HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 28th November, 2014

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 28th November, 2014, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Lizzy Adam**
Telephone: **03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
UKIP (3):	Mr A D Crowther, Mr J Elenor and Mr C P D Hoare
Labour (2):	Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor P Beresford, Councillor J Burden, Councillor R Davison and Councillor Mr M Lyons

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UNRESTRICTED ITEMS

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

Item Timings*

1. Substitutes

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

3. Minutes (Pages 5 - 16)

4. Dates of 2015 Committee Meetings

(1) The Committee is asked to note the following dates for meetings in 2015:

Friday 30 January
Friday 6 March
Friday 10 April
Friday 5 June
Friday 17 July
Friday 4 September
Friday 9 October
Friday 27 November

5. Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy and Stroke Services (Pages 17 - 32) 10.05

6. Patient Transport Services (Pages 33 - 38) 10.45

7. Medway NHS Foundation Trust (Written Update) (Pages 39 - 46)

8. Date of next programmed meeting – Friday 30 January 2015

Proposed items:

- North Kent: Emergency and Urgent Care Review and Redesign (Short Term)
- SECAmb - Future of Emergency Operation Centres
- CQC Report & RCS Report - Maidstone Hospital (Written Update)
- Medway NHS Foundation Trust (Written Update)
- Kent Community Health NHS Trust: Community Dental Clinics (Written Update)

EXEMPT ITEMS

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

**Timings are approximate*

Peter Sass
Head of Democratic Services
(01622) 694002

20 November 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, 10 October 2014.

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

ALSO PRESENT: Dr J Allingham, Ms S Allum, Mr A H T Bowles, Ms C J Cribbon and Mr S Inett

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

UNRESTRICTED ITEMS

69. 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.

70. Minutes
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions which 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 will be circulated to Members at the end of October.

(b) Minute Number 64 – East Kent Outpatients Services. The Scrutiny Research Officer wrote to NHS South Kent Coast CCG to arrange a meeting with Dr Eddy to discuss the future of services at Deal Hospital. In response to the meeting request, the CCG asked to bring an item to the November meeting to outline its plans for an Integrated Care Organisation. A response was circulated to Members on 7 October.

(c) Minute Number 67 – NHS England: General Practice and the development of services. A detailed case study of the difficulties faced

by a GP returning to practice after a period of absence was produced by Dr Allingham and circulated to Members on 3 October. The Scrutiny Research Officer wrote to Professor Tavabie (Interim Dean Director, Health Education Kent, Surrey & Sussex) to arrange a meeting with the working group. A response was awaited.

(d) Minute Number 68 – Date of the next programmed meeting. The Scrutiny Research Officer circulated the 'Quality and the Health and Wellbeing Board' paper to the Committee on 9 September.

(2) RESOLVED that the Minutes of the Meeting held on 5 September 2014 are correctly recorded and that they be signed by the Chairman.

71. Child and Adolescent Mental Health Services (CAMHS) - Tiers 1, 2 & 3
(Item 4)

Sue Mullin (Commissioning Manager, Kent County Council), Ian Ayres (Accountable Officer, NHS West Kent CCG), Colm Donaghy (Chief Executive, Sussex Partnership NHS Foundation Trust), Simone Button (Divisional Director, Children and Young People's Services, Sussex Partnership NHS Foundation Trust) and Jo Scott (Programme Director, Kent and Medway, Children and Young People's Services, Sussex Partnership NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Mullin began by giving an overview of Kent County Council's role in the commissioning and development of emotional wellbeing and mental health services for children and young people in Kent. In 2010, an Ofsted Review had found that the outcomes for children and young people in care were inadequate, which led to Kent County Council and partners to review all provision, including mental health and emotional wellbeing, and established a framework for early intervention and prevention services.

(2) Ms Mullin reported that in July 2011 Kent County Council and NHS Kent & Medway had agreed to align funding in order to jointly commission emotional wellbeing and mental health services for children and young people. Kent County Council led the procurement of emotional wellbeing services and the NHS led the procurement of the CAMHS services. Contracts were awarded in September 2012 for a three year period. Kent County Council aligned funding into the CAMHS service to specifically support provision for Children in Care. It was stated that there was no waiting list for Children in Care and Kent County Council was happy with the provision of services for Children in Care by Sussex Partnership NHS Foundation Trust (SPFT).

(3) Ms Mullin stated that HOSC on 31 January 2014 was a watershed moment for the commissioners: NHS West Kent CCG and Kent County Council. As a response to the disparity of provision, services and commissioning arrangement identified by HOSC, the commissioners developed, with multi-agency partners, the draft Emotional Health and Wellbeing (EMHW) Strategy for 0-25 year olds in Kent which would go out for public engagement in October 2014. Ms Mullin reported that the new partnership response was a positive approach to improve emotional wellbeing and mental health services for children and young people in Kent.

(4) Mr Ayres gave an update on actions taken to improve the performance of CAMHS in Kent. SPFT were now compliant with contract standards for waiting times for routine referrals: referral to assessment and assessment to treatment. SPFT were on track to clear historic backlogs by the end of October 2014. SPFT had completed team restructures and teams were operating close to full capacity. The performance notice served on SPFT by the CCG in February 2014 was fully achieved at the end of August 2014; the CCG were assured that the current contract performance regime could end. He stated that significant progress had been made but further action was still required.

(5) He reported that NHS West Kent CCG had commissioned Kent and Medway NHS and Social Care Partnership Trust (KMPT) and SPFT to deliver a Section 136 Place of Safety in Kent in Dartford. The Place of Safety replaced arrangements for children picked up by the police under Section 136 to wait in A&E and police custody for inpatient admission. The CCG had introduced Serious Incident reporting, for when children were not housed appropriately, as part of the monthly performance review.

(6) On the request of HOSC, a peer review of the performance plan and current model of service was undertaken by Oxford Health NHS Foundation Trust. Their initial findings were positive but had found that the Common Assessment Framework was a barrier to accessing services. The full report would be available at the end of October 2014.

(7) Mr Ayres noted that NHS West Kent CCG had been working with Kent County Council, Kent Health and Wellbeing Board, NHS England and Healthwatch Kent to jointly review commissioning arrangements for CAMHS and develop the Emotional Health and Wellbeing Strategy for 0-25 year olds in Kent. Mr Ayres reported that the contracts for existing commissioned services were due to end in October 2015. He highlighted the need for holistic procurement across the tiers based on the learning from previous procurements.

(8) Mr Donaghy congratulated SPFT staff on their efforts to make improvements. On visits to staff in Kent, he had been greatly impressed with their commitment and motivation to improve care for children in the county. He stated that the SPFT was not complacent and recognised that there was still further work to be done.

(9) The Chairman invited Ms Cribbon, local Member for Gravesham East, to speak. She raised concerns about the lack of access to CAMHS services by the Troubled Families programme in Gravesham. Ms Mullin and Mr Ayres stated that they were not aware of any issues relating to the Troubled Families Programme particularly in Gravesham but they would investigate this matter further.

(10) Members of the Committee then proceeded to ask a series of questions and make a number of comments. Mrs Allen thanked the Chairman for having CAMHS on the Committee's agenda. She stated that the reports would be circulated to the relevant committees.

