HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 30th January, 2015

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 30th January, 2015, 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 - 12)

4. Medway NHS Foundation Trust and NHS Swale CCG: Medway's Emergency Department (Pages 13 - 28) 10.05

5. NHS South Kent Coast CCG and NHS Thanet CCG: Integrated Care (Pages 29 - 56) 11.00

6. East Kent Hospitals University NHS Foundation Trust: Clinical Strategy (Pages 57 - 76) 11.45

7. SECAmb: Future of Emergency Operation Centres (Written Update) (Pages 77 - 80)

8. Kent Community Health NHS Trust: Community Dental Clinics (Written Update) (Pages 81 - 84)

9. Faversham MIU (Written Update) (Pages 85 - 88)

10. Date of next programmed meeting – Friday 6 March 2014 at 10:00 am

Proposed items:

- Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy and Stroke Services
- NHS England: General Practice and the development of services
- North Kent CCGs: Community Services
- Patient Transport Services

EXEMPT ITEMS

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

**Timings are approximate*

Peter Sass
Head of Democratic Services
(01622) 694002

22 January 2015

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, 28 November 2014.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr G Lymer, Mr C R Pearman, Cllr R Davison, Cllr M Lyons, Mr H Birkby (Substitute for Mr C P D Hoare) and Cllr Mrs A Blackmore (Substitute for Cllr J Burden)

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Mr P D Wickenden (Democratic Services Manager (Members))

UNRESTRICTED ITEMS

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

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

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

79. 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 were asked to provide an update on the design of the community hubs. An update paper on the Community Care Review was circulated to Members on 4 November 2014.

(b) Minute Number 67 – NHS England: General Practice and the development of services. A meeting has been arranged for the working group to meet with Professor Tavabie (Interim Dean Director, Health Education Kent, Surrey & Sussex) in February 2015.

(c) Minute Number 71 – Child and Adolescent Mental Health Services (CAMHS) – Tiers 1, 2 & 3. On 31 January 2014 HOSC requested that NHS West Kent CCG to identify an outstanding trust to assess improvements that could be made in the way in which the Sussex

Partnership Trust was carrying out the Kent and Medway CAMHS contract and to report back to the Committee.

Oxford Health NHS Foundation Trust was commissioned to carry out a high level review of Kent and Medway CAMHS (provided by Sussex Partnership NHS Foundation Trust) and to make recommendations about how the clinical service could continue to improve in line with the service recovery plan. The report was circulated to Members on 14 November 2014. The Committee will consider the report at a formal meeting on 10 April 2015.

The CAMHS papers submitted to HOSC for 10 October meeting were circulated to the Corporate Parenting Panel on 27 October.

(2) RESOLVED that the Minutes of the Meeting held on 10 October 2014 are correctly recorded and that they be signed by the Chairman.

80. Dates of 2015 Committee Meetings
(Item 4)

(1) The Committee noted 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

81. Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy and Stroke Services
(Item 5)

Glenn Douglas (Chief Executive, Maidstone and Tunbridge Wells NHS Trust), Dr Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Douglas began by giving an update on the clinical strategy. The strategy was being finalised and written. The Trust was required to produce a clinical strategy for the NHS Trust Development Authority (TDA) as part of their assurance process for clinical quality and sustainability. He stated that the Trust believed that they had a viable future.

(2) Initial findings of the strategy had found that the Trust should focus on establishing a strategic hub for emergency care; improving productivity; serving a larger population base and developing patient pathways and community focus. There was an opportunity for the Trust to develop a Keogh Centre for emergency care at Tunbridge Wells Hospital to serve West Kent

and parts of East Sussex. The Trust had already made £22.4 million of savings on the 2014/15 budget of £400 million; it was acknowledged further savings could be made through improving productivity and serving a larger population base including Medway and East Sussex. The Trust was also looking to carry out more elective surgery and outpatient services or expanding their emergency. It was stated that the Trust did not need to merge with the Conquest Hospital, Hastings or Medway Maritime Hospital to become a financially viable organisation.

(3) Four key enablers had been identified to achieve the strategy: improving capability; promoting innovation to reduce costs; seizing opportunities for development and growth such as proactive care management; and being able to compete in tender processes. The Strategy will be taken to the Trust's Board in December for approval. Mr Douglas stated that the strategy would be a dynamic document which would be regularly refreshed. An implementation plan, including a comprehensive stakeholder engagement plan, was being developed in addition to a review of the Trust's governance structure.

(4) Dr Sigston gave an update on the Trust's plans for stroke service improvement as part of the clinical strategy. He explained that stroke was a major focus and concern for the Trust's Board. A Stroke Improvement Board, Stroke Clinical Steering Group and Engagement Group had been established. He stated that the Trust was conscious of the need to meet the Government's four tests for service reconfiguration. The Trust had undertaken early engagement with stroke patients and survivors, staff, GPs and MPs.

(5) The Trust found that patients thought the service was good but the Trust had identified improvements. A clinical case for change had been developed. Both hospital sites did not meet stroke standards as measured by Sentinel Stroke National Audit Programme (SSNAP) data; improvements had been made during the last nine months with both sites moving from the lowest rating 'E' to 'D'. The Trust had identified significant delivery options to improve their SNNAP performance to the highest rating 'A'. The Trust was also required to meet the stroke specification issued by the South East Coast Clinical Network. The specification included a hyper acute service, similar to London, and a seven day rapid access to transient ischaemic attack (TIA) service which was currently lacking.

(6) It was explained that the Stroke Clinical Steering Group had developed a long list of options for delivery. Early patient and public engagement would help inform a shortlist of options before public consultation on the options in May 2015. He noted the importance of taking time to engage with the public in order to reach a consensus.

(7) Mr Ayres stated that NHS West Kent CCG, as lead commissioner of the Trust, welcomed the development of the strategy. He explained that there had been a joint CCG and Trust appointment to develop the strategy. He stated that the CCG believed that the Trust had a sustainable long term future without the need to merge and were keen for the Trust to develop a Centre of Excellence. He noted that the CCG would lead on the public consultation and that the clinical strategy would need to return to HOSC prior to public consultation in May 2015.

(8) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about engagement with GPs and implementation of the strategy. Dr Sigston explained that GPs were engaged with the strategy through NHS West Kent CCG, NHS High Weald Lewes Havens CCG and the Stroke Clinical Steering Group. Mr Douglas acknowledged that there was a long timescale for implementation. The Trust had hoped to consult sooner but was restricted by the 2015 General Election. He explained that the Trust was carrying out extensive pre-consultation engagement prior to the election and would go out to public consultation as soon as practical after the election. Once the public consultation had concluded, the implementation process would begin. He stated that in the interim, the Trust would continue to make improvements to the stroke service.

(9) In response to a specific question on the hyper acute service in London, Mr Ayres explained that 30 local hospitals in London, which had previously received stroke patients, were reduced to eight hyper acute stroke units. Once stabilised the patient was transferred to a Stroke Unit in the same hospital or closer to home. Dr Sigston stated that this may involve a longer ambulance journey, passing several hospitals, but enabled patients to be assessed by a specialist, have access to CT scan and receive thrombolysis. This acute stroke care model had improved outcomes for patients in London. A similar model for cardiac patients had been developed in East Kent. Mr Douglas confirmed that there was no hyper acute stroke unit in Kent based on the London model. He stated the Trust's intention to develop a hyper acute stroke unit on either of its sites with improved rehabilitation and community services for stroke patients.

(10) A Member asked for clarification on mergers. Mr Douglas explained that the Trust was financially viable without the need for mergers and acquisitions. He noted that there were issues in Hastings and Medway and the Trust had been drawn into relationships with these Trusts. The Trust had recently opened up outpatient appointments to Swale residents via the Choose and Book system. There had also been an increasing number of referrals and births at Tunbridge Wells Hospital following a reconfiguration at Conquest Hospital, Hastings. He acknowledged that the Trust may be required to merge with other Trusts in the future but the Trust would be able to merge on their own terms. He stated that there was more synergy with Medway than East Sussex. Mr Ayres stated that the Trust was a standalone trust and that there was no reason for it to merge at this time.

(11) A number of comments were made about advanced warning of strokes, the use of technology and private sector equipment. Dr Sigston explained that GPs were aware of patients with co-morbidities who would be prone to stroke. He stated that it was difficult to know in advance when an arterial bleed or clot would occur. A transient ischaemic attack (TIA) was a warning sign that unless urgent preventative action was taken, a major stroke could occur. He noted that the Trust was moving towards a new IT system which would be implemented within the next 18 months. Dr Sigston explained that a seven day access carotid Doppler imaging machine was required as part of the South East Coast Clinical Network's Stroke Specification. Private hospitals such as the Kent Institute of Medicine and Surgery (KIMS) were not able to provide this facility as their staff worked for other Trusts which would prevent seven day access.

(12) There was discussion about a return visit by the Trust to the Committee before purdah. Mr Wickenden advised that the purdah period typically began six weeks before the scheduled election; an informal briefing to the Committee could be organised during purdah if required. Mr Douglas suggested a return visit to the Committee on 6 March 2015 with a shortlist of options for stroke services. A Member requested additional information on rehabilitation and community services for stroke patients to be brought to the March meeting.

(13) RESOLVED that:

(a) there be ongoing engagement with HOSC as the Trust's five year clinical strategy and strategy for stroke is develop.

(b) the Trust return to the Committee in March 2015 with a shortlist of options for stroke services and additional information on rehabilitation and community services for stroke patients.

82. Patient Transport Services
(Item 6)

Ian Ayres (Accountable Officer, NHS West Kent CCG) and James Graydon (Account Director, Kent Care Services, NSL) were in attendance for this item.

(1) Mr Ayres began by giving an update on the latest performance figures. He noted that there had been little improvement. Whilst 'Discharges/Transfers booked "On the Day" collected within 2 hours – 80%' performance had improved, this had a negative effect on the other key performance indicators. He noted that there was a peak of discharges daily at 14.00 hours. He explained that Trusts were not booking discharges ahead of time; the majority of discharges were booked on the day as the Trusts struggled to clear beds for emergency admissions.

(2) Mr Ayres commended NSL for their support in helping Medway Maritime Hospital discharge patients. He noted improvements in the service since the appointment of James Graydon in July who provided local operational leadership. He stated that a discrete ring-fenced renal service would be introduced and tested in East Kent.

(3) Mr Ayres confirmed that CCGs in Kent and Medway, in discussions with providers, had agreed to re-procure at the end of the existing three year contract. A working group of CCGs and providers had been developing the project plan for re-procurement and the service specification. The group was aiming to complete the final draft service specification by the end of January 2015 in order to commence procurement from April 2015. He stated that there was no intention to change the eligibility criteria but there were discussions about options for the future delivery of the service – a Kent and Medway wide service or an individual service for each Trust.

(4) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about extreme waits for discharge. Mr Ayres explained that extreme waits were reducing slowly, since August there had been a focus on discharges. On an average day, there

would be 30 – 40 booked discharges for Medway Maritime Hospital; recently there had been 100 discharges booked on one day as the Trust struggled to clear beds for emergency admissions. He commented that PTS was an enabler of quality within a Trust; if PTS worked well, it enabled the hospital to perform better but if PTS did not work well, it put pressure on the rest of the hospital.

(5) A number of comments were made about planned discharge. Mr Ayres explained that all Trusts estimated an approximate discharge date for each patient when admitted. He stated that it was much easier for NSL to plan if they were given the approximate discharge date in advance, even if it was later cancelled and rescheduled, than being booked on the day of discharge. He noted that the new specification would require a discharge protocol to be agreed between the PTS provider and each Trust. Mr Graydon highlighted that NSL was engaging and reviewing the discharge policy with each acute trust to improve the booking of discharges. It was difficult for NSL to plan without advance booking due to the geographical spread of the seven acute sites in Kent and Medway. However Mr Ayres stated that the target to collect 98% of patients discharged from hospital within two hours was found to be reasonable when benchmarked against other providers.

(6) A Member highlighted the work of the Integrated Discharge Team at Dartford and Gravesham NHS Trust. The Member enquired if there was a cut off time for returning patients home at night. Mr Ayres explained that patients should be returned home with support in place by 21.00. He acknowledged that patients who lived closer to the hospital, who had support in place, could be returned home by 22.00. In addition, he stated that patients should be readmitted to the hospital, if they are unable to be transported at a sensible time. He noted that some residential homes did not accept admissions beyond 17.00; NHS West Kent CCG was in discussions with KCC contracted residential homes to extend the admission time.

