HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 6th March, 2015

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 6th March, 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. CQC Inspection Report: Maidstone and Tunbridge Wells NHS Trust (Pages 13 - 18) 10.05

5. Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy and Stroke Services (Pages 19 - 26) 10.45

6. Patient Transport Services (Pages 27 - 70) 11.15

7. East Kent CCGs: Out-of-Hours Services (Pages 71 - 76) 11.45

8. NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG: Adult Community Services (Written Update) (Pages 77 - 84)

9. Date of next programmed meeting – Friday 10 April 2014 at 10:00 am

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

26 February 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, 30 January 2015.

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

ALSO PRESENT: Mr A H T Bowles and Mr S Inett

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

UNRESTRICTED ITEMS

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

2. Minutes
(Item 3)

(1) There were no actions to update the Committee on since the Meeting held on 28 November.

(2) RESOLVED that the Minutes of the Meeting held on 28 November 2014 are correctly recorded and that they be signed by the Chairman.

3. Medway NHS Foundation Trust and NHS Swale CCG: Medway's Emergency Department
(Item 4)

Dr Phil Barnes (Acting Chief Executive, Medway NHS Foundation Trust), Morag Jackson (Chief Operating Officer, Medway NHS Foundation Trust), Patricia Davies (Accountable Officer, NHS Swale CCG), Dr Fiona Armstrong (Chair, NHS Swale CCG) and Elliot Howard-Jones (Interim Area Director, NHS England (Kent and Medway)) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Dr Barnes began by giving an update on three key developments at the Trust: leadership, CQC

inspection and recovery plan. He stated that there had been a high turnover of the executive team. He reported there was now a strong executive team following the appointment of a Chief Operating Officer, Interim Chief Nurse, Director of Health Informatics and Director of Workforce. He noted that, following a second wave of recruitment, there would be interviews in mid-February for a substantive Chief Executive.

(2) Dr Barnes reported a further unannounced CQC inspection on 9 December 2014 which looked at the emergency department and surgical theatre services. The final inspection report was due to be published shortly. Initial feedback given to the Trust indicated that there was some progress within the emergency department: improved clinical leadership and better partnership working between the nursing and medical staff. He stated that there was a need to improve internal and external patient flow particularly in trauma.

(3) Dr Barnes explained that on 29 January 2015 the Trust's Board had agreed a comprehensive recovery plan with 30,000 separate actions. He stated that previous plans were reactive and poorly co-ordinated; the new plan had been developed over four months and incorporated previous plans into a single logical plan. He stated the aim of the recovery plan was to stabilise the Trust by April 2016 in order to deliver targets and be removed from special measures.

(4) Further to the three key developments, Dr Barnes noted that there had been no improvement to the 4 hour wait. He stated that South East Coast Ambulance Service NHS Foundation Trust (SECAmb) was concerned about their ability to admit patients by ambulance due to stacking at the hospital. Dr Barnes reported that a number of process and safety measures had been implemented to improve ambulance handover times.

(5) Morag Jackson reported that previous plans had been poorly managed and tracked. She stated that the new recovery plan would be different as it would be appropriately managed, controlled and reported by an experienced team of staff. She noted that the plan needed complete buy-in by the new executive team including the new Chief Executive in order to be successfully implemented.

(6) Patricia Davies updated the Committee on NHS Swale CCG's plans to support the Trust. She reported that patients in Swale were now able to choose and encouraged to use Maidstone and Tunbridge Wells NHS Trust for their cardiology and care of the elderly outpatient appointments. A small number of Swale patients were using this new patient pathway; there was an increasing amount of activity. The CCG was looking to develop plans with Maidstone and Tunbridge Wells NHS Trust to provide further services in the future. She stated the CCG was disappointed that the four hour access target was not being adhered too. She acknowledged that there had been some recent improvement in A&E and handover performance but it was still far short of the target. She stated that the CCG would continue to support the Trust.

(7) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about signposting to primary care services. Dr Armstrong explained that signposting would be a key part of the North Kent Urgent and Emergency Care Review. The CCG was

looking to create integrated primary care teams – a network of health professionals, aligned to GP practices, delivering care in the community. She stated that local practices in Sittingbourne and Sheppey were bidding to become access pilots in the second wave of the Prime Minister's Challenge Fund. Ms Davies explained that improving GP access was part of the CCG's commissioning plans and would be funded by the CCG if the bid to the Challenge Fund was not successful. Ms Jackson stated that currently 25% of the Trust's A&E attendances were diverted to the onsite primary care facility.