(11) A number of comments were made about commissioning and the importance of the tender specification and accurate data. In response to a specific

question about the lack of a waiting list for Children in Care, Ms Mullin explained that Kent County Council had a duty to monitor and record data accurately for Children in Care. When commissioning the services for Children in Care, it had been easier to determine the resources required for the service as the prevalence and need had been accurately recorded by the Council which had resulted in a lack of a waiting list for Children in Care. Mr Ayres acknowledged the importance of accurate data and early procurement. He was reviewing all NHS West Kent CCG's contracts to ensure data was being collected, monitored and recorded accurately. He commended Kent County Council's approach to data collection.

(12) A Member noted and welcomed the inclusion of the Healthwatch Kent report on Tier 2 and 3 services in the Agenda papers. Mr Inett explained that Healthwatch Kent would like to undertake further work to look at Tier 1 and 4 services and how changes to Tier 2 and 3 services were implemented as the report was written during a period of change. Patients, their families and carers had highlighted to Healthwatch Kent the difficulty in building relationships with the service provider and their staff due to high turnover of staff. Mr Inett stressed the importance of consistency as part of future CAHMS commissioning. Mr Ayres thanked Healthwatch Kent for their report. He stated that he was keen to work with Healthwatch Kent in the future particularly with the Emotional Health and Wellbeing Strategy for 0-25 year olds in Kent. He acknowledged that changes to service providers and staff resulted in a lack of knowledge transfer.

(13) A Member enquired about the increase in the number of actual referrals received and the decrease in the number of contacts and caseload. Ms Scott explained that the Trust was implementing the model they had tendered for; in order for the model to work the caseload needed to be reduced. The Trust had a finite resource and was concentrating on those clients who were ready to be discharged in order to reduce the caseload. The number of planned contacts had reduced as the number of emergency referrals was higher than expected which took clinicians away from routine referrals.

(14) A further question was asked about the seasonality of referrals and long term reduction in referrals. Whilst there was a planned long term reduction in referrals; it was noted that referrals to CAMHS services across the UK dipped over the summer holidays and spiked in September and October. It was explained that many referrals came from school during term time and significant transition points for young people occurred in September and October. Mr Ayres noted the significant reduction in the numbers waiting for treatment since August 2013.

(15) Concerns were expressed about transition. Ms Button made reference to the Commissioning for Quality and Innovation (CQUIN) scheme in which providers can earn incentive payments of up to 2.5% of their contract value by achieving agreed national and local goals for service quality improvement. She explained that as part of the contract refresh for 2014/15 SPFT and KMPT had been set a joint CQUIN to improve transition arrangements between children and adult services. The Trust was actively working with KMPT to improve transition; there had been successful partnership working with KMPT's Early Intervention Psychosis service. She stated that the Trust was keen to provide services for young people up to the age of 25. Mr Ayres reported that

transition was part of the Emotional Health and Wellbeing Strategy for 0-25 year olds in Kent.

(16) A number of comments were made about crisis resolution and Kent Integrated Adolescent Support Service (KIASS). Ms Button highlighted the success of the Trust's home treatment service which was able to offer intensive support for young people in crisis at home seven days a week. The service had helped to reduce pressure on the limited Tier 4 inpatient beds. With regards to KIASS, the Trust was looking to broaden and develop partnership working.

(17) The Scrutiny Research Officer read a statement from The Rt Hon Greg Clark MP. Mr Clark expressed his gratitude to HOSC, NHS West Kent CCG and Sussex Partnership NHS Foundation Trust for all their work to improve CAMHS services in Kent.

(18) RESOLVED 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 progress reports to the Committee within six months and at the end of the financial year.

72. West Kent: Out of Hours Services Re-procurement
(Item 5)

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

(1) The Chairman welcomed Mr Ayres to the Committee. Mr Ayres gave an overview of the three core primary care services commissioned by NHS West Kent CCG to deliver urgent and emergency care: out of hours GP service, an enhance rapid response service to support patients with acute medical conditions in the community and GPs working in A&E to see and treat primary care type patients.

(2) Mr Ayres explained that the contract for West Kent out of hours provision was coming to an end; in order to comply with NHS financial regulations and competition rules, the CCG was required to retender the out of hours contract. The short term proposal was to procure the three core services within one contract for two years (2015 – 2017) in order to improve integration and reduce fragmentation. Mr Ayres stated that the plans had not been taken to the CCG's Governing Body as he wanted to engage early with HOSC. The long term proposal was to integrate health and social care services: acute, community, emergency and social services. He noted that these proposals would be brought to a future HOSC.

(3) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member questioned the resilience of the acute hospitals to act as a hub for the three core primary care services which delivered urgent and emergency care. Mr Ayres explained that GPs in A&E and the enhanced rapid response team would strengthen hospitals' resilience as it would reduce pressure on A&E admissions. He stated that blockages in A&E were cause by minor rather than major trauma. A growing number of A&E attendees were people who required care but did not require care in a

hospital setting. Mr Ayres noted that the short term proposals were aligned with the Keogh Urgent Care and Emergency Care Review.

(4) In response to a specific question about the impact on surrounding areas, it was explained that the CCG had taken account of changes in the surrounding areas and had had discussions with commissioners and providers. It was noted the longer term proposals would require extensive engagement; the short term proposals provided the CCG with time to develop the complex and radical redesign of health and social care in West Kent.

(5) A number of comments were made about the use of IT to share patients' medical data. Mr Ayres stated that there was a need for a system to share real time information with a range of professionals. This would enable clinicians to make better judgements, with regards to clinical risk, to admit or discharge patients. He noted that this would form part of the long term proposals.

(6) Mr Inett offered Healthwatch Kent's assistance with the Equality Impact Assessment and to share best practice consultation and engagement with the CCG. Mr Ayres welcomed the opportunity to work with Healthwatch Kent to improve the CCG's engagement strategy for the short term proposals. Mr Ayres acknowledged Members' comments regarding the need for further engagement on the short term proposals.

(7) RESOLVED that:

(a) The Committee do not deem this change to be substantial.

(b) 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 that they be invited to submit a report to the Committee in six months.

73. North and West Kent: Dermatology Redesign
(Item 6)

Jim Loftus (Commissioning Programme Manager, NHS Swale CCG), Patricia Davies (Chief Accountable Officer, NHS Swale CCG and NHS Dartford Gravesham and Swanley CCG), Dr Christopher Markwick (GP Lead, NHS Medway CCG), Zoe McMahon (Commissioning Programme Manager, NHS Dartford Gravesham and Swanley CCG), Ian Ayers (Accountable Officer, NHS West Kent CCG) and Caroline Friday (Commissioning Manager, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Loftus began by giving an overview of the proposals to redesign and re-commission an integrated Dermatology service for children and adults in North and West Kent.

(2) Mr Loftus explained that a significant proportion of patients requiring dermatology services could be treated by a skilled workforce within a community setting. At present 85% of new patients were referred to an acute hospital for their first outpatient appointment; the majority of these

appointments took place at Medway NHS Foundation Trust. It was anticipated that 60 – 70% of patients could receive future services within a community setting by a multi-disciplinary team, releasing capacity within the acute trust to treat patients with more complex conditions. He noted that there was rising demand for dermatology services and a need for activity to take place in the community to release acute capacity. Following public engagement, the proposed service specification included the provision of services in a local community setting, with good access in terms of clinic location and clinic times. He reported that there were a number of providers interested in delivering the service.

(3) The Chairman invited Mr Bowles, local Member for Swale East, to speak. Mr Bowles noted respondents' preference to be treated locally, in a GP practice or community clinic, in the patient questionnaire. He stated that community based services could lead to a carbon reduction as patients would travel shorter distances.

