - Reason for referral
- Impact on patient flows (A&E waiting times)
- A&E staff satisfaction
- Discharge date
- Discharge destination (for example GP, community falls service, acute, Romney ward, rehabilitation, reablement, social services, mental health, voluntary services, hospice)
- Total management days provided to the patient,
- Diagnostics undertaken
- Diagnosis, including secondary diagnosis (including if ambulatory care)
- If the referral was rejected, rationale for why the referral was rejected and onward referral made
- Response time for assessment and treatment
- If the treatment was or was not completed and rationale if treatment was not completed
- Prescribing undertaken and drugs dispensed
- Number of people supported to have a good death in their usual place of residence

6.2.2 The provider will be required to support the CCG to carry out an annual audit / case note review in order to track and trace patients to review their longer term outcomes and the services impact on hospital admissions.

6.2.3 For patients seen through the primary are assessment unit the provider will be required to support the CCG to carry out an audit of a selection of case notes to

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assess the effectiveness of the service:

- Mean length of time of patients in the department
- Number of patients referred to specialty teams
- Number of patients admitted to hospital
- Number and type of pathology tests ordered
- Number and type of radiology tests ordered
- Medications / fluids administered whilst in department
- Medications given to take home

6.3 Applicable quality requirements (See Schedule 4 Parts A-D)

- Safeguarding issues, near misses, incidents and Serious Untoward Incidents (SUI's)
- Complaints, compliments
- C Difficile reporting
- Patient satisfaction and patient reported outcome measures. Specifically satisfaction with service, satisfaction with staff, understanding the service, and patient reported measures of improvement.

6.4 Applicable CQUIN goals (See Schedule 4 Part E)

N/A

7. Location of Provider Premises

The Provider's premises will be co-located at Maidstone Hospital and Tunbridge Wells hospital's A&E departments.

Co-location within additional community sites maybe identified by the provider as beneficial in order to meet the needs of patients and improve integration and working arrangements with other services

8. Individual Service User Placement

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 10 October 2014

Subject: North and West Kent: Dermatology Redesign

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Dartford, Gravesham and Swanley, NHS Swale and NHS West Kent CCGs

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

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1. Introduction

(a) NHS Dartford, Gravesham and Swanley, NHS Swale and NHS West Kent CCGs have asked for the attached report be presented to the Committee.

(b) Dermatology is the study and treatment of skin, hair and nail diseases. There are over 1000 recognised dermatological conditions. The Royal College of Physicians estimates that about a quarter of the population in the UK are affected by a skin disease that would benefit from medical care (Royal College of Physicians 2014).

(c) Dermatology is largely an outpatient-based specialty with most referrals coming from GPs. Community specialist nurses and pharmacists play a major role in the treatment of patients outside a hospital setting and can support the self-management of mild chronic inflammatory skin diseases such as eczema and psoriasis (Royal College of Physicians 2014).

(d) Dermatologists also work closely with oncologists (doctors who specialise in the management of cancer), paediatricians (doctors who specialise in the medical care of infants, children and adolescents) and histopathologists (doctors who specialise in studying the changes caused by disease in human tissues) (Royal College of Physicians 2014).

2. Potential Substantial Variation of Service

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

(b) Medway Health and Adult Social Care Overview and Scrutiny Committee considered the proposals on 19 August 2014.They determined that the proposals did not constitute a substantial variation of service.

(c) 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.

(d) 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 CCGs after the meeting. The timetable shall include the proposed date that the CCGs intend 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.

3. 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 submit a report to the Committee in six months.

If the proposed service change is *substantial*:

RECOMMENDED that the proposed service change constitutes 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

Royal College of Physicians (2014) *'Dermatology (24/03/2014)'*, https://www.rcplondon.ac.uk/specialty/dermatology

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West Kent Clinical Commissioning Group
Swale Clinical Commissioning Group

Kent Health and Social Care Overview and Scrutiny Committee (HOSC)

10 OCTOBER 2014

PROPOSED DEVELOPMENT OF THE HEALTH SERVICE OR VARIATION IN PROVISION OF HEALTH SERVICE – CHANGES TO DERMATOLOGY SERVICES

Report from: Jim Loftus NHS Swale CCG (Commissioning Programme Manager.)

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Summary
This report advises the Committee of a proposal under consideration by NHS West Kent CCG, NHS Swale CCG, and NHS Dartford Gravesham & Swanley CCG working in collaboration with NHS Medway CCG to reconfigure/recommission dermatology services. In the view of the CCGs, **this is not** a substantial service reconfiguration.

1. Budget and Policy Framework

1.1 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Kent. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it,

and in particular, relevant information provided to it by a local Healthwatch. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People's Overview and Scrutiny Committee as set out in the Council's Constitution.

2. Background

2.1 Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires relevant NHS bodies and health service providers ("responsible persons") to consult a local authority about any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authority's area. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment. Where more than one local authority has to be consulted under these provisions those local authorities must convene a Joint Overview and Scrutiny Committee for the purposes of the consultation and only that Committee may comment.

2.2 The terms "substantial development" and "substantial variation are not defined in the legislation. Guidance on health scrutiny published by the Department of Health in June 2014 suggests it may be helpful for local authority scrutiny bodies and responsible persons who may be subject to the duty to consult to develop joint protocols or memoranda of understanding about how the parties will reach a view as to whether or not a proposal constitutes a "substantial development" or "substantial variation".

2.3 In the previous protocol on health scrutiny agreed between Kent and NHS bodies a range of factors were listed to assist in assessing whether or not a proposed service reconfiguration is substantial. These are still relevant and are set out below

- *Changes in accessibility of the service. For example, both reductions and increases on a particular site or changes in opening times for a particular clinic. There should be discussion of any proposal which involves the withdrawal of in-patient, day patient or diagnostic facilities for one or more speciality from the same location.*

- *Impact of the service on the wider community and other services, including economic impact, transport and regeneration.*

- *Number of patients/service users affected. Changes may affect the whole population (such as changes to accident and emergency) or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example, renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial.*

- *Methods of service delivery e.g. moving a particular service into a community setting from an acute hospital setting.*

2.4 The enclosed outline proposal from North and West Kent CCG's (see attached Appendix A) was recently submitted to the Medway Health and Adult Social Care Overview and Scrutiny Committee and approved. It informs on factors listed in paragraph 2.3 above, assuring that the proposed change meets the Government's four tests for health service reconfigurations (as introduced in the NHS Operating Framework 2010-2011) and providing information the Committee may need to demonstrate it has considered in the event of a decision to exercise the right to report a contested service reconfiguration to the Secretary of State for Health.

2.5 The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State in certain circumstances, after reasonable steps have been taken locally to resolve any disagreement between the local authority and the relevant responsible person on any recommendations made by the local authority in relation to the proposal. The circumstances in which a report to the Secretary of State is permitted are where the local authority is not satisfied that consultation on the proposed substantial health service development or variation has been adequate, or where the authority considers that the proposal would not be in the interests of the health service in its area.

3. Proposed service development or variation

NHS West Kent CCG, NHS Swale CCG, and NHS Dartford Gravesham & Swanley CCG are working in collaboration with NHS Medway CCG to redesign dermatology services for children and adults. Services will continue to be provided under the NHS standard contract offering choice of provision to all patients living within the CCGs areas. Our intention is to enable a larger proportion of the works to be undertaken outside an acute hospital setting. The majority of registered patients currently attend Medway Foundation Trust (MFT) acute services with a minority proportion being treated within the community setting. By far, the largest volume of activity takes place as out-patient consultations within Medway Foundation Trust by consultant dermatologists in the acute service, although, Kent Community Health Trust (KCHT), DMC Healthcare, Concordia and KSYOS Teledermatology provide some community based services. However, there are a significant proportion of patients who could be treated by a skilled workforce within the community setting (level 3), releasing specialist appointment capacity within the acute service. Currently community based services are limited and vary across CCGs. Any service provider awarded a future contract will be expected to provide the service delivering to a high quality service specification with services available closer to home, in a number of local community settings, providing good access, both in terms of clinic location and clinic times. Detail in Appendix A.

4. Advice and analysis

4.1 The Committee needs to determine in discussion with the responsible person whether or not the proposed reconfiguration is substantial and therefore subject to the formal requirement for consultation with Overview and Scrutiny.

4.2 If the proposed reconfiguration is substantial the Committee should be advised of the date by which the responsible person intends to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny Committee comments must be submitted.

4.3 If it is agreed that the proposed change is not substantial the Committee may make comments and recommendations to the Commissioning body and or Provider organisation as permitted by the regulations in relation to any matter it has reviewed or scrutinised relating to the planning, provision and operation of the health service in Kent.

5. Risk management

5.1 Risk management is an integral part of good governance. The Council has a responsibility to identify and manage threats and risks to achieve its strategic objectives and enhance the value of services it provides to the community.

The risks associated with the redesign of dermatology services within North and West Kent have been identified within the risk log (see next page)

NHS Dartford Gravesham and Swanley Clinical Commissioning Group

NHS West Kent Clinical Commissioning Group

NHS Swale Clinical Commissioning Group

North and West Kent Dermatology Redesign Risk Log

Risk Description	Current: Consequence	Current: Likelihood	Current: Initial Risk	Mitigations/Key Controls in Place	Internal & External Assurances on Controls	Target: Consequence	Target: Likelihood	Target: Residual Risk
If there is no fully defined service specification to meet requirement of our local population,there would be failure in delivering project objectives which impact negatively on service provisions to patients.	3	3	9	NK and WK Dermatology Redesign Group established who have been involved in identifying the local service needs. Patients Group representatives have been consulted for their comments on their Dermatology service needs. Patients and public consultation has been completed to further ensure patients' views on local service requirement . Draft Service Specification presented at the initial market engagement to potential service providers' and their feedback was captured via SWOT analysis. 1-2-1 potential providers' consultation surgeries have been completed. All the above will ensure that service specification reflect the needs of local population including the availability of service providers' for service delivery within the service specification.	Market Engagement event feedback evaluation report. Minutes of meetings with all four CCGs. Emails correspondences between the four CCGs on the editions of the Draft service specification. Patients, public and clinicians engagement completed questionnaires and report	3	1	3
If we fail to attract interest from appropriately skilled and resourced service providers to deliver against service specification, project objectives will not be delivered and this will have a negative impact on the services provided to the local populations including patients being put at risk.	3	3	9	Engaged interested providers at the market testing engagement event and at the 1:1 follow up commissioner/provider consultation sessions. Providing timely responses to questions raised by potential service providers. Successful providers' market engagement event completed. Review of workforce/skill mix to take place with the provider of the service following completion of a skills audit.	Market Engagement Event Expression of Interest Register and the event attendance register. 1-2-1 consultation surgeries attenadance register	3	1	3
If information is not properly managed, there is a potential to destabilise existing service provider during the period of service redesign and market engagement events. This will result in an inadequate service being delivered to patients which will increase waiting times and result in potential delays in diagnosis and treatment. This will subsequently have impact on increase in patients complaints and reduce patients confidence level in the service provision and the CCG integrity.	3	4	12	Involve current service providers in all necessary communications. Prompt identification and effective management of issues and risks relating to service delivery. Ensure ongoing service performance monitoring including scrutiny of activity data. Prompt identification of challenge with existing providers including resolution as appropriate. Develop dermatology service in the community to mitigate for pressures on existing resources in the acute setting threatening to destabilise the existing provider.	Agreement through NK& WK Dermatology Redesign Group on actions with current providers if need arises. Market Engagement Event Expression of Interest Register and the event attendance register. 1-2-1 consultation surgeries attenadance register	3	1	3
If there is no clarity of the understanding and the implication of TUPE system on project, there may be risk of service delivery not attracting service providers as most providers does not want to inherit TUPE costs	3	3	9	Met with HR representative to understand TUPE system. Got appropriate advice from HR and Finance to understand the implication of TUPE system on project. HR representatives to be involved at an appropriate time as the project progress.	Met with HR representative to understand TUPE system. Got appropriate advice from HR and Finance to understand the implication of TUPE system on project. HR representatives to be involved at an appropriate time as the project progress.	2	2	4

Risk RAG Scoring Matrix		Likelihoods				
Consequencies		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost Certain
	Catastrophic (5)	5	10	15	20	25
	Major (4)	4	8	12	16	20
	Moderate (3)	3	6	9	12	15
	Minor (2)	2	4	6	8	10
	Negligible (1)	1	2	3	4	5

6. Consultation

North Kent (including Medway) and West Kent Clinical Commissioning Groups consulted with dermatology service users to understand their treatment pathways (from referral to treatment) and their experiences of the service to date. Over 1700 questionnaires were distributed between 9 June and 25 July across North and West Kent CCG areas via acute, community and primary care providers. A standard questionnaire format has been used for this engagement with face to face consultations carried out to capture unique experiences from referral to treatment. 411 questionnaires were completed and returned. Analysis of the completed questionnaires has been done with draft report produced for the commissioners to consider in progressing the project in the right direction. Detail in Appendix A.

7. Financial implications

7.1 This work will be undertaken under existing CCGs budget

8. Legal implications

8.1 Provision for health scrutiny is made in the Local Authority (Public Health, Health and wellbeing Boards and Health Scrutiny) Regulations 2013 together with a requirement on relevant NHS bodies and health service providers to consult with local authorities about any proposal they have under consideration for a substantial development of or variation in the provision of health services in the local authority's area

9. Recommendations

9.1 The Committee is asked to consider the proposed development or variation to the health service as set out in this report and Appendix A and decide whether or not it is substantial together with the consequential arrangements for providing comments to the relevant NHS body or health service provider.

Background papers

Appendix A: Dermatology HOSC Questionnaire
Appendix B: Pre-Engagement Report

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Appendix A: North and West Kent Dermatology Paper - HOSC brief outline of proposal

Kent Health and Social Care Overview and Scrutiny Committee (HOSC)

Assessment of whether or not a proposal for the development of the health service or a variation in the provision of the health service in Kent *(West Kent, Swale and Dartford Gravesend & Swanley)* is substantial

A brief outline of the proposal with reasons for the change

Commissioning Body and contact details:

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Dartford Gravesend & Swanley Clinical Commissioning Group (DGS CCG)
Zoe McMahon (Commissioning Programme Manager)
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Current Providers:
Medway Foundation Trust & Kent Community Health Trust – West Kent CCG
Medway Foundation Trust , Concordia & DMC Health Care– Swale CCG
Medway Foundation Trust & KSYOS Teledermatology Provider - DGS CCG

Outline of proposal with reasons:
NHS West Kent CCG, NHS Swale CCG, NHS Dartford Gravesham & Swanley CCG is working in collaboration with NHS Medway CCG to redesign and commission an integrated Dermatology service for children and adults. Services will continue to be provided under the NHS Standard Contract offering choice of provider to all patients. Our intention is to enable a larger proportion of work to be undertaken outside of an acute hospital setting.

The majority of registered patients currently attend Medway Foundation Trust (MFT) acute services with a minority proportion being treated within various community

settings as specified above. By far the largest volume of activity takes place as out-patient consultations within Medway Foundation Trust by consultant dermatologists. In addition, Kent Community Health Trust (KCHT), DMC Healthcare, Concordia and KSYOS Teledermatology provide some community based services in Kent and Medway Community Health in Medway. These services are delivered by a combination of consultants, nurse specialists and GPs with special interests in dermatology.

Clinically, for some patients with conditions such as basal cell and squamous cell carcinomas, malignant melanomas and those requiring systemic medication (level 4 and above) treatments and monitoring; the acute hospital setting is absolutely the right place to be treated. However, there are a significant proportion of patients who could be treated by a skilled workforce within the community setting (level 3), releasing specialist appointment capacity within the acute service. Currently community based services are limited. Any service provider awarded a future contract will be expected to provide the service delivering to a high quality service specification with services available closer to home, in a number of local community settings, providing good access, both in terms of clinic location and clinic times.

Intended decision date and deadline for comments (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require the local authority to be notified of the date when it is intended to make a decision as to whether to proceed with any proposal for a substantial service development or variation and the deadline for Overview and Scrutiny comments to be submitted. These dates should be published.

Decision to proceed with the service design will be taken as follows;

West Kent (WK) CCG – NHS WK Performance Oversight Group on 17 September 2014; Clinical Strategic Group (CSG) on 14 October 2014

Swale CCG –NHS Swale Clinical Strategic Committee on 14TH November 2014 and Finance and Performance on 21st.November 2014

DGS CCG - NHS DGS Clinical Cabinet on 11th November 2014 and Finance and Performance on 18th November 2014

Alignment with the Kent Joint Strategic Needs Assessment (JSNA) 2012

Please explain below how the proposal will contribute to delivery of the priority themes and actions set out in Kent JSNA:

The CCGs are using a procurement process to ensure that patients continue to

have choice and are able to access a timely, quality service. This is consistent with the overall ambition expressed in the Kent JSNA to improve overall health of the population.

The CCG will follow due process as laid out in guidance published by Monitor 2013 (Procurement, Patient Choice and Competition no.2 Regulations) http://www.legislation.gov.uk/uksi/2013/500/regulation/3/made

We will set contractual targets with key performance indicators to ensure positive impacts for patients. The services will be provided in a more integrated way (including with other health care services, health-related services, or social care services), ensuring good accessibility and allowing patients a choice of services within a setting in their local community.

The equality analysis details positive impacts for patients through the dermatology service redesign, improving access to services within community settings without removing access to acute provision as clinically appropriate.

Please provide evidence that the proposal meets the Government's four tests for reconfigurations (introduced in the NHS Operating Framework 2010-2011):

Test 1 - Strong public and patient engagement

(i) Have patients and the public been involved in planning and developing the proposal?
(ii) List the groups and stakeholders that have been consulted
(iii) What has been the outcome of the consultation?
(iv) Weight given to patient, public and stakeholder views

The CCGs have worked together to consult with dermatology service users to understand their treatment pathways (from referral to treatment) and their experiences of the service to date through a number of mechanisms outlined below. Potential service providers and clinical experts have also been consulted**.**

- *CCG Patient Participation Group (PPG) Engagement:* A project presentation was delivered to the PPGs across all the CCGs. This was used to inform and engage the PPG group on this project which successfully gained their support for the project. (July/August 2014)

- *Patients & Public Engagement:* Kent & Medway Commissioning Support Unit led and completed this aspect of the project on behalf of the 4 CCG's. Between 9 June and 25 July 2014 clinical staff across a number of providers handed out over 1,700 questionnaires to their patients with 411 returned and completed. Analysis of these questionnaires is completed with draft report produced in August 2014 (attached below).Information emerged from the report showed that

patients value the acute hospital service.

However patients feedback shows:

- Appointments booking process is inefficient
- Long waiting times for appointments
- Access to local service and appointment in a timely manner are important
- Parking access and charge concerns
- Consultation with clinician is brief
- Long distance travelled to access Dermatology service by some users

- *Clinician Engagement*: The need to reconfigure services was identified through engagement with CCG GPs and Consultants in MFT. All clinical leads across the CCGs including representative GPs from all GP practices have been successfully informed-involved-engaged on this project.

- *Initial Providers' Market Engagement Event:* successfully completed. Over 40 delegates were in attendance across 16 different organisations. Completed evaluation of the event outcome have been used to positively develop the project (July 2014)

- *Providers' 1-2-1 Consultation Surgeries:* successfully completed with 10 different potential providers. The successful outcome of these surgeries assisted the commissioners to measure the true potential providers' interest in providing services and potential models of service delivery, which further informed on the final model to procure (August 2014)

- Wider Stakeholders Engagement: British Association of Dermatologist (BAD) and Strategic Clinical Network (Cancer). These consultations have clarified the need for the retention of services such as level 4 and above specialist provision in a setting with access to high level equipment and resources and robust multi-disciplinary team.

- This consultation also highlighted the national and local shortage of consultant dermatologists and stressed the importance of configuring services so that patients are seen by the most appropriate health care professional for their particular needs thus utilising consultant dermatologists where their expertise is required.

Overall the outcome of this consultation directs us to the need to reconfigure dermatology services so that community services are integrated, equitable and available locally thus enabling a safe and effective move of more provision to the community ensuring quality remains whilst retaining certain specialist dermatology services in the acute hospital setting..

Test 2 - Consistency with current and prospective need for patient choice

The CCG has actively engaged with patients, local GPs, clinicians, current providers, British Association of Dermatology and Strategic Clinical Network (Cancer) to understand current issues and choices being made by patients. A key focus of the service review and redesign is to ensure that patients continue to have choice of local provision and are able to access timely, quality services locally.

Our proposal aims to provide an integrated community Dermatology service which is equitable both in terms of patient access and choice – this will address the issues/inequities experienced by current service provision. The service specification will be developed to ensure that the programme is offered from a number of geographical areas across West Kent and North Kent with good transport links and parking facilities. In addition, choice will still apply to patients in West Kent and North Kent. Clinics at the acute trust hospital will remain with expansion of community service provision. The services will be provided in a more integrated way (including with other health care services, health-related services, or social care services), ensuring good accessibility and allowing patients a choice of provision within a setting in their local community.

We will continue to support patients and where appropriate offer informed choice of treatment and care options.

Test 3 - A clear clinical evidence base

(i) Is there evidence to show the change will deliver the same or better clinical outcomes for patients?
(ii) Will any groups be less well off?
(iii) Will the proposal contribute to achievement of national and local priorities/targets?

The Government's White Paper *Our Health, our care, our say: a new direction for community services* (published 2006) proposed a planned shift of care closer to the patient and their community. The National Dermatology Workforce Group (sub group of the Long Term Conditions Care Group Workforce Team), was commissioned by the Workforce Review Board to assess current service models for dermatology and suggest future models. A report was published in January 2007.