(7) A Member noted the deterioration in performance for renal patients. Mr Graydon explained that if a patient arrived more than 30 minutes before their appointment, NSL would fail their Key Performance Indicator. He noted that 90% of renal patients arrived within 20 minutes of their appointment. He highlighted that from the week commencing 1 December 2014, PTS for renal patients was being ring-fenced. This would mean that renal patients would be given their own transportation which could not be knocked out by a discharge or transfer.

(8) A Member enquired about the culture at NSL. Mr Ayres explained that within NSL there were two groups: front line staff and the leadership. In his view, the front line staff did a great job; they had been through a period of significant change when they were TUPEd across from other Trusts to NSL. Mr Ayres expressed his concerns about the quality of local leadership, prior to Mr Graydon's appointment, as demonstrated by the poor performance.

(9) In response to a specific question about terminating the contract, Mr Ayres explained that there was a no fault clause in the contract which allowed a 12 month early termination. Under procurement law, the CCG would have to then advertise the contract in the European Journal for 15 – 18 months which would result in a termination six months early and would require a new provider to

take over the service during the middle of winter. If the CCG terminated the contract on a faults basis, there was a risk of legal action by NSL. He confirmed that lessons learnt from the previous procurement would be incorporated into the re-procurement. If a contract variation was required prior to re-procurement, this would be negotiated between NHS West Kent CCG and NSL.

(10) A number of comments were made about voluntary transport services and patients who were not eligible for PTS. Mr Graydon confirmed that NSL used 35 voluntary car service drivers. Mr Ayres stated that NSL had a responsibility to signpost patients, who were not eligible for PTS, to non-NHS funded voluntary sector transport. Funding for PTS was restricted to patients who were eligible.

(11) A Member requested that the Chairman should write to all Trusts, on behalf of the Committee, about the importance of pre-booking discharges in advance with NSL. Mr Ayres suggested that he return to the Committee in March 2015 with the service specification, a more detailed performance summary and focused analysis of discharges by each Trust. He noted that there was good practice and a Trust by Trust analysis would identify specific Trusts who needed to make improvements. The Member agreed to this proposal.

(12) RESOLVED that the report be noted and that CCG colleagues be invited to attend the March 2015 meeting of the Committee.

83. Medway NHS Foundation Trust (Written Update)
(Item 7)

(1) A Member noted and welcomed the update report which was produced in advance of the latest CQC inspection report published on 26 November 2014. The Member requested that the Trust be asked to produce an update on the patient journey through the Emergency Department, leadership stability and the use of technology when the Trust returns to the Committee.

(2) RESOLVED that Medway NHS Foundation Trust and NHS Swale CCG be invited to attend the January meeting of the Committee to provide an update on actions taken to support Medway's Emergency Department.

84. Date of next programmed meeting – Friday 30 January 2015
(Item 8)

(1) Since Agenda publication on 20 November, with the Chairman's agreement, a number of the proposed agenda items had changed:

- South Kent Coast CCG: Integrated Care Organisation
- Medway NHS Foundation Trust and NHS Swale CCG - Medway Emergency
- SECAmb - Future of Emergency Operation Centres (Written Update)
- Kent Community Health NHS Trust: Community Dental Clinics (Written Update)
- Faversham MIU (Written Update)

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Item 4: Medway NHS Foundation Trust and NHS Swale CCG – Medway's Emergency Department

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 January 2015

Subject: Medway NHS Foundation Trust and NHS Swale CCG – Medway's Emergency Department

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

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.

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 2014a).

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 2014a).

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 2014a).

(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 2014a).

(c) The CQC inspected Medway NHS Foundation Trust between 23 and 25 April 2014 with an unannounced inspection visit on 1 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 2014a).

(e) Medway NHS Foundation Trust was the only Trust found to have failed in making significant overall progress. It was recommended that the Trust remained 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 2014a).

(f) The CQC carried out an unannounced inspection of the Emergency Department on 27 and 28 July 2014 to follow up on its findings from April and in response to receiving information of concern from two separate sources. The key findings from the inspection were:

- The Emergency Department was in a state of crisis with poor clinical leadership;
- The Emergency Department had failed to review and optimally utilise its escalation policy within the ED to avoid the need to 'stack' patients;
- The Emergency Department continued to fail to ensure that children attending the department underwent initial assessment which was in line with national standards (CQC 2014b).

(g) On 30 July 2014 the CQC formally wrote to the Chief Executive of Medway NHS Foundation Trust setting out its concerns and to request the necessary assurances that appropriate action would be taken to ensure the safety and welfare of patients who used the service (CQC 2014b). A Section 31 Notice was issued. Under Section 31, the CQC can suspend the registration or extend a period of suspension of a registered person for a specified period of time; it can also vary, remove or impose conditions to registration. The CQC must have reasonable cause to believe that unless it acts using this section, a person will or may be exposed to the risk of harm (CQC 2013).

(h) The CQC carried out a further inspection of the Emergency Department on 26 August 2014; they found that the Emergency Department

continued to lack any form of effective clinical leadership and there remained a lack of cohesive working amongst nursing, medical and allied healthcare professionals. The process of initially assessing patients in a timely manner remained flawed; in some instances patients were experiencing delays of more than two hours before any effective clinical intervention or treatment was commenced. The inspection report was published on 26 November 2014 (CQC 2014b).

(a) In response to the Section 31 Notice, NHS commissioners and providers in Kent and Medway met with Monitor and NHS England to develop a partnership plan to support Medway Maritime Hospital.

(b) On 10 October 2014 the Committee considered proposals by NHS Swale CCG to reduce elective activity at Medway Maritime Hospital in order 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. At the end of the discussion, the Committee agreed the following recommendation:

- *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.*

(c) On 28 November the Committee considered a written update on Medway NHS Foundation Trust which was produced in advance of the latest CQC inspection report published on 26 November 2014. The Committee agreed the following recommendation:

- *RESOLVED that Medway NHS Foundation Trust and NHS Swale CCG be invited to attend the January meeting of the Committee to provide an update on actions taken to support Medway's Emergency Department.*

5. Recommendation

RECOMMENDED that the reports be noted and that Medway NHS Foundation Trust and NHS Swale CCG be invited to attend a meeting of the Committee in six months.

Background Documents

CQC (2013) *'Enforcement Policy (28/06/2013)*', http://www.cqc.org.uk/sites/default/files/documents/enforcement_policy_june_2013.pdf

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

CQC (2014b) *'Medway Maritime Hospital Reports (26/11/2014)*', http://www.cqc.org.uk/location/RPA02/reports

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (06/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=25799

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

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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Medway NHS
NHS Foundation Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

30 JANUARY 2015

MEDWAY NHS FOUNDATION TRUST

Report from: Dr Phil Barnes - Acting CEO Medway NHS Foundation Trust

Author: Morag Jackson Chief Operating Officer Medway NHS Foundation Trust

Summary

This report has been requested to provide the Committee with an update on the measure in place to support the hospital emergency department.

1. Background

1.1 Non-Elective care pressures have continued at Medway NHS Foundation Trust (MFT) across 2014/15. A tripartite approach from Monitor, the Care Quality Commission (CQC) and NHS England is in place to monitor actions and support improved performance. Whole system working across providers and commissioners in Medway and Swale is coordinated via the Medway and Swale Executive Programme Board.

2. Care Quality Commission (CQC) Inspection

2.1 A further CQC Inspection was conducted at MFT on 9 December 2014. The results of this inspection have not yet been made available publicly, but whilst the Trust remains rated as inadequate they recognised that there was some small progress being made to improve the situation within the emergency department.

3. Winter Pressures

3.1 Planning for winter started earlier than any previous year this year. This year the Operational Resilience Capacity Plan (ORCP) was signed off on 3 July 2014 by the Overview and Scrutiny Committee. A significant proportion of the plan was reliant on additional winter funds. The Executive Programme Board took the decision to start some schemes early in August going at risk. The funding was eventually agreed in tranches with final sign off agreed following re-submission of the plan in December.

Funding allocation	Allocation £000	Date
1st Tranche	1,722	Oct
2nd Tranche	3,097	Oct
Mental health funding	295	Dec

3.2 This year there has been significant NHS England scrutiny and there is a monthly submission made on the 15th of each month, which records progress in terms of key performance delivery, risks and expenditure against budget. The Medway & Swale system faces significant challenges. These were summarised at the Star Chamber on 13 November 2014.

3.3 The agreed month by month (average performance) 4 hour trajectory is set out below. This trajectory recognises that whilst there will be a continued operational drive to ensure existing pathways are working at an optimum level (internal and external) the new models/pathways will come on line during January.

	Nov	Dec	Jan	Feb	Mar
Planed Average monthly performance	**80%** *(un-validated)*	**85%**	**85%**	**90%**	**95%**
Actual performance to date	**80.16%**	**76.56%**	**N/A**	**N/A**	**N/A**

3.4 Performance for December has been a national issue with unprecedented demands placed on emergency departments across the country. MFT has struggled to increase performance against a back drop of challenges these are summarised into the following categories with mitigating actions being undertaken:

a. ***Trust leadership and governance***. Monitor has been working with the Trust and has supported the Trust through the engagement of a substantive Chair and subsequent Trust led growth of an executive team to populate the revised structure. They have facilitated a 12 week period of support in Autumn 14 from University Hospitals Birmingham (UHB) with the delivery of both clinical and management support to the Trust, culminating in improvement plans across a number of areas in the Trust. The Trust declared a serious incident under the North Kent escalation plan over Christmas holiday period and was on black status. System wide daily conference calls have been implemented to address system blockages

b. ***Workforce*** *(availability and recruitment*) ORCP funding has provided additional workforce resources in Emergency Department, on wards and in terms of management support.

c. ***Peak in attendance***. Attendances were above forecast plan by 23% during 26th and 27th December. An additional communication plan specific to the event was implemented on 29th December. ORCP communications began during December with target specific marketing intensifying in January. Further work is currently being led by public heath forecasting future demand and modelling impact.

d. ***Increase in acuity***. The Trust Emergency Department consultants have indicated that patients coming through the Emergency Department appear to have higher levels of acuity with a significant number of frail elderly patients requiring support. Following the ECIST visit in November, the ORCP Frailty pathway programme will provide Geriatricians within the Emergency department in January. To increase capacity in the emergency department. Further ORCP investment has been made to increase primary care provision. The MedOCC service has been extended to seven days a week with an

increased support from paramedic practitioner. This currently is working well increasing numbers referred month on month.

e. ***Hospital flow*** –Work has begun within the hospital to understand what restricting performance in terms of internal waits. Subsequently ORCP investment has been made to increase areas of concern in terms of equipment and staff. A new AMU short stay facility is now in place but has not been fully functioning due to bed capacity issues. An increased focus on discharge implemented internally within the trust with some system wide mapping work started on 14 January.

f. ***External*** - Oak Group International have been commissioned to undertake an audit, Making Care Appropriate for Patients (MCAP), to understand in more detail the decisions around lower levels of care, capacity and service gaps. The audit started at the beginning of January and is due to reach conclusion by the end of January. This will inform future commissioning requirements.

4. Conclusion

4.1 Most of the high impact schemes for the Trust come on line in January. MFT has a PMO in place and has identified resources to ensure performance is tracked and managed within the plan. Delivery of schemes to date is broadly on track, but impact on the 4-hour target is not yet evident.

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NHS
Swale Clinical Commissioning Group

Briefing to Kent County Council HOSC Friday 30 January 2015

Subject: Update on actions taken by NHS Swale Clinical Commissioning Group to support Medway's Emergency Department.

Date: 30 January 2015

Introduction

This paper provides members of the Kent County Council Health Overview and Scrutiny Committee (HOSC) with an update on the actions taken by NHS Swale Clinical Commissioning Group (CCG) to support Medway's Emergency Department, which is run by Medway NHS Foundation Trust (MFT).

At the October meeting of the HOSC, NHS Swale CCG provided an overview of a short term proposal to assist MFT to implement recommendations made by the Care Quality Commission (CQC) for the Emergency Department (ED), following the issue of a Section 31 Notice by the CQC (which could fully or partially close the ED).

Three proposals were presented by NHS Swale CCG in response to the notice. These proposals, worked up by the Kent and Medway system, were proposed to give MFT some headroom during the busy winter period, to make key changes that will satisfy CQC that care provided by the hospital is safe.

The proposals, which were supported by the HOSC, were:

1. The reduction of elective activity at MFT by encouraging Swale patients to be seen at Maidstone and Tunbridge Wells NHS Trust (MTW) for their elective outpatient appointments, increasing internal capacity at Medway Maritime Hospital (MMH). MTW had agreed to this for a period of six months for three specialties - respiratory, cardiology and care of the elderly. Patients choosing to be seen at MTW for their elective outpatient appointments would continue to receive their care at MTW until their episode of care has been completed. This includes those patients requiring elective surgical procedures.