(4) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A question was asked about caseload. Dr Markwick explained that a third of dermatology patients were managed by their GP (Level 1 & 2), a third were seen by acute specialists (Level 3 & 4); and a third required high level acute specialist services for life threatening conditions (Level 5 & 6). He stated a significant proportion of Level 3 patients could be treated by a skilled workforce within a community setting which would release specialist appointment capacity within the acute service.

(5) A Member enquired about the shortage of dermatologists. Dr Markwick explained that there was a shortage of dermatology specialists, locally and nationally. The new model was designed to build the capacity of the workforce and deliver the service through a multi-disciplinary team with a range of skill sets. In response to a specific question about a resident dermatologist at Maidstone Hospital, Dr Marwick noted that there was a team of consultant dermatologists who rotated between Medway Maritime Hospital, Maidstone Hospital and Darent Valley Hospital.

(6) RESOLVED that:

(a) The Committee do not deem this change to be substantial.

(b) 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 that they be invited to submit a report to the Committee in six months.

74. CQC Inspection Report - East Kent Hospitals University NHS Foundation Trust *(Item 7)*

Stuart Bain (Chief Executive, East Kent Hospitals University NHS Foundation Trust) and Helen Goodwin (Deputy Director of Risk, Governance and Patient Safety, 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 giving an update on the action plan. He reported that Monitor had appointed

Sue Lewis as Improvement Director; she would work at the Trust for three days a week until Special Measures were lifted. Her role was to hold the Trust to account for making progress against the improvement plan. The Trust would have a monthly meeting with Monitor to discuss the progress of the action plan. An updated action plan would be published monthly on the NHS Choices and Trust's website. He explained the references used in the action plan: 'M' was a must do action and 'KF' was a key finding.

(2) He stated that the Trust had previously recognised many of the actions highlighted in the CQC inspection report; they were challenging the accuracy of some findings. The Trust had already developed plans to address two key areas before the inspection: outpatients and staffing. A £28 million investment had been agreed to develop outpatient services; £23 million was spent on the new Dover Hospital and a further £5 million would be spent to improve existing outpatient facilities.

(3) Following a nursing review in January 2013, the Trust's board agreed a £2.9 million investment to fund additional nursing posts. The Trust had recruited all locally trained nurses and nurses from Ireland, Portugal and Spain; 75 % of the posts were filled and the Trust continued to recruit. Mr Bain highlighted the national shortage of nurses and A&E staff. There was a high turnover of staff from the Trust; staff gained experience at the Trust and then moved onto the London Teaching Hospitals which were seen as a more attractive option.

(4) Mr Bain expressed concern about the inspection findings which found poor engagement with staff and a lack of of openness and transparency. He stated that he did not tolerate bullying and encouraged staff to speak about their concerns. He recognised the criticisms in the report regarding the estate; he noted that improvements to the estate were under continual renewal.

(5) The Chairman invited Mr Angell to speak as he had attended the Quality Summit on behalf of the Committee with the Scrutiny Research Officer. Mr Angell stated his disappointment that the Trust had been rated inadequate and offered his support to the Trust. He noted concerns about A&E in the inspection report and enquired if the Emergency Care Centre at the Kent and Canterbury Hospital could be upgraded to an A&E. Mr Bain explained that there was an unrelenting pressure on Urgent and Emergency services which was beyond the control of the Trust. It was reported that the Emergency Care Centre was an integral part of the system and was viewed as a successful model by experts. He stated that the former A&E at the Kent and Canterbury Hospital was underutilised.

(6) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member asked for clarification on two key findings in the action plan: poorly maintained buildings and equipment (KF17) and long waits between pre-assessment and surgery (KF21). Mr Bain reported that a new facilities management system CAFM would go live next month; the system would replace paper based fault reporting for buildings and equipment and would provide real time updates for staff. He noted that the long waits between pre-assessment and surgery affected one clinic only; patients would now be given a specific time slot. He noted that timeframes for actions would be confirmed within six weeks and included in the monthly reports.

(7) In response to a specific question about the level of seriousness for each action, Mr Bain explained that all the findings in the action plan were pertinent. He highlighted a number of key findings from the inspection report which needed to be urgently addressed and the action being taken:

- Data accuracy (KF02) – The Trust had commissioned an independent assessment of data accuracy for all data used in reports to the Board.
- Cultural issues (KF03 and KF04) - The Trust was carrying out a root cause analysis of the culture gap; a staff engagement strategy would be developed using the findings of the analysis. It was explained that a change of culture would take time.
- Out of date policies across the Trust (KF14) – The Trust would remove all out of date paper policies from walls. It was explained that all staff had access to a central electronic database of the Trust's policies which were updated year on year.
- Patients being moved at night (M21) – The Trust had developed a Delivery Board with partners to look at the demand, capacity and flow across the whole system.

(8) Mr Lyons informed the Committee that the Council of Governors had written to every member of staff following the publication of the inspection report in support of the Trust. He enquired if staffing levels had been taken into consideration by the CQC. Mr Bain explained that the Trust had adequate staffing for the contracted number of beds. When the CQC inspected in March, additional beds (above the contracted level) were put in place to facilitate the number of patients who required admission. It was reported that the additional beds, resulting from winter pressures, meant that the patient experience was not as good and staffing levels were not at the appropriate level.

(9) Mr Bain concluded by stating that the Trust was not complacent and taking the inspection report very seriously. He reported that the Trust had a 20% lower mortality rate than the national average and delivered good clinical outcomes for patients.

(10) RESOLVED 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 attend a meeting of the Committee within six months with a progress report.

75. Adjournment
(Item)

(1) The meeting adjourned until 13.10.

76. North Kent: Emergency and Urgent Care Review and Redesign (Long Term)
(Item 9)

Patricia Davies (Chief Accountable Officer, NHS Swale CCG and NHS Dartford Gravesham and Swanley CCG) and Dr Fiona Armstrong (Clinical Chair, NHS Swale CCG) were in attendance for this item.

(1) The meeting reconvened at 13.10. The Chairman welcomed the guests to the Committee. Ms Davies began by giving an overview of the proposals to reconfigure and recommission emergency and urgent care services in North Kent. She reported that the three North Kent CCGs: Medway, Swale and Dartford, Gravesham and Swanley considered the review to be a substantial change.

(2) Ms Davies highlighted that urgent and emergency care services in North Kent were under significant pressure. Further, a number of urgent and emergency care contracts would end in April 2016 and were not able to be extended. The CCGs were using this opportunity to reconfigure the provision of urgent and emergency care in North Kent using guidance from the Keogh Urgent Care and Emergency Care Review. Patient, public and stakeholder engagement was planned and would include a 12 week public consultation.

(3) The Scrutiny Research Officer was asked to provide guidance on the recommendation. She advised that if the HOSC deemed the service change not to be substantial, this would not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the CCGs. The HOSC would also lose its formal power to refer to the Secretary of State for Health.

(4) RESOLVED that:

(a) The Committee do not deem this change to be substantial.

(b) 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 that they be invited to attend a meeting of the Committee in six months.

77. North Kent: Emergency and Urgent Care Review and Redesign (Short Term) *(Item 10)*

Patricia Davies (Chief Accountable Officer, NHS Swale CCG and NHS Dartford, Gravesham and Swanley CCG) and Dr Fiona Armstrong (Clinical Chair, NHS Swale CCG) were in attendance for this item.