In summary, the report found that the present balance of service provision may be skewed with too many patients attending hospital based services for the provision of care that could be managed in a community setting. Any future model should concentrate on service delivery governed by three broad statements:

- Secondary care teams should do those things that only they can do;
- Care should be delivered in the right place by individuals with the right skills and at the right time (first time);
- Policies should facilitate patient self-management.

While various community services have been developed in Kent and Medway in the period since this report they have not been optimally integrated and this project aims to address that integration. Our market research has identified areas where integrated community dermatology services are already being delivered with evidence of improved patient experience, good outcomes and shorter waiting times and gives us confidence that this can be done for our patients

In addition there will be a focus of developing and future proofing a model that meets the needs of patients within the financial envelope. The model proposed will improve access and experience for all users and no user groups will be disadvantaged by this reconfiguration.

Services should be delivered in line with the following guidance:

- Our Health, Our Care, Our Say; A new direction for community services (DH January 2006)
- Commissioning Framework for Health and Well-being (DH 2007)
- Commissioning safe and sustainable specialised paediatric services (DH 2008)
- Shifting care closer to home dermatology report (DH 2006)
- Implementing care closer to home, Parts 1 – 3 (DH 2007)
- Revised guidance and competences for the provision services using GPwSI (DH 2011)
- Commissioning Guidance (British Association of Dermatologists 2008)
- Improving Outcomes for People with Skin Tumours including Melanoma (NICE 2006)
- Model of Integrated Service Delivery in dermatology
- Improving Outcomes Guidance for Skin Tumours including Melanoma (NICE updated May 2010)
- Skin cancer Peer Review Measures (NCAT 2008 and update 2011)
- Referral guidance for skin cancer (NICE 2005)

The guidance documents detailed above are not an exhaustive list and providers will be expected to work to new and emerging policy guidance which relates to and links the delivery of dermatology community services and the well-being of patients.

Test 4 - Evidence of support for proposals from clinical commissioners – please include commentary specifically on patient safety

All the CCGs clinical leads including the member GP Practices have been fully engaged at every stage and are fully in support of the project development.

As part of the governance process within CCGs, the progress and recommendations of this project have been reported to Clinical Strategy Boards and appropriate Governing Bodies. Final approval of business cases is expected in October/November.

The clinical leads for the dermatology service redesign workstream are as follows;

Dr Mark Ironmonger - West Kent CCG
Dr Mick Cantor - Swale CCG
Dr Balaji Chalapathy - Dartford, Gravesham and Swanley CCG
Dr Chris Markwick - Medway CCG

The CCGs are working to ensure that community dermatology services are commissioned to a consistently high quality, to ensure that services are:

- Safe – ensuring that the services are safe
- Effective – focused on delivering best outcomes for patients
- Standardised – all services are provided to consistent standard and format so patient can expect the same quality of care and access to care where ever they are treated.
- Fair – available to all, taking account of personal circumstances and diversity

The service specification document will specify the outline for a community dermatology service (Level 3 of the overall Dermatology Service) for patients seen locally in a community setting. The key drivers for the development of a community dermatology service are to provide a local, more accessible and cost effective service for patients, as set out in government documents such as:

- 'Our Health, Our Care, Our Say; A New Direction for Community Services[1],
- 'Improving Outcomes for People with Skin Tumours including Melanoma[2]'.
- 'Model of Integrated Service Delivery in Dermatology[3]'
- Next Stage Review and[4];
- High Quality Care for All[5].

[1] Our Health, Our Care, Our Say; A New Direction for Community Services, DH (2006)
[2] Improving Outcomes for People with Skin Tumours including Melanoma
[3] Model of Integrated Service Delivery in Dermatology, Skin Care Campaign (2007)
[4] Next Stage Review 2008 [5] High Quality Care for All 2009

Effect on access to services

(a) The number of patients likely to be affected
(b) Will a service be withdrawn from any patients?
(c) Will new services be available to patients?
(d) Will patients and carers experience a change in the way they access services (i.e. changes to travel or times of the day)?

Data shows that there are approximately 48,000 appointments for dermatology services across the 4 CCG areas (excluding level 5&6).
The majority of the CCGs patients (approx. 80-85%) are currently referred annually as new patients for a first out- patient appointment to an acute hospital, the vast majority of these being to Medway Foundation Trust. with the remainder being seen by community providers It is anticipated that 60% – 70% (approximately 23,500) of patients will receive future services within the community setting releasing capacity in the acute trust to treat patients with more complex conditions.

Whilst potential demand is expected to increase the model aims to support patients within the management of primary care, with additional training and support to GP's in a primary setting.

The CCGs will take action to improve quality and efficiency in the provision of the services, ensuring that the model is financially sustainable; this will also be supported with a drive coming from the current hospital acute provider.

The services will be provided in a more integrated way (including with other health care services, health-related services, and social care services as relevant), ensuring good accessibility and allowing patients a choice of provision of the services within a setting in their local community. We have used the patient engagement/consultation feedback to inform our service specification to improve access to services as outlined in the response to Test 1.

Demographic assumptions

(a) What demographic projections have been taken into account in formulating the proposals?
(b) What are the implications for future patient flows and catchment areas for the service?

The growth in need for dermatology services mirrors the well documented changes in population growth and demographics, particularly the rising elderly population. It is recognised that there is a year on year growth and the need for a percentage of

activity to take place in the community. This will achieve cost effectiveness and value for money of community services.

The dermatology service review and redesign proposals support the Kent Joint Strategic Needs Assessment (2012) results in regards to patient experience of acute hospital out-patient appointment waiting times in the departments. The JSNA notes that patient experience is adversely affected by long waits in the out-patient system. Future community based services will release capacity within the acute out-patient department improving experience. Patients currently travel from all over the CCGs area to the acute hospital, it is envisaged that community provision will increase the choice of clinic location and appointment times.

Diversity Impact
Please set out details of your diversity impact assessment for the proposal and any action proposed to mitigate negative impact on any specific groups of people in Kent?

There are positive impacts to the dermatology service redesign, improving access to services within community settings without removing access to acute provision as clinically appropriate.
The Dermatology service redesign is in the design phase with various options of service delivery in the community being considered. The patient and carer engagement draft report was completed in August 2014and the outcome of this has and will continue to help to inform future decisions.

Financial Sustainability
(a) Will the change generate a significant increase or decrease in demand for a service?
(b) To what extent is this proposal driven by financial implications? (For example the need to make efficiency savings)
(c) What would be the impact of 'no change'?

Referrals to dermatology services increased by 5% in 2013/14 compared to the previous year 2012/13. To continue investing into acute hospital services without developing community based services is untenable. Continuing to refer patients to dermatology services in the acute setting is not cost effective for the majority of patients who do not require specialist services. The acute specialist services currently treat patients with a clinical diagnosis that although requiring specific high level quality services do not need a specialist multi-disciplinary team approach in hospital.
We recognise that there is a shortage of dermatology specialists (locally and

nationally). The new model will be building capacity of a workforce and delivering a service through a multi-disciplinary team with range of skill sets.

Wider Infrastructure

(a) What infrastructure will be available to support the redesigned or reconfigured service?

(b) Please comment on transport implications in the context of sustainability and access

Dermatology service (level 3) which was previously only available from the acute hospital will be located in community based settings within the CCG area basing services in GP surgeries, community hospitals, healthy living centres and Gateways. The high quality services will be delivered with consideration given to public transport access for patients both in terms of clinic location and clinic times.

Is there any other information you feel the Committee should consider?

The Clinical Commissioning Group has actively engaged with patients, local GPs, clinicians, British Association of Dermatology and the South East Coast Strategic Clinical Network (Cancer) to understand current issues and choices being made by patients. Any specific issues raised or key themes that emerge from the engagement sessions have been considered during business case and service specification development. A key focus of the service review and redesign is to ensure that patients continue to have choice of local providers and are able to access timely, quality services locally.

On 19th August 2014, Medway CCG presented Dermatology service redesign paper to Medway Health and Social Care Advisory Committee (HASC). The committees concluded that the dermatology proposals did not constitute a substantial variation or development of service.

Please state whether or not you consider this proposal to be substantial, thereby generating a statutory requirement to consult with Overview and Scrutiny

The Clinical Commissioning Groups do not believe the proposed new dermatology model is a substantial service variation. The development of the service will be undertaken through a robust procurement process. Any service provider awarded a

contract will be expected to provide the service delivering to a high quality service specification with services available closer to home, in a number of local community settings, providing good access, both in terms of clinic location and clinic times.

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KMCS>

NHS

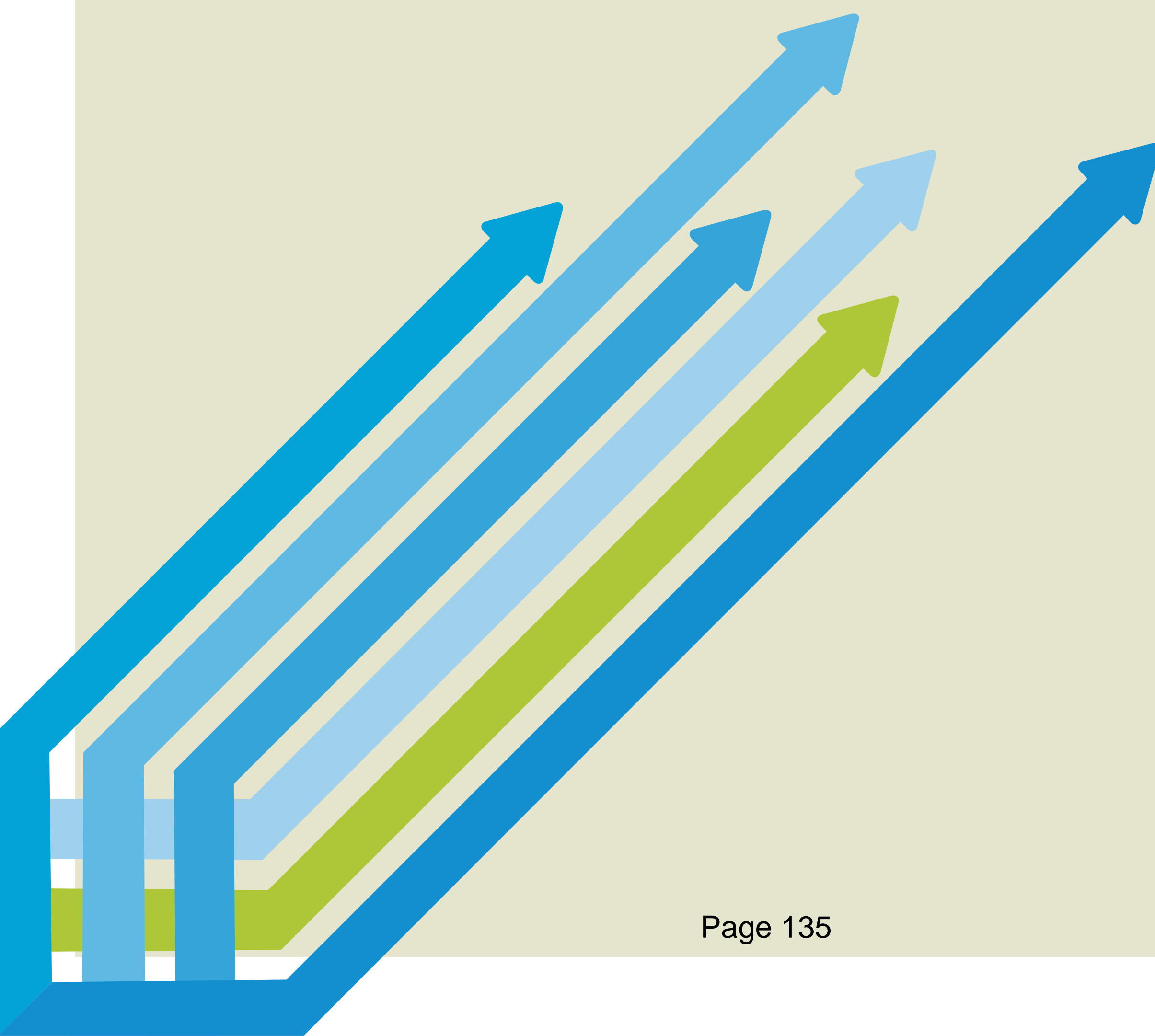
Kent and Medway
Commissioning Support Unit

APPENDIX B:

Dermatology service procurement –

Pre-engagement

September 2014



1 Document control sheet

Document history			
Version	Date	Author	Comments
0.1	31.7.14	F.Gaylor	
0.2	4.8.14	F. Gaylor	Comments from Katie Blissett
0.3	9.9.14	F. Gaylor	Comments from Swale, West Kent and **Medway Commissioners**

Approvals Records			
Version	Date	Approver	Comments

Dermatology services procurement
North and West Kent Clinical Commissioning Groups
July 2014
Patient engagement snapshot

Clinical Commissioning Groups in Medway, Swale, West Kent and Dartford Gravesham and Swanley wanted to find out patients experience of using local dermatology services.

The key driver for dermatology service redesign is to avoid disparate local service provision, improve patient experience and outcomes, provide a local, more accessible and cost effective service for patients meeting local need, in line with internal commissioning priorities, national policy direction and models of service delivery. The end goal for this project is for an integrated secondary, community, primary care Dermatology pathway through re- procurement, which makes best use of available expertise.

About the current service

Medway NHS Foundation Trust provides the majority of dermatology services for Medway, DGS, Swale and West Kent CCGs through consultant led secondary care services at Medway Hospital. Medway Community Healthcare provide community based nurse led services with consultant overview only for Medway CCG with various community models providing services across DGS, Swale and West Kent, including tele–dermatology, GPwSI clinics and consultant led community clinics.

About the questionnaire

In partnership with Kent and Medway Commissioning Support Unit a patient questionnaire was developed to help commissioner's to understand patients' experiences and any improvements that could be made to the service (information about those who participated – including demographics can be found at Appendix 1).

Patients were asked to comment about a number of factors around their experience including:

- Before entering the Dermatology service (i.e. referral process into the service)
- Accessibility of appointments (timings, locations and date)
- Areas for improvement and future preferences
- Patient pathway through primary, community and secondary services

For clarity, the survey was not aimed at assessing the quality and experience of individual providers or clinics.

Clinic staff across a number of providers handed surveys out over 1,700 questionnaires to their patients between 9 June and 25 July 2014. All patient health networks and voluntary

and community groups across Medway, Swale, West Kent and Dartford Gravesham and Swanley were also given the opportunity to participate via an online survey. West Kent also discussed this with their PPG Chair's group as part of the project.

To complement the survey method, eighteen face-to-face sessions with patients were undertaken by KMCS and CCG staff on the following dates:

Date	Clinic	Provider
2nd July	Parkwood (Medway)	Medway Community Healthcare
8th July	Sittingbourne Memorial (Swale)	DMC
10th July	Medway Hospital	Medway Foundation Trust
11th July	Rochester Healthy Living Centre (Medway)	Medway Community Healthcare
11th July	Maidstone Hospital (West Kent)	Medway Foundation Trust
14th July	Lordswood Healthy Living Centre (Medway)	Medway Community Healthcare
14th July	Edenbridge (West Kent)	Medway Foundation Trust
15th July	Lordswood Healthy Living Centre (Medway)	Medway Community Healthcare
15th July	Lordswood Healthy Living Centre (Medway)	Medway Community Healthcare
15th July	Lamberhurst GP Surgery (West Kent)	Specialist GP
17th July	Medway Hospital (Medway)	Medway Foundation Trust
21st July	Borough Green (West Kent)	Medway Foundation Trust
22nd July	Sheppey Community Hospital (Swale)	DMC
22nd July	Sittingbourne Memorial Hospital (Swale)	DMC

22nd July	Lamberhurst GP Surgery (West Kent)	Specialist GP
23rd July	Darent Valley Hospital (West Kent)	Medway Foundation Trust
25th July	Sevenoaks hospital (West Kent)	Medway Foundation Trust
25th July	Maidstone Hospital (West Kent)	Medway Foundation Trust

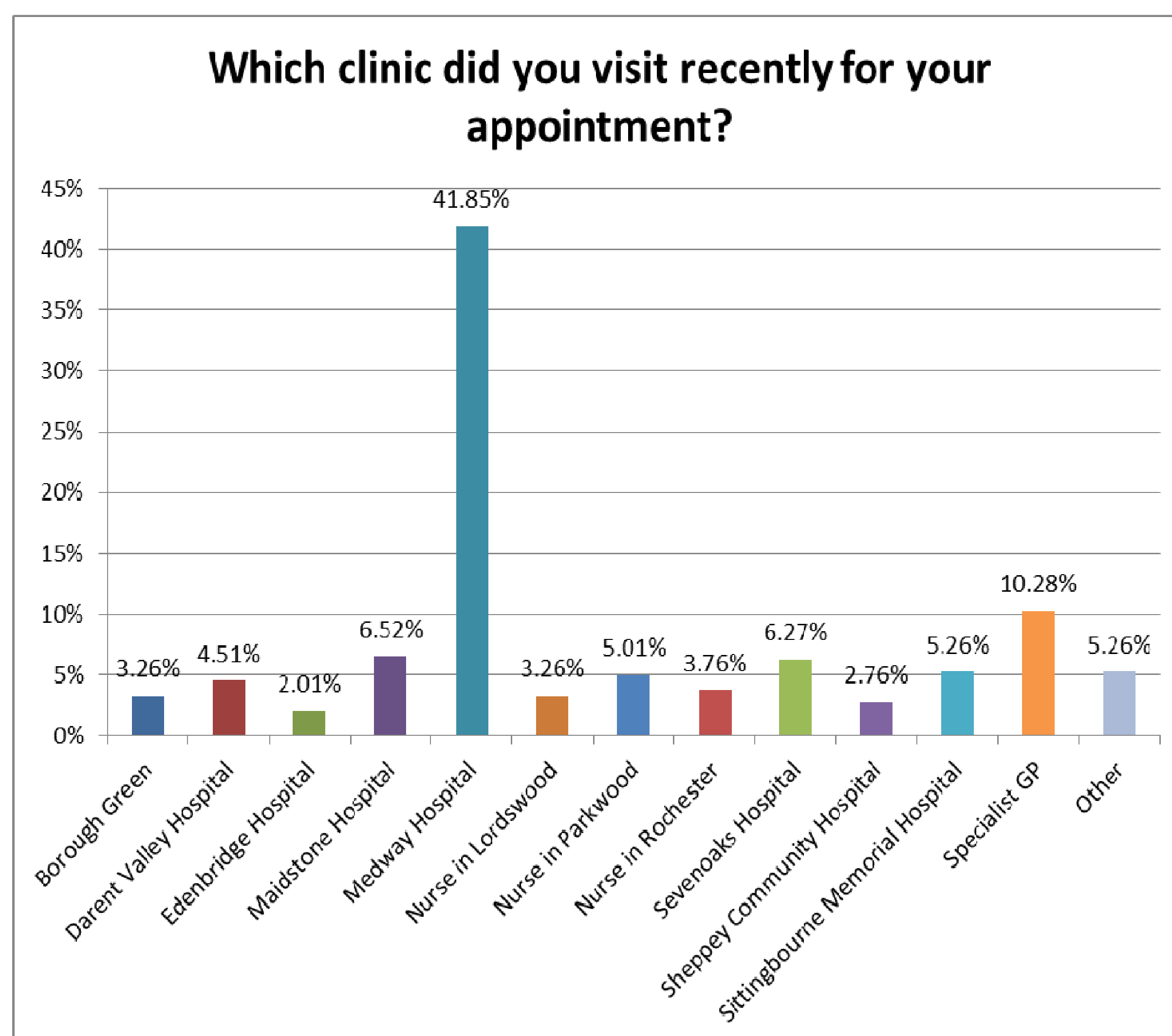
It is estimated that approximately half of all responses collected were through face-to-face work.

Survey analysis

In total, 411 responses were received between the 9th of June and the 25th of July 2014. Of those who responded, the majority were from Medway Hospital (which is proportionate to activity data provided by commissioners), which is the only acute site, offering Dermatology services across North and West Kent.

Patients also reported (under the "Other" category) that they were being seen at Orpington, Guys Hospital and some other private providers.

Graph 1: ***Which clinic did you visit recently for your appointment? (See Appendix 2 for Table 1)***



By looking into postcode data provided, the below table (Table 2) provides details on which CCG area patients are responding from:

Table 2: ***Which Clinical Commissioning Group are respondents from***

CCG area	**Responses**	**%**
DGS	56	13.63
Medway	138	33.58
Swale	54	13.14
West Kent	152	36.98

The remaining 3% of responses were incomplete and did not detail postcode information. When looking at outpatient activity data, over a year, in Dermatology, it is fair to say that (during the six week time period) the numbers collected were a representative sample (approximately 10% of the population of dermatology service users). It is also representative in terms of numbers of patients interviewed per CCG area.