   Update: This was implemented for cardiology and care of the elderly in November. Due to the introduction of a new patient pathway at MTW, it was agreed that respiratory referrals would not be encouraged at this point until the impact of embedding this pathway for MTW patients was known. It is difficult to see an increase in cardiology and care of the elderly referrals at this point as it takes an average of six weeks from the point of referral to see the numbers going through the system. Swale and West Kent commissioners continue to meet monthly to review referrals and monitor the impact of the respiratory pathway.

2. Ambulance transfer of Swale patients to MTW to provide headroom in MMH ED and the hospital as a whole by reducing ambulance attendances and non-elective admissions. At the time of the HOSC, the predicted activity levels for this proposal were still being reviewed.

Update: This has not been taken forward at this time due to the risk of impacting on MTW capacity during the winter period, placing delivery of the trust's own four-hour ED performance at risk. This may be reviewed again at a later date.

3. Provision of a 24/7 Primary Care unscheduled care service through MedOCC at Medway Hospital by relocation of the MedOCC out of hours service overnight from its base at Quayside to the MedOCC base within Medway Maritime Hospital. Additional GP capacity, specifically during the evening and overnight, would increase the number of patients MedOCC can see from ED, supporting both the ED 24/7 and the flow of out of hours from NHS 111.

Update: This was funded through winter resilience money (see below) and successfully implemented on 10 November with the service seeing on average 24 per cent of the ED activity.

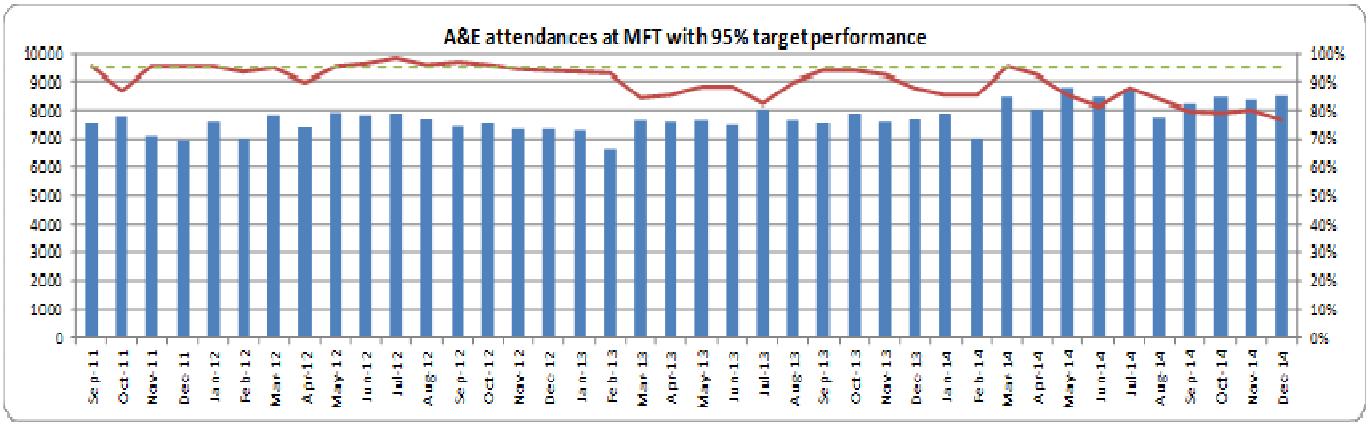
Current Performance Management

Due to capacity and issues elsewhere in the system, it was not possible to enact all the original proposals in full however, all the original support remains, for example the Integrated Discharge Team, the Psychiatric Liaison Team in ED etc.

The four-hour access target has not been met by MFT in line with their agreed trajectory with Simon Stevens, Chief Executive, NHS England.

	Nov	Dec	Jan	Feb	Mar
Agreed average monthly performance	80%	85%	85%	90%	95%

Current performance (validated position shown below) shows that although the trajectory was met for November it was not met in December. December saw higher levels of activity across the whole of Kent and Medway with Medway Maritime Hospital being no exception to this.



14/15 Activity and Performance at MFT								
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
8022	8788	8435	8735	7739	8179	8421	8323	8464
92.40%	84.89%	81.02%	87.45%	83.74%	79.66%	79.25%	80.16%	76.56%

The weeks of January show a deteriorating position, below, however this position is currently unvalidated.

Week ending	Performance
4 January 2015	70.11%
11 January 2015	72.41%
18 January 2015	72.34%

Meetings at executive level are held weekly between NHS Medway CCG and MFT to review progress against the trajectory plan.

During the Christmas and New Year period, daily calls were held at executive level with all Medway and Swale providers. Chaired by the North Kent CCG Director on call, these provided the mechanism to identify any blockages in the system on a daily basis, and agree actions to remove these.

A stakeholder conference call at executive level is held weekly with the information circulated to the Chief Executives and the Medway and Swale Executive Programme Board.

Operational Resilience and Capacity Plan – to support delivery of four-hour access target

In October, NHS England released funds of £5.491million to NHS Medway and NHS Swale CCGs to support MFT in achieving the four-hour access target. (£2.394million in Tranche 1, £3.097million in Tranche 2). MFT received 85% of the Tranche two funds.

NHS Swale and NHS Medway CCGs have worked (and continue to work) in partnership with MFT, the South East Coast Ambulance Service NHS Trust (SECAmb), social care partners Kent County Council and Medway Council, mental health trust Kent and Medway NHS and Social Care Partnership Trust (KMPT) and the providers of community services for Medway and Kent to develop an Operational Resilience and Capacity Plan (ORCP) to support the delivery of the four-hour access target during the winter months with resilience funds.

The ORCP seeks to provide maximum 'operational headroom' for MFT to accelerate its Trust plan. Both plans were reviewed by executives from NHS Medway and NHS Swale CCGs and MFT to provide an overall plan that focuses on changes in models and 'doing things differently' so that sustainable models are in place going forward. These include:

- Emergency Department – improving quality, safety and flow through ED
- Admissions Avoidance (Ambulatory Care, ED Observational Unit and optimal use of MedOCC (primary care) pathway)
- Acute Medical Unit/Short Stay ward (non-complex admissions with a length of stay under 72 hours)
- Frailty pathway/unit.

The models and pathways above are further supported by a focus on:

- Reducing internal waits to ensure timely discharge
- Reducing external waits to ensure timely discharge

- Operational resilience – additional corporate resilience and provision of extended and additional hours as part of a flexible plan to meet demand and ensure flow over the winter period.

These plans were discussed at a system-wide meeting in November which identified and agreed the key interfaces for each of the models, to provide assurance of delivery within the timescale. NHS Medway CCG meets weekly with MFT to monitor progress against the plan.

Operational Resilience Plan Summary

The schemes included in the ORCP are listed below, grouped as follows:

1. Admission Avoidance
2. Emergency Department
3. Internal Waits
4. Operational Resilience
5. External Waits
6. Communications and Engagement

The schemes that sit within these are listed below:

1.	**Admissions Avoidance**
	• 24/7 MedOCC GP service working alongside ED • Paramedic practitioner working with MedOCC supporting increased capacity for urgent care referrals to be seen outside of A&E for extended hours • Seven day therapy provision at Swale community hospitals increasing their capacity to take and treat step down patients from MFT and step up patients from GPs and SECAmb • Extension of the Dementia Crisis Intervention Service supporting those experiencing a dementia crisis in nursing and residential care homes • Provision of crisis/wellbeing cafés supporting an alternative to attendance at A&E or GP for people with mental health needs. Street Triage Service in partnership with Kent Police providing a response service seven days a week to those in a mental health crisis. • Enhanced nursing support for residential care homes
2.	**Emergency Department**
	• Older Adult Consultant Psychiatrist in ED providing case identification, early intervention and alternative management strategies for patients with dementia and delirium to avoid admission • Additional four Emergency Nurse Practitioners within ED facilitating flow, increasing nursing capacity, enhancing patient care and supporting junior staff • Hospital Ambulance Liaison Officers based in ED improving clinical handover and supporting patient flow. • Increase in the number of nurses on the Critical Care Out-reach team • Provision of 24/7 psychiatric liaison service
3.	**Internal Waits**
	• Additional Discharge Registrar facilitating discharge seven days a week. • Ward - clerks supporting ward staff with facilitating timely discharge by ensuring a patient has everything in place to prevent a delay in discharge (i.e.: discharge letter, booked transport etc.)

4.	**Operational Resilience**
	• Transformation Manager supporting operational delivery of the ED transformation plan. Development of a whole systems database to provide the ability to predict surge capacity across the Medway and Swale economy
5.	**External Waits**
	• Expansion of the Integrated Health and Social Care Discharge Team (IDT) based at MFT increasing safe, timely discharges for complex patients, supporting the identification of palliative care patients in ED/assessment units to avoid subsequent admission, increasing the availability of rapid therapeutic support and enablement to prevent hospital re-admissions. • Expansion of the Community Dementia support team providing 8-8 service seven days a week service, supporting the ED/Assessment units with urgent response within four hours for patients • Appointment of two Carer Support co-ordinators aligned to the Dementia Support Team and the Integrated Discharge Team • Purchase of disposable nebulisers for all COPD patients to treat at home • Additional equipment for community, supporting increased demand and timely discharge • Additional equipment store in Sheppey, supporting timely access to equipment for quicker discharge to home • Home from Hospital voluntary service in Swale, supporting people to remain in the community
6.	**Communications and Engagement**
	• A number of targeted activities have been undertaken to further understand the demand for ED. – Clinical Audit of attendances (July/August 14) – Patient and Public Survey (1400 people) – in ED and Street Survey (September 2014) – Left without being seen analysis (Medway Public Health) • The output from these activities have informed the local A&E campaign (and are feeding into the North Kent Urgent and Emergency Care Review). The A&E campaign will consist of a multi-channel marketing approach using large format advertising, print, radio, direct mail, press and social media. Messaging started in December and will run through to March with the bulk of the campaign running late January. Much of the work has taken place jointly with the Department of Health behaviour change unit to apply behavioural psychology techniques to current communications in order to achieve the best outcomes.

The models and pathways noted above support MFT with 'headroom' to achieve the agreed four-hour access trajectory target.

Delivery of the ORCP is overseen by a Programme Management Office which reports to the Medway and Swale Executive Programme Board.

Next Steps - Supporting Sustainability

While the ORCP provides support to MFT in the short term, there are a number of initiatives within the plan that will continue past March 2015 and embed into the system as business as usual, supporting future sustainability of the four-hour target. Additional work streams sit alongside this to support sustainability in the system in the medium and longer term. These are:

- Prime Minister's Challenge Fund – A number of GP practices in Swale have worked together to develop and submit an expression of interest to be one of the second wave of pilots to

help improve access to general practice and stimulate innovative ways of providing primary care services. If the bid is successful, this will see the establishment of a GP urgent care hub in Sittingbourne, as well as providing additional support to ensure health care prevention is given more focus, with the introduction of paramedic practitioners to help with urgent house visits and a health care co-ordinator who will help provide seamless movement of patients between health and social care seven days a week. This will provide learning and begin to shape how primary care in Swale responds to the growing demands being faced within the local health and social care system, and ease the pressure on A&E by ensuring patients are treated and supported appropriately outside of a hospital setting.

- North Kent Urgent and Emergency Care Review - in the longer term, the three North Kent CCGs are working collaboratively to review urgent and emergency care across Medway, Swale and Dartford, Gravesham and Swanley. The review, presented to the HOSC in October, will see a model of care that will reduce demand within ED, prevent unnecessary admissions and provide quality rapid access to emergency care for those who need it.

- Community Services re-specification and expansion of the Integrated Primary Care Team model

END

Item 5: NHS South Kent Coast CCG and NHS Thanet CCG: Integrated Care

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 January 2015

Subject: NHS South Kent Coast CCG and NHS Thanet: Integrated Care

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

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

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1. Introduction

(a) NHS South Kent Coast CCG and NHS Thanet CCG have asked for the attached report to be presented to the Committee.

(b) The Dalton Review, published on 5 December 2014, examined new options and opportunities for providers of NHS Care. This Review considered seven different organisational forms including Integrated Care Organisations.

(c) An Integrated Care Organisation (ICO) involves the vertical integration of one or more providers across a spectrum of care that could include primary, secondary (acute and mental health), community and social care. These are population based and deliver services to a defined cohort of patients with the aim of improving their outcomes, particularly for long-term conditions, by managing the coordination of their care (Dalton 2015).