(1) Ms Davies began by providing an overview of the short term proposals to assist Medway NHS Foundation Trust to implement recommendations made by the CQC for the A&E.

(2) Following the issue of a Section 31 Notice by the CQC (which could fully or partially close the A&E), Kent and Medway commissioners and providers met with NHS England to develop a plan to support the Trust. It was reported that the full or partial closure of Medway A&E would have a severe impact on local and neighbouring health economies.

(3) Proposals included the reduction of elective activity at Medway NHS Foundation Trust to increase internal capacity. Maidstone and Tunbridge Wells NHS Trust agreed to offer Swale patients the option to be seen at Maidstone Hospital for their elective outpatient appointments in three specialties – care of the elderly, respiratory and cardiology. Ms Davies applauded Maidstone and Tunbridge Wells NHS Trust for their support.

(4) Members of the Committee then proceeded to ask a series of questions and make a number of comments. Mr Angell and Mr Inett enquired about the issue of the Section 31 Notice by the CQC. Ms Davies explained that the Notice had been issued but not enacted. Following a meeting with the CQC, Monitor and the Trust, she stated that she did not believe that it would be enacted until a further unannounced inspection had taken place. She noted that the CQC were conscious about the impact on the wider system if the A&E at Medway Maritime Hospital was fully or partially closed.

(5) A Member asked for clarification about the outpatient proposal. Ms Davies confirmed that elective outpatient appointments at Maidstone Hospital for Swale residents in three specialities would be introduced imminently and would be enacted by patient choice.

(6) A number of comments were made about lack of improvement at the Trust. Dr Armstrong explained that the Trust had employed Dr Laurence Gant and two A&E nurses from the Homerton University Hospital NHS Foundation Trust for two days a week to support the Emergency Department and investigate patient flow. The Trust was looking to extend their contract to four days a week to enable them to develop a fit for purpose system for patient flow. It was reported that the Homerton A&E was one the best A&Es in the country and the first to be rated as Outstanding by the CQC. It was based in a deprived area of London and had poor transport link similar to Medway.

(7) Ms Davies reported that Member Practices' in NHS Swale CCG also had concerns about the lack of improvement and the referral of patients to the Trust. The proposals were developed in response to those concerns and looked at different options to make improvements. Ms Davies expressed her support for Dr Philip Barnes; she stated that he had a refreshing focus on quality. She noted that he needed time and support to deliver changes to the Trust.

(8) The Chairman asked Mr Bowles, local Member for Swale East, to speak. Mr Bowles informed the Committee that he had signed off a letter to the Secretary of State for Health, as Leader of Swale Borough Council, expressing his disquiet at the speed of change at Medway NHS Foundation Trust. He stated that he was increasingly concerned about Swale residents being referred to the A&E at Medway Maritime Hospital. Ms Davies commented that NHS Swale CCG had a good relationship with Swale Borough Council and the local Health and Wellbeing Board was making every endeavour to support Medway NHS Foundation Trust.

(9) In response to a specific question about partnership working, Ms Davies explained that the CCG was working very closely with partners to deliver service change including the CCG Accountable Officers and local authorities. A further question was asked about the knock on effect of the proposals. Ms

Davies reported that the shift of elective outpatient appointments would not have a wider negative impact. She reported that only 5% of NHS Swale CCG population receive their treatment in East Kent.

(10) A question was asked about staffing shortages at the Trust A&E. Ms Davies explained that Dr Gant's view was that medical staffing levels were not poor comparatively. He believed that the department needed to relearn the most appropriate patient flow and care.

(11) A number of comments were made about the excellent work carried out by the staff at Medway Maritime Hospital. Dr Armstrong reported that there were pockets of excellence at the Trust; A&E was the main area of concerned. She stated that NHS Swale CCG was committed to working with the Trust to enable it to make changes and provide quality of care for patients. Ms Davies thanked the Members for their support.

(12) RESOLVED that the Committee are supportive of the decision to take urgent action at Medway NHS Foundation Trust, that the CCG be thanked for their attendance at the meeting and that they be invited to attend the Committee in January with a progress report.

Item 5: Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy and Stroke Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 28 November 2014

Subject: Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy and Stroke Services

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

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

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1. Introduction

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

2. Clinical Strategy

(a) Maidstone and Tunbridge Wells NHS Trust attended HOSC on 18 July 2014 to present their developing clinical strategy. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that the guests be thanked for their attendance and their contributions, and that there be on-going engagement with HOSC as plans are developed with a return visit to a meeting of the Committee at the appropriate time*

3. Stroke Services

(a) A stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off. There are two main causes of strokes (Healthcare for London 2008; NHS Choices 2014):

- Ischaemic – where a blood clot blocks an artery carrying blood to the brain(this accounts for 85% of all cases);
- Haemorrhagic – where a burst blood vessel bleeds into the brain (intracerebral haemorrhage) or into the surrounding area (subarachnoid haemorrhage).

(b) There is also a related condition known as a transient ischaemic attack (TIA). A TIA is often called a 'mini' or 'mild' stroke. The symptoms are similar to a full stroke however they do not last as long. A TIA can be a serious warning sign that unless urgent preventative action is taken a major stroke could occur (Healthcare for London 2008; NHS Choices 2014).

(c) Stroke is a major health problem in the UK. It is the third largest cause of death after heart disease and cancer. It accounted for over 56,000 deaths in England and Wales in 1999, which represented 11% of all deaths. Most people survive a first stroke, but often have significant morbidity. Each year in England, approximately 110,000 people have a first or recurrent stroke and a further 20,000 people have a TIA. More than 900,000 people in England are living with the effects of stroke, with half of these being dependent on other people for help with everyday activities (NICE 2014).

(d) In England, stroke is estimated to cost the economy around £7 billion per year. This comprises of direct costs to the NHS of £2.8 billion, costs of informal care of £2.4 billion and costs because of lost productivity and disability of £1.8 billion (NICE 2014).

(e) A National Stroke Strategy was developed by the Department of Health in 2007. This outlined an ambition for the diagnosis, treatment and management of stroke, including all aspects of care from emergency response to life after stroke. In 2010, the National Institute for Health and Clinical Excellence (NICE) produced quality standards that focused on the clinical aspects of stroke care.

(f) In March 2014, NHS England published a refreshed business plan: *Putting Patients First: the NHS England business plan for 2014/15 – 2016/17*. NHS England set out its aims to develop a specific case for acute stroke service reconfigurations in two geographical locations by April 2015 and to promote the reconfiguration of stroke services across the country, building on the evidence-based model developed in London (NHS England 2014).

(g) The model of acute stroke care in London was centralised in 2010. 30 local hospitals, who had previously received stroke patients, were reduced to eight hyper-acute stroke units (HASU). All stroke patients are taken by ambulance to the nearest HASU located no more than 30 minutes travel time away (Healthcare for London 2008).

(h) On arrival a patient is assessed by a specialist; has access to a CT scan; and receives clot busting drugs such as thrombolysis, a vital treatment in reducing the impact of ischaemic stroke, within 30 minutes. Patients are then transferred to a HASU bed where they receive high dependency care for the first 72 hours following admission. Once stabilised the patient is transferred to a Stroke Unit, either in the same hospital or closer to home. Patients are rehabilitated in the Stroke Unit and discharged to the appropriate care in the community (Healthcare for London 2008).