Comparing CCG area with treatment location enables us to see how many patients are receiving treatment in another CCG area:

Table 3: ***Which patients have been seen out of their CCG area (determined by patient's postcode) for treatment***

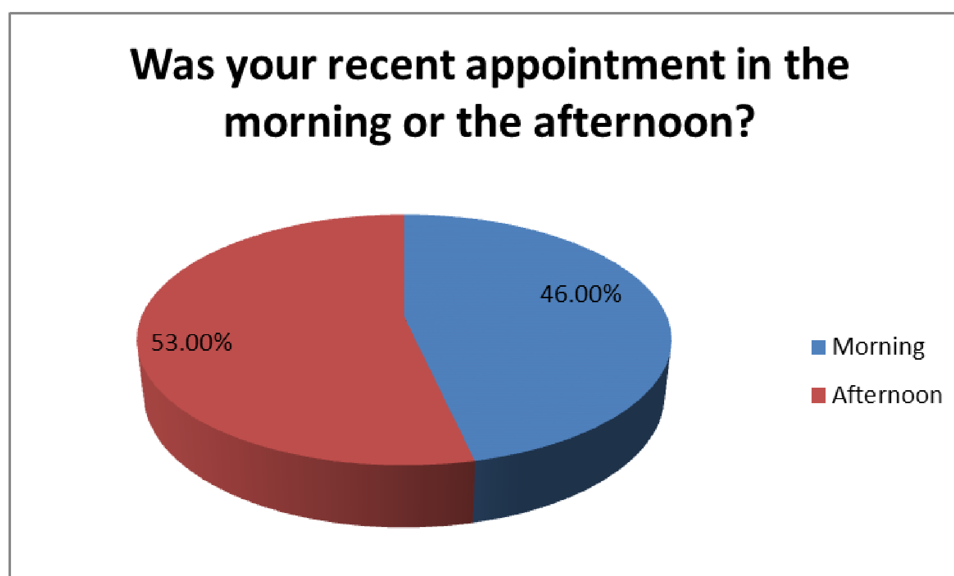
	Borough Green	**Darent Valley**	**Maidstone Hospital**	**Medway Hospital**	**Medway Community Healthcare**	**Sheppey Community Hospital**	**Sittingbourne Memorial Hospital**	**GP specialist**	**Other**
DGS				38					
Medway	1	1	4			1	2	3	
Swale				17	1				
West Kent				36			3		5

Of those that responded, 27% were treated, for either a first or follow up appointment, out of their CCG area, the majority of which were seen at Medway Hospital (Table 3).

Anecdotal evidence from face-to–face sessions indicated that patients, who are being seen out of their CCG area, do not realise clinics are available closer to them. It appeared that some satellite clinics provided by Medway Foundation Trust are follow up clinics rather than active treatment centres, with some patients actively commenting that they had to travel to Medway Hospital for active treatment, for example UV showers, and were now being followed up at other clinics.

The percentage of patients attending either a morning or an afternoon appointment was roughly the same, 46% in the morning and 53% in the afternoon, as shown below (Graph 2):

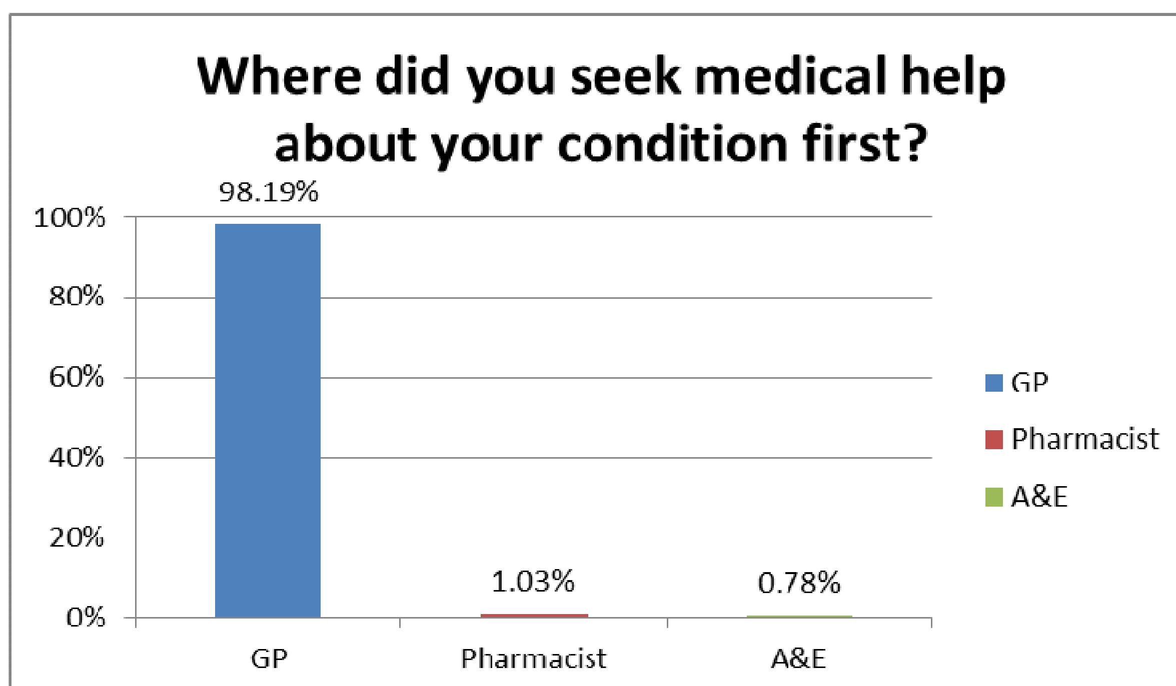
Graph 2: ***Was your recent appointment in the morning or afternoon? (393 patients)***



As part of the survey, patients were asked to explain the skin, hair or nail condition they were being treated for. The top conditions included; warts, moles, verruca's, skin cancer, psoriasis and acne.

When patients first noticed their problems, overwhelmingly 98% visited their GP for help (Graph 3).

Graph 3: ***Where did you seek medical help first ? (387 patients)***



Other healthcare professionals such as health visitors, podiatrists and gynaecologists were also listed as the first point of contact for dermatology patients.

Over 50% of patients who went to see a GP about their skin, hair or nail condition visited them more than once before being referred to the dermatology department. Over 30% were seen only once by a GP before being referred to dermatology (Graph 4).

During face-to-face discussions, many patients explained they felt they had to push for a referral, or had been given alternative treatments in primary care before being referred on. At follow up appointments 67% of patients were receiving active treatment, with the remaining 33% being reviewed and monitored.

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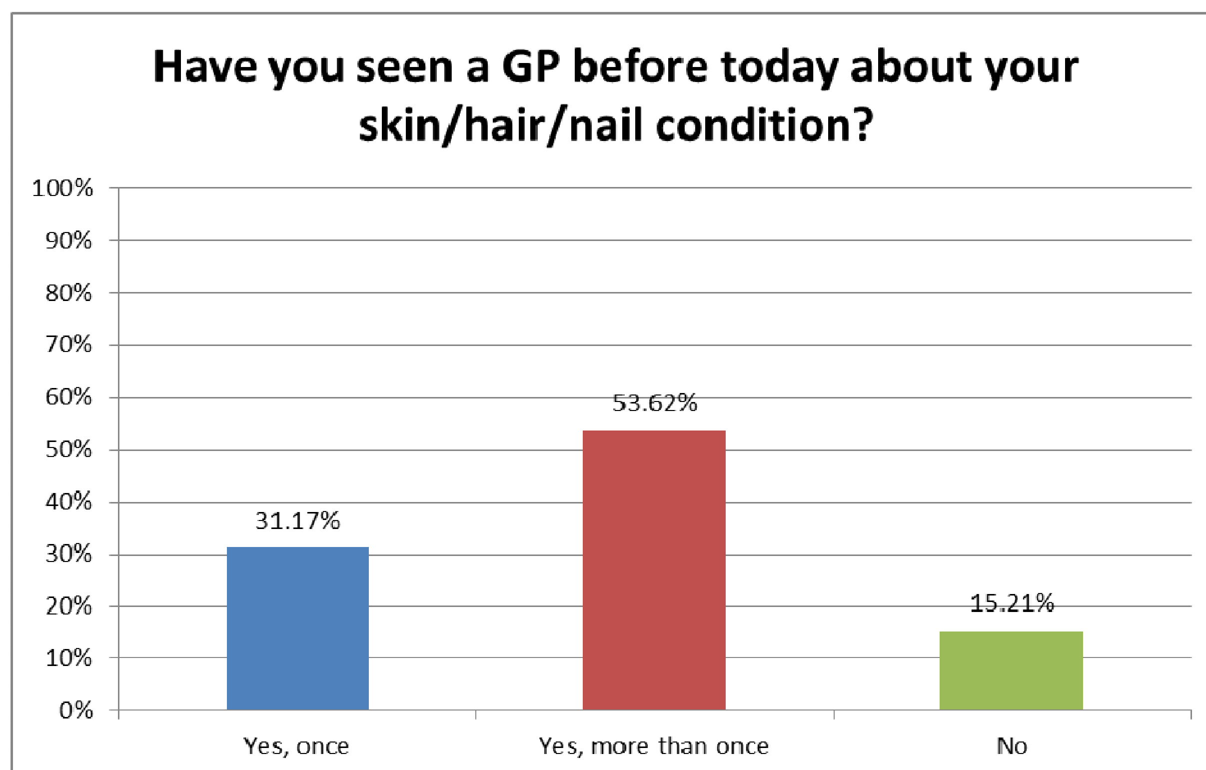
Graph 4: ***Have you been to see a GP, before today, about your skin/ nail/ hair condition? (401 patients)***



At the point of referral, half of patients felt completely happy with the explanation the GP gave about why they were being referred to dermatology and what would happen next. During face-to-face sessions, patients commented that they sometimes had to ask many questions to understand what was happening with 15% of patients feeling they did not get a good explanation of the referral process and next steps.

Of those that responded, most (80%) had not used tele-dermatology services across North and West Kent.

Over 50% of patients had previously had an appointment in dermatology, with 47% being seen, for their first appointment, more than one year ago, indicating that a large portion of patients are long term. A small number of patients, during face-to-face sessions explained that they had been receiving some form of dermatology services for more than ten years. A quarter of patients were first seen less than three months ago.

In terms of waiting times, from the time of referral to first appointment, 48% of patients waited two to six months and 26% waited one month for an appointment (Graph 5 and Table 4). It is important to note that, after the dissemination of questionnaire, it became apparent that providers have a target of seeing patients within 3-4 months of receiving a referral. Therefore the answer category "between *two and six months*" is a wide time range and so cannot be indicative of whether their targets are met or not.

Forty eight patients recorded skin cancer (including carcinoma, melanoma or suspicious moles) as their reason for being seen. Of those who were being seen for skin cancer, 33% were attending for their first appointment, 67% were follow ups. Of those first time attenders for skin cancer (16 respondents) 43% were seen within two weeks (Graph 5, Table 4 – Appendix 2).

Graph 5: ***How long have you had to wait, since you saw your GP, for this appointment? (353 patients)***

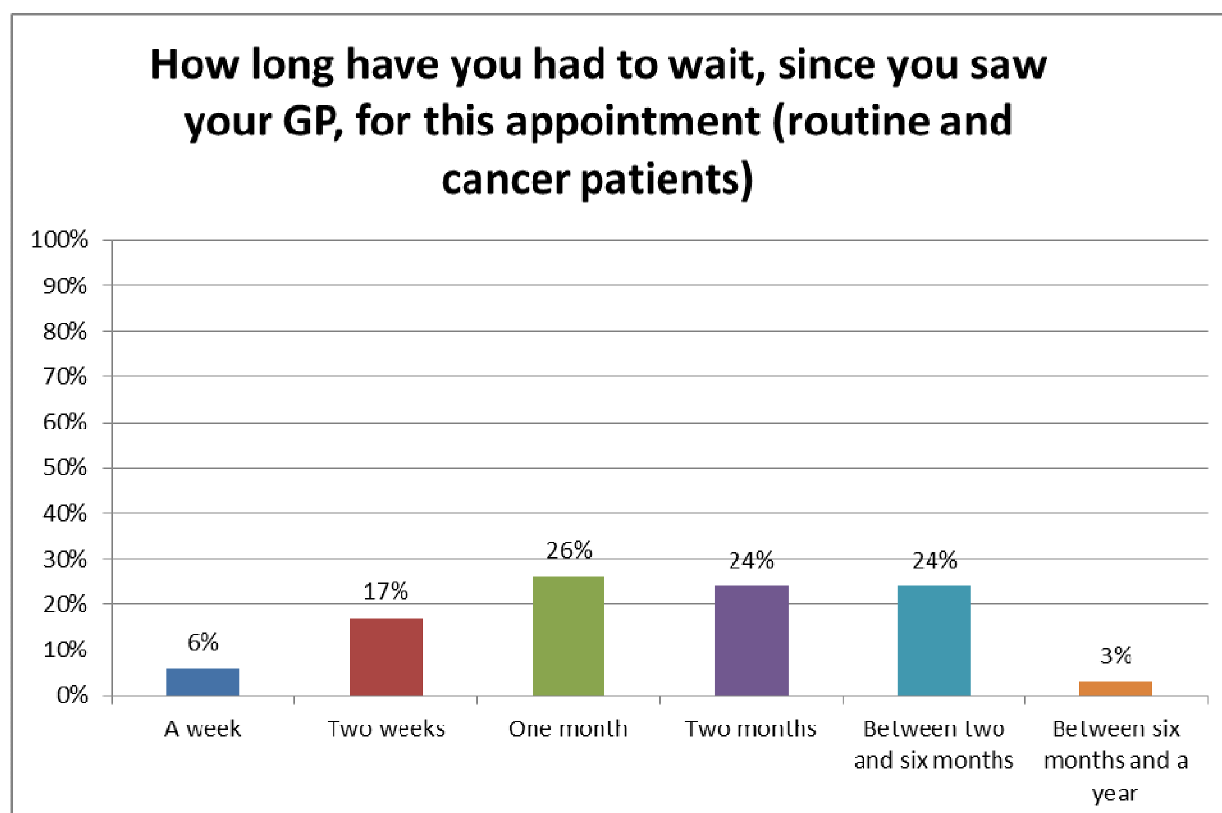


Table 5***: Skin Cancer waiting times from referral to first appointment***

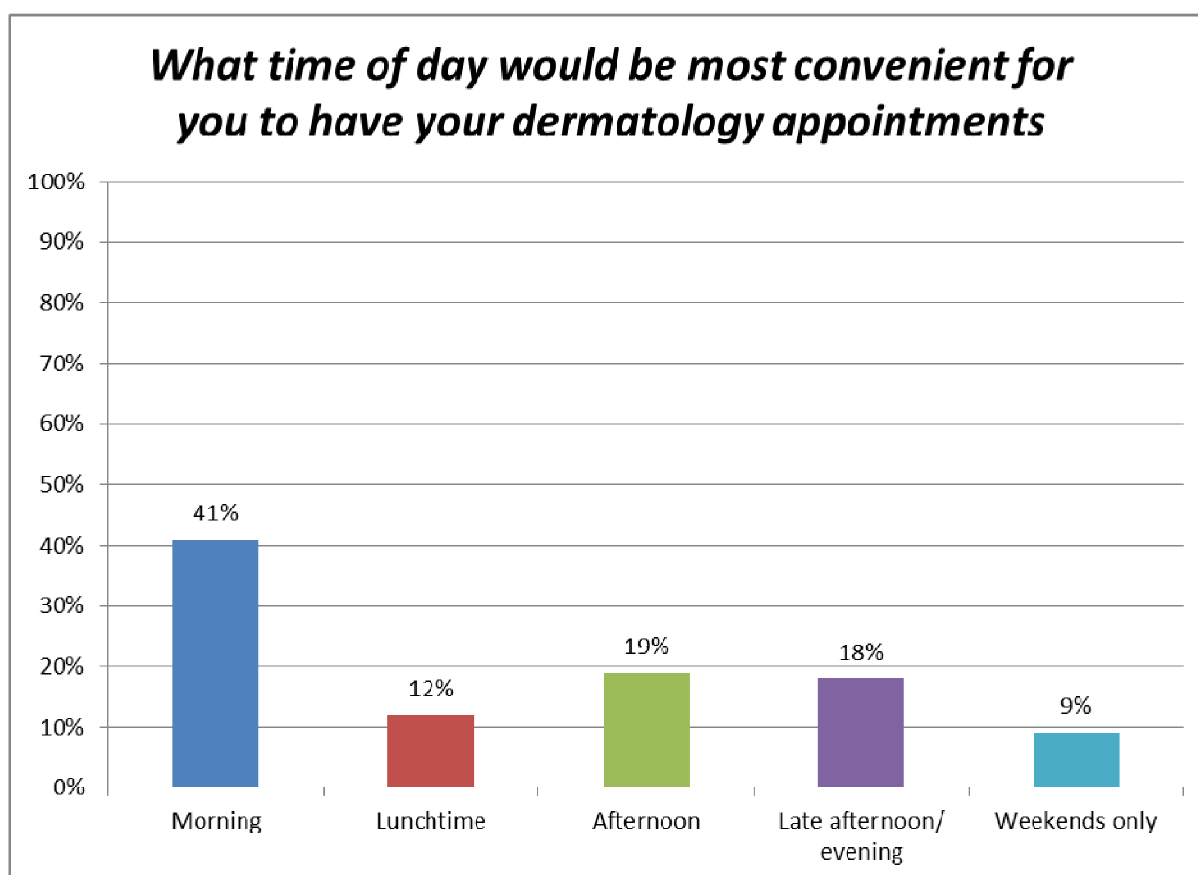
Timeframe	**Responses**	**%**
A week	1	**6.25**
Two weeks	6	**37.5**
One month	4	**25**
Two months	5	**31.25**
Between two and six months	0	**0**
Between six months and a year	0	**0**

Accessibility of appointments

Patients were mostly unable to choose the date, time and location of their appointments, (73%) with 40% not minding that they had no choice. Anecdotally, patients commented that they had had to take annual leave, or felt their condition was urgent enough that they made arrangements to take the appointment that was given to them. However, 89% of patients said the time and day of today's appointment was convenient to them, even if they weren't able to choose it.

When asked what time of day would be most convenient for dermatology appointments, most patients indicated that they would prefer morning appointments (Graph 6, Table 6 – Appendix 2). Late afternoon, evening and weekend appointments were attractive to 27% of patients.

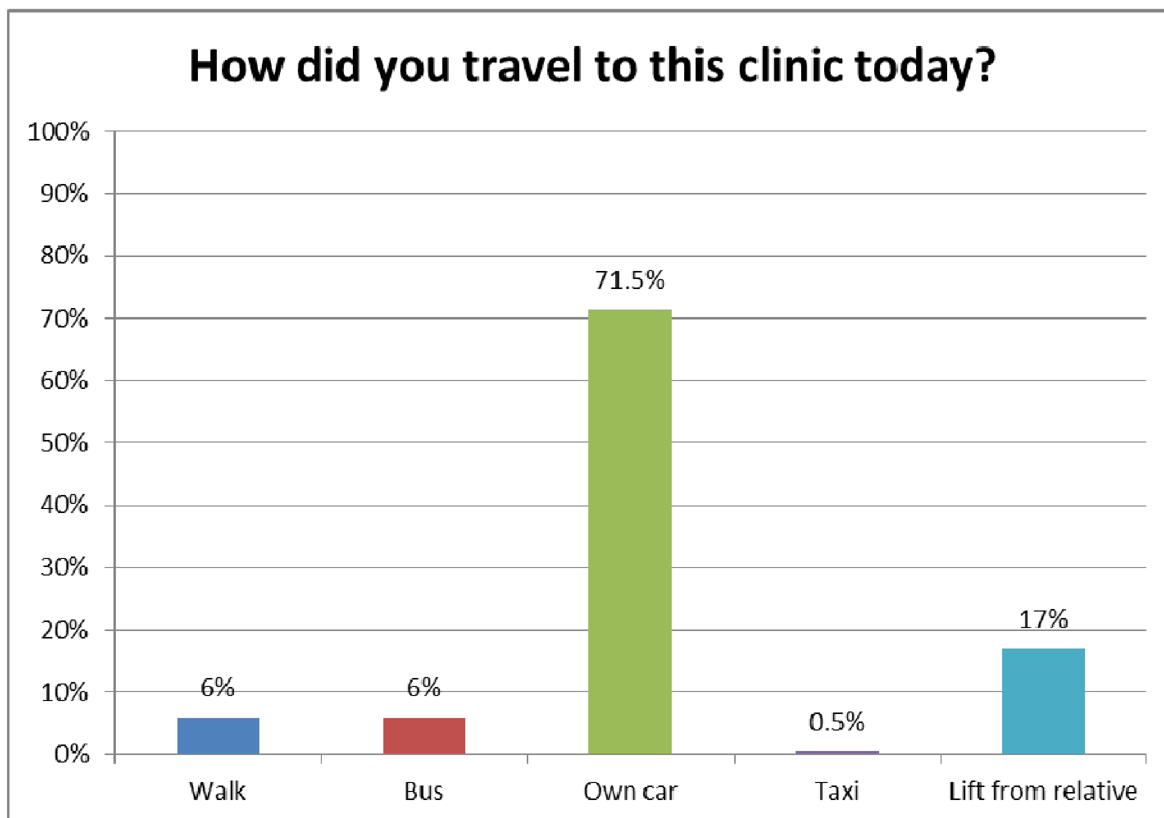
Graph 6: What time of day would be most convenient for you to have your dermatology appointments (546 responses)



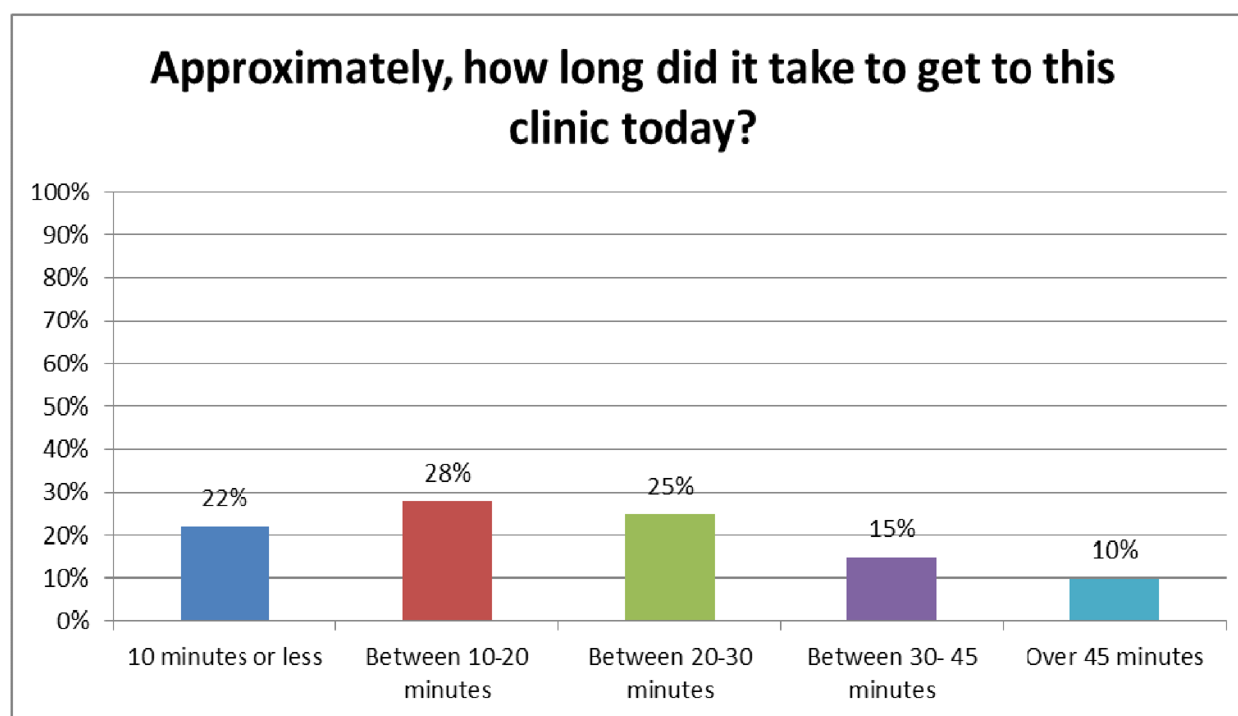
The preferred mode of travel to get to an appointment was by car with 88% of patients saying that it was easy for them to get to their appointment (Graph 7, Table 7-Appendix 2). However, a number of patients said they found parking a problem in some locations (primarily Medway Hospital and Maidstone Hospital).