(d) This organisational form can be either primary care or secondary care led. Where it is secondary care led it allows hospitals to operate in new areas of out of hospital care and to balance an investment in community-based services with a divestment in hospital-based care, without undue financial risk to the organisation. This is considered to provide an attractive model for secondary care providers, who might otherwise resist a transfer of resources from their organisation (Dalton 2015).

(e) An ICO would usually require investment in integrated data systems to account for patient activity in each element of the integrated service, and the return on this investment may take several years. Integration should primarily be considered for improving outcomes and patient experience over the medium to long term; it does not provide a quick route to cost saving and may require significant technical detail to be worked through. This organisational form is a good example of where getting the clinical model right first should lead to organisational form later (Dalton 2015).

(f) The Lambeth Living Well Collective (LWC) is cited as a case study. LWC brings together a number of mental health providers including the voluntary sector and South London and Maudsley (SLaM) NHS Foundation Trust, social care, public health, primary care as well as service users and commissioners. Building on these existing strong relationships between providers and commissioners, the LWC decided to develop an integrated model through an alliance contract across a wide range of providers in the system, initially with a small group before expanding to bring in a wider spectrum of care. The CCG and local authority will co-commission the alliance contract, based around outcomes develop by the LWC. As well as delivering better outcomes and experience for patients, the contracting approach is expected to deliver shared savings across the system (Dalton 2015).

(e) The Dalton Review is intended to complement the NHS Five Year Forward View which sets out proposals around seven new care models. The covering report for the East Kent Hospitals University NHS Foundation Trust: Clinical Strategy item provides further information about these.

2. Recommendation

RECOMMENDED 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.

Background Documents

Department of Health (2014) *'Examining new options and opportunities for providers of NHS care: the Dalton review (05/12/2014)*', https://www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care

NHS England (2014) *'The NHS Five Year Forward View (23/10/2014)*', http://www.england.nhs.uk/ourwork/futurenhs/

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Developing integrated care in South Kent Coast and Thanet

1. Introduction

NHS South Kent Coast (SKC) Clinical Commissioning Group (CCG) is made up of the 30 GP practices covering the Deal, Dover, Folkestone and Romney Marsh areas. It has £270 million to spend on hospital, community and mental health services for the 199,000 people living in this area.

NHS Thanet CCG is made up of 19 member practices covering a population of 143,000 with a budget of £200m

Each CCG has a five-year strategy that sets out our objectives for the coming years. Key to the delivery of this strategy will include:

- Improving care in hospital care and making sure that acute care requiring specialist facilities, whether for physical or mental health needs, will be highly expert to ensure high quality. This will involve us working closely with East Kent Hospitals University Foundation Trust (EKHUFT) on their clinical strategy.

- Improving out of hospital care, making sure that only those services which really need to be delivered in a hospital setting are there.

Part of this will involve developing an integrated model of care out of any acute hospital setting, wrapped around the patient, and clinically co- ordinated by their GP.

This briefing outlines both CCG's plans for developing their own Integrated Care Organisation (ICO) and our progress in developing out of hospital care in each of our local communities.

2. Background

A case for change

Local NHS and social care partners recognised that the current pattern of health and social care locally could not continue in its current form for four key reasons:

a) It will not be able to cope with the rising level of demand for care that can be anticipated over the next few years

b) It is highly unlikely that the funding available for health and social care will be sufficient to meet that growth in demand
c) Patients have indicated that they want health and care to be more joined up and better able to meet their needs. Currently, the fragmentation of responsibilities for commissioning and provision makes it difficult to do this systematically and consistently
d) There are already difficulties in attracting and retaining a clinical workforce in the right numbers and with the right skills to deliver the care we need – these problems will worsen unless services are designed in a way that makes working in them attractive to health and care professionals

With an increasing demand for services, a growing older population with a rise in multiple long term conditions and health and social care budget restraints better integrated care is seen as an essential requirement to improve the quality and efficiency of the NHS.

At present the provision of out of hospital care is highly fragmented. It is provided by multiple organisations that are often differently engaged and governed through the NHS or local government. Provision spans statutory public organisations such as NHS Trusts, Kent County Council (KCC) and local government directly managed provision, private sector, voluntary and charitable organisations.

Individual organisations are incentivised to do things in their own parochial interests shaped largely by the current business practice of their commissioners/ funders .This is not universally systematic nor aligned to provide a seamless integrated approach. It is also not focused on common outcomes for patients and the local population.

3. Achieving our vision for out of hospital care

NHS South Kent Coast and NHS Thanet CCG's strategic plans includes the development of a systematic model for health and care services out of any acute hospital setting, wrapped around the patient, co-ordinated by their GP.

Our vision is to provide a more coherent and sustainable service model, designed and delivered around patients rather than the needs of patients being forced to fit around services already available.

Achieving our vision will involve reorganising the local provider market to focus on a common purpose of improved local population outcomes, experience and value.

It will also involve us working closely with local people and organisations, including Kent County Council, district councils, providers of health and social care and the voluntary and community sector to prioritise and design the services that each community needs.

4. A local vision for integrated care

Integrated care is a fundamentally different way to meet health and care for a defined population and tailored care to meet individual needs. It means changing the design of services, the people that deliver them and how services are paid for.

Integrated care service models mean that the traditional segmentation of care by provider organisations (e.g., primary, secondary, community, social, mental health) is no longer appropriate. In the first instance, integrated care means that care services, the care team, and the overall budget for the health and care for a defined community have to be brought together.

The vision for integrated care can be explained as:

One Service	• To the public it feels like one cohesive, coordinated service is being commissioned and delivered with integrated clinical and professional governance
One Team	• To care providers it feels like they are all involved in, and responsible for people's care and support working together as one team, no matter who employs them
One Budget	• All providers demonstrate they understand their responsibility for adding value and for managing the resources available for the whole population as well as for individual patients

5. Benefits of integrated care

By providing care in an integrated way and ensuring that the citizen is at the centre the following benefits can be expected

- Better health and wellbeing
- Greater responsibility born by patients/public
- Better patient and carer experiences
- Better coordination/greater efficiency/better value
- Better preventative health (universal)
- Better preventative care for at risk groups
- A sustainable health and care system

6. Approach taken

Both CCGs appointed independent consultants to establish a 12 week programme of work that enabled current providers serving South Kent Coast and Thanet Communities to establish a coordinated and robust service model for the provision of sustainable comprehensive services outside hospital, working together with partners across health and social care and voluntary sector.

Both CCGs' approach has been to develop a shared view of the future service model 'bottom up'. The aim was to encourage front line staff and patients across local services to be engaged in the final design from the outset. It was also believed that this would encourage more innovative solutions.

Public and patients have been fully engaged through a number of different stakeholder events and a patient and public panel was established to co design and drive change.

An oversight group was established at the beginning consisting of key provider stakeholders this provided senior organisation "sign up", commitment and leadership to the overall direction and process.

Separate Thanet and South Kent Coast workshops were held to build consensus about the scope of integrated care for each locality. Over 200 frontline health, social care and voluntary sector practitioners came together to map current services for each CCG and design what integrated care could look like in the future. A "Big Picture" of integrated care for the future was developed. This was followed by a workshop for senior leaders to review the emerging model, comment on the outputs and consider the organisational

delivery options for integrated care. The outputs from these workshops were presented to an oversight group.

A number of infrastructure workshops took place focusing on finance, workforce, information and IT and commissioning. These were to consider the type of infrastructure support and capacity that would be needed by the system as it moves into implementation of integrated care.

In developing the right out of hospital care it is critical to establish the right relationship between GP's and hospital consultants to ensure services are developed in the right place. Both CCG's have had detailed successful meetings with their hospital consultant colleagues through the design process. This will also inform EKHUFT's own clinical strategy. For Thanet CCG this includes the opportunity to develop Queen Elizabeth the Queen Mother Hospital (QEQMH) as a community asset.

Further meetings have been held with the CCG membership to discuss where GPs and practices see themselves in the emerging framework. These discussions will continue with the full Local Medical Council (LMC).

The University of Kent has developed an evaluation framework and therefore this integration programme is underpinned with best practice, action research and evaluation and learning.

7. Progress

NHS South Kent Coast and NHS Thanet CCGs are now at the position where an outline model for integration has been designed locally. Whilst this work was happening the *Five Year Forward View* was published which outlined 4 new models of care for integration. The work that both CCGs are doing fully aligns with this direction of travel.

The local GPs in South Kent Coast are looking to lead the establishment of a 'Multi Specialty Community Provider'. Ultimately this will become a full risk-sharing, population-based approach to organising integrated care locally.

The local model of care will be developed from current resources and centred on the natural local communities of Romney Marsh, Folkestone, Dover and Deal.

In Thanet a further design session is being planned to advance thinking on the locality model for integration focusing on the role of QEQMH as an integral element of the model providing community orientated acute provision ensuring that services are drawn into Thanet wherever possible.

There is further engagement planned to design with residents and clinicians the service details of the local areas within Thanet (Broadstairs, Margate, Ramsgate) and those services which are all across Thanet.

A number of integration projects in each locality are already in place locally moving localities towards the developing vision for integrated care these are outlined in **Appendix 1& 2**

8. Next steps

This is an ambitious programme of work and will need to be taken forward in a phased approach. It will be necessary to ensure that safe care continues to be delivered whilst totally transforming the way that health and social care is provided in the future.

A detailed integrated programme plan will be developed with clear phasing and governance for delivery. There is a significant amount of detailed preparation and planning work still to be done before the model can be fully agreed by all stakeholders. Implementation of integrated working practices are beginning to be implemented these are working towards the defined vision.

There is the opportunity to become a test bed site (outlined in the *Five Year Forward View Planning Guidance). NHS* SKC CCG is exploring this opportunity.
National Support will be given to areas who become test bed sites, there are a number of challenges that will require significant work locally and nationally in order for new integrated models to be established focusing on challenges such as organisational legal forms, procurement routes, new contractual models.

APPENDIX 1

1. NHS South Kent Coast CCG

Developing out of hospital care in local communities
Alongside the work to shape the provider market, we are actively engaging with our local communities to help prioritise and design the services that they need.

(a) Deal
Following public events in January and April 2014, the CCG is working with the local community and providers to develop a health and care hub. Deal Hospital will have a prominent role.

Services already in place include:

- A clinical care pilot to develop better integrated services to support patients with long-term conditions and multiple needs.
- A pilot dementia care project to ensure that patients newly diagnosed with dementia can remain living independently for as long as possible with access to appropriate support.
- An extension to the minor injury unit opening hours to 8pm (daily) to increase access.

(b) Next steps
Work is in progress to:

- Explore the possibility of nurse-led outpatient services
- Identify opportunities to undertake same day acute hospital treatment at Deal Hospital
- Run clinics and drop-in sessions for local people needing advice and support, including mental health
- Improve use of short term care beds at the hospital so that the most appropriate patients have access.
- Expand the use of technology to provide 'virtual' consultations without the need to travel.
- Retain clinics at Deal Hospital including anticoagulation, dermatology, community child health and ear, nose and throat.

2. Folkestone

(a) Progress

Following discussions with local people in July 2014, a primary care hub is being developed at the Royal Victoria Hospital. The hub is open from 8am to 8pm seven days a week for both booked and walk in urgent and routine care.

Patients can use the hub like a branch surgery of any of the local GP practices and clinical records are accessible via a linked computer system.

(b) Next steps

Plans are in place to expand the range of services to provide:

- Primary care mental health assessments
- Paramedic urgent visiting
- Access to temporary care home beds
- Improved links to community and social care
- Integrate intermediate care, adult social care and mental health services.

3. New Romney

In October the CCG held public workshop in the Marsh Academy Community Hub where Romney Marsh residents discussed which NHS services they would like provided locally. Feedback from the event is being evaluated so that plans to improve out of hospital services can be developed.

4. Dover

A public meeting with local stakeholders will take place on the 26 January 2015 to begin discussions around the development of out of hospital care in Dover.

APPENDIX 2

1. Thanet CCG

Thanet has further work to do in defining the model of integrated care across the locality. This includes the design of hospital services at QEQMH and the function of the acute hospital within a community focused model of care. A future event is planned to take this design work forward.

There are a number of projects that are happening locally that contribute to the development of integrated care in Thanet and will ultimately support the direction of travel. These are:

(a) Redesigning Thanet

Work has started to look at defining the natural communities of Thanet and designing the primary care model around these. Workshops have been held with GPs and the acute trust consultants to initially agree the communities for primary care followed by discussion on what "out of hospital care" delivered by consultants could look like.