(i) A before and after study of the new model found that the thrombolysis rate increased from 5% to 12%, the survival rate increased from 87.2% to 88.7%, and centralisation achieved an estimated 90 day cost saving of more than £5 million a year (Hunter et al 2013).

4. Recommendation

RECOMMENDED that there be ongoing engagement with HOSC as the Trust's five year strategy and clinical strategy for stroke is developed with a return visit to a meeting of the Committee at the appropriate time.

Background Documents

Healthcare for London (2008) *'Stroke Strategy for London (01/11/2014)*', http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/London-Stroke-Strategy.pdf

Hunter R M, Davie C, Rudd A, Thompson A, Walker H, et al. (2013) *'Impact on Clinical and Cost Outcomes of a Centralized Approach to Acute Stroke Care in London: A Comparative Effectiveness Before and After Model* (01/08/2013)', http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0070420

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (18/07/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29191

NHS Choices (2013) *'Stroke (14/11/2013)*', http://www.nhs.uk/conditions/stroke/Pages/Introduction.aspx

NHS England (2014) *'Putting Patients First: the NHS England business plan for 2014/15 – 2016/17 (31/03/2014)*', http://www.england.nhs.uk/about/business-plan/

NICE (2014) *'Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA) (01/05/2014)'*, https://www.nice.org.uk/guidance/cg68

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Maidstone and Tunbridge Wells NHS
NHS Trust

Maidstone and Tunbridge Wells NHS Trust

Presentation to Kent HOSC

28 November 2014

Glenn Douglas

Chief Executive

Strategy

to achieve clinical and financial sustainability

- Currently being finalised
  - work streams led by clinicians
  - business analysis completed
- Initial findings indicate trust should focus on
  - Strategic hub for emergency care (Keogh centre at TWH)
  - Improve productivity
  - Focus on larger population base
  - Develop patient pathway and community focus
- To become a financially viable organisation no need for major structural changes or mergers/acquisitions

Strategy

to achieve clinical and financial sustainability

- Four key enablers to achieve strategy
  - Improve capability
  - Promote Innovation to drive down costs
  - Seize opportunities for development/growth
    - For example, pro-active care management
  - Be able to compete
    - Tender management

Strategy

to achieve clinical and financial sustainability

- Next steps
  - Further review of output from business analysis
  - Write Strategy document, including specific outcomes to be achieved over next 5 years
  - Develop implementation plan, including comprehensive stakeholder engagement plan
  - Review governance structure

Stroke Service Improvement

- Governance

- Trust Board focus
- Governance arrangements
  - Stroke Improvement Board, chaired by Medical Director with WK CCG and HW&L CCG representatives
  - Stroke Clinical Steering Group, chaired by Clinical Director, includes WK CCG and other stakeholders
  - Engagement Group, chaired by Deputy Director of Strategy, includes Healthwatch and local CCG representatives
- Need to meet Government 4 tests
  - Strong public and patient engagement
  - Clear clinical evidence base
  - Patient choice
  - Support from commissioners

Stroke Service Improvement

- Public and patient engagement

- One of Government 4 tests for key service changes
- Early engagement undertaken includes
  - Survey of over 200 patients regarding existing stroke services
  - Discussions with stroke survivors at Stroke Association meetings
  - Survey of over 200 members of trust
  - Discussions with stroke staff to enable them to raise any concerns/ suggest opportunities for improvement
  - Briefing MPs and GPs
- Engagement plan developed to get all stakeholder views on

  i) Case for change ii) Model of care

  iii) Assessment method iv) Long list of delivery options

Stroke Service Improvement

- Clinical case for change

Robust clinical case for change developed and agreed by West Kent CCG. Two key opportunities for improvement.

1. Stroke standards as measured by SSNAP data not met

although improvement made during last 9 months

	Overall SSNAP Jul to Sep 2013	Overall SSNAP Oct to Dec 2013	Overall SSNAP Jan to Mar 2014	Overall SSNAP Apr to Jun 2014
Maidstone	E	E	D	D
Tunbridge Wells	E	E	E	D

Comparative performance to local trusts confirms opportunity to improve

Stroke Service Improvement

- Clinical case for change

	Overall SSNAP Jul to Sep 2013	Overall SSNAP Oct to Dec 2013	Overall SSNAP Jan to Mar 2014	Overall SSNAP Apr to Jun 2014
Medway	E	E	D	D
Darent Valley	E	E	E	D
Eastbourne	E	D	D	D
William Harvey	D	D	D	C
Kent and Canterbury	D	D	D	E
QEQM Margate	C	D	D	C
Frimley Park	E	D	C	B
Epsom	C	C	C	B
St Peter's	D	D	D	C
Princess Royal	E	E	D	D
Royal Surrey County	D	D	C	C
Royal Sussex County	D	D	D	D
East Surrey	D	E	D	C
St Richard's Sussex	E	E	E	D
Worthing	E	D	D	D

Stroke Service Improvement
- Clinical case for change

2. Requirements of the Stroke specification issued by South East Coast Clinical Network not met, for example
    - Hyper acute service
        - Lack of discreet area
        - Longer than specified thrombolysis times
    - 7 day rapid access to TIA service
        - Only provided 5 days/wk
        - Carotid doppler imaging at Maidstone

Case for change forms part of early public/patient engagement.

Stroke Service Improvement

- Model of care and possible delivery options

- Stroke Clinical Steering Group have

i. Agreed need to adopt requirements set out by South East Coast Clinical Network regarding
   - Stroke specification for model of care (eg includes Hyper acute service)
   - Stroke quality and service standards

II. Generated a draft long list of options for delivery

III. Developed draft assessment criteria and method to produce short list

All of above forms part of early public/patient engagement.

Summary

- Strategy to achieve clinical and financial sustainability being finalised
- Opportunities to improve stroke service being driven by the Trust in partnership with stakeholders

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Item 6: Patient Transport Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 28 November 2014

Subject: Patient Transport Services (PTS)

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

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

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1. Introduction

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

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

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

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

(c) At the end of the discussion on 5 September 2014, the Committee agreed the following recommendation:

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

2. Recommendation

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

Background Documents

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

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

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

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

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

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

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (05/09/2014)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5399&Ver=4

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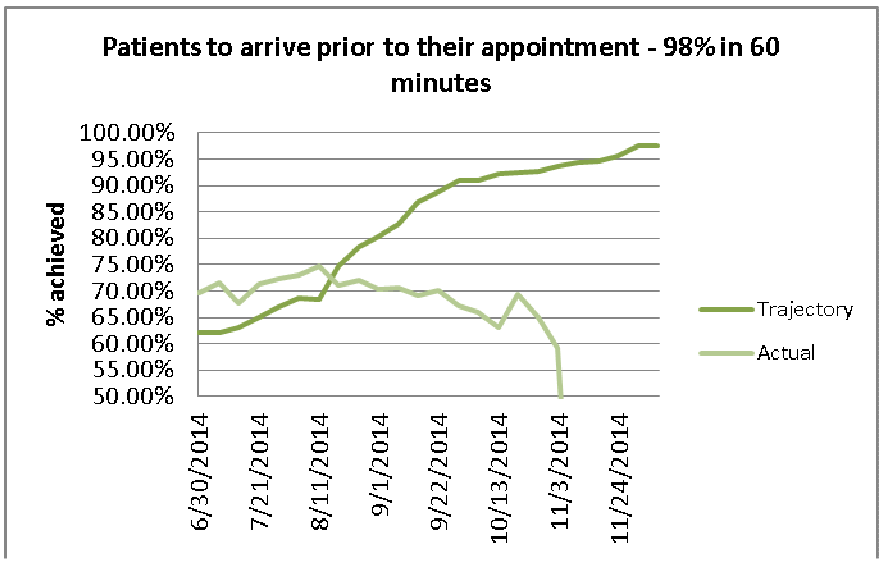
Patient Transport Services Contract