To get to an appointment, 77% of patients were travelling up to 30 minutes with 9% travelling over 45 minutes (Graph 8, Table 8- Appendix 2), which is largely attributed to patients travelling outside their CCG area for treatment.

Graph 7: How did you travel to this clinic today? (380 patients)



Graph 8: Approximately, how long did it take to get to this clinic today? (389 patients)



When asked what patients felt is an acceptable length of time to get to travel to get to a dermatology appointment, over 70% responded up to thirty minutes (Table 9).

***Table 9:* What, do you feel, is an acceptable length of time to get to a dermatology appointment?**

Time spent travelling to appointment	**Responses**	**%**
5 minutes	3	1.1
10 minutes	11	4
15 minutes	28	10.3
20 minutes	54	19.9
25 minutes	5	1.8
30 minutes	109	40.07
40 minutes	8	2.9
45 minutes	17	6.2

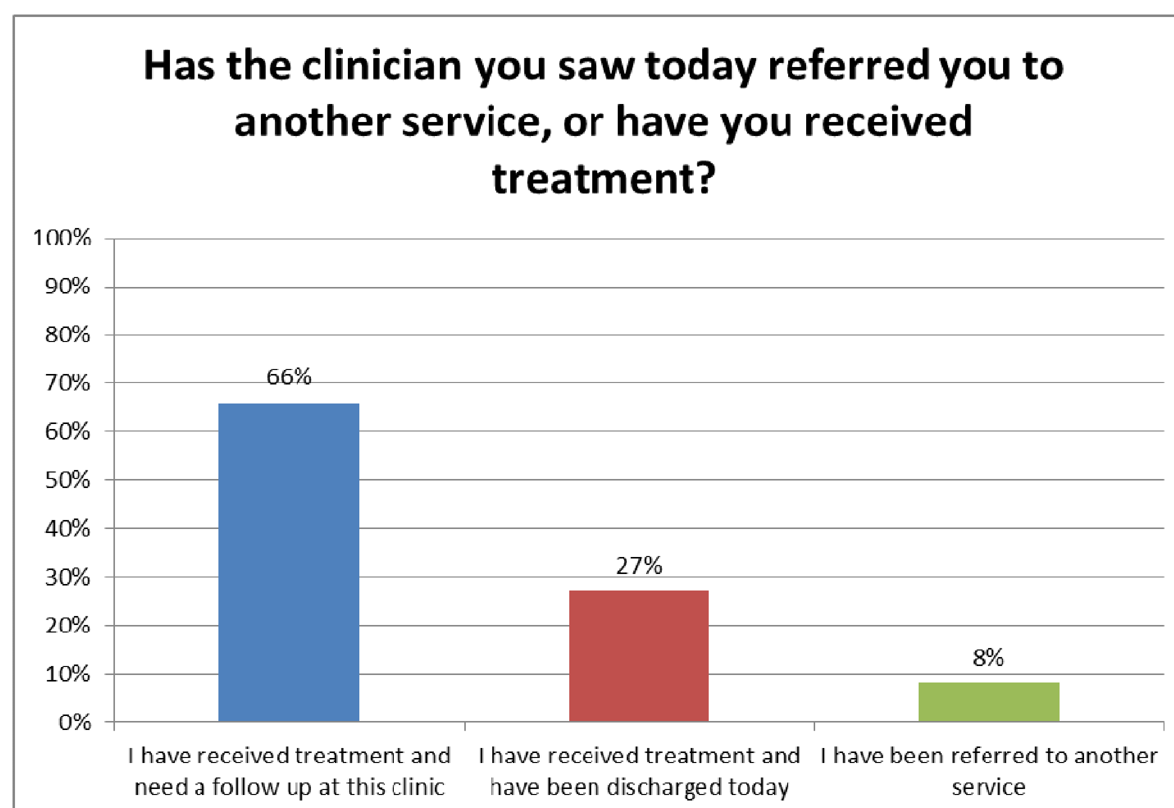
60 minutes	31	11.39
90 minutes	1	0.37
120 minutes	4	1.5
180 minutes	1	0.37

The patient's recent appointment

The majority of patients surveyed were seen by a consultant or registrar (55%) with 23% being seen by a nurse.

Following their appointment, 66% of patients had treatment and needed to be followed up in another clinic (Graph 9). A number of patients spoken to in the face-to-face sessions told us they had received a prescription and some had open-ended appointments so if treatments didn't work, or flare-ups occurred, patients could return to the service by making a telephone call.

Graph 9: Has the clinician you saw today referred you to another service, or have you received treatment? (294 patients)



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When asked if patients were confident about what happened during their appointment, and what the next steps were, 86% replied that they were with less than 2% saying they weren't.

Satisfaction and experience of the current service

Patient satisfaction of the service, overall, is very high, with more than 97% of patients who responded saying they were either very satisfied, or satisfied.

Given the opportunity to choose what type of building they would prefer to be seen in, marginally more people would prefer to be seen in a local GP practice than either a community clinic or hospital (Table 11). Patients, who commented they did not mind, explained that as long as the service was local, and the staff well trained, they did not mind where they were seen.

Table 11: Preferred treatment location

Preferred treatment location	Responses	%
Local GP practice	117	33
Community clinic	98	28
Hospital	98	28
Don't mind	40	11

When asked about their current experiences of the service, patients raised a number of points:

- On the whole it was felt staff are informative, knowledgeable, polite and helpful.
- Seeing a different clinician each time for follow-ups was considered unhelpful, with consistency of care being the preference
- Although many patients commented that appointments were usually on time, many felt appointment times needed to be longer as they felt rushed and clinics sometimes ran up to an hour and a half late.
- Problems with the appointments system meant some patients were unable to book follow up appointments within the time period the clinician had stated because they were too full up.
- Being able to choose the appointment date and time would have also improved some patient's experiences.
- Active treatment, for example UV showers, seems to only be available at some main sites, with satellite clinics being more for follow ups, which was a frustration for patients.

- Some patients explained they had been receiving treatment in one location and had been later moved to another, which was inconvenient
- Being able to be seen closer to home at their local clinics was considered important
- Patients commented that they were having long waits from the time of referral to treatment
- Patients told us GPs were , in some cases, hesitant to refer patients to dermatology
- Patients felt the referral process could be explained better to them by GPs
- There were some parking problems when attending dermatology appointments.

When asked what could be improved about their experience, patients said:

- Reduce waiting time, from referral to treatment as well as the time waiting for an appointment when in clinic
- Have treatment in more locations rather than just follow ups
- Make sure patients can choose their appointments, with wider use of choose and book
- Improve parking , and reduce car parking fees
- Implement a better appointment system
- Have more locations for treatment so that patients have to travel less
- Information needs to be given to patients when attending appointments, this will give patients more confidence in the GP and whether the referral should be made or not.
- If future services move away from the hospital, it is important to make sure they will be of the same standard and contain the same range of services in a community setting
- The one-stop service when attending hospital might be confusing for patients, especially those that are older or frailer as departments are not, at the moment, close together. Any delays would cause anxiety for following clinics
- A one-stop service would be good if this meant that on attending a clinic appointment, all tests, scans and other interventions were carried out on that appointment, rather than having to re-attend to have these carried out
- Making sure there is enough staff is important as well as ensuring any new clinics or sites has properly trained staff who have the specialist skills to deal with dermatology conditions

Future service

To better understand patient's priorities, they were asked to rank, in order of importance the following areas of the service:

- having a short waiting time from referral to treatment,
- a local service
- timings of clinics
- a one-stop service.

Patients told us that a short waiting time, and a local service would be the most important factors in any future service, with a one-stop approach being least important. Of a total of 361 patients, with 1266 responses in total, 164 responses rated short waiting time as most important, 113 responses rated a local service as most important, 100 responses ratedtimings of clinics as most important and 80 responses rated a one-stop approach as most important.

Next steps

Commissioners are to consider the findings of this report when developing and shaping the service specification in preparation for the procurement process.

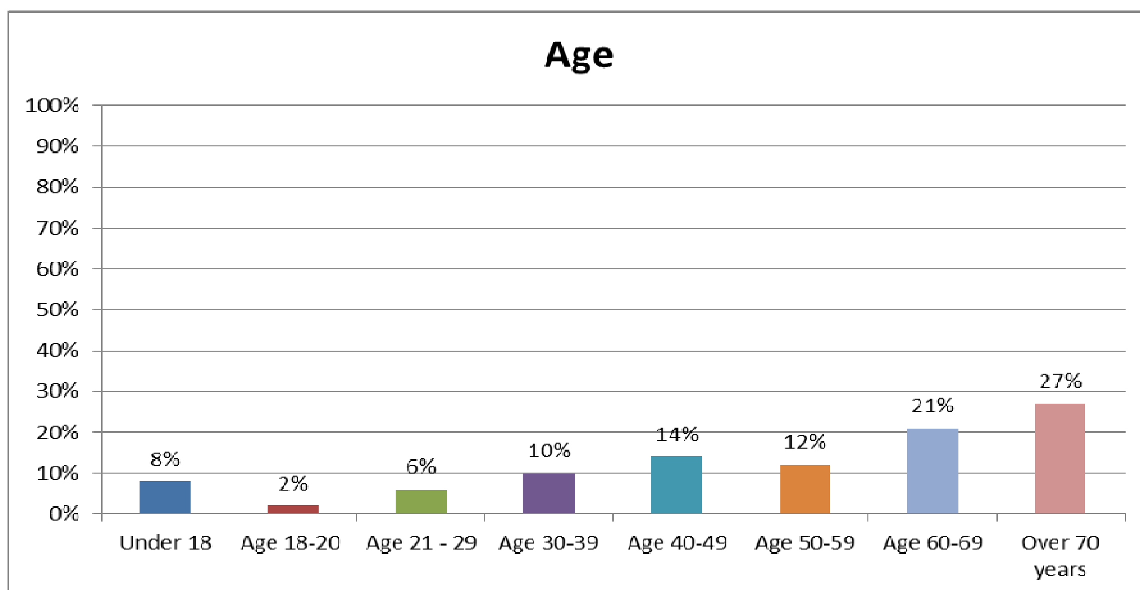
From this patient engagement exercise, a number of patients across all CCG areas have expressed an interest in supporting the evaluation of bids. The KMCS engagement team will make contact with these patients shortly.

Appendix 1

About the patients who participated

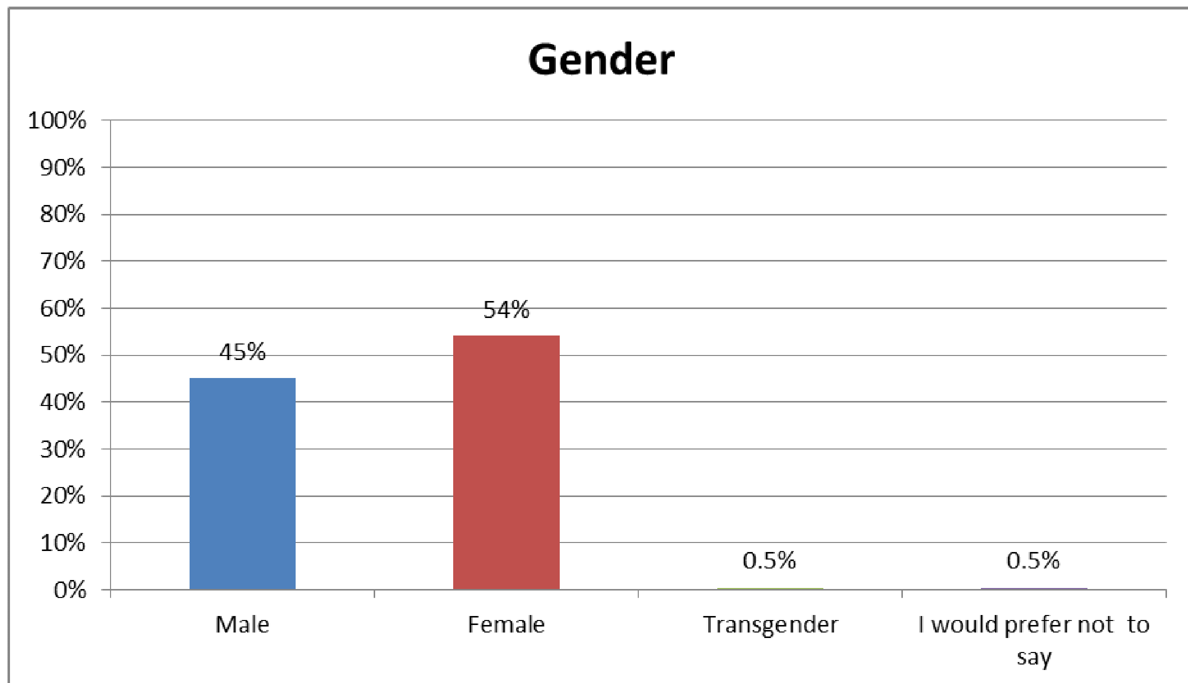
A breakdown of demographics for respondents can be found below. This information shows a good spread in terms of age and gender were achieved, however we cannot state categorically that this is representative of each individual CCG area.

Age



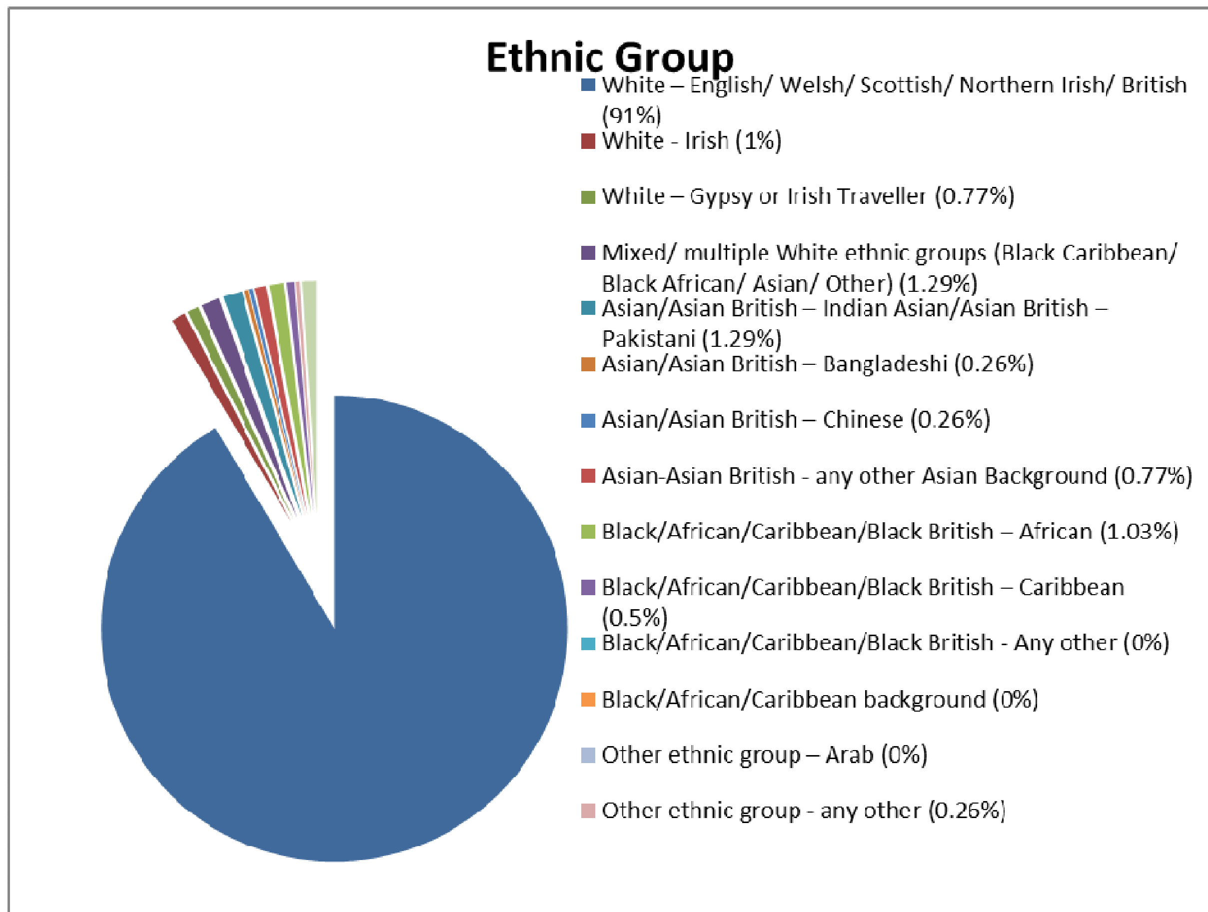
Age group	Responses	%
Under 18	31	8
Age 18-20 years	9	2
Age 21-29 years	24	6
Age 30-39 years	38	10
Age 40-49 years	55	14
Age 50-59 years	48	12
Age 60-69 years	80	21
Over 70 years	103	27

Gender



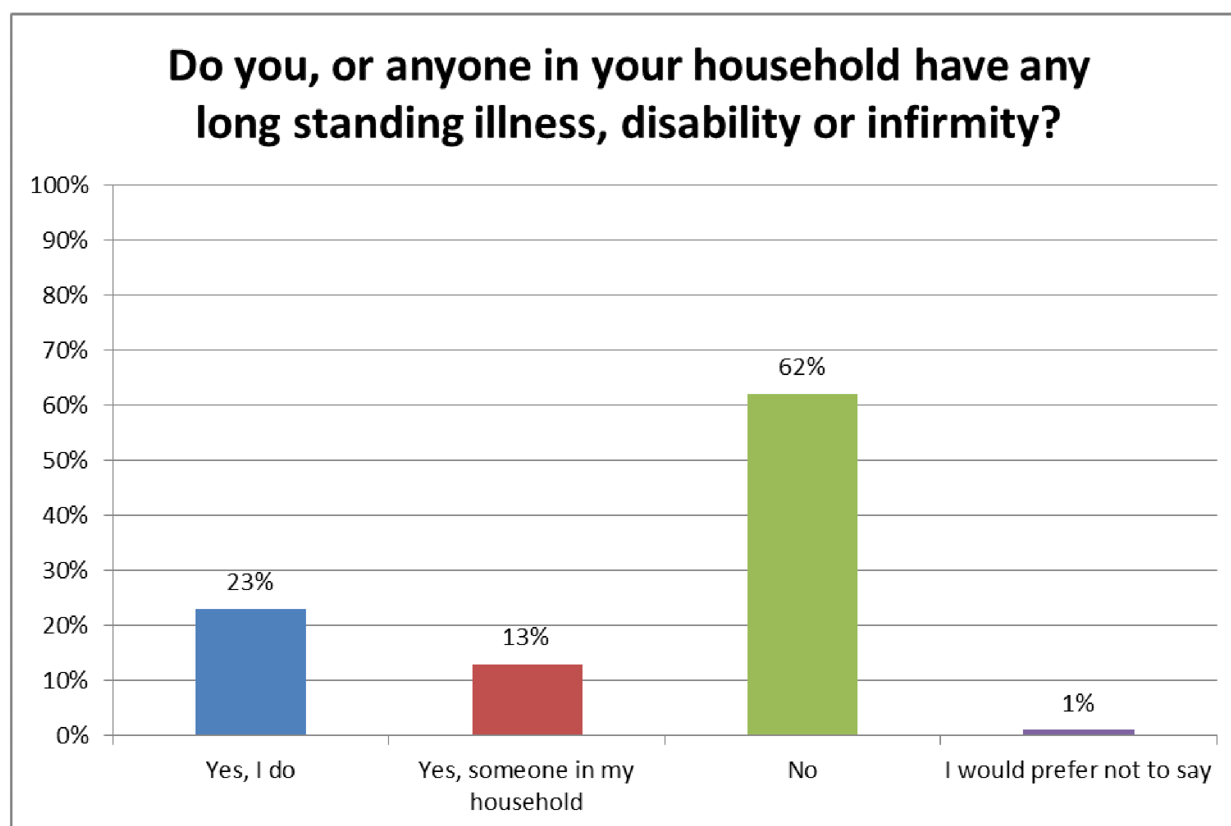
Gender	Responses	%
Male	175	45
Female	208	54
Transgender	2	0.5
I would prefer not to say	2	0.5

Ethnicity



Ethnic Group	Response	%
White – English/ Welsh/ Scottish/ Northern Irish/ British	355	91
White - Irish	4	1
White – Gypsy or Irish Traveller	3	0.77
Mixed/ multiple White ethnic groups (Black Caribbean/ Black African/ Asian/ Other)	5	1.29
Asian/Asian British – Indian Asian/Asian British – Pakistani	5	1.29
Asian/Asian British – Bangladeshi	1	0.26
Asian/Asian British – Chinese	1	0.26
Asian-Asian British - any other Asian Background	3	0.77
Black/African/Caribbean/Black British – African	4	1.03
Black/African/Caribbean/Black British – Caribbean	2	0.5
Black/African/Caribbean/Black British - Any other	0	0
Black/African/Caribbean background	0	0
Other ethnic group – Arab	0	0
Other ethnic group - any other	1	0.26
Other (please specify)	4	1.03

Disability



	Responses	**%**
Yes, I do	90	23
Yes, someone in my household	52	13
No	242	62
I would prefer not to say	5	1

Appendix 2

Table 1: ***Which clinic did you visit recently for your appointment?***

Clinic	**Responses**	**%**
Borough Green	13	3.26
Darent Valley Hospital	18	4.51
Edenbridge Hospital	8	2.01
Maidstone Hospital	26	6.52
Medway Hospital	167	41.85
Nurse in Lordswood	13	3.26
Nurse in Parkwood	20	5.01
Nurse in Rochester	15	3.76
Sevenoaks Hospital	25	6.27
Sheppey Community Hospital	11	2.76
Sittingbourne Memorial Hospital	21	5.26
Specialist GP	41	10.28
Other	21	5.26

Table 4: ***How long have you had to wait, since you saw your GP, for this appointment?***

Waiting time	**Responses**	**%**
A week	20	6
Two weeks	55	17

One month	84	26
Two months	75	24
Between two and six months	75	24
Between six months and a year	10	3

Table 6: What time of day would be most convenient for you to have your dermatology appointments?