(b) Prime Ministers Challenge Fund bid

A bid has been submitted to establish a primary care centre at QEQMH. This will improve access to GP's providing an 8 – 8 pm service seven days per week.

(c) Integrated primary care teams

These teams are being established (including Nurses, mental health, social care) centred around localities with GP s at the heart of an integrated health and social care team.

(d) **Over 75yrs primary care initiatives**

Thanet has a number of local service developments based around individual practices supporting local care homes.

(e) **GP step up beds**

12 beds have been purchased from local care homes used as step up beds to reduce the need for hospital admission.

(f) **Integrated discharge team**

A hospital based team has been developed, supporting the discharge of patients from hospital and reducing the admissions from A&E.

(g) **Carers' breaks**

The pooling of funding to support integrated carers support services.

Hazel Carpenter

Accountable Officer
NHS Thanet CCG and NHS South Kent Coast CCG

30 January 2015

Organising Integrated Care
NHS South Kent Coast CCG
and NHS Thanet CCG

Dr Darren Cocker – Clinical Chair NH S South Kent Coast CCG

Hazel Carpenter - Accountable Officer NHS South Kent Coast CCG and NHS Thanet CCG

Case for change

- Ongoing rising demand for care
- Insufficient funding
- Fragmented services
- Unattractive clinical and practitioner roles
- Perverse incentives

What we have now?

- Not enough emphasis on wellbeing
- Lack of a clear contract between patients/public/community and the system
- Sub-optimal patient and carer experiences
- A lot of complexity with too many 'boundaries' and hand-offs
- Questionable efficiency and patchy value – some gaps, some duplication
- Not enough focus on preventive health for everyone
- Inadequate preventive care and early intervention for at-risk groups
- A health and care system that even in the short run is *not* sustainable

Should we?

- **Increase the size of services** to deal with rising demand including increasing numbers of those in crisis?
-
- **Manage demand** by rationing services, tightening eligibility, hiking charges?

or intervene positively to……..

- **Change the service model** by right sizing health and care capacity and intentionally working to support individuals, families and communities to stay strong, diverting people from formal services wherever possible through sustainable, local, flexible individual and community solutions?

What will it be like for me……

7. Through the ICO we will provide the people of South Kent Coast & Thanet with the skills and tools to better manage their conditions.

8. development of community hubs where local care is planned and managed

1. Prime Ministers Challenge Fund

6. Big Picture engagement events have been held to ensure that our focus is on meeting the local population needs in South Kent Coast & Thanet

4. Development of a integrated shared care plan

5. Further use of Integrated Personal Budgets

4. Development of multidisciplinary community hubs

3. Development of an Integrated Care Organisation, including horizontal integration of teams

Integrated care: how would we know if we had it?

One Service

- To people it feels like one cohesive, coordinated service is being delivered

One Team

- To care providers it feels like they are all involved in and responsible for people's care and support - working together as one team, no matter who employs them

One Budget

- All providers understand their responsibility for adding value and for managing the resources available for the whole population as well as individual patients

Provider development approach

Procurement – why not?

- Difficulty in specifying the requirement for a new service model; as yet undeveloped.
- Need for commissioner led tight project management of delivery to align with the management of activity shifts from EKHUFT into a different setting.
- Variation in potential time lines for alignment of some service procurement which could prevent optimal scope of the project and alignment of key services.
- Distraction from the core purpose of the project to improve outcomes and experience for a better per capita cost

A 'bottom up' approach

- Built on delivery of 'I' Statements
- Enables form to follow function.
- Development of a common purpose across the local clinical and care community (putting quality as the primary focus)
- Development of a genuine sense of affiliation and common code of ethics.
- Focus of better patient outcomes.
- Single version of the truth.
- Built on Triple Aim principles of:
- Better patient experience
- Better clinical outcomes
- Better value for money
- Engages the entire front line clinical and caring community in real time change and improvement through collaborative, co-design social movement model
- Avoids costs of organisation structural change to an unknown end point
- Creates a 'safer' environment for multi-organisation service model redesign

Approach Taken

- Bottom up design which is professionally led
- Work together with partners across health and social care and voluntary sector
- Agreement on an Incremental process
- Strongly influenced by providers
- Form to follow function

Through

- Workshops to build and develop a shared “big picture” of what integrated care should look like
- Inclusive oversight and governance – leadership group
- A peoples panel to co design and drive change
- Corporate infrastructure groups: finance, commissioning, workforce
- CCG membership meeting, and acute consultants/GP meeting
- Social Care transformation programme
- Local implementation and leadership
- Underpinned with best practice, action research and evaluation and learning

Stakeholders identified some characteristics of IC SKC

- Person centred
- Keeping people well - prevention
- Managed care - care is actively managed, one care plan that is followed by everybody
- Organisation - clear and consistent funding, value for money (vfm)
- Location - looked after locally
- Care is integrated – multi professional, one team
- First contact – always get the right service

Multispecialty Community Provider Model

It's about *all* of us…

- We are all members of this 'enterprise/society' all the time – not just when we are patients
- We will be supported in taking more responsibility for our health and well being - as individuals and as communities
- We will have information and advice to help us stay healthy and to help us know how/when to seek professional advice.
- There is proactive, early identification and support for people whose health could be at risk

Membership

We always get the right service…

- A single approach to assessing people's needs means my details are shared with the professionals that will help me
- One phone call will me to the right advice or service first time.
- If I access care through a different route I can be confident that I will get the right services for my needs without unnecessary delays
- Health and care professionals know the services and support that's available and can direct me to the right place

First contact

Our care is integrated…

- We are supported by multi-professional teams are organised around common functions
- They work as one team even when not co-located and share information to enable better care to be provided
- Everybody in the system is aware of what others are doing and following the care plan
- My care is integrated across locations, over time and by conditions

Integrated care

Our care is actively managed…

- I have one care plan that supports my health and wellbeing
- My plan is understood and followed by everybody in the system
- The plan summarises my responsibilities and the support I can expect.
- If I have complex needs a care co-ordinator helps me manage the different elements of my care so it meets my needs and preferences
- If I need to get specialist treatment in a hospital, my local team will know about it and put in place the care and support I need to return home

Managed Care

We are looked after locally…

- I can get most of my care at home, in GP surgeries or in a larger community health & wellbeing centre
- Consultant advice will be available to me and my doctor locally wherever possible
- Modern technology helps in monitoring people's health and keeping health professionals in touch
- Integrated care is organised for the whole of SKC but its tailored for my community

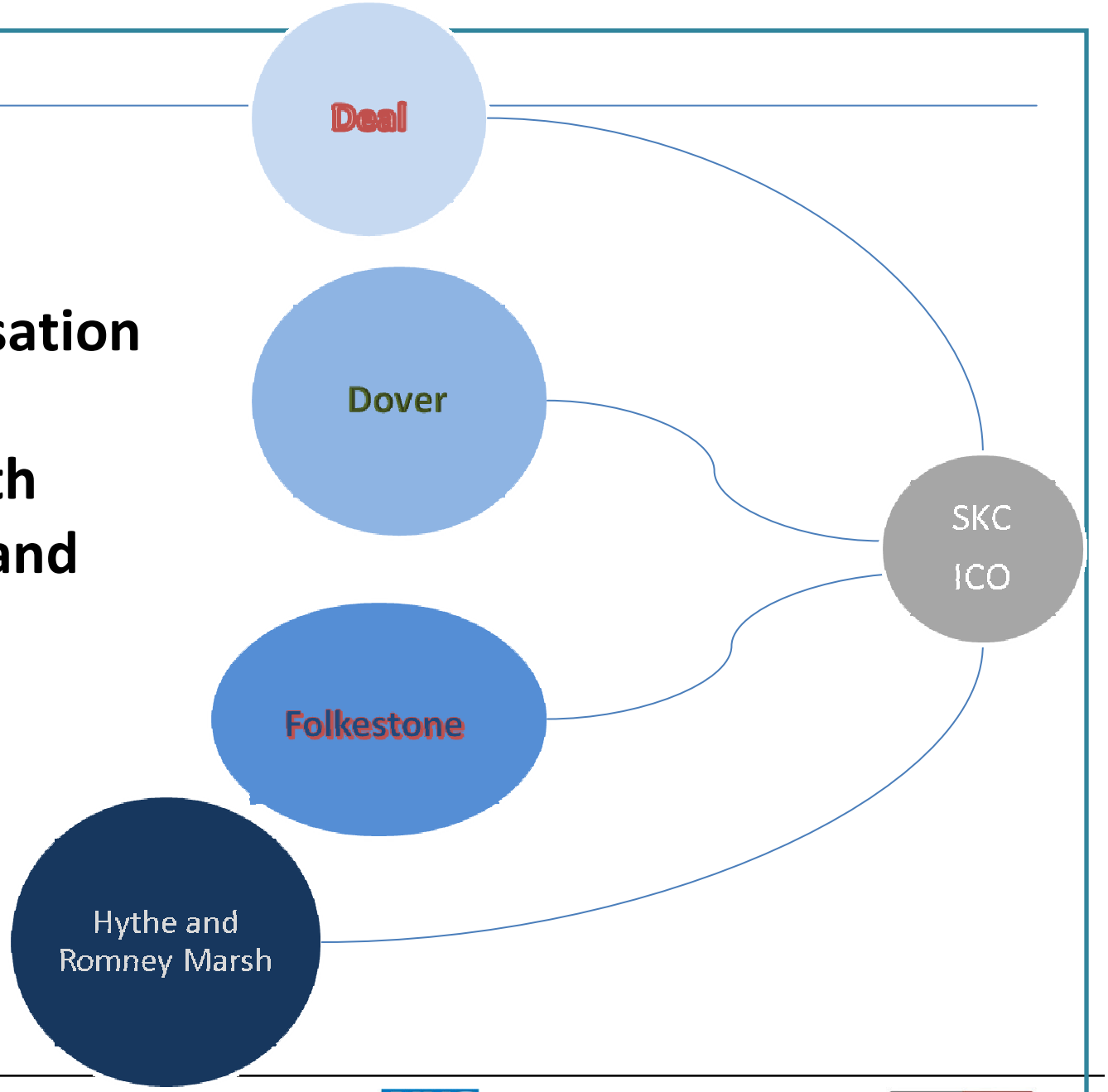
Location

We have clear and consistent funding…

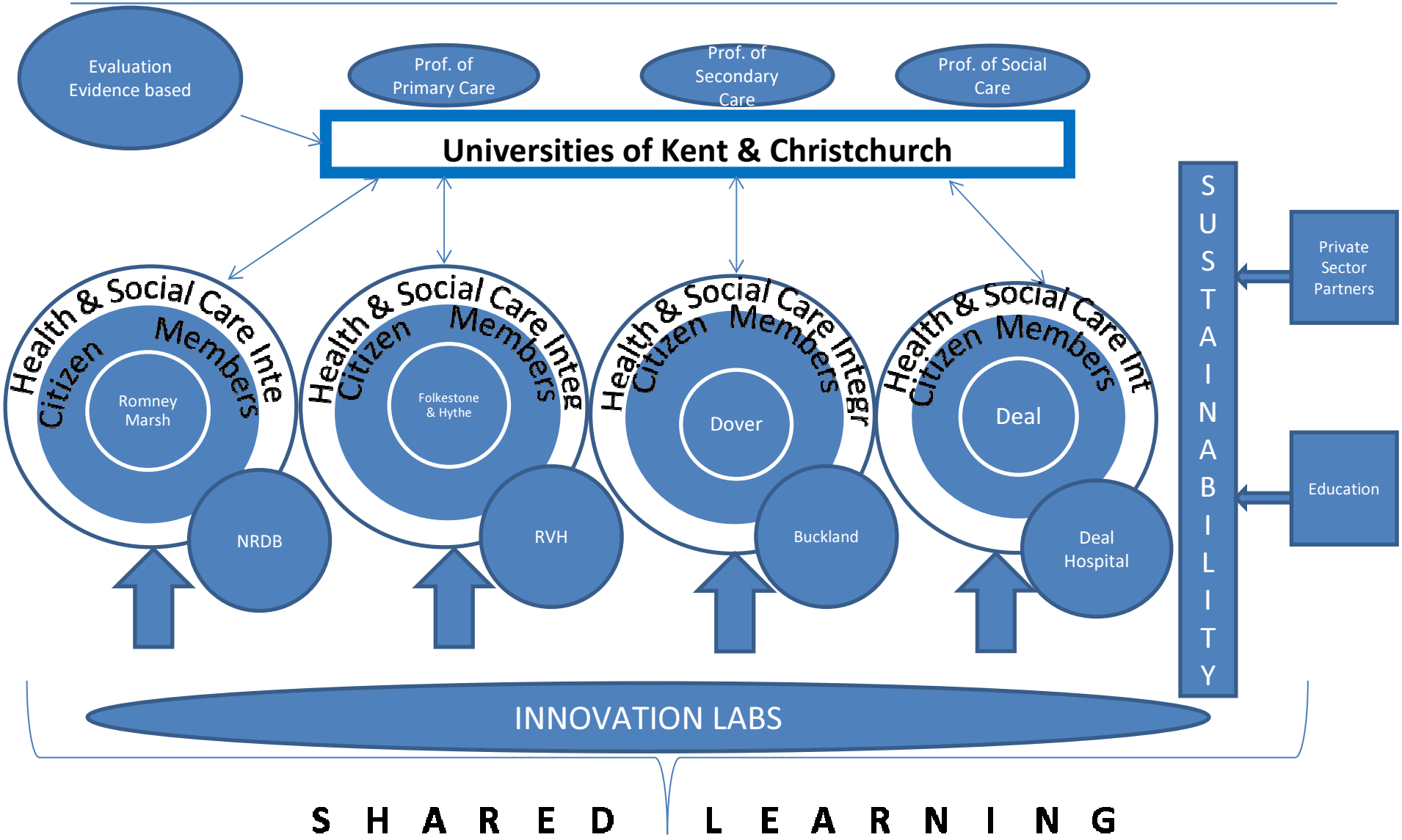
- There is one consolidated budget that supports the health and care needs of the whole population
- We use our community's assets to support health and wellbeing as well as the budget for public services
- Value for money is constantly reviewed to make sure that resources are used to match changes in need and to maximise health outcomes and wellbeing
- We are able to hold the organisation to account for how it looks after us and spends our money