Update to Kent HOSC – 28 Nov 2014

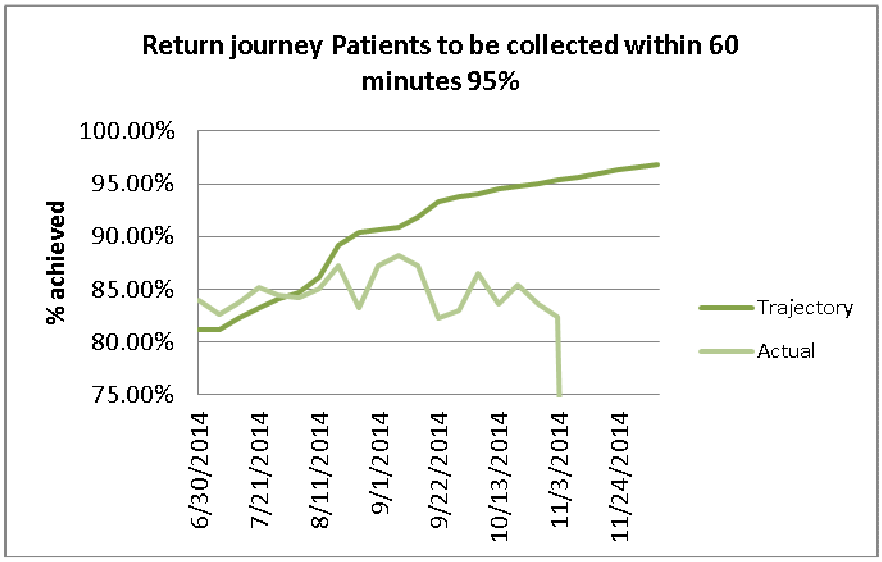
This short report updates HOSC on performance of the PTS contract since the Sept update.

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

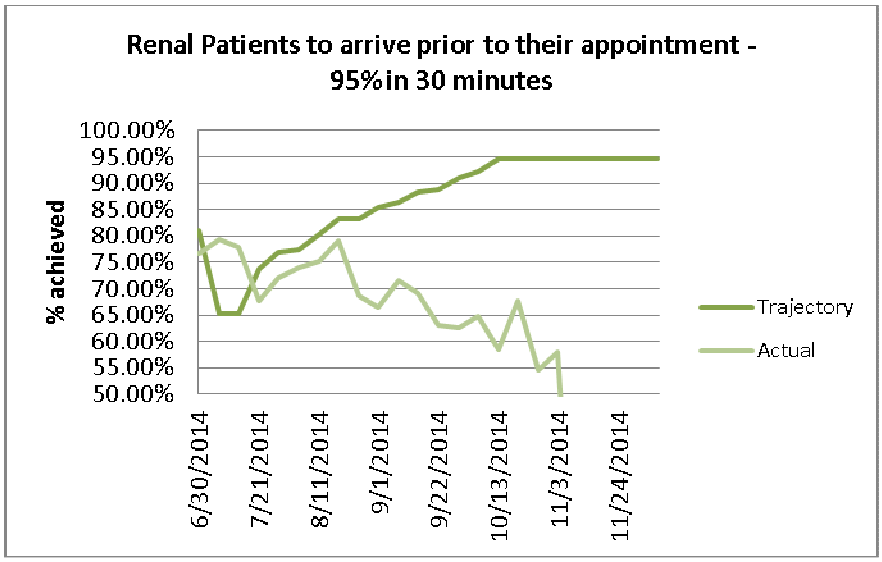
- Timeliness of taking patients into an outpatient appointment,



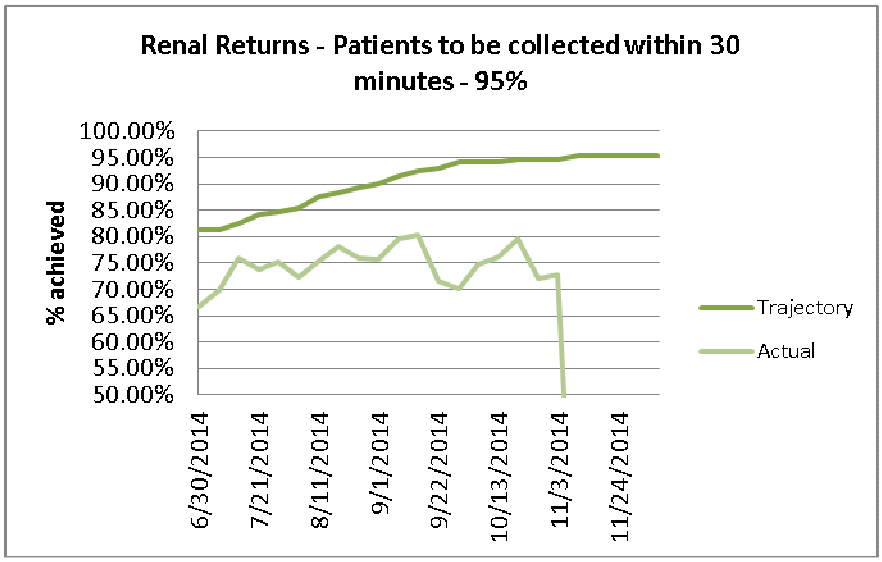
- Timeliness of collecting patients from an outpatient appointment



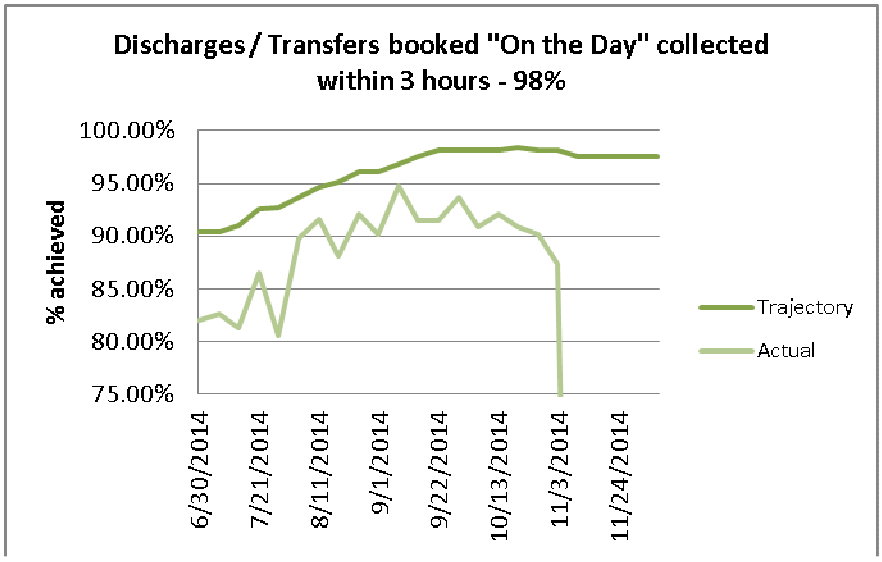
- Timeliness in bringing renal patients in for treatment