Time of day	Responses	%
Morning	225	41
Lunchtime	66	12
Afternoon	106	19
Late afternoon/ evening	99	18
Weekends only	50	9

Table 7: ***How did you travel to this clinic today?***

Mode of transport	Responses	%
Walk	21	6
Bus	22	6
Own car	271	71.5
Taxi	2	0.5
Lift from relative	64	17

Table 8: Approximately, how long did it take to get to this clinic today?

Time spent travelling	Responses	%
10 minutes or less	86	22
Between 10-20 minutes	108	28
Between 20-30 minutes	99	25
Between 30-45 minutes	57	15
Over 45 minutes	39	10

Item 7: CQC Inspection Report: East Kent Hospitals University NHS Foundation Trust

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 10 October 2014

Subject: 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 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 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 be invited to submit a progress report to the Committee within six months.

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)*',
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Robert Brookbank
Chairman
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By mail: HOSC@kent.gov.uk

Our Ref: SB/jc

2 October 2014

From the Chief Executive: Stuart Bain

Dear Robert

HOSC 10 October 2014

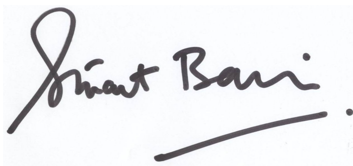
Following publication of the CQC report and my attendance at the HOSC on 5 September, I agreed that I would attend the forthcoming meeting on 10 October to answer questions on the Trust's action plan.

For your information I enclose a brief report outlining the process the CQC undertook and a summary of their findings together with the Trust's action plan that was submitted to the CQC.

When releasing the report into the public domain, the CQC recommended to Monitor that we be put into special measures and Monitor have followed that recommendation and as a consequence will be holding monthly meetings with the Trust to monitor progress against the action plan.

As a trust we will also be publishing monthly progress reports on the NHS choices and our own websites.

Yours sincerely



Stuart Bain
Chief Executive

Putting patients first

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EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

RESPONSE TO CQC INSPECTION 03-07 MARCH 2014

1 BACKGROUND

1.1 The Trust was notified of the Care Quality Commission's (CQC) intention to inspect as part of the Wave 2 new inspection programme in November 2013. The new CQC inspection regime commenced in September 2013 and followed a model developed by them following the Keogh inspection programme undertaken in the 14 acute trusts in England with the highest standardised mortality rates during the last financial year.

1.2 The new inspection programme followed the publication of bandings for all acute trusts in the first publication of the CQC's Intelligent Monitoring Report; East Kent Hospitals University NHS Foundation Trust (EKHUFT) was banded as 3 in a range of 1 – 6, with Band 6 trusts being seen as the lowest risk and Band 1 trusts as the highest risk. The categorisation therefore placed the Trust as being one of "medium" risk within the scoring model against a range of nearly 200 separate measures. The final report for the Kent and Canterbury Hospital states that the Trust is considered by the CQC as being "high risk".

1.3 Trusts with a range of bandings and with differing geographical locations were identified for Wave 2 inspections in order to test the methodology in the Intelligent Monitoring Report to identify the acute trusts posing the greatest risk to patients; wave 1 inspections were a cohort of acute trusts that were either in "Special Measures" with Monitor or where there were outstanding concerns following the previous inspection model around the "Essential Standards for Quality and Safety".

1.4 EKHUFT had no outstanding compliance issues with the CQC's previous inspection model and had a "green" governance rating and the highest level of assurance around the financial position with Monitor. The Trust was not in "Special Measures" at the time of the inspection. This means that EKHUFT is the first Trust in the country to be rated as "inadequate" without already being subject to Special Measures.

1.5 Only acute trusts were part of the inspection programme during this stage; the process has subsequently been extended to community, ambulance and mental health trusts, with specialist providers not yet included.

2 KEY CHANGES TO THE CQC INSPECTION REGIME

2.1 Following the Keogh review programme the CQC changed the focus of their inspection programme by recruiting practicing clinicians, expert patients/carers and managers, as well as staff employed by the CQC to undertake the inspections. There is an identified Head of Inspection for each assessment, who

is an employee of the CQC; there is also a Chair for each inspection, who is normally a senior manager within the NHS.

2.2 The domains for the inspection changed to assess the performance of trusts against the following five areas:

2.2.1 Safe
2.2.2 Effective
2.2.3 Caring
2.2.4 Responsive
2.2.5 Well-led.

2.3 The inspection process now includes announced and unannounced components as well as meetings with key personnel at Executive level, focus groups of staff, listening events held in the locality of the trust being inspected as well as the traditional direct observation of care delivery.

2.4 The inspection is focused on eight clinical areas that are seen by the CQC as having the greatest risks to patients. These are:

2.4.1 A&E;
2.4.2 Medical Services (including the frail elderly);
2.4.3 Surgical services (including operating theatres);
2.4.4 Critical Care (Intensive Care, Coronary Care and High Dependency Units);
2.4.5 Maternity and family planning;
2.4.6 Children's services/paediatrics;
2.4.7 End of Life Care;
2.4.8 Outpatients.

2.5 Wave 2 also saw the CQC applying a rating to each of the clinical areas, against the five domains, against each Trust site and overall. The rating system follows the system used in the education sector by Ofsted, namely:

2.5.1 Outstanding
2.5.2 Good
2.5.3 Requires improvement
2.5.4 Inadequate.

3 PRE-INSPECTION PREPARATIONS

3.1 The Medical Director and the Deputy Director of Risk, Governance and Patient Safety attended a scheduled event in December 2013 hosted by the CQC, where the inspection process was outlined.

3.2 The Trust then adopted an approach that built on the lessons learned from the trusts inspected during Wave 1. This included:

3.2.1 Appointment of a small project team;
3.2.2 Independent review against the five domains used by the CQC in their inspection;
3.2.3 Regular staff briefings;
3.2.4 Communication strategy via Trust News, a booklet to all staff on the process and timing and dissemination in other social media;
3.2.5 A programme of ward-based mock inspections and feedback.

3.3 The Head of the Inspection team for the Trust was identified at the event in December 2013. There was a discussion regarding the number of bed-holding locations and the geographical distance between the sites. Other than the Royal Cornwall Hospitals NHS Trust, EKHUFT has the greatest distance between sites. In order to prepare for the inspection, the CQC Head of the team visited each site in February 2014 and was escorted around each location by the Chief Executive, the Medical Director and the Chief Nurse and Director of Quality and Operations. The CQC preparations for the actual inspection were based on this visit.

3.4 The Trust received a draft datapack on 28 February 2014, which summarised performance against the five domains and reported against some of the measures within the Intelligent Monitoring Report. There were a number of significant errors in the report including the classification of the Trust as “high risk”, missing the areas of Thanet and Shepway from the catchment area and demographic assessment of deprivation and stating that the Trust employs 3,000 staff, rather than the 7,500 it currently employs.

4 INSPECTION

4.1 The three main sites were inspected on three sequential days. The CEO delivered a presentation on 03 March 2014, outlining some of the challenges faced by the Trust, as well as some areas of good performance and innovation. Neither the Head nor the Chair of the inspection team was present at this presentation.

4.2 The Queen Elizabeth the Queen Mother Hospital was inspected on 04 March, the William Harvey Hospital on 05 March and The Kent and Canterbury Hospital on 06 March. The team were on the three sites collectively on the morning of 07 March, before verbal feedback was delivered to the CEO, Medical Director and the Chief Nurse and Director of Quality at mid-day.

5 DRAFT REPORT

5.1 The draft inspection report was received by the Trust on 10 June and, in line with the CQC’s procedures, a factual accuracy report was submitted by the Trust to the CQC ahead of their time frame of 10 working days. There were 503 separate points of factual accuracy reported; some minor e.g. spelling and grammatical errors and some more fundamental e.g. the areas of inaccuracy in the datapack highlighted at paragraph 3.4 of this report, the birth to midwifery ratio stated in the

report and the lack of consultant anaesthetic cover for critical care areas to cover the weekends.

5.2 The Trust started to develop a set of actions at this stage; however, with the report being embargoed, it was not possible to engage with a full range of staff directly at this stage.

5.3 A letter was also written to the CQC Chair of the Hospital Inspection Programme at the same time highlighting inconsistencies in the report findings and grading applied. The grading applied to the Trust overall at this stage was “inadequate”, that for the WHH and QEQMH also “inadequate” and for the K&CH “requires improvement”.

5.4 The Head of the CQC inspection team and the deputy chief CQC inspector then visited the Trust on 10 July to work through some areas where the report findings did not reflect the evidence supplied by the Trust prior to and during the inspection.

6 FINAL REPORT AND QUALITY SUMMIT

6.1 The final reports were received by the Trust on 04 August. There had been some changes to some of the “Key Findings” outlined in the draft reports. This did not result in any changes to the overall Trust grading, which remains as “inadequate”, as does that for the WHH. The grading for the K&CH worsened to “inadequate” as the CQC had miscalculated the scoring in their draft report; the grading for the QEQMH improved to “required improvement”. This site has more action to take against the “must do” areas identified by the CQC.

6.2 The purpose of the Quality Summit is to develop a plan of action and recommendations based on the CQC inspection team’s findings as set out in the final inspection report. This plan will be developed by partners from within the health economy and the local authority. The Quality Summit took place on 08 August where the Trust presented its first overview of the actions required. There was representation from a number of stakeholders including the commissioners, Health Education England Kent, Surrey and Sussex (HEKSS), the General Medical Council (GMC), Kent County Council and HealthWatch. It was agreed that a mid-point review would take place before the submission of the finalised action plan; this took place on 11 September.

6.3 The reports were released into the public domain on 13 August and since then, the Trust, with engagement of staff and patient feedback has been developing an Improvement Plan. The most current version of the High Level Improvement Plan is attached at Appendix 1. A more detailed plan is in place to support the high level plan and there is an additional plan to address the issues raised in the report about raising concerns, bullying and harassment and leadership. The current version is attached at Appendix 2.

6.4 After the Quality Summit and the feedback from stakeholders, the Trust has been placed in Special Measures by Monitor. This means that an Improvement Director will be appointed to provide support to the Trust and hold it to account for making progress against the Improvement Plan. The Trust will also publish monthly updates of the changes it is making to improve the services it offers to patients. Monitor is also imposing an additional license condition on the Trust so that if it fails to make the changes needed, further action could be taken including replacing members of the Trust's leadership team if necessary.

7 NEXT STEPS

7.1 The Trust is monitoring progress against the plan. This will be overseen by Monitor and the Improvement Director once appointed.

7.2 The CQC will re-inspect the Trust at some stage as part of its unannounced programme; there will be a formal announced inspection too; however this is likely to occur once the Trust has had an opportunity to make progress against the Improvement Plan.

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Ref	Service	CQC recommendation	Root Cause (Staff/Trust feedback)	High level action	Action taken to date	Outcome expected following action implementation	Outcome measure	Executive Lead	Planned completion	Source of Executive & Board approval	Additional resources	Stakeholder assistance
M01	Trustwide, K&CH & WHH	Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSW	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, midwives and Paediatric cover for A&E and the middle grades in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for physician's assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training (targets tbc) 2. Data on Agency/Overtime/NHSP usage (targets tbc) 3. Overall improvement in % of shifts filled during the night and the day (target tbc) 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1 (targets tbc) 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	1. Improvements in measures begin Nov-14 2. Jun-15 and on-going	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign
M02	Trustwide & WHH, K&CH	Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.	1..Divisional structure had acted as a barrier to focus more holistically on the needs of children. 2. The emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Establish a Trustwide Children's services action group with input from the identified Board lead for Children and Young People. 2. Review the speciality paediatric input into A&E, Out-patient, Operating Theatre and Day surgery areas to ensure there is appropriate cover 3. On ESR identify posts in A&E, Out-patient, Operating Theatre and Day surgery areas that require paediatric training	1.Trustwide Children's action group established. 2. Executive lead identified for Children and Young people 3. Improvement targets to be confirmed contingent on baseline	All Children and Young People cared for across the Trust by staff who have appropriate qualifications and experience.	1. Number & % of vacancies for RN Child (targets tbc). 2. National Standards achieved in A&E, Out-Patients, Day Surgery, Operating Theatres (targets for vacancy rates on ESR tbc)	Chief Nurse & Director of Quality	1. Improvements in measures begin Nov-14 2. Mar-15 and then on-going	Divisional governance meetings feeding into QAG, Quality Committee and the Board of Directors	None	CCGs to assess and approve the proposed models in line with national standards
M03	Trustwide, K&CH	Ensure that, at a board level, there is an identified lead with the responsibility for services for children and young people.	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None
M04	Trustwide, K&CH& WHH	Ensure all staff are up to date with mandatory training.	IT interface difficulties with linking the training output from NMS/ESP. This may have been compounded by the use of Smartcards to access the national on-line training.	1. Agree with Commissioners the compliance for staff training and revise in the relevant policy and procedure. 2. Improve compliance with mandatory training across all divisions and staff groups by reviewing the reporting of compliance information to ensure that the management teams have the correct information to deliver the target of 85%. 3. Managers to monitor performance.	1. By the end of September 2014, new starters and substantive staff will not require a Smartcard to access NLMS. 2. Review of need to use Smartcards that are currently required for accessing training on the NLMS. 3. Assessment of the IT interface with ESR and NLMS. 4. Pay progression linked to completion of all mandatory training 5. Dedicated time allocated to staff to complete mandatory training	Maintain target of 85% or greater across all areas of mandated training	1. Compliance for each individual element of mandatory training to be improving from Oct 14 and at 85% for organisation by Mar 15. 2. Following individual areas to be monitored and improving from Oct 14 and at 85% by Mar 15: ECC; A&E; ITU (resuscitation), Harbledown; and Stroke K&C	Director of HR	1. Review by 01/03/2015 2. Improvement trajectory to be agreed	1. Training compliance report to the QAB, Quality Board and BoD meetings; 2. Education and Training Group to monitor compliance	None	None

Ref	Service	CQC recommendation	Root Cause (Staff/Trust feedback)	High level action	Action taken to date	Outcome expected following action implementation	Outcome measure	Executive Lead	Planned completion	Source of Executive & Board approval	Additional resources	Stakeholder assistance
M05	Trustwide, K&CH & WHH	Protect patients by means of an effective system for reporting all incidents and never events of inappropriate or unsafe care, in line with current best practice, and demonstrate learning from this.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current NHS England consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded and disseminated across the Trust, sites and individual departments. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review and audit commissioned by an independent third party; incident reporting is a component of this review; 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS); 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors and provide feedback to clinical areas on the lessons learned	1. Actual number of incidents reported by month increase from Oct 14. 2. % as a proportion of the average reporting levels for large acute Trusts 6-monthly via NRLS. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results	Chief Nurse & Director of Quality	Jun-15	Quarterly incident reports to the QAB, Quality Board and the monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade. 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. Commitment to and clarification of a revised policy SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
M06	Trustwide, K&CH & WHH	Ensure that paper and electronic policies, procedures and guidance that staff refer to when providing care and treatment to patients are up to date and reflect current best practice.	Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. Non-responsiveness from some staff to the results of audit. The system was not set up as a full document management system. Ward and departments using out of date printed versions of policies	Review the document management system used across the Trust for corporate documentation. Update all corporate policies and remove out of date hard copy policies from wards and departments	Project to review and revise all current policies and procedures with expert clinical input outlined. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. Project to review the document management system.	All current policies in line with national guidance, and being followed by all clinical and support staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys)	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
M07	Trustwide, K&CH & WHH	Ensure that the assessment and monitoring of patients' treatment, needs and observations are routinely documented to ensure they receive consistent and safe care and treatment.	1. Wi-Fi resilience and coverage perceived as being a problem by staff. 2. Temporary loss of Wi-Fi coverage in some parts of the Trust. (VitalPac™ has a robust back up system, with no loss of data, and a full business continuity plan is in operation). 3. Patient Safety Plan monitored monthly via PSB with outcome measures including, standardised mortality, complication rates etc. reported and monitored	1. Review current documentation and clinical risk assessments in light of VitalPac™ availability and recording potential as part of Business Continuity arrangements. 2. Assess the Wi-Fi coverage and resilience of the current network; identify areas of inconsistent cover. 3. Test areas of blind spots within the Trust and ensure that staff are supported to report	1. VitalPac™ in operation across all wards; 2. Feasibility of adoption across all A&E/ECC departments in progress. 3. Wi-Fi testing and a start date of Spring 2015 to implement project for greater Wi-Fi cover for patients and other service users (no reports of temporary Wi-Fi failure since the inspection)	Deteriorating patients are identified in a timely way and escalation processes result in timely clinical treatment	1. No reports of Wi-Fi failure. 2. Test for Wi-Fi blind spots. 3. Resolve any blind spot issues	IT/Facilities Director	Mar-15	Quarterly report to PSB on response times to deteriorating patients, reports to Divisional Governance Groups and Management Board Meetings	To be determined	None
M08	Trustwide, K&CH & WHH	Ensure that the environment in which patients are cared for is well maintained and fit for purpose.	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) are aligned with local refurbishment programmes in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Use the EPSV programme for staff to report environmental problems 4. Communicate the schedule for refurbishment more effectively and target maternity and out-patient areas as a priority.	Schedules reviewed and £1.6 million spent in line with the programme for 2014/15	Patients are cared for in an environment that is safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements	Director of Strategic Development	1. Jun-15 2. Mar-15 3. Mar-15	PEIC reports annually to SIG	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation	Governors and HealthWatch
M09	Trustwide, K&CH & WHH	Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are undertaken.	Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Business cases agreed for equipment libraries for all three sites. 2. Initial roll-out programme planned 3. Planned testing of the new service agreed	Patients are cared for supported by clinical equipment that is clean, safe and well maintained	1. Equipment libraries are established. 2. Equipment is all up to date and subject to PPM. 3. Staff do not report difficulties in obtaining the equipment required	Director of Operations	Jun-15	Medical Devices Group and H&S minutes	Funding identified	Governors and HealthWatch