Organisation

A central organisation supporting communities with different needs and patterns of care.



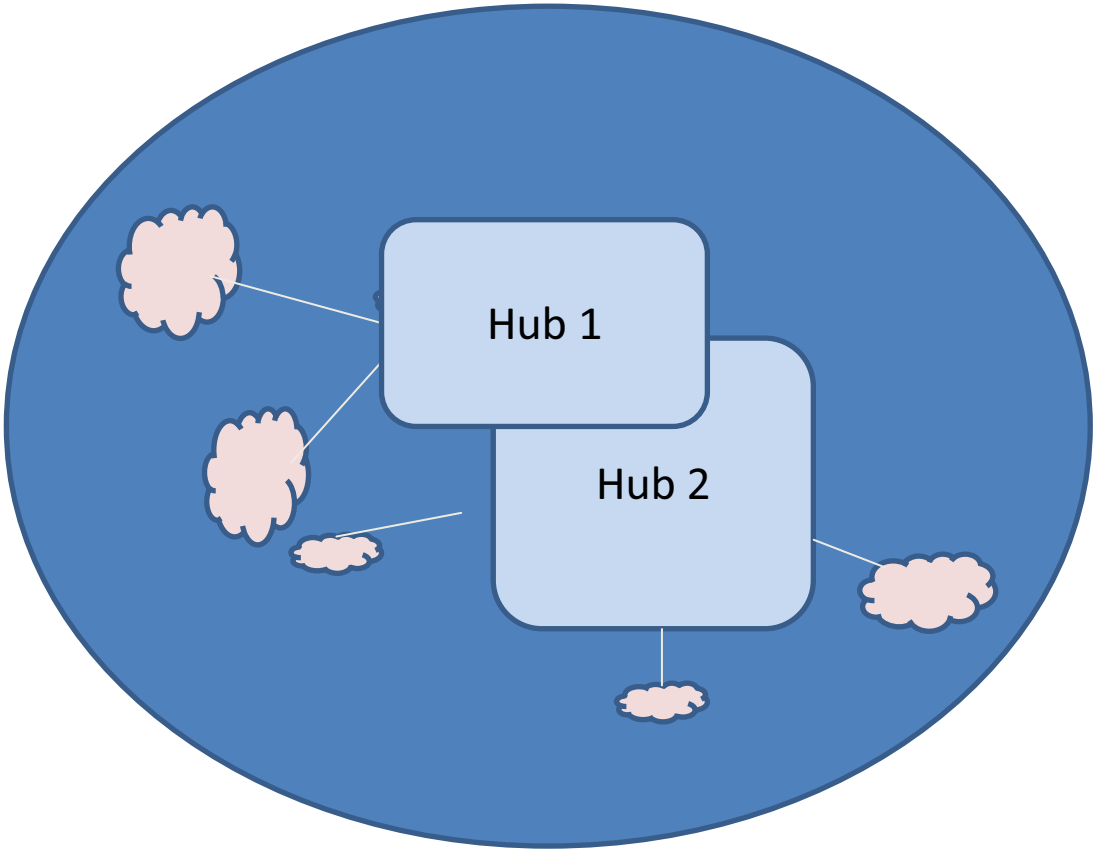
SKC Organisation of Integrated Care



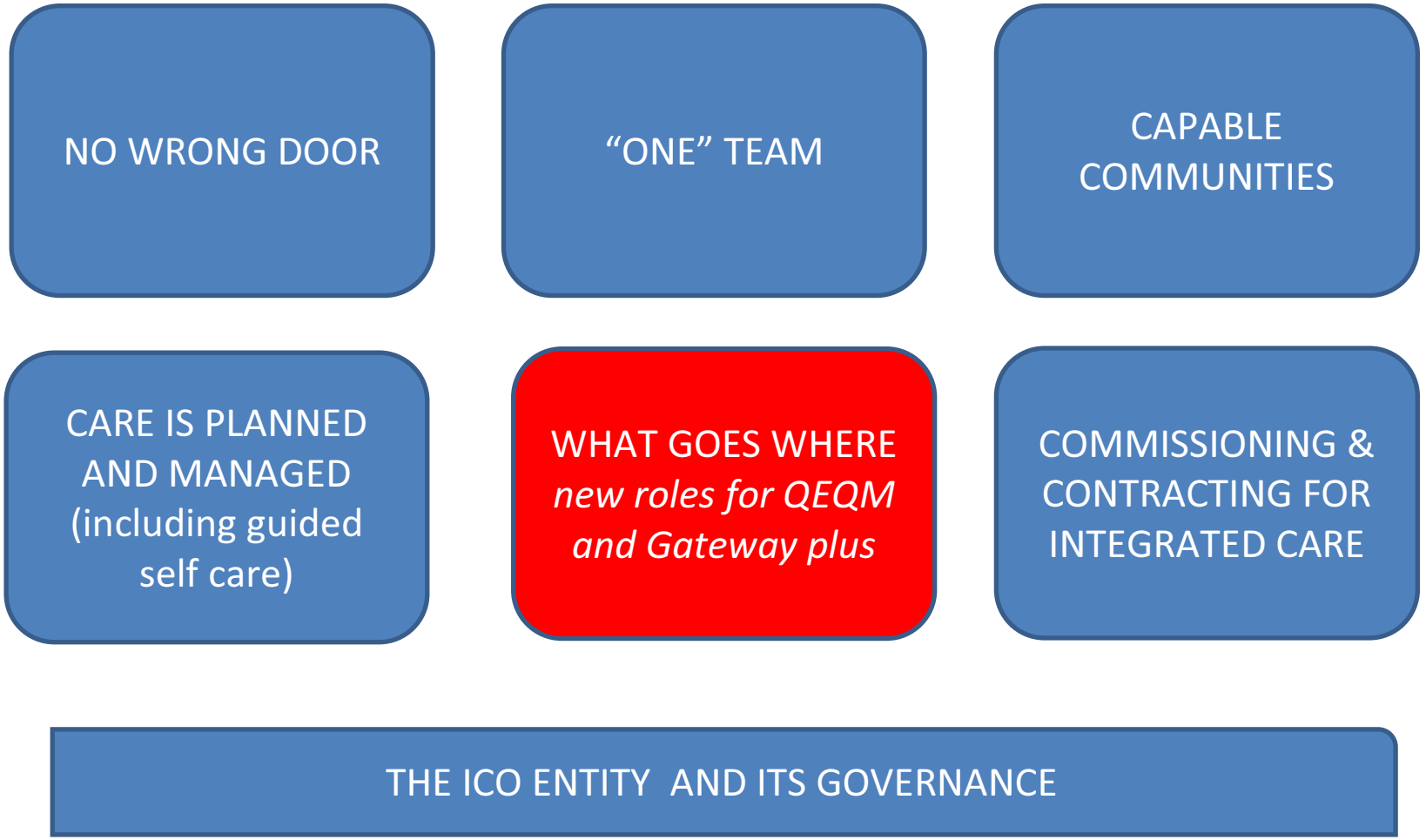
Thanet's ICO will have some similarities but some key differences to that that for SKC

THANET'S ICO

- NOT a solely medical model, it needs to focus on reducing health inequalities
- Thanet's communities are enabled to support health and wellbeing with multi specialty teams
- The option of 1 or 2 hubs.
- QEQM is a central point for the community
- Maximise delivering care in Thanet



Thanet's integrated care building blocks



Challenges and next steps

Challenges

- Shared vision/tough choices
- Continued engagement – taking the public and workforce with us
- Workforce – skills and competencies and numbers
- Organisational form, risks and rewards to enable change
- Leadership to deliver and ensuring delivery of safe care through significant change
- Information sharing

Next Steps

- Develop integration programme plan
- Implementation of new models of care – phased approach
- Identify locality leadership to take forward
- Continuous stakeholder engagement
- Possibility of test bed site
- Design the evaluation model
- Explore integrated commissioning approach
- Model the financial flows

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Item 6: East Kent Hospitals University NHS Foundation Trust: Clinical Strategy

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 January 2015

Subject: East Kent Hospitals University NHS Foundation Trust: Clinical Strategy

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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) East Kent Hospitals University NHS Foundation Trust (EKHUFT) has asked that the attached report be presented to the Committee.

(b) HOSC has considered the development of Trust's previous clinical strategy on three occasions: 3 February 2012, 12 October 2012 and 7 June 2013. An area of particular focus was the East Kent Outpatient Services which the Committee considered on 11 October 2013, 11 April 2014, 6 June 2014 and 5 September 2014.

2. Five Year Forward View

(a) The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS based on seven new models of care. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority.

(b) *Multispeciality Community Providers (MCPs)*

MCPs would involve extended groups of primary care practices which could be federations, networks or single organisations. They provide a much greater range of services for their registered patients. Practices could employ consultants or take them on as partners, and employ therapists, pharmacists, nurses and social workers. MCPs would shift the majority of outpatient consultations from hospitals. As MCPs develop, some GPs could be allowed to directly admit patients to hospital, and they could take on delegated responsibility for managing NHS budgets or pooled budgets.

(c) *Primary and Acute Care Systems (PACS)*

Under PACS, single organisations could provide primary care and hospital services plus mental health and community care services.

There would be different arrangements dependent on local situations. For example, in deprived areas which struggle to provide sufficient primary care, hospitals would be allowed to open GP surgeries with registered lists. This would allow the investment power of foundation trusts to expand primary care; safeguards would be needed to ensure the primary care element was not used to drive patients into traditional services provided by the hospital. Alternatively, a mature MCP could take over running a district general hospital with an expanded range of treatments and diagnostics. A developed PACS could become accountable for the whole health needs of a registered list of patients under a delegated capitated budget; this would be similar to Accountable Care Organisations developing in America and elsewhere.

(d) *Urgent and emergency care networks*

The NHS is seeking to improve and simplify the urgent and emergency care system. Ways of doing this will include greater evening and weekend access to GPs, nurses in community bases able to offer a much greater range of tests and treatments, ambulance services empowered to make more decisions, and greater use of pharmacies. There will also be networks of hospitals linked to speciality emergency centres, building on the success of trauma centres in reducing mortality for people who have had strokes and heart attacks. Hospital patients will have access to seven-day services where this improves outcomes, and there will be integrated mental health crisis services. Patients will be helped to navigate the system more easily.

(e) *Viable smaller hospitals*

The report indicates that local hospitals should not provide complex, high volume acute services, so some services will need to be shifted to other locations. However, local hospitals providing clinically effective services and supported by commissioners and communities have a role in the new NHS landscape. NHS England and Monitor will consider whether the NHS payment regime needs to be amended to allow small units to remain viable. New models will include:

- a local acute hospital may share management of the whole organisation or the back office functions of a similar hospital not in its immediate vicinity – a hospital chain;
- a smaller local hospital may have some of its services on a site provided by another specialised provider – satellite sites;
- a PACS model integrated provider.