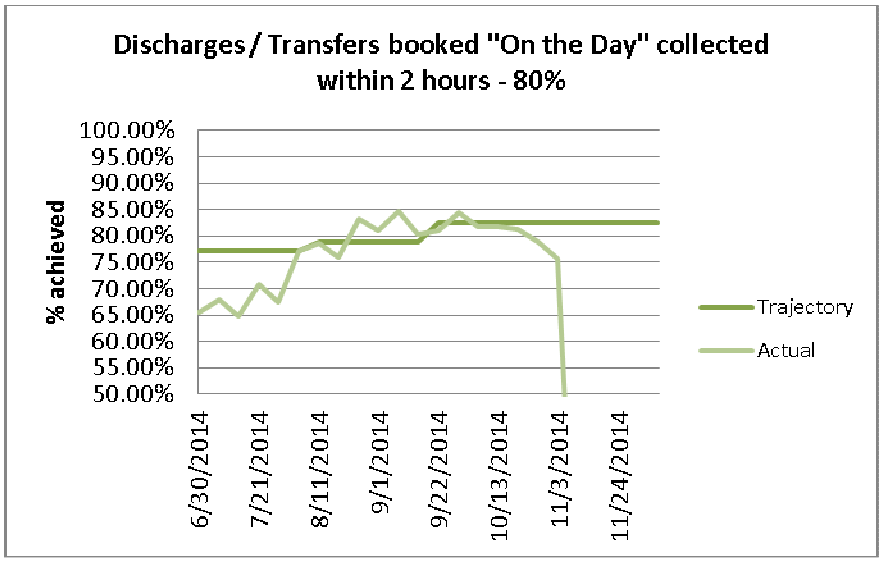


- Timeliness in collecting renal patients from treatment



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

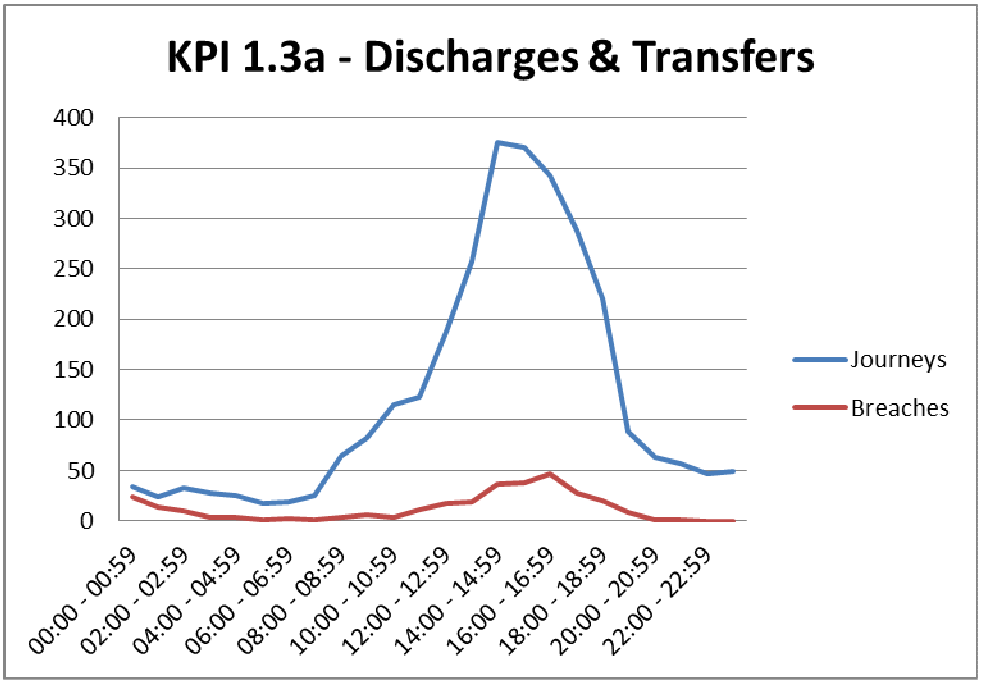




The above graphs show weekly data up to the end of October.

A review of the actions NS has taken to improve performance is undertaken monthly. At the end of October it was clear that NSL continue to make many of the changes needed. .

Data for the month of October has been analysed and, whilst overall it shows little improvement over the previous months, performance has not worsened as Trusts struggle to manage A&E performance issues. The challenge for NSL is that Trusts are not booking discharges ahead of time, and the majority of discharges are booked on the day with very significant increases in discharges some days as trust struggle to clear beds to make space for new patients. On occasion this has doubled the average daily numbers of discharges. To compound the challenges there is a significant peak in bookings over the middle of the day.

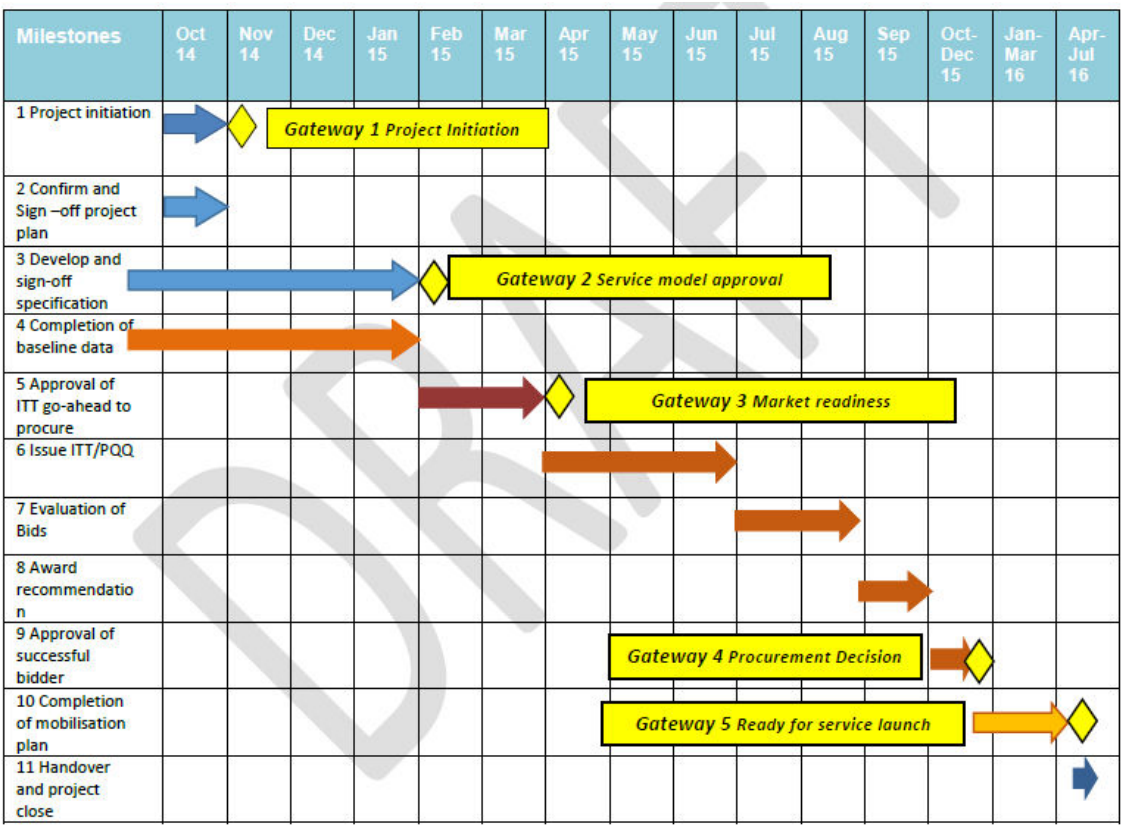


Reviewing complaints and NSL collected patient experience data shows that, where NSL collect on time, patient satisfaction is high. Concerns focus almost solely on failure to collect or deliver on time.