Ref	Service	CQC recommendation	Root Cause (Staff/Trust feedback)	High level action	Action taken to date	Outcome expected following action implementation	Outcome measure	Executive Lead	Planned completion	Source of Executive & Board approval	Additional resources	Stakeholder assistance
M10	Trustwide, K&CH & WHH	Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply, and that in-depth cleaning audits take place in all areas.	Relationships and programme management associated with the delivery of the current contract	Ensure cleaning schedules reflect NHS/CCG policy through the 49 standards in the NHS cleaning guidance are being delivered consistently	1. Soft FM steering group (which reports to the FM Partnership Board) is responsible for ensuring adherence to cleaning schedules and for reviewing Dashboard audits of cleaned areas. 2. All exiting areas are routinely audited with weekly published scores, RCAs are carried out for those areas which drop below the 95% threshold. 3. PPE stock levels are monitored by Materials management - stock reordered process is being republished. 4. Materials management are developing a random stock check process for PPE	1. Patients are cared for in an environment that is clean and safe 2. staff have unlimited access to all personal, protective equipment necessary	1. Daily cleaning scores meeting national standards 95% - (98% in high risk areas) of the time. 2. Patients and visitors report high satisfaction levels with cleanliness	Director of Strategic Development	Dec-14	FM Partnership Board meetings reporting annually to the BoD	None	Governors and HealthWatch
M11	Trustwide & K&CH	Ensure that staff in children's services audit their practice against national standards.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services provided. 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements; 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	1. Project to review and revise all current policies and procedures to reflect national standards with expert clinical input outlined. 2. Agree the clinical audit programme to audit the national standards	1. All policies and procedures are up to date and staff are aware of how to access these on the Intranet. 2. Staff involved in clinical audit programmes are able to articulate learning and improvement	1. % of policies up to date is at 98%. 2. Clinical audit programme includes monitoring policies against the national standards, specifically in children's services	Divisional Medical Director and Chief Nurse & Director of Quality	1. 01/03/2015 2. As part of the 2015/16 audit planning cycle	Report to Quality Assurance Board and thence to the Quality Committee and the BoD	None	Support from Associate Chief Nurse for Quality lead identified by commissioners to verify policies and procedures developed for national standards
M12	Trustwide, K&CH & WHH	Implement regular emergency drills for staff, and ensure relevant policies are up to date.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training in the next two months; by Oct-2014, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of December. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA (target tbc). 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
M13	Trustwide, K&CH & WHH	Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; seek feedback and audit practice to ensure the desired impact has been achieved. 2. Conversations and documentation of ceilings of treatment to be recorded 3. Participate in the wider health economy improvement programme on End of Life Care	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified. 4. Meeting arranged with Advocacy Service (SEAP) to plan training for clinicians around difficult conversations	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey (targets tbc). 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover 6. Evidence of Trust participation in health economy wide improvement programme	Medical Director	1. 01/01/2015 2. Agree improvement plan and re-audit Sept-15	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	1. Identify the commissioner for End of Life Care. 2. Agree and sign off the End of Life Care policy. 3. Macmillan Support involvement
M14	Trustwide, K&CH & QEQMH	Ensure that procedures for documenting the involvement of patients, relatives and the multidisciplinary team in 'Do Not Attempt Cardiopulmonary Resuscitation' (DNA CPR) forms are followed at all times. All forms must be signed by a senior health professional.	1. Documentation of the decision-making not always made or countersigned by a senior member of medical staff. 2. Not all decisions countersigned by consultant in charge	1. Ensure that patients and families are involved in deciding ceilings of treatment and care, including DNACPR and these are clearly signed and documented in the Healthcare record. 2. Ensure staff are trained in communicating DNACPR decisions with patients and NOK. Review DNA CPR form to include ceilings of treatment	Latest DNA CPR audit presented to the Patient Safety Board and the legal requirement to involve the next of kin in the DNA CPR decision discussed at the Clinical Management Board (now the Clinical Advisory Board)	Consultants and medical staff feel confident to have conversations about DNA CPR decisions and document in the healthcare record	1. % of doctors who have completed MCA training successfully increases from baseline. 2. % of consultants and registrars completing advanced communication skills training successfully increases from baseline. 3. Improvement in audit of senior health professional signing DNACPR form	Medical Director	Mar-15	DNA CPR audits reported 6 monthly to the PSB and to Quality Committee	Dedicated facilitator on each acute site. HEKSS to advise. Possible engagement of HealthWatch	1. Ceilings of treatment to be discussed with GPs and primary care providers and documented; 2. possible involvement of SEAP

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M15	Trustwide K&CH & QEQMH Out-patients	Ensure that patients are not experiencing unnecessary waits for follow-up appointments with outpatients clinics, and when waiting in outpatients to be seen, that they are not delayed.	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the out patient booking improvement plan. 2. Improve the communication around waiting times in Out-patients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for out-patient referrals by Mar-15 as part of a phased reduction programme 5. Demonstrate improvements in clinic start times	Partial booking of follow-up appointments to improve patient choice	More efficient use of out-patient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme 01/03/2015 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increase use of Choose & Book or equivalent
M16	Trustwide K&CH & QEQMH Out-patients	Ensure there is adequate administrative support for the outpatients department.	The implementation of the Admin and Clerical review during a period of increased demand that was not aligned with the volume of increased referrals	1. Review current resource and appropriate levels of administrative functions in line with current and forecast activity in line with clinical strategy and PAR. 2. Match capacity and demand	Demand and capacity review completed, which has identified a shortfall in the increasing demand for new out-patients appointments.	A detailed and comprehensive improvement plan that has the confidence of the system	Audit turn around times for letters from Out-Patient department and meet agreed turn around times	Director of Operations	1. 01/12/2014 2. Trajectory to be determined	All governance meetings, minutes of Management Board meeting and IAGC. External audit	Possible additional staffing resource identified as part of the demand and capacity review, funding yet to be determined	None
M17	K&CH Out-patients	Assess and mitigate the risk to patients from the high number of cancelled outpatient appointments and the delay in follow-up care.	Increased volume of referrals outside the predicted levels within contract agreement in some specialties	1. Improve triage and clinic maintenance 2. Increase the use of "one stop" clinics and technology 3. Support commissioning intentions to reduce overall demand. 4. Agree a reduction target with commissioners for out-patient referrals as part of a phased reduction programme 5. See also actions for M15 and M16	Agreement from CCGs to support engagement with GPs to improve the use of an electronic referral system from the current 25% using this model	Improved quality of referrals and more efficient triage and booking to appropriate consultant clinics	1. See actions for M15 and M16 2. Choose and Book referrals for 2 week cancer pathway at 80%. 3. 80% of all specialties receiving referrals by Choose & Book	Director of Operations	1. See M15 and M16 2. Understand the demand and capacity and then plan for 2015/16 activity 3. Sep-15 4. Sep-15	All governance meetings, minutes of Management Board meeting and IAGC	None	1. Commissioners to support engagement programme with GPs and agree a reduction target for referrals with the Trust. 2. Assess the feasibility of moving to a full electronic referral system via Choose & Book
M18	QEQMH	Ensure there are appropriate levels and skills mix of staffing to meet the needs of all patients.	National and local supply challenges for medical and nursing staff. The timing of the establishment review and getting staff into post following recruitment	1. Address the challenges in recruiting to the right calibre of medical, nursing, midwifery and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in ECC, A&E, Surgery K&C and WHH, Harbledown, midwives and Paediatric cover for A&E and the middle grades in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues.	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for physician's assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15. 5. Improvement targets to be confirmed contingent on baseline	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training (targets tbc) 2. Data on Agency/Overtime/NHSP usage (targets tbc) 3. Overall improvement in % of shifts filled during the night and the day (target tbc) 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1 (targets tbc) 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	1. Improvements in measures begin Nov-14 2. Jun-15 and on-going	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	Support from HEKSS to identify secondment opportunities and workforce redesign

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M19	A&E QEQMH	Ensure safety is a priority in A&E.	1. There were vacancies at the time of the inspection; there was an active recruitment programme. 2. Consultant cover is not operated on a two site model as quoted in the report. 3. Paediatric pathways and links to the investment planned was identified and partially implemented at the time of the inspection. 4. Governance meetings, including patient safety measures however, were not well established at the time	1. Review attendance pathways to determine the safest possible route for the patient through the department, either to admission, on-going care or discharge. 2. Refresh the A&E & urgent care recovery plan across the systems and implement the agreed actions to include: - Establish Joint Integrated Hospital-based team to avoid admission where appropriate. - Revised A&E recovery plan to cover the potential closure of the Unit at MFT, to be implemented. - Recruitment and retention plan and a governance review to be implemented; the later to cover emerging issues around patient safety and experience.	Funding agreed as part of operational resilience plan; recovery plan and risk register in place, reviewed monthly with all partners	Patient pathways are safe and efficient and patients are treated in the most appropriate part of the system	1. Separate consultant on-call arrangements for QEQMH and WHH. 2. 10/13 consultants in post. 3. 13/13 consultants in post by Sept-15. 4. See outcomes for M01 & M02. 5. Minutes of governance/patient safety meetings discussed at UC<C. 6. Evidence of embedded learning and pathway improvements. 7. 95% A&E standard to be maintained 8. Re-admissions reduced to national average	Director of Operations	1. Mar-16 2. Review Mar-15 3. Sept-15	Integrated Urgent Care Board, reports to Divisional Governance Board and reviewed as part of EPR. Performance overseen at the Management Board meeting and BoD	1. Possible additional staffing resource identified as part of the review; 2. Business cases for additional staff in A&E and staff covering at night	1. On-going implementation of an integrated approach to Urgent Care. 2. Manage demand effectively outside the acute sector. 3. Make explicit the extra capacity to manage demand outside the acute sector and provide on 24/7 basis
M20	QEQMH	Ensure patients leave hospital when they are well enough with their medications.	The delay in pharmacy issuing patients with their TTO medication is due to the delay in prescribing the necessary medication in a timely way before discharge in many cases	1. Provide an increased pharmacy presence on the wards to support timely completion of TTO medication in order to process the TTO before the point of discharge. 2. Roll out the increased staffing provision following the successful service development bid and continue to recruit to new pharmacist and pharmacy technician posts. 3. Target the resource to wards and specialist areas with a high patient turnover over the next six-months. 4. Discharge planning and EDN completion by medical staff to be timely and prioritised against discharged schedule. 5. Assess the feasibility for nurse-led dischar	1. Medicines management and audit part of the external governance review. 2. Recruitment in progress for Near Patient Pharmacy Service (NPPS) provision	Patient discharges are not delayed because of the delayed availability of their prescribed medication to take home and medication is recorded as having been provided on time.	1. Establish a baseline and improvement trajectory for TTOs available at discharge by Oct-14. 2. Number of patients discharged by mid-day to have increased. 3. Patients report a higher level of satisfaction with discharge arrangements in national patient surveys	Divisional Director CSSD	1. Trajectory to be set following audit in Oct-14 2. Mar-15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	Support from Associate Chief Nurse for Quality lead identified by commissioners
M21	QEQMH	Ensure that maintaining flow through the hospital and discharge planning is effective and responsive. Patients must not be moved numerous times, and not during the night. When patients are well enough they must leave hospital.	There are challenges with aligning discharges with Social and Continuing Health Care which affects their ability to facilitate timely discharges for patients. This is compounded by an increasing number of delays for assessment and care package development. There is an increasing number of ambulance conveyance and patients self-attending in A&E; this is specifically in the 18-30 year age group attending in minors. There is a change in the time that patients are conveyed by ambulance to A&E to much later in the day and their is a lack of integrated teams to support admission avoidance.	1. Through a system-wide delivery Board, work with the CCGs and other partners to understand better the demand and capacity across the whole system 2. Reduce the number of ward transfers experienced by patients during their stay. 3. Specifically, reduce the number of delayed transfers of care (DTOC) by the timely intervention of Social Services, Continuing Health Care and Community Care provision. 4. Audit capacity against the number of patient transfers between wards. 5. Optimise decision-making for patients by clarifying and strengthening the governance of the system 6. Create transparency of workforce gaps across the health economy 7. EDD established within 24 hours of admission	ToR of the Delivery Board agreed; mapping of current ward transfer position underway	1. Demand and capacity across the system understood and robust plans in place to address any shortfalls. 2. Fewer inappropriate transfers and fewer extra unfunded beds 3. Effective resilience planning across the system	1. Reduction in DTOC from current level of 15 to 10 DTOC across the Trust each day 2. Patients assessed within 24 hours of receiving Fax 1 for Social Services assessment TBC 3. Audit of patient moves is undertaken in Oct-14 to establish baseline in order to determine our target for improvement	Director of Operations	Mar-15	Minutes of the Delivery Board to Management Board and BoD	None	1. Agree and execute a policy with commissioners and Social Services around appropriate pathways of care and define definitions of inappropriate ward transfers. 2. Alignment with the Urgent Care Plan and East Kent ORCP . 3. Audit against these standards' including 24/7 service provision
M22	QEQMH	Ensure that staff are aware that at board level there is an identified lead with the responsibility for services for children and young people. See M03	In place but lack of clear visibility	Identify and disseminate the name of the Executive lead for Children and Young People	Board level Executive lead identified	Wide staff knowledge of leadership role at the Board for Children and Young People	Staff are able to state who the Board level role is for Children and Young people. Tested annually using a questionnaire format with an improving score from the first baseline exercise	Chief Nurse & Director of Quality	Complete 1. Baseline by Jan-15 2. Initial 6-month review, than annually thereafter	Board minute and evidence of dissemination of information	None	None

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M23	QEQMH	Ensure staff are fulfilling their roles in accordance with current clinical guidance.	1. Staff not active in the dissemination of learning from relevant national clinical audits for relevant paediatric services provided. 2. Data validation and verification not completed in a timely way and full participation in relevant audit programmes not consistent	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Audit key policies for compliance; share the report and address any practice changes through the children's services action group and maternity governance committees. 3. Vibrant clinical audit programme agreed and a process to ensure learning is fully embedded	Project to review and revise all current policies and procedures with expert clinical input outlined	All policies and procedures are up to date and staff are aware of how to access these on the Intranet	1. Audit baseline established in Paediatrics and Children in non-paediatric areas, with policies audited for compliance. 2. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 3. 95% of policies in date monthly by division reported on Balanced Scorecard 4. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys). 5. Audit appraisal rates and set improvement trajectory	Divisional Medical Director and Chief Nurse & Director of Quality	01/12/2014 and on-going as part of 2015/16 planning cycle	Report to Quality Assurance Board and then to the Quality Committee and the BoD	None	None
M24	QEQMH	Ensure medications are stored safely.	This specifically relates to the storage of medications subject to cold-chain compliance, as the drug fridges were not all locked at the time of the inspection, despite the facility being available.	Audit adherence with Trust Policy on the safe storage of medication and demonstrate improvement in line with best practice.	1. External governance review commissioned by and independent third party; medicines management is an integral component of this review. 2. Top up pharmacy team review storage issues weekly and report any non-compliance to ward managers such as unlocked cupboards/fridges. 3. SOP written to formalise checking process. 4. Formal 6-monthly trustwide audit in place from Mar-2014, next due Sept-14	The storage, management and control of all medication is in line with national best practice	1. Base line audit results from Mar-14 2. Improvement trajectory established based on the most recent audit results TBC 3. Recording daily temperatures on all drug fridges 100% of the time.	Director of Operations & Medical Director	Dec-14	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M25	QEQMH	Ensure the administration of all controlled drugs is recorded.	1. The finding was based on the single nurse Controlled Drug checking in operation in the Trust. This is fully in line with legislation, NMC professional standards and Trust policy. 2. The six-monthly, trustwide audit of CD compliance has never highlighted an issue with drug reconciliation and recording	1. Audit adherence to the legal requirements around the recording of all Controlled Drugs administered. 2. Undertake risk assessments for complex CD administration to identify those where a 2-person checking and recording is required and update policy to reflect this.	1. External governance review commissioned by and independent third party. 2. Medicines management is an integral component of this review. 6-monthly audit of compliance.	The storage, management and control of all medication is in line with national best practice and demonstrated by regular audit	1. Strengthen the medicines management policy around the circumstances when single registered nurse administration is appropriate 2. Indentify which unregistered staff groups can provide a second check. 3. Trust wide risk assessment around single registered nurse administration of Controlled Drugs	Director of Operations & Medical Director	1. CD recording is audited by Dec-14 2. Embed the learning from audit by Feb-15	6-monthly audit reported to D&T committee and thence to Quality Committee	None	None
M26	WHH	Review the provision of end of life care to ensure a coordinated approach.	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care. 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey (targets tbc). 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	01/12/2014 and on-going as part of 2015/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF01	Trustwide	There was a concerning divide between senior management and frontline staff.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business case development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap. 2 Develop a revised engagement and involvement plan with staff, including the WeCare engagement programme. 3. Undertake a diagnostic and following this develop a Staff Engagement Strategy. 4. Review the effectiveness of internal communication channels (Board to Ward; line management and executive visibility).	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff Engagement Strategy being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place and staff say they feel more involved and engaged in decisions measured by metrics developed as part of the diagnostic exercise	1. Outcome measures included in HR, staff engagement and culture IP. 2. Improvements in staff survey results in all areas reported as being in the lowest quartile by Mar-17. 3. Feedback via FFT. 4. Track progress internally by staff surveys that are more frequently undertaken than the national annual survey	Director of HR	1. Baseline and trajectory for improvement based in the diagnostic for staff engagement & an annual review of progress 2. Mar-17	Reports to Management Board and IAGC and thence to BoD	We Care implementation programme to be funded.	Actively seeking assistance form external agencies with good models of staff engagement

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KF02	Trustwide & WHH	The governance assurance process and the papers received by the Board did not reflect our findings on the ground.	1. This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list and the 4 hourly A&E target. 2. There is a misunderstanding of the national requirement to report sleeping mixed sex accommodation and not bathroom breaches on UNIFY by commissioners and the CQC. 3. The statement by the CQC that the midwife to birth ratio was greater than 1:33 was made in a report to the divisional board. It failed to incorporate MSW in the report as it was to increase the number of qualified midwives in line with an increasing birth-rate	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally, including Never Events and SIs. 2. In collaboration with commissioners and national guidance, develop data definitions for Mixed Sex, 4 hourly A&E performance, WHO check-list completion and birth to midwife ratios. 3. Undertake regular observational audits of the completion of WHO safer surgery checklist. 4. Undertake a data quality review diagnostic; on the basis of these findings, plan for further reviews.	1. 4-hourly A&E wait performance subject to two Internal Audit reviews. 2. External governance review commissioned by an independent third party. 3. WHO checklist database developed. 4. Review of all data recorded in operating theatres 5. ToR for external review in draft	1. There is confidence in the data used to provide assurance on the accuracy any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec-14. 2. Act on recommendations and findings. 3. Test information going to the BoD.	Director of Finance	Mar-15	WHO checklist audit results to surgical governance board. Reports to Management Board and IAGC and thence to BoD	None	1. Ensure MSA policy is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO audits are agreed and signed off by commissioners. 5. Agree the role of commissioners in providing external assurance
KF03	Trustwide	The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years. It reflected behaviours such as bullying and harassment. The staff engagement score was amongst the worst 20% when compared with similar trusts.	1. There are pockets of staff who have raised concerns but these were not addressed in a satisfactory way or taken seriously at the start. 2. Some staff are too worried about the perceived consequences of raising their concerns	1. Review and revise the current processes for staff to be able to raise their concerns and any reports of bullying and harassment. 2. Seek ways to enhance the demonstrated commitment by the BoD to an open, fair and transparent patient safety culture. 3. Identify and agree with staff the most effective ways to raise their concerns.	1. Staff sign-posted to the process of raising concerns and who to talk with. 2. Staff invited to participate in Board meetings where the agenda is focused on patient safety 25% of the time. 3. Listening event held and confidential staff email set up to facilitate staff feedback. 4. Executive Team & Chairman has worked with individual and teams to identify specific actions to improve staff engagement	1. Policy and process is in place that supports staff to actively raise concerns internally and that the Trust responds in a manner that is supportive to them. 2. Their willingness to act is independently confirmed. 3. A mature safety culture is established. This action is part of a more detailed plan around culture and behaviour. 4. Staff report they are more engaged in decisions taken	1. Outcome measures included in HR, staff engagement and culture IP. 2. Reduction in the bullying and harassment scores within the staff survey	Director of HR	1. Baseline and trajectory for improvement based in the diagnostic for staff engagement & an annual review of progress 2. Mar-17	Reports to Management Board and reports to BoD on FFT results and following the annual staff survey	1. We Care implementation programme to be funded. 2. Staff engagement plan will require implementation support - funding yet to be determined	None
KF04	Trustwide	Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns about the care being delivered and the culture of the organisation.	1. Team meetings not occurring consistently and staff not having time to access communication electronically. 2. Staff not understanding each others roles, specifically in middle and general management. 3. Lack of effective processes for business cases development and approval around estates and equipment. 4. Fundamentally staff do not feel they are being listened to	1. Understand the culture of the Trust and identify the root causes of the cultural gap and the effectiveness of internal communications. 2. Undertake a diagnostic and following this develop a Staff Engagement Strategy based on the We Care Engagement Programme	1. Business case to engage external support with effective roll-out of the We Care implementation programme. 2. Staff engagement strategy and involvement being formalised. 3. Staff listening events organised and undertaken with analysis of key themes.	An effective management approach is in place that enable staff to raise concerns about the care being given and staff say we respond to their concerns and they feel more involved and engaged in decisions	1. Raising concerns policy reviewed. 2. Staff report awareness of the policy and revisions. 3. Audit number of raising concerns issues raised and investigated. 4. Baseline and review the results from the GMC audit completed by doctors in training	Director of HR, Chief Nurse & Director of Quality & CEO	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	Actively seeking assistance form external agencies with good models of staff engagement
KF05	Trustwide	The number of staff who would recommend the hospital as a both a place to work or to be treated is significantly less than the England average.	1. There are pockets of staff who do not feel valued and communication to rectify this is not effective. 2. The variation in holding regular meetings means therefore there is inadequate feedback on the contributions that individuals make	1. Agree a code of conduct for the all leadership teams, including the Consultant body, that reflects the "We Care" values. 2. Develop an action plan to implement the "We Care" programme across the Trust and address results of staff survey. 3. The clinical leadership development programme to articulate the behaviours expected	1. WeCare programme implemented. 2. Staff FFT results being nationally benchmarked	The number of staff recommending the Trust increases	1. Establish FFT (staff) using Q1 & Q2 data (targets TBC). 2. Outcome measures included in HR, staff engagement and culture IP.	Chief Nurse & Director of Quality & Director of HR	1. Baseline and trajectory for improvement based in the diagnostic for staff engagement & an annual review of progress 2. Mar-17	Report to the BoD on FFT results and following annual staff survey	To be determined	NED &Governor support and engagement
KF06	Trustwide	Risk to patients was not always identified across the organisation and when it was identified it was not consistently acted on or addressed in a timely manner.	1. There are areas where the management of risk is ineffective. 2. Discussions and the management of risk at a divisional and specialty level is not always consistent with the Risk Management Strategy	1. Take action to mitigate or resolve patient safety risks identified on departmental, specialty, divisional and corporate risk registers and review the process and assessment of risk across the Trust. 2. Complete the annual review of the Risk Management Strategy and signpost more clearly the roles of staff. 3. External governance review commissioned by an independent third party to review risk management across the Trust..	Risk registers in place across all areas	All patient safety risks are reported to the relevant divisional governance committees, to the corporate Quality Assurance Board and subsequently to the Board of Directors.	1. On the basis of Board and Divisional governance reviews, all recommendation action identified in risk registers at the BoD and at Divisional level. 2. Further actions based on the results of the governance reviews	Chief Nurse & Director of Quality	1. Improvement trajectory is dependent on the flinging of the external governance reviews. 2. Sept-15	Regular reporting to the BoD	None	Commissioners to review the Risk Management Strategy and feedback