(f) *Specialised care*

NHS England will work with local partners to develop services where there is a strong relationship between number of patients treated and health outcomes, pursuing the model of specialised stroke units into some cancer and other services such as orthopaedics.

(g) *Modern maternity services*

NHS England will commission a review of future models of maternity units to report by summer 2015. The review will investigate how tariff-based funding can support women's choices and how groups of midwives can be facilitated to set up their own NHS-funded midwifery services.

(h) *Enhanced health in care homes*

In partnership with councils and the care home sector and 'using the opportunities created by the Better Care Fund' (BCF), NHS England will develop new models to enhance the health input into care homes, such as medication reviews and in-house rehabilitation services. Such approaches have been found to improve quality of life and reduce hospital use by a third with significant cost savings.

(i) In addition to the seven models of care, the report sets out immediate steps to stabilise general practice through the expansion and strengthening of primary and out of hospital care. The 'new deal for primary care' includes stabilising core funding, giving CCGs more influence over the NHS budget, using a challenge fund to provide more funding, increasing the numbers of GPs trained, and incentives to encourage doctors and new practices in under provided areas.

3. Recommendation

RECOMMENDED 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.

Background Documents

Kent County Council (2012) '*Agenda, Health Overview and Scrutiny Committee (03/02/2012)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=19539

Kent County Council (2012) '*Agenda, Health Overview and Scrutiny Committee (12/10/2012)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3983&Ver=4

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

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (11/10/2013)*',

Item 6: East Kent Hospitals University NHS Foundation Trust: Clinical Strategy

https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5075&Ver=4

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

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

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (05/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29239

LGiU (2014) *'Policy Briefing: NHS Five Year Forward View (29/10/2014)*', http://www.lgiu.org.uk/wp-content/uploads/2014/10/NHS-Five-year-forward-view.pdf

NHS England (2014) *'The NHS Five Year Forward View (23/10/2014)*', http://www.england.nhs.uk/ourwork/futurenhs/

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East Kent Hospitals University NHS
NHS Foundation Trust

Delivering our Future

5 to 10 Year Strategy

January 2015

Putting patients first

We are doing well

•The Trust is currently in a good position compared with many other foundation Trusts in England

•We continue to be among the better performing Trusts in the country as measured by Monitor, the health sector regulator.

•We are also one of the safest acute Trusts in the country maintaining exceptionally high performance for infection control and our hospital death rates are around 20% lower than the national average

•Our turnover (for 2013/14) reached a new high of nearly £526 million

•We are continuing to invest in our services e.g. new endoscopy suite, cardiac laboratory, one-stop out patient clinic facilities and the new hospital in Dover.

But we face challenges and must address these at pace

• Our recent CQC report identified weaknesses in our current models of care e.g. emergency services (A&E), medicine and surgery

• A number of our services are struggling with workforce constraints

• We have operational issues in A&E and with meeting waiting time targets

• This year we are forecast to make a financial deficit of around £6.6m

Other pressures

- Demographic changes; a growing and ageing population
- Patients and their relatives, rightly, continue to expect high-quality care as close to their homes as possible
- The workforce pressures that we are currently experiencing are expected to continue and get worse:

  - Availability of junior doctors
  - Training requirements and a continuing drive towards doctors becoming more specialised
  - Multiple on-call rotas – maintaining multiple rotas in multiple layers on numerous sites is labour intensive, expensive and unsustainable
  - Availability of qualified staff – nursing staff numbers for the future is a problem being faced both nationally and internationally
  - We are facing a reduction in the amount of income we receive at the same time as the costs of providing those services increase

Can we stay as we are?

Activity changes from 2013 to 2023 driving these changes are:

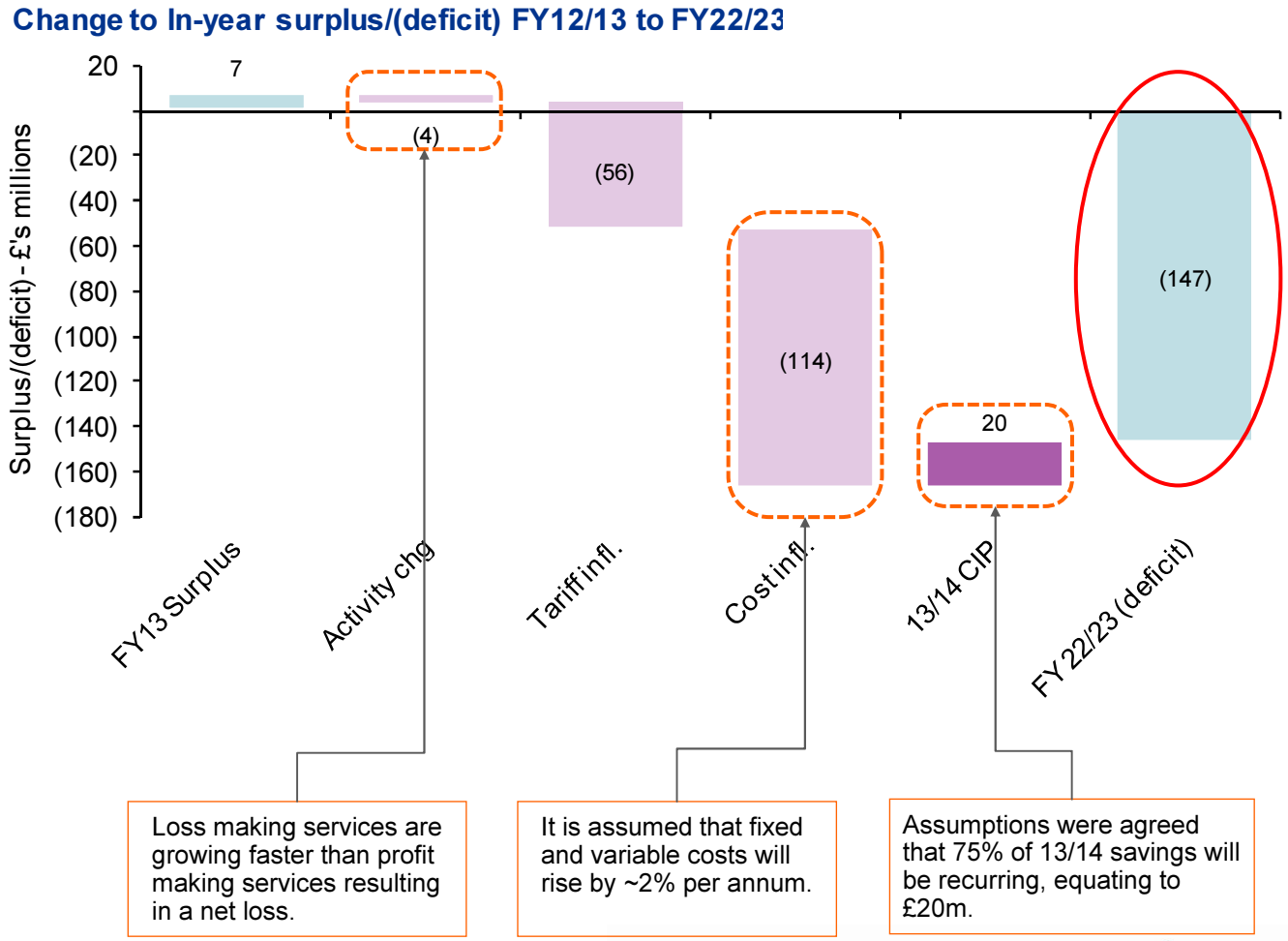
-Inpatient: +16%

-Day case: +17%

-Outpatient: +14%

-OPP: +16%

If the Trust continues to deliver against 2012/13 performance, with no efficiency gains, there will be a deficit of £40m 2017/18 and £147m by 2022/23.



The figure present the change in in-year surplus/deficit between 2012/13 and 2022/23.

All figures presented are annual totals.

So, what's the answer?

•We need to re-consider how we deliver care in the future

•We cannot continue to provide the current pattern of services on three hospital sites

•But we need to ensure we continue to deliver services locally wherever possible

•So, where absolutely necessary we have to consolidate services in a single high-risk hospital, supported by vibrant bases

•Delivery of this model is only achievable if we have a truly integrated care strategy

- greater integration with primary care, community & social care;
- teaching nursing homes; and
- tiers of care.

National Picture – Primary Care Integration

- The 2022 GP: A Vision for General Practice in the future NHS" (May 2013), Royal College of General Practitioners

- Stimulus – EKHUFT has been approached to look at models of integration on 5 of its sites. Other examples where this has happened:
  - Torbay care Trust
  - Birmingham – Vitality Partnership
  - Newcastle-upon-Tyne Hospital
  - Northumbria Healthcare Foundation Trust and Ponteland Medical Group

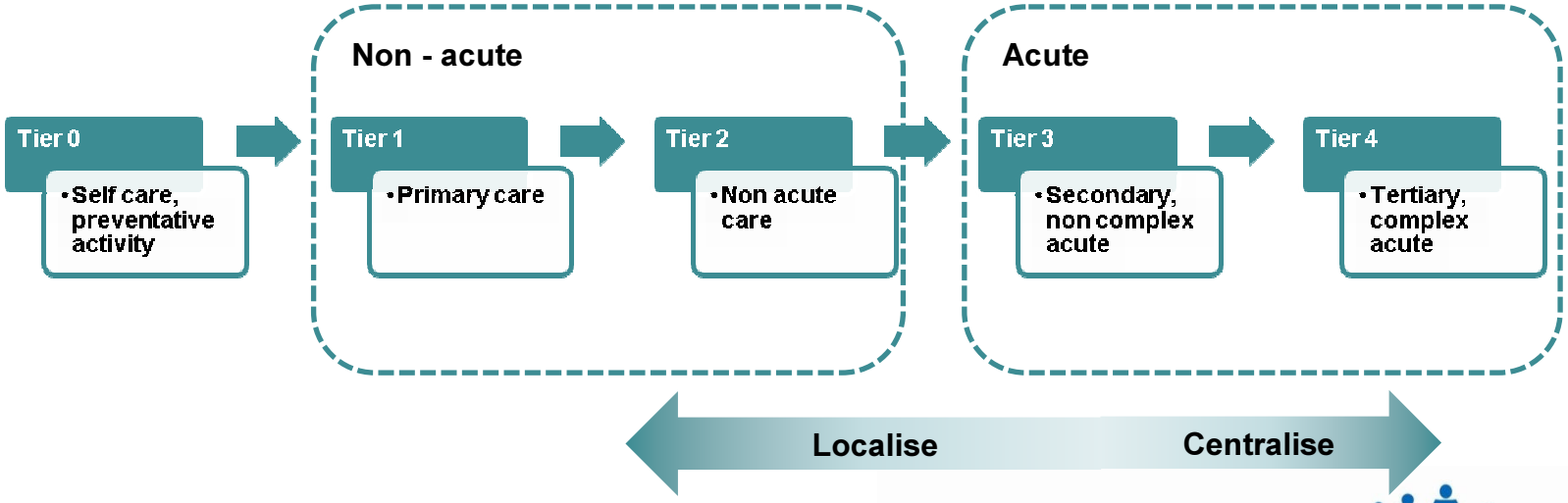
- Shared strategic aims to:
  - reduce the activity attending single emergency & high-risk / local hospital sites;
  - design a healthcare system with less reliance on acute inpatient beds;
  - focus on long-term conditions and on the aging population;
  - ensure local services for local people when and where ever possible; and
  - deliver integrated service provision.

Teaching Nursing Homes

- This model is successfully running in a number of countries e.g. Holland, Japan
- It is an elderly care facility in which there is synergy between clinical care, education and research.
- Francis report states the Government is “aiming to strengthen the focus on the complex needs of older people through training of the nursing workforce”.
- Other healthcare providers have identified the same opportunity - BUPA establishing the first teaching dementia home in the UK.
- Clinically-led visit to Holland in September to see how the system works.

Tiers of care across the system

- A key question that needed to be addressed was “what are the appropriate settings to deliver care to patients?”
- In order to provide structure to this question we defined five broad tiers of care. The diagram below present the five tiers of care used in the analysis.
- Using the concept of the tiers of care, the key questions that we asked were:
  - What services could be delivered locally?;
  - What services should be centralised?;
  - What services should EKHUFT stop delivering? and
  - What services should EKHUFT start / carry on delivering / perhaps in a different setting?.