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

Re-procurement

CCGs in Kent and Medway, in discussion with Providers have agreed to re-procure from the end of the existing three year contract (July 2016). Termination earlier would risk legal action and would only result in termination 6 months early. A project Board is being established to oversee the process. The Board will include CCGs and Providers. A stakeholder group is being established to provide patient input to the specification and process. The time line for the re-procurement is as below.



A Working group of CCGs and Providers has been developing the project plan for re-procurement and the service specification. The group has met three times and aims to complete the development of the final draft service specification by end January 2015 in order that procurement can commence from April 2015.

Item 7: Medway NHS Foundation Trust (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 28 November 2014

Subject: Medway NHS Foundation Trust (Written Update)

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

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

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

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1. Introduction

(a) Medway NHS Foundation Trust has attended the Health Overview and Scrutiny Committee on three occasions (6 September 2013, 7 March 2014 and 5 September 2014) following the publication of Professor Sir Bruce Keogh KBE's review into the quality of care and treatment provided by 14 hospital trusts in July 2013.

(b) At the end of the discussion on 5 September 2014, the Committee agreed the following recommendation:

- *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.*

2. Keogh Review

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

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

Department of Health. It is a measure based upon a nationally expected value and can be used as a 'smoke alarm for potential deviations away from regular practice' (NHS England 2013a; NHS England 2013b; NHS England 2013c).

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

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

3. Monitor

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

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

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

4. CQC

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

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

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

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

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

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

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

5. Recommendation

RECOMMENDED that the Trust be invited to submit a written report for the January meeting and attend the March meeting of the Committee.

Background Documents

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

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (05/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29237

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

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

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

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

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

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Update to Kent Health Overview and Scrutiny Committee (HOSC)

The report sets out changes since the last update.

Stabilising the leadership of the organisation

The Committee is aware of steps that have been taken to agree a new management structure, and to recruit to that structure with permanent appointments. Working with colleagues from University Hospitals Birmingham (UHB), the MFT Trust Board has approved a new organisational structure. 2014 has been a challenging year for the Trust, with a turnover at leadership level, and the appointment of many temporary posts at Executive level. Following approval of the structure, the Trust Board has appointed the following new posts:

- Shena Winning, Chair
- Morag Jackson, Chief Operating Officer
- Trisha Bain, Director of Health Informatics
- Dr Steve Beaumont, Chief Nurse
- Roberta Barker, Director of Workforce

The Trust has recently undergone a recruitment process for a substantive chief executive. Following the process, we were not able to appoint a suitable candidate to this critical role. The Trust will continue to search for a substantive chief executive. In the meantime, to ensure stability and continuity, Dr Phillip Barnes will continue in the post as acting chief executive officer.

One improvement plan

The new Trust Board are keen to have visible and measurable improvements. The Board is keen to ensure its local population has good visibility of changes, and the Board, Monitor (our regulator), can ensure the Board honours its commitments to improvement. Our staff, too want to see improvements for the hard work they put in. In the past, the Trust has had a number of plans covering discreet areas of the work of the Trust. The Board has tasked the new Trust Executive with ensuring that one single plan covers all improvement actions underway within the Trust. This is due to be operational from the end of January 2015.

New organisational structure

MFT is now changing the organisational structure to ensure the Trust is able to effectively deliver care to its local population. The new structure was one of the major requirements of

the work that UHB was employed to deliver. Consultation is now taking place with key internal groups before implementation of a new structure.

As part of the consultation on organisational structure, the Trust has been working with the Good Governance Institute to assist the Trust in designing and implementing a 'model' governance structure for Medway FT. This addresses many of the key findings from the Care Quality Commission report from July 2014.

Changes in the Emergency Department (ED)

The Trust has been fortunate to secure external support from Homerton University Hospital NHS Foundation Trust. It is recognised that the Homerton has an excellent ED. This work was for a period of 8 weeks and includes one of their senior consultants and a nursing leader that had worked at the Homerton. Dr Laurence Gant, the consultant delivered a report on improvements that could be made. The MFT welcomed the findings of Dr Gant and have been fortunate to secure his services for the period of one year to implement these improvements, as well as others that have been agreed.

The Trust Board at MFT has asked Dr Gant and his colleagues to address a number of key stages on the patient journey through the patient journey. These include:

1. Patients to be seen for first assessment within 15 minutes
2. Patients to receive a medical assessment within one hour
3. Patients to be referred to a specialist (where needed) within 2 hours
4. A reduction in delays handing over patients from an ambulance
5. Patients total time within the ED

Section 31 notice
On 29th August 2014, the Care Quality Commission imposed conditions on the Trust registration as a service provider in respect of the above regulated activity.

"The Registered Provider must operate an effective system which will ensure that patients attending Accident and Emergency at Medway Maritime Hospital have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department."

Since this time the Trust has measured itself against this 15 minute standard for assessments of all patients. The general performance against this standard has been good

(usually over 95%), although on occasional weeks this standard has been missed where there has been a very busy period.

Improvements in the surgical division

Following the Trust CQC report in July, the division with responsibility for surgical care has developed an improvement plan to address the 'inadequate' rating received for the service overall. In particular since the implementation of the plan the Trust has seen significant improvements in the waiting times for patients leaving recovery (the area patients move to after the operating theatre). This is key to ensuring a better patient experience, as well as more efficient use of operating theatres, the most expensive asset of the Trust.

7 Day Working

The Committee will be aware of correlation between differences found in standards of care on a weekday and weekend. As a result there has been an increasing focus on increasing the availability of emergency services 7 days per week. Emergency surgical theatres and those having suffered an orthopaedic trauma (such as broken bones) have operated at MFT for some time. The Trust has been significantly increasing the range of consultant led services available for emergency services at the weekend. Recent improvements include:

- 7 day consultant services in both medical and surgical divisions to review all emergency patients and provide consultant led intervention where required in areas such as services for patients with a gastro-intestinal bleed
- 7 day services to support discharging patients such as pharmacy; transport; therapists; medical cover

Seasonal planning

Each year the Trust and its partners refresh the seasonal plans. The winter months are often marked by an increasing demand for healthcare services (for example due to fractures or breathing difficulties). The local health and social care economy has benefited from new non-recurring investment. This has totalled £5.8m and covers the period 1st October 2014-31st March 2015. Medway and Swale Clinical Commissioning Groups (CCGs) have led a process to allocate this resource. There are a significant number of schemes but in summary the schemes fall under the following headings:

- Improvements in Emergency Department flow

- Improvements in ambulance handover
- Improvements in flow through the hospital and increased focus on timely discharge
- Increasing support to people with Mental Health conditions
- Increased preventative capacity within the community

Conclusion

Medway Foundation Trust recognises that there is much to do, as one of the Trust in ‘special measures’, our improvements must also be signed off by our regulators. The organisation has put in place immediate improvements, as well as enabled the changes to be long lasting through new leadership arrangements.