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KF07	Trustwide & QEQMH	Throughout the trust there was a number of individual clinical services that were poorly led; the QEQM Hospital was not well-led	1. This is linked with the challenges around the management of staffing gaps in some areas and the potential for patient safety risks. 2. Leadership styles and behaviours are contributory issues as well as a visibility of some leaders	1. Continue to enable access to the various clinical leadership programmes, including the development programme for newly appointed consultants, the clinical leadership programme for ward managers and consultant nurses and ensure that the current clinical leaders engage. 2. Identify new clinical service leads and include them in the most relevant programme. 3. Ensure more Director and senior manager presence is observed by staff on the QEQMH site	Currently recruiting to the fourth cohort of leadership training for nurses and Allied Health Professionals	Clinical leadership is effective at all levels of the organisation	1. Baseline ward managers who have completed the Leadership Programme 2. Increase by 20% by Mar-15 (completed or engaged), with 100% by Mar-16. 3. Baseline medical clinical leads completing the Programme; ensure 100% by Mar-16. 4. All directors and senior managers to be located at QEQMH at least on one day per week. 5. Improve baseline score on "Medical Engagement Scale" scoring using national and interim staff surveys	Medical Director, Director of HR and Chief Nurse & Director of Quality	01/11/2014 and then rolling programme	Reports to the Educational and Training Group, to CAB and the Quality Committee	1. Funding identified for development programme. 2. Nurse consultants seconded as facilitators	Consultant development programme is joint with General Practitioners but this may need expanding to those in existing roles and for clinical leads
KF08	Trustwide, QEQMH & WHH	There were insufficient numbers of appropriately trained staff across the three sites and in different areas of the trust. Specific staffing concerns were in the emergency departments, on wards at night and in areas across the trust where children were being treated.	1. National and local supply challenges for medical and nursing staff. 2. The timing of the establishment review and getting staff into post following recruitment. 3. The calculation of the Birth to Midwife ratio in the paper given to the CQC did not include MSW. 4. Divisional structure had acted as a barrier to focus more holistically on the needs of children; the emphasis has been on the Safeguarding function, which is regarded as being very successful	1. Address the challenges in recruiting to the right calibre of medical, nursing and AHP vacancies and, where possible identify innovative approaches to managing the workforce gap, specifically for nurses in A&E, Surgery and Paediatric cover for A&E and the middle grades in General Surgery. 2. Review the current function of the Hospital at Night Team and ensure this function is working effectively and efficiently. 3. Provide 6-monthly reports to the BoD on workforce issues and review the effectiveness of e-rostering. 4. Establish a Trustwide Children's services action group with input from the identified lead for this area. 5. Review the paediatric input into A&E, Out-	1. 75% of the way through recruitment against the £2.9 million investment in nursing; some success in consultant recruitment in A&E and general surgery. 2. HEKSS funded project to understand workforce gaps across urgent care system, including plans for physician's assistant programme and Associate Practitioner roles. 3. Monthly assessment of the Birth-rate to midwife ratio shared with commissioners. 4. Planning in progress for the next planned ward staffing review in November 2014, with a report to the BoD in Jan-15.	1. Staff in post 2. Assurance of effective plans and mitigation can be provided. 3. External reporting via UNIFY on ward staffing 4. Percentage of nursing shift vacancies filled to be published and Accountability Framework developed. 5. Trustwide Children's action group established. 6. Executive lead identified for Children and Young people	1. Number & % of vacancies for Registered Nurses, HCA/Technicians, Consultant and Doctors in Training (targets tbc) 2. Data on Agency/Overtime/NHSP usage (targets tbc) 3. Overall improvement in % of shifts filled during the night and the day (target tbc) 4. Agreement on OOH medical cover and duties 5. Specific reports as per points 1 to 3 above for those areas highlighted in column E para 1 (targets tbc) 6. Re-establish site based Banks to cover short-term staff sickness difficulties	Chief Nurse & Director of Quality and Medical Director	1. Improvements in measures begin Nov-14 2. Jun-15 and on-going	Meeting of HoN, QAG, Quality Committee and the Board or Directors	1. Practice educators for overseas nurse recruits and newly qualified nurses. 2. Seconded support to deliver workforce and culture design. 3. Business cases for additional staff for A&E and out of hours services	1. Support from HEKSS to identify secondment opportunities and workforce redesign. 2. CCGs to approve and assess the proposed models in line with national standards
KF09	Trustwide & WHH	Staff were referring to a trust major incident plan that was out of date; the staff we spoke with were not trained and had not participated in a practice exercises, given the location of this trust and its proximity to the channel tunnel this is a significant concern.	1. Up to date Action Cards and policy developed with staff, however, they were not aware of the changes to the name required by NHS England. 2. Staff in A&E did not feel confident of their abilities to articulate the plan	Ensure all staff are trained in the Incident Response Plan and participate in regular simulated and table-top exercises	1. A&E staff booked onto specific training in the next two months; by Oct-2014, 90 to 100 staff are scheduled to complete training and this is expected to increase to 200 staff by the end of December. 2. Trauma Governance lead contacted to arrange exercises via the Trauma network	All staff are aware of their role in the Incident Response Plan and are competent to perform that role at the required level	1. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA (target tbc). 2. All staff when asked are aware of how to access the policy	Director of Operations	Mar-15	Quarterly report to Quality Committee and the BoD	Funding yet to be determined	1. Notification of any relevant table-top exercises and collaboration with other Trusts to improve the practical experience. 2. Established training programme with Coventry University
KF10	A&E/ECC at QEQMH & WHH	We had concerns in relation to the accuracy of the documentation of waiting times in the A&E department.	1. This finding was based on a single observation of an apparent mis-recording of the 4 hourly A&E target and staff in one of the A&Es raising a concern about the accuracy. 2. As a consequence of the raising concerns and the policy, two independent audits have been commissioned and completed	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally. 2. Demonstrate the accuracy of the 4-hourly A&E performance figures reported nationally	1. Records of data validation created and saved on PAS and subject to two Internal Audit reviews and a 2-step validation model implemented. 2. External governance review commissioned by an independent third party	1. There is confidence in the data used to provide assurance on the accuracy any performance. 2. Any area where data validation are questioned are reported. 3.Partners have confidence in the accuracy of performance figures	1. Complete data quality review by Dec-14. 2. Baseline audit against key findings and recommendations from report and implement	Director of Finance	Mar-15	Reports to Management Board and IAGC and thence to BoD	None	1. Agree data definitions for 4-hourly reporting. 2. Agree the role of commissioners in providing external assurance

Ref	Service	CQC recommendation	Root Cause (Staff/Trust feedback)	High level action	Action taken to date	Outcome expected following action implementation	Outcome measure	Executive Lead	Planned completion	Source of Executive & Board approval	Additional resources	Stakeholder assistance
KF11	Trustwide	An incident reporting system was in place, but patient safety incidents were not always identified and reported, and the staff use of the system varied considerably across the trust.	1. National guidance open to local interpretation. 2. Lack of agreement between Commissioners and the Trust on the criteria for reporting onto STEIS. 3. Under reporting by some professional groups, specifically medical staff	1. Respond to the current consultation on SI reporting and implement changes when agreed. 2. Implement a incident reporting and learning improvement plan and demonstrate clear Trustwide learning from incidents, complaints and claims with evidence of sustainable change recorded. 3. Simplify the template and the reporting process and address areas of under-reporting	1. External governance review commissioned by an independent third party; incident reporting is a component of this review. 2. Grand Round presentations on each site on the learning identified from SIs	1. Achieve above average reporting levels for large Acute Trusts (NRLS). 2. Ensure learning is embedded and sustained across the Trust to reduce the risk of repeated errors	1. Actual number of incidents reported by month increase from Oct 14. 2. % as a proportion of the above average reporting levels for large acute Trusts 6-monthly. 3. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan-15 figures. 4. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results. 5. Demonstrate embedded learning and improvement from the top 5 areas emerging from incident reporting	Chief Nurse & Director of Quality	Jun-15	Quarterly incident reports to the QAB, Quality Board and the monthly to BoD meetings	1. £2,500 to develop a work and testing environment before the next upgrade 2. Additional Band 3 to support increased reporting. 3. Assistance from HEKSS to highlight the professional duties to report incidents.	1. Commitment to and clarification of a revised policy SI policy and reporting process. 2. Working in a open relationship to raise concerns in a timely way. 3. Support from Associate Chief Nurse for Quality lead identified by commissioners
KF12	Trustwide & WHH	Policies and procedures for children outside of the neonatal unit did not reflect National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidance for paediatrics.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system	1. Ensure that all policies and procedures are up to date and reflect national requirements. 2. Disseminate the policies and procedures compliance report and address any practice changes through the children's services action group and maternity. 3. Identify key policy and guidance.	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16 & on-going 4. Dec-15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None
KF13	Trustwide & WHH	Children's care outside of recognised children's areas (such as the children's ward, the neonatal unit and the children's centre) fell below expected standards. Equipment in areas where children were being treated was identified as being out of date and not safe.	This specifically related to the lack of a paediatric resuscitation trolley in day case surgery at the WHH and the use of burettes to administer intra-operative fluids. There was a fully equipped trolley within the area at the time of the inspection and burettes were being used in accordance with current practice in the major paediatric tertiary centres	Electronics and Medical Engineering (EME) department to log all theatre equipment on the central asset register, and life cycle to be identified.	1. Tertiary paediatric care services contacted for an assessment of the equipment in current use. 2. Additional paediatric resuscitation trolley purchased and fully equipped. Infusion devices used for all intra-operative fluid management in paediatric surgery	Patients are cared for in an environment and with equipment that is clean, safe, well maintained and in accordance with national best practice	1. Monitoring reports against equipment and facilities to be checked during EPSV to all paediatric areas. 2. Daily checking of resuscitation trolleys	Chief Nurse & Director of Quality	Complete	Reports to Management Board	None	External assessment of the adequacy of the changes made
KF14	Trustwide	There was a lack of evidence-based policies and procedures relating to safety practices across the three sites, and a number of out of date policies across the trust.	1. Poor project plan and implementation of the IT system due to inadequate structure and functionality of the system. 2. Non-responsiveness from some staff to the results of audit. 3. The system was not set up as a full document management system 4. Wards and departments using out of date printed versions of policies	Revise the procedure for uploading, revising and removing policies from the IT system. Remove all printed versions of out of date policies from all wards and departments	1. Project to review and revise all current policies and procedures with expert clinical input outlined. 2. Divisions reviewing all policies held on IT system and a quarterly audit of compliance with review dates. 3. Project to review the document management system	All current policies in line with national guidance, and being followed by all clinical staff	1. 98% of policies in date (to allow for review time slippage and alignment to approval committees. 2. 95% of policies in date monthly by division reported on Balanced Scorecard 3. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys) 4. Policies reflect national guidance and there is an established audit programme; identify and close any gaps	Trust secretary	1. Mar-15 2. Mar-15 3. Mar-16 & on-going 4. Dec-15	Policy to the QAB, Quality Board and the BoD meetings	1. Project Management support/lead to review the current system, structure and approval process. 2. Consider increasing the licences for an alternative product (Q-Pulse) currently in use in Pathology	None

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KF15	Trustwide	In the areas we visited we saw limited evidence of how clinical audit was used to provide and improve patient care.	There was full evidence supplied of current and previous years' clinical audit programmes including CQUINS, ERP and EQP programmes. Staff awareness of how clinical audit and service improvement models are used to improve care may not have been fully and consistently embedded	Review the clinical audit programme to focus on key areas of safety & quality including nationally mandated audits and raise the awareness of clinical audits with staff at their regular meetings and disseminate learning	Risk-based model in place to assess progress against specialty clinical audit programme Divisional clinical audit leads identified and regular meeting set up with the clinical audit teams	1. There is an approved clinical audit programme that aligns with the national programme and the specific clinical risks identified from the clinical governance disciplines. 2. Staff are aware of clinical audit programmes and outcomes are shared	1. Audit programme agreed and meets national programme requirements. 2. Feedback from national audits shows at least average performance. 3. Implement actions to improve performance. 4. Clinical Audit office to be informed of all participation in national audit programme. 5. Prioritise areas for action 6. 75% audits completed and improved compliance against national audit programme and publish in the Quality Accounts; monitored by CAEC.	Medical Director	1. Include as part of annual planning cycle for 2015/15 2. Mar-15 and on-going	Quarterly reports to the Quality Committee and annually to the BoD	None	Engage commissioning clinical leads in the clinical audit programme and align with clinical risk
KF16	Trustwide	We saw examples where audits had not been undertaken effectively and provided false assurance.	This finding was based on a single observation of an apparent mis-recording against the WHO safer surgery check-list. There is a misunderstanding of the single member of staff questioned about the procedure	1. In collaboration with Partners, obtain an independent assessment of data accuracy for all data used in reports to the Board and externally; Access Governance Team to validate data independently. 2. Undertake a programme of observational audit of the WHO safer surgery checklist and ensure that staff within theatre understand the audit process, the reasons for completion and can articulate this when questioned	The surgical division and the BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. There is confidence in the data used to provide assurance on the accuracy any performance, which has been externally verified; any area where data validation are questioned are reported. 2. Partners have confidence in the accuracy of performance figures. 3. Surgical Division and BoD have confidence in data quality as reported in specific audits and this reflects the practices being audited	1. Complete independently run data quality audit by Dec-14. 2. Act on recommendations and findings. 3. Test information going to the BoD.	Medical Director	1. Complete independently run data quality audit by Dec-14. 2. Act on recommendations and findings. 3. Test information going to the BoD.	Audit findings and any necessary actions presented to the Quality Committee and the BoD	None	1. Ensure MSA is agreed and signed off by commissioners. 2. Agree data definitions for MSA and against the Birth-rate Plus model. 3. Agree the role of commissioners in providing external assurance. 4. Ensure WHO checklist audits are agreed and signed off by commissioners 5. Agree the role of commissioners in providin
KF17	Trustwide & WHH	We found examples of poorly maintained buildings and equipment. In some cases equipment was not adequately maintained and was out of date and unsafe. See M08 and M09	1. Inadequate communication of the refurbishment and maintenance schedules. 2. Lack of staff awareness of the process for purchasing equipment and for ensuring a planned programme of preventative maintenance	1. Ensure a rolling programme of maintenance schedules (via new CAFM system) are aligned with local refurbishment programmes in place. 2. Patient and staff feedback in place via existing PLACE and PEIC forums. 3. Communicate the schedule for refurbishment more effectively and target maternity and out-patient areas as a priority. 4. Establish Medical Equipment libraries across QEQMH, K&CH and WHH to improve management of equipment delivered to ward areas and monitor use of the equipment library by tracking the use of equipment	1. Ring fenced PEIC (patient environment and investment committee) in place. 2. Estates helpline in place. 3. New CAFM system to replace paper based fault reporting 4. Schedules reviewed and £1.6 million spent in line with the programme for 2014/15 5. Medical Equipment Business cases agreed for all three sites. 6. Initial roll-out programme planned 7. Planned testing of the new service agreed	Patients are cared for in an environment that is safe and well maintained with clinical equipment that is clean, safe and well maintained	1. Improve PLACE score from current 90% to 91.5% (national average) 2. Reduce number of risk items on condition survey from current £26m by £3m each year. 3. Reduce total numbers of backlog maintenance requirements 4. Equipment libraries are established. 5. Equipment is all up to date and subject to PPM. 6. Staff do not report difficulties in obtaining the equipment required	Director of Strategic Development and Director of Operations	1. Jun-15 2. Mar-15 3. Mar-15 4. Jun-15 5. Jun-15	1. PEIC reports annually to SIG3. 2. Reports to H&S Committee and then to Quality Committee 3. Medical Devices Committee	1. Performance review of current building contractor and resolution of all current outstanding and snagging issues. 2. Possible uplift to the refurbishment allocation 3. Funding for Medical equipment Libraries identified	Governors and HealthWatch
KF18	Out-patients - main report	Patients had excessively long waits for follow-up appointments and then, when attending the outpatients department, they also experienced considerable delays waiting to be seen. See M15	Significant demand and capacity mismatch and increase in the number of referrals via Direct Access diagnostics, 2-week referrals and 18-week pathways in some specialties	1. Implement the Out patient booking improvement plan. 2. Improve the communication around waiting times in Out-patients. 3. Undertake a demand and capacity review linked to consultant job plans and templates. 4. Agree a reduction target with commissioners for out-patient referrals by Mar-15 as part of a phased reduction programme	Partial booking of follow-up appointments to improve patient choice	More efficient use of out-patient capacity with patients requiring follow-up receiving this in a timely way	1. 5% reduction in direct access referrals for diagnostics. 2. 5% reduction in 2 week rapid access referrals. 3. 10% reduction in the number of follow-up appointments. 4. 50% of referrals across all CCGs via Choose and Book for T&O	Director of Operations	1. Part of phased reduction programme 01/03/2015 2. Trajectory to be confirmed on the basis of demand and capacity modelling	CSSD governance meeting, minutes of Management Board meeting and IAGC. External audit	None	1. Programme Delivery Group to review new to follow-up rates. 2. Understand and manage the significant increase in the volume of referrals. 3. Improve the quality of referrals including the increase use of Choose & Book or equivalent

Ref	Service	CQC recommendation	Root Cause (Staff/Trust feedback)	High level action	Action taken to date	Outcome expected following action implementation	Outcome measure	Executive Lead	Planned completion	Source of Executive & Board approval	Additional resources	Stakeholder assistance
KF19	Trustwide	Communication following the withdrawal of the Liverpool Care Pathway had been poor and resulted in confusion and misunderstanding about alternative tools to support patients at the end of their life. See M13 and M26	Failure to embed the current policy and tools by the time of the assessment	1. Design and implement a campaign to improve staff awareness of the current policy and tools available to support end of life care; 2. Seek feedback and audit practice to ensure the desired impact has been achieved. 3. Conversations and documentation of ceilings of treatment to be recorded	1. End of Life Steering Group in the process of developing the Campaign. 2. Current tools being revised in line with Alliance Tool. 3. Schwartz rounding project identified	Patients receive appropriate, dignified care from competent caring staff	1. % Staff aware of EoLC guidance measured by interim staff survey (targets tbc). 2. National standards define the audit programme and audit tool. 3. Audit against standards demonstrates improvement from the base-line figure. 4. Staff aware of patients requiring full CPR treatment in the case of collapse. 5. Ceiling of care on SBAR handover	Medical Director	01/12/2014 and on-going as part of 2015/16 planning cycle	End of Life Campaign and audit of effectiveness reported to the Quality Committee and the BoD	HEKSS funded project	Identify the commissioner for End of Life Care. Agree and sign off the End of Life Care policy. Raise awareness of ceilings of treatment and management planning and communicate the management plans using the necessary IT infrastructure
KF20	Trustwide	The complaints process was not clear or easy to access. The trust applied its own interpretation of the regulations and had two categories of complaints. A high a number of complaints were referred to the Ombudsman, and there were 16 open cases as of December 2013.	1. The policy distinguishes between formal and informal complaints. Although this is not a distinction which is recognised by The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, it is an internal system the Trust uses to distinguish between those complaints that can be managed in a shorter timeframe. This is to prevent unnecessary delays and offer a more responsive service. For example, the trust's guidelines for structured management of complaints refer to 'informal complaints' being resolved within five days. 2. The PHSO cases are reviewed regularly and those that remain open are complex cases awaiting Ombudsman action; most cases are not fully upheld. 3. Delays from the Trust are not evident at	1. Review and revise the complaints process, align with national best practice and demonstrate a clear and transparent process for complaints. 2. Ensure that the reporting of complaints is in line with national best practice.	1. Full staffing review and improvement plan completed. 2. Complaints policy reviewed and awaiting formal sign off at the Quality Assurance Board. 3. Formal PALS re-established	Effective handling of complaints with first response to complainant within the agreed timescale 85% of the time. Disseminate the lessons learned and use to improve practice and services to patients	1. Results of in-patient survey on accessing the complaints process; performance ahead of peers. 2. Increase number of complaints responded to at the first response. 3. Use complaints balanced scorecard to align the remaining outcome measures. 4. Close the 16 cases from Dec-13 as soon as possible	Chief Nurse & Director of Quality	Jan-15	Complaints steering group, QAG and thence to the BoD as part of the monthly CQ&PS report	None	Commissioners to review and endorse the revised policy. Support from Associate Chief Nurse for Quality lead identified by commissioners. Involvement of HealthWatch
KF21	QEQMH	Patients who had attended pre-assessment before undergoing surgery experienced long waits before seeing a doctor. We met two patients who had waited over two hours and staff told us this was not unusual	This is a specific issue affecting one trauma and orthopaedic consultant where the current job plan does not clearly articulate this requirement	Review and revise job plan to include pre-assessment responsibilities. Develop processes for monitoring delays in pre-assessments	Identified as a risk and incorporated into the wider service review currently in progress in Trauma and Orthopaedics	Patients are seen in a timely way for all pre-assessments before surgery	1. Baseline audit to be completed and a trajectory for improvement indentified. 2. Reduction in average and longest wait times by Apr-15	Director of Operations	Apr-15	Site surgical governance meetings reporting to divisional governance meetings and then to EPR	None	Involvement of Governors and HealthWatch
Other	Corporate	ADDITIONAL ACTION Building relationships so that the systems for health and social care work effectively together for its common purpose	Frustration with the communication style between the commissioners and the Trust resulting in polarised views thereby disabling effective working relationships	Work with external consultants on improving the communication difficulties with commissioners.	Initial facilitated workshop held, follow up on the next steps being planned with commissioners and external consultants.	Confidence in the system is achieved through effective working relationships with a clear understanding of the impact that the report has had on the whole system; patients and services users experience a quality service	Number of reports of an improving relationships with Commissioners and external stakeholders	Chief Executive	Mar-15	Feedback from workshops with agreement of the further actions required	£20,000 for on-going consultancy support over the next 6-months	Commissioners to participate within the facilitated programme and engage with the external consultants
Other	Corporate	ADDITIONAL ACTION Commission a detailed review from an external consultant to provide assurance around data quality used to inform Board decision-making	Identification of number of issues around data quality within the CQC reports	1. Commission a review of the data collected, collated and verified to the BoD. 2. When the findings and recommendations contained within the report is published, act on the results and address any gaps identified. 3. Act on the findings of the external review once published; this will form part of the iterations to the HLIP	1. Terms of reference in draft. 2. External consultants indentified	The data quality verification and validation procedures in place are in line with national best practice	All actions identified are completed within the agreed timeframe	Chief Executive	Dec-15	Reports to the IAGC and the BoD	£75,000 for diagnostic; further costs may accrue based on the findings	Commissioners to agree the ToR once drafted and be cognisant of the findings and recommendations

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Other	Corporate	ADDITIONAL ACTION Commission and undertake a governance review under Monitor's Risk Assessment Framework and in line with their Code of Governance	Identification of number of issues around governance within the CQC reports	1. Commission an external review of governance arrangements across the Trust. 2. When the findings and recommendations contained within the report is published, act on the results and address any gaps identified. 3. Act on the findings of the external review once published; this will form part of the iterations to the HLIP	1. Terms of reference in draft.	The governance systems across the Trust are fit for purpose and the governance challenges faced by the sector are addressed	All actions identified are completed within the agreed timeframe	Chief Executive	Dec-15	Reports to the IAGC and the BoD	TBC on the basis of the tender exercise currently in progress	Commissioners to agree the ToR once drafted and be cognisant of the findings and recommendations

Item 9: North Kent: Emergency and Urgent Care Review and Redesign (Long Term)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 10 October 2014

Subject: North Kent: Emergency and Urgent Care Review and Redesign (Long Term)

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

It provides additional background information which may prove useful to Members for Agenda Items 8 and 9.