Delivering Our Future

Phase 1 (complete)

- Initial clinical discussions.
- Development of initiatives.
- Development of options.
- Illustration of impact of options.

Current Engagement Phase (Detailed analysis)

- Continue clinical engagement.
- Initiate discussions with commissioners, community, voluntary, private sector and primary care providers.
- Confirm specialty delivery by tier.
- Refine management information.
- Carry out detailed capacity and demand planning.

Development & consultation of strategic plan

- Continue stakeholder consultation with clear strategic plan.
- Develop long-term condition strategy.
- Plan for community integration.

Key messages so far

Since the beginning of June we have held a large number of engagement events:

•81 internal engagement events and meetings for staff

•28 engagement events and meetings for external stakeholders

•Clinical discussion feedback from South Kent Coast CCG Membership event 5th November 2014

•7th January – Thanet CCG's GP and Consultants' Meeting

•11th February – Canterbury and Ashford CCG's Clinician to Clinician Event

•Kent Healthwatch – public reference groups

•General support from all four of East Kent's CCGs

Key messages so far

Acute, hospital care

•Prevent attendances to hospital wherever possible
•Greater integration between secondary, primary and community care with improved continuity of care
•Improved rapid access and enhanced referral system, especially potential cancers, which should be less than 2 weeks

•Considering options around acute, high-risk services on one site and variations on this theme e.g. emergency surgery and medicine, obstetrics, inpatient paediatrics
•Considering the required clinical adjacencies within the other specialties, supporting infrastructure and other services required for this to happen
•Centralisation for specialty services across a wider area (Kent and Medway) e.g. Renal, PPCI, Vascular, NICU, etc

Key messages so far

Non-acute care

- Development of integrated multidisciplinary services and robust shared care arrangements

- Low / medium risk inpatient procedures
- Day Surgery procedures
- Local rehabilitation and step-up and step-down care
- Outpatient clinics, including one-stop services
- Urgent Care Centres
- Children's Ambulatory Care services
- Hot and cold Ambulatory Care
- Closer working with Primary Care, Community and Social services to ensure patient flow and that patients are cared for in the right environment
- Improved education and training for GPs and GPSIs

Making it happen

- Implementing the Outpatient Strategy
  - Estuary View, Whitstable
  - New Dover Hospital
- Exploring Strategic Estates Partnership
- Co-location of GP Practices at acute hospital sites
- Unified approach with:
  - Community Network Groups
  - Integrated Care Organisations (ICOs)
  - Multi-specialty Community Providers (MCPs)
  - Primary and Acute Care Systems (PACS)
- 7 day working
  - Integration of workforce
  - Consultant-delivered care

Proposed next steps

Continue wide stakeholder engagement

- A series of public and patient focus groups
- “Trade fair style” engagement events
- Engagement with local patient groups
- Engage with the CCGs’ Community Network Groups / IOC Meetings
- Engage with Kent Health and Wellbeing Board and Kent Healthwatch
- Reaching out to hard-to-reach groups
- Continue to keep the Kent HOSC informed and updated throughout

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Item 7: SECAmb - Future of Emergency Operation Centres (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 January 2015

Subject: SECAmb - Future of Emergency Operation Centres (Written Update)

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

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

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

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1. Introduction

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

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

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

(d) On 5 September 2014 the Committee considered SECAmb's Emergency Operations Centre (EOC) Reconfiguration Project. The Committee's deliberations resulted in agreeing 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 three months.*

(e) Due to the number of substantive items on the Agenda, this item has changed from a verbal to a written update.

2. Recommendation

RECOMMENDED that the report be noted and SECAmb be requested to provide a written update to the Committee in six months.

Background Documents

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

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Up-date to Kent County Council HOSC

1. Introduction

1.1 An up-date was provided to the Kent County Council HOSC on 5 September 2014 regarding South East Coast Ambulance Service's (SECAmb's) plans to move from three Emergency Operations Centres (EOCs) to two. In addition, a new Trust Headquarters would be provided alongside one of the new EOCs.

1.2 The Committee is reminded that our plan is to move to the following model:

- A new "EOC West" - to be located in the Gatwick/Crawley area, co-located with the new HQ
- A new "EOC East" - to be located in Kent

The drivers for the change, as well as the benefits the new reconfiguration will bring, were also outlined to the Committee in the previous presentation. However, the Committee is also reminded that no definitive locations had been identified at that point.

2. Current position

2.1 Since September 2014, work has been on-going to identify specific locations for both of the new EOCs. However, given the specific pressures affecting the Sussex EOC (located in Lewes), the Trust Board has agreed to prioritise re-locating the EOC West as phase one of the project, to be followed by EOC East.

2.2 As explained in the earlier presentation, our preferred strategic location for the EOC West/new HQ is in the Gatwick/Crawley area.

2.3 A variety of commercial sites have been explored, however an opportunity has arisen during the past twelve months to locate the EOC West/new HQ on a site in Crawley owned by Surrey County Council. Surrey CC is looking to establish a "campus" site, including other emergency and council services.

2.4 SECAmb's Trust Board has given approval for the "campus" option to be our preferred option for the EOC West/new HQ. Details are currently being finalized but if plans progress as hoped, the new site will be ready for occupation in late 2016/early 2017.

2.5 Further up-dates will be provided to the Committee as required.

Janine Compton, Head of Communications

On behalf of South East Coast Ambulance Service NHS Foundation Trust

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Item 8: Kent Community Health NHS Trust: Community Dental Services (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 January 2015

Subject: Kent Community Health NHS Trust: Community Dental Services (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent Community Health NHS 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) Kent Community Health NHS Trust requested the opportunity to bring an update report to the attention of the Committee.

(b) In March 2014, Kent Community Health NHS Trust informed the Committee of proposed changes to the gum disease clinic in Deal and the community dental service at Folkestone Dental Clinic, subject to consultation with patients and staff. Details of the consultation were circulated to Members of the Committee on 10 March 2014.

(c) On 6 June 2014 the Committee considered a written update on the outcome of the consultation and the Trust's decision to proceed with the changes. The Committee's deliberations resulted in agreeing the following recommendation:

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

2. NHS Dental Services - Overview

(a) NHS dental services are provided in primary care and community settings, and in hospitals for more specialised care. NHS England directly commissions all dental services for the NHS. There are over a million patient contacts with NHS dental services each week.

(b) Dentists working in general dental practices are independent providers from whom the NHS commissions services. They are responsible for whom they employ within their own dental teams and for the

management of their practices. It is common for dental practices to offer both NHS-funded and private services.

(c) The NHS in England spends around £3.4bn per year on dental services; the value of the private market is estimated at £2.3bn per year.

(d) 21 Dental Local Professional Networks have recently been established across England to promote a strategic, clinically informed approach to the planning and delivery of dental services that reflects the needs of local populations.

(e) Adult patients make a financial contribution for receiving dental care from the NHS unless they meet certain exemptions. There is a 3-band fixed charge for primary care treatment depending on the care provided by the dental practice. The dental charges system contributed £653m to the NHS budget last year.

3. Recommendation

RECOMMENDED that the report be noted.

Background Documents

NHS England, *Improving Dental Care and Oral Health - A Call To Action*, February 2014
http://www.england.nhs.uk/wp-content/uploads/2014/04/imprv-oral-health-info.pdf

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16 January 2015

In Spring 2014 Kent Community Health NHS Trust (KCHT) consulted with patients and staff in relation to changes to its community dental service. Kent County Council's Health Overview and Scrutiny committee was informed of the original proposals and subsequently, received a report on the outcome of the consultation in March 2014.

This report provides an update to the committee on the two changes which were implemented in June 2014:

1. To move the specialist gum disease service from Deal to the Trust's dental clinic at Dover Health Centre
2. To move the community dental services provided at Folkestone to more modern and accessible clinics at Ashford, Dover and New Romney.

Moving the specialist gum disease service from Deal to the Trust's dental clinic at Dover Health Centre has improved physical access for people with disabilities. The service is also available five days a week instead of one and patients are benefitting from better parking and public transport links in Dover.

More than 90 per cent of patients who attend this specialist clinic were not local to Deal and it has increased access for people living in Ashford, Shepway and Canterbury.

Moving the community dental services provided at Folkestone to clinics at Ashford, Dover and New Romney has provided patients with access to more modern and spacious facilities including a waiting area and larger disabled access lift.

The service is provided for patients who need special care. The changes have meant that patients can now also receive treatment under sedation where required, at the same clinic where they are assessed, instead of having to be referred on to a different clinic for this element of their care.
Of the patients that attended the Folkestone clinic, 50 per cent of the patients were not local to Folkestone, while 40 per cent of all patients travelled from Ashford to the clinic for their treatment.

Prior to the changes patients were contacted about their nearest clinic but were also advised that they could choose an alternative clinic if they preferred (or if this would mean they could continue to see the same dentist). The number of patients seen from the Deal and Folkestone area has increased from 521 in the six months prior to the changes to 890 in the six months since the changes. This is largely due to patients being seen at clinics where there are larger and more diverse dental teams offering a broader skill mix and the capacity to see more patients.

Patients were provided with information about voluntary patient transport schemes and information on how to reclaim their travel costs if they were eligible. Following the changes the service has not received any complaints. Patient feedback and satisfaction remains high with patients continuing to receive high quality care and treatment.

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Item 9: Faversham Minor Injuries Unit (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 January 2015

Subject: Faversham Minor Injuries Unit (Written Update)

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

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

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

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1. Introduction

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

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

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

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

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

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

- *RESOLVED that its guests be thanked for their attendance and contributions to the meeting along with their answers to the Committee's questions, and that they return to the Committee within three months to give an update on the consultation and final*

outcome of the steering group review before a final decision is made by the CCG governing body.

(e) On 18 July 2014 the Committee considered a further update provided by NHS Canterbury and Coastal CCG. The Committee's deliberations resulted in agreeing the following recommendation:

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

(f) NHS Canterbury and Coastal CCG has asked that the attached report be presented to the Committee.

2. Recommendation

RECOMMENDED that the report be noted and NHS Canterbury and Coastal CCG be requested to keep the Committee informed with progress.

Background Documents

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

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

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

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee, Kent County Council, (18/07/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29194

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NHS
Canterbury and Coastal
Clinical Commissioning Group

Faversham Minor Injuries Unit
Briefing Paper
January 2015

Background

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

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

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

4. To help support the review, the CCG established a local Steering Group comprising representatives from the local community, patients, The Friends of Faversham Cottage Hospital and Community Health Centres, Faversham GPs, Faversham Town Council, Swale Borough Council, Kent County Council, Healthwatch and the CCG.

5. On 4 June 2014 the CCG governing body considered a briefing paper, presented by two members of the public, from the steering group. The governing body supported the recommendation that the CCG should commence a new procurement process for an MIU service in Faversham. The contract would be for an initial three years, extendable to five by agreement, with regular reviews.

6. In the meantime the existing contract to allow time for the procurement process to be completed.

Progress

Since the last update to the HOSC in July 2014 the CCG, supported by members of the stakeholder group, has:

- Developed a detailed service specification and agreed this with both the stakeholder group and the CCG governing body.

- Completed a range of assessments including:

- an assessment by NHS Property Services indicating that it might be possible to provide a static X-ray service from Faversham Health Centre.

- an assessment by an independent radiographer, indicating that x-ray could be located on site, recommending the make and model of x-ray, IT infrastructure, personnel model and personnel requirement.

- an electrical assessment to check that the current power supply to the hospital is sufficient for the x-ray machine and if not, the subsequent actions that would be required and costs.

- a structural assessment to confirm that the rooms identified as possible locations for the general digital x-ray room on the Faversham Cottage Hospital/Health Centre site are suitable.

- a detailed financial analysis of the proposed model, with scenario testing to identify a model that is most viable

- On the basis of these assessments, NHS Canterbury and Coastal CCG has:

    - agreed a specification for procurement which will provide a revised service by end of June 2015

    - agreed a practical procurement approach with CCG and KCC procurement experts

    - issued an invitation for expressions of interest from interested providers to run the Minor Injury Unit (MIU) service at Faversham.

Next steps

- The CCG received a positive response to the invitation and is now working with internal procurement teams to establish the next steps on the procurement timeline.

- A response has been sent to the interested providers with a proposed timeframe for the full procurement process.

- A market day will be held in the first week of February 2015. This will allow providers to ask any further questions required to support their bid. The market day panel will include contracts and procurement expertise, finance expertise, steering group representation and CCG representation.

- The CCG then expects to be able to award a contract in April 2015 so that the service can commence by the end of June 2015.

ENDS