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1. Introduction

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

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

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

(c) Phase two of the review is now under way, overseen by a delivery group comprised of more than 20 different clinical, managerial and patients' associations. A report on progress was published in August 2014. Actions taken by the Review Team included the development of commissioning guidance and specifications for new ways of delivering urgent and emergency care; identifying sites to trial new models of delivery for urgent and emergency care and 7 day services; and developing new payment mechanisms for urgent and emergency care services, in partnership with Monitor (NHS England Urgent and Emergency Care Review Team 2014).

2. National pressures

(a) Keogh reported that the current system of urgent and emergency care is under 'intense, growing and unsustainable pressure' (Keogh 2013: 5). Each year the NHS deals with 438 million visits to a pharmacy in England for health related reasons; 340 million GP consultations; 24 million calls to NHS urgent and emergency care telephone services; 7 million emergency ambulance journeys and 21.7 million attendances at A&E departments, minor injury units and urgent care centres. Demand for these services has been rising year on year with almost a 50% increase in emergency hospital admissions over the last 15 years.

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

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

3. Winter Pressures

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

(b) £221 million non-recurrent funding was allocated to Trusts for winter 2013/14 including Dartford and Gravesham NHS Trust (£4 million) and Medway NHS Foundation Trust (£6.1 million). This allocation was followed up in November 2013 by a further £150 million distributed across all 157 Clinical Commissioning Groups in England (NHS England 2013).

(c) Further initiatives to relieve winter pressure on A&E in 2013/14 included the development of the Better Care Fund, a £3.8 billion integration fund to join up health and social care services and a £15 million cash injection to NHS 111 to prepare the service for potential winter pressures (Department of Health 2013).

(d) In June 2014 it was announced that Urgent Care Working Groups, which were established to reduce winter pressures in 2013/14, would become System Resilience Groups to provide year round capacity planning (NHS England 2014a). In August 2014, an additional £2.6 million of funding was announced to grow and support the work of volunteers in hospitals to reduce winter pressures (NHS England 2014b).

4. Types of Emergency Care

(a) Emergency care departments are divided into a number of types, corresponding to different levels of care provision (House of Commons Library 2014).

(b) Type 1 departments are defined as those with a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients. They are sometimes known as ‘major’ A&E departments, and are the kinds of large facilities that are traditionally associated with A&E. Type 1 departments make up around two-thirds of all A&E attendances in England (House of Commons Library 2014).

(c) Type 2 departments are consultant led facilities with a single specialty, such as ophthalmology or dentistry. An example of this is Moorfields Eye Hospital in London whose A&E department accounts for around one-seventh of all type 2 attendances in England. Around 15% of NHS providers recorded in the NHS England statistics operate a type 2 emergency department (House of Commons Library 2014).

(d) Type 3 departments are other types of A&E/minor injury unit with designated accommodation. They may be doctor-led or nurse-led and treats at least minor injuries/illnesses. They can be routinely accessed without appointment. They exclude NHS walk-in centres and services which are mainly or entirely appointment-based such as GP practices or outpatient clinics. Type 3 departments make up just under a third of all A&E attendances (House of Commons Library 2014).

5. Key Trends – Attendance

(a) In 2013/14 there were 21.8 million attendances at England’s A&E departments. 65% of attendances were at Type 1 departments. A&E attendances in England represented almost 87% of all emergency attendances in the UK. Despite the perception that A&E attendance has risen substantially, Type 1 departments have experienced only a modest rise in attendance since 2004, with 7% higher attendance recorded at Type 1 departments in 2013/14 than in 2004/05. While attendances at Type 1 departments have risen in line with changes in the level and age structure of the population, attendances at Type 3 departments have risen at a faster rate (House of Commons Library 2014).

(f) The elderly are most likely to attend A&E, and are most likely to arrive by ambulance. Of working age adults, those aged 20-24 have the highest rate of attendance at A&E. Attendances for those aged 85+ have risen 20% more than would be predicted by population growth alone (House of Commons Library 2014).

(c) A&E departments tend to register more attendances in the summer and fewer in the winter. January is the quietest month, while the period from late spring to mid-summer is the busiest. 59% of A&E attendances occur between 09.00 and 18.00; only 9% of A&E attendances are between the hours of midnight and 07.00. Monday is the busiest day in A&E, with levels of attendance almost 10% above the daily average and 8% above the second-busiest day, Sunday (House of Commons Library 2014).

(d) In 2012/13 dislocation/joint injury/fracture/amputation (4.4%) was the most common category of first diagnosis for A&E patients, followed by sprain/ligament injury (3.7%) and gastrointestinal conditions (3.7%). Over half the recorded patients in 2012/13 received either no treatment or only guidance: 37% of A&E attendance resulted in only guidance or advice and a further 14% resulted in no treatment (House of Commons Library 2014).

(e) Attendance rates at A&E are higher in England and Northern Ireland than in Scotland or Wales. In England, attendances are highest relative to population size in major cities and lowest in rural areas. In 2013/14 the highest A&E attendance rate was in Birmingham & the Black County and lowest in Lancashire (House of Commons Library 2014).

Table 1 - A&E attendance rates per 1,000 resident populations

NHS Area	**Type 1** (per 1000 population)	**Type 2 & 3** (per 1000 population)
Birmingham & the Black County	343	237
Lancashire	210	66
Kent and Medway	262	113

6. Key Trends – Performances

(a) There are a variety of measures of waiting times at A&E, including average time to treatment, average time spent in A&E, and percentage of patients spending less than four hours in A&E. NHS England has a target that 95% of patients at A&E departments should be discharged, admitted or transferred within four hours of their arrival. This is measured on a quarterly basis against all A&E departments (House of Commons Library 2014).

(b) Medway NHS Foundation Trust was one of the providers with the highest % of patients (14.4%) waiting over four hours in Type 1, 2 & 3 A&E departments in April - June 2014. The worst performing provider was South Devon Healthcare NHS Foundation Trust with 16.4% of patients waiting over four hours. Table 2 shows the % of patients

spending over 4 hours in a Type 1 A&E department and rank[1] for the four acute providers in Kent (House of Commons Library 2014).

Table 2 - Provider-level waiting times data for Type 1 A&E departments in Kent

Provider	2012		2013	
	%	Rank	%	Rank
Dartford and Gravesham NHS Trust	4.7%	47	5.0%	49
East Kent Hospitals University NHS Foundation Trust	6.4%	89	6.7%	93
Maidstone and Tunbridge Wells NHS Trust	7.2%	108	4.4%	33
Medway NHS Foundation Trust	6.0%	82	11.1%	134

(c) The number and percentage of patients spending over four hours in A&E has risen in recent years. 2014 has so far seen higher rates of patients spending over four hours in A&E than previous years in England. In 2013/14 the number of patients spending over four hours in A&E departments was 38% than in 2004/05 and almost three times higher than in 2005/06 (House of Commons Library 2014).

(d) The average time to treatment is just under one hour which has remained stable since 2008. Patients who are eventually admitted to hospital typically spend twice as long in A&E as those who are not. 70% of patients who are admitted to hospital spend longer than 3 hours in A&E, while 19% of those who are discharged with no follow-up and 27% of those who are discharged with a GP follow-up spend longer than three hours. Almost a quarter of all admitted patients leave A&E in the ten-minute period between 3 hours 50 minutes and 4 hours after their arrival (House of Commons Library 2014).

(d) The number and percentage of patients admitted to hospital via Type 1 departments has risen in recent years. Around three-quarters of all emergency admissions are via A&E departments. 99% of admissions are Type 1 A&E departments, with only 42,000 coming via Type 2 & 3 departments in 2013/14. 3.8 million patients were admitted to hospital via a Type 1 department – just over a quarter of all attendees at Type 1 departments in 2013/14. There was a 6.6% increase in admissions at Type 1 departments in the quarter ending June 2014 than the equivalent quarter in 2013. The percentage of long waiting times for admissions is closely related to overall A&E performance (House of Commons Library 2014).

[1] 140 Trusts, who provide Type 1 A&E departments, were ranked using NHS England Weekly A&E SitReps Data; rank 1 had the lowest and rank 140 had the highest % of patients spending over 4 hours in a Type 1 A&E department and

7. Potential Substantial Variation of Service

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

(b) Medway Health and Adult Social Care Overview and Scrutiny Committee considered the proposals on 30 September 2014. They determined that this service change constituted a substantial variation of service. If the HOSC determines the proposed service change to be substantial, a Joint HOSC will need to be established.

(c) If the HOSC deems this service change as not being substantial, this does not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to NHS Dartford, Gravesham and Swanley CCG, NHS Medway CCG and NHS Swale CCG.

(d) If the HOSC determines this proposed change of service to be substantial, a timetable for consideration of the change will need to be agreed between the Joint HOSC and NHS Dartford, Gravesham and Swanley CCG, NHS Medway CCG and NHS Swale CCG after the meeting. The timetable will include the proposed date that NHS Dartford, Gravesham and Swanley CCG, NHS Medway CCG and NHS Swale CCG 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.

(e) If a Joint HOSC is established, the power to refer to the Secretary of State will not be delegated to the joint committee, the power to refer will remain with the individual committees (Kent HOSC and Medway HASC) which appointed the joint committee.

8. 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:

(a) The proposed service change constitutes a substantial variation of service and that a Joint HOSC be established with Medway Council, with the Kent HOSC receiving updates on the work of the Joint Committee.

(b) 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.

Item 9: North Kent: Emergency and Urgent Care Review and Redesign (Long Term)

Background Documents

Cabinet Office (2014) '*£2.6 million funding for volunteers that support hospitals (08/08/2014)*', https://www.gov.uk/government/news/26million-funding-for-volunteers-that-support-hospitals

Department of Health (2013) '*Prime Minister announces £500 million to relieve pressures on A&E (09/08/2013)*', https://www.gov.uk/government/news/prime-minister-announces-500-million-to-relieve-pressures-on-ae

House of Commons Library (2014) *'Accident and Emergency in the UK: Statistics (22/09/2014)*', http://www.parliament.uk/briefing-papers/sn06964/accident-and-emergency-care-in-the-uk-statistics

Keogh KBE, Sir Bruce (2014) *'Transforming urgent and emergency care services in England - Urgent and Emergency Care Review: End of Phase 1 Report (13/11/2013)*', http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

NHS England (2013) *'Winter Pressures – Media Briefing Note (01/11/2013)*', http://www.england.nhs.uk/wp-content/uploads/2013/11/150mill-ease-wntr-pres.pdf

NHS England (2014a) *'Operational resilience and capacity planning for 2014/15 (13/06/2014)',* http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf

NHS England (2014b) *'Volunteer groups to get £2m to support vulnerable patients this winter (08/08/2014)*', http://www.england.nhs.uk/2014/08/08/winter-volunteer/

NHS England Urgent and Emergency Care Review Team (2014) *'Transforming urgent and emergency care services in England - Update on the Urgent and Emergency Care Review (19/08/2014)*', http://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf

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Briefing to Kent County Council HOSC Friday 10 October 2014

Subject: Emergency and Urgent Care Review and Redesign – North Kent

Date: 26 September 2014

1. Purpose of report

This report advises the Kent Health Overview and Scrutiny Committee (HOSC) of a proposal under consideration by NHS Medway, Swale and Dartford, Gravesham, Swanley Clinical Commissioning Groups (CCGs) to reconfigure and recommission emergency and urgent care services.

The committee is asked if they consider the changes substantial and therefore require presentation to a Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC).

1. Introduction

Both nationally and locally the current system for delivering urgent and emergency care is under pressure. Under the leadership of Sir Bruce Keogh, Medical Director of the NHS, a vision for change for urgent and emergency care was published in November 2013. A case for change was put forward with the high level vision stating:

- Those people with urgent but non-life threatening needs must be able to access highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible.

- Those people with more serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities, in order to maximise their chances of survival and good recovery.

Locally, urgent and emergency care services are under significant pressures with MFT consistently unable to meet the four hour access target where 95 per cent of all A&E attendances should not wait more than four hours from arrival in A&E to admission, transfer or discharge. Whilst DVH met their 95 per cent operational target for 2013/14, MFT achieved only 88.88 per cent. The achievement year to date (as at 31/08/14) is 80.84 per cent with only two out of the twenty two weeks reported as meeting the 95 per cent target. There are a number of factors impacting on current performance and improvements as set out in the CQC inspection reports are necessary to ensure the overall quality, safety and access is improved.

2. Strategic Alliance

The North Kent CCGs are committed to providing access to the highest quality urgent and emergency care within an integrated approach for the population of North Kent.

The three CCGs; Medway, Swale and Dartford, Gravesham, Swanley (DGS) share the same strategic direction – to reduce demand within the Accident and Emergency departments (A&E) at the acute hospitals, prevent unnecessary acute hospital admissions by delivering a coordinated health and social care response and provide quality rapid access to emergency care for those who need it.

This strategic alliance across North Kent enables the sharing of skill and effective use of resource to benefit patients and the public, and as such there is an agreement that the urgent and emergency care review will be undertaken jointly. This collaboration will ensure a co-ordinated approach is taken with the review which will inform a new model of care and service delivery.

While a collaborative approach is being taken with the review, this paper is submitted to the HOSC on behalf of NHS Swale and Dartford, Gravesham and Swanley CCGs. NHS Medway CCG is submitting a paper to the Medway HASC on 6 October.

3. Scope

The review will include the Accident and Emergency departments (A&E) at both Medway NHS Foundation Trust (MFT) and Darent Valley Hospital. It will also incorporate the walk in centres (WICs), minor injury units (MIUs) and out of hours services (OOHs). The review will include the proposal for a single 24/7 urgent care 'front door' model at MFT focusing on triage and navigation to the right urgent care or community service.

For DGS and Swale CCGs, the scope of the review includes the following services –

Accident and Emergency Departments

- Medway Maritime Hospital, Gillingham (Medway NHS Foundation Trust)
- Darent Valley Hospital, Dartford (Dartford and Gravesham NHS Trust)

Minor Injury Units (Kent Community Health NHS Trust) located at –

- Sittingbourne Memorial Hospital, Bell Road, Sittingbourne
- Sheppey Community Hospital, Plover Road, Minster on Sea, Sheerness
- Gravesham Community Hospital, Bath Road, Gravesend

Walk in Centres located at –

- Vale Road, Northfleet, Gravesend (Fleet Healthcare)
- Sheppey Community Hospital, Plover Road, Minster on Sea, Sheerness (Dulwich Medical Centre-DMC).
- DMC also provide a mobile WIC throughout Sheppey

Out of Hours

- Medway on Call Care (Medway Community Healthcare-MCH) – commissioned by both Medway and Swale CCGs
- IC24 – commissioned by DGS CCG

NHS 111 - A national telephone service, provided in Kent Surrey and Sussex by South East Coast Ambulance NHS Foundation Trust (SECAmb), working in partnership with Care UK. The specification for the NHS 111 service includes the 'Speak to GP' disposition. This element of the NHS 111 service is also being considered as part of this review. Options for the 111 call handling service ahead of contract end date are to be discussed across Kent and Medway.

4. Approach

The urgent and emergency care review is complex as it covers multiple providers and multiple CCGs. The CCGs consider that the review is a substantial change. In light of this a 12 week public consultation is scheduled into the plan.

A initial draft business case and service specification will be submitted to each CCG. Further planning work is required but based on an indicative timeline, it is anticipated these will be submitted in March 2015. This will enable a decision to be reached to proceed to a public consultation on the service redesign model(s).

Following public consultation, revisions will be made to the business case and service specification (as appropriate) which will then be submitted for a decision to proceed to procurement with the service redesign. This is expected to be in August 2015.

4.1 Patient, Public, Stakeholder Engagement

The following engagement with patients, public and stakeholders for planning and developing the proposal will take place;

- **Patient survey** – due to the significant pressures at MFT, the plan is to consult with 1,000 people during a three week period in October 2014 to understand the public's experience of using services to date. This will include face to face consultations with 1,000 patients in the Emergency Department (ED) at MFT as well as 400 face to face consultations with members of the public in the community at both Sittingbourne and Gillingham town centres.

- **Clinical audit** – a clinical audit was conducted at the MFT ED during July and August 2014 with involvement from key stakeholders (including SECAmb, MFT, GPs, Medway Community Health Trust and the Psychiatric Liaison Team. The aim of the audit is to review how patients' access and present to the ED, the conditions they are presenting with a view to identifying possible gaps in service provision and whether an alternative care pathway could have been used. This will feed into the longer term model.

- **Stakeholder event** - planned for November, will engage with a number of key stakeholders. It is expected that this event will provide an overview of the review, identify key principles of the review and high level benefits.

- **Clinical reference group** - will be established to review the current urgent care system, to understand the strengths and weaknesses, agreeing the clinical case for change and produce recommendations on potential options for a new clinical model. This group will be tasked with the development of a clinical model that is sustainable for the future and meets the future needs of patients.

- **Patient reference group** – will be established to review the proposed options from the clinical reference group and will be a critical friend to ensure that the patient voice is heard. There will be a clear recruitment process for this group to ensure the population of each CCG is represented.

- **Provider group** – will be established to ensure that all current providers are kept informed of the review and will have the opportunity to review the information being used to develop the business case.

A 12 week public consultation will begin in preparation for procurement and finalisation of the business case and service specification. Although the public will be involved in the options development (through the Patient Reference Group above) the views of the wider public, and those affected by the changes, will be sought on the proposals and their impact. This is expected to begin in April 2015. Further details will need to be clarified on the pre election period (Purdah), and the impact on this phase, as the public consultation is potentially at the time when a General election will take place.

The outputs of the public consultation will be collated and reflected in the final business case and service specification for CCG agreement. A paper will also be prepared to provide details to the HOSC.

5. Effect on Access to Services

As part of the review, potential options for a new clinical model will be developed through the clinical and patient reference groups. Detailed modelling and analysis will be undertaken to define parameters and assumptions of the model. Demographic projects and future patient flows will be a key element of this modelling to build a robust business case for change.
Further work will be undertaken alongside this to understand infrastructure requirements and potential risks including transport sustainability and access. This will ensure that high quality services will be delivered with consideration given to public transport access for patients in terms of location and availability.

It is anticipated there will be numerous positive impacts of the urgent and emergency care review design. The CCGs are committed to ensuring that through this review, a new 24/7 model provides services in a more integrated and co-ordinated way (and includes other health care, health related and social care services) ensuring good accessibility and consistency and supports patients in making an informed and considered choice through improved clinical input and support.

6. Timeline

It is anticipated this will be a 20 month programme with a new urgent and emergency care system in place from July 2016. Patient and clinical reference groups will be established in November 2014 coinciding with an initial stakeholder event to begin the review.

7. Next steps

The committee is asked if they consider the changes substantial and therefore require presentation to a JHOSC.

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