(8) A number of comments were made about hospital discharge. Ms Davies explained that an Integrated Discharge Team (IDT) had been set up at the Trust. It was based on the IDT at Dartford and Gravesham NHS Trust which had been in operation for twelve months. The IDT at Dartford and Gravesham NHS Trust was led by the acute trust and fully integrated with Kent County Council, Kent and Medway NHS and Social Care Partnership Trust (KMPT), Kent Community Health NHS Trust and the voluntary sector. She stated that IDT at Medway NHS Foundation Trust was not fully integrated and led by NHS Swale CCG. Dr Barnes explained that the IDT at the Trust had not been as successful as Dartford and Gravesham NHS Trust because the Trust had no control or ownership of the IDT. He stated this needed to be reviewed urgently to improve discharges. Mr Howard-Jones explained that IDTs' were critical to improving discharge but stressed the importance of alternative provision such as out of hospital care which may be more appropriate for some patients.

(9) A Member enquired about staff morale. Mr Howard-Jones explained that the NHS England (Kent and Medway) area was the first area where all acute trusts had been fully inspected by the CQC. He stated that a CQC inspection provided an opportunity to develop an action plan on areas for improvements which caused an immediate dip in morale. He believed that in the long term, the acute trusts would be able to build on their successes and increase morale. Ms Jackson explained that a lack of executive leadership and framework had caused low staff morale; overall sickness in the Trust was only 3.4% despite the low morale. She stated that the new stable executive leadership team would be able to turn around the Trust including morale within 18 months.

(10) A number of Members commended Ms Jackson for her honesty and determination to turn the Trust around. A Member enquired about how long the Trust would remain in special measures. Mr Howard-Jones explained that the Trust needed to move out of special measures as soon as possible. NHS England, Monitor and CQC were committed to improving the Trust through the recovery plan.

(11) In response to a specific question about system capacity, Mr Howard-Jones noted that the Five Year Forward View looked at the capacity required in the system over the next five years. The View promoted increased investment in health; identified efficiencies and ensured people were treated in the correct setting.

(12) A number of comments were made about the expansion of hospital, the four hour access target, the working patterns of interim executives and alternative providers. Dr Barnes explained that work was planned to improve the hospital's environment as there was no possibility of the relocating the

hospital. Dr Barnes stated that he had no control over the four hour access target. He believed it to be a reasonable target for emergency departments. Ms Jackson noted that the Trust had received funding to expand the A&E which would include medical and surgical assessment units to enable patients to move through the emergency department as quickly as possible and improve the four hour access target. Dr Barnes noted that many interim executives chose to work a four day week as part of their work life balance. Ms Davies explained that the NHS Swale CCG had considered other providers; the CCG had discussions with a variety of providers to ensure the best service for its local population.

(13) The Chairman invited a local Member, Mr Bowles, to speak. Mr Bowles expressed concern that there had been no sign of progress over the last 18 months.

(14) RESOLVED that the reports be noted and that Medway NHS Foundation Trust and NHS Swale CCG be invited to attend the June meeting of the Committee.

4. NHS South Kent Coast CCG and NHS Thanet CCG: Integrated Care
(Item 5)

Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG), Dr Darren Cocker (Chair, NHS South Kent Coast CCG) and Alison Davis (Integration Programme Health and Social Care on behalf of NHS South Kent Coast, NHS Thanet CCG and Kent County Council) were in attendance for this item.

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

- Case for Change
- Vision for out of hospital care
- Vision for integrated care
- Approach taken in NHS South Kent Coast CCG and NHS Thanet CCG
- Progress
- Next steps

(2) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member commended the CCGs for their professional approach and illustration of the way forward.

(3) A question was asked about the retention of clinics at Deal Hospital. Dr Cocker explained that the CCG was looking to retain and run additional clinics which met the needs of the local population. He stated that the CCG was in discussions with the charity Turning Point about running a drug clinic at Deal Hospital. He stated he would be happy to provide more detailed information to Dr Eddy.

(4) In response to a specific question about the Prime Minister's Challenge Fund, Dr Cocker explained that the CCG had originally bid for funding for the entire NHS South Kent Coast CCG area. The pilot was scaled down by the Department of Health to 90,000 patients in Dover and Folkestone. The CCG

was looking to extend additional GP access in Deal and Romney Marsh; local practices were bidding to become second wave access pilots

(5) A Member enquired about the role of the GP in collating information. Ms Carpenter explained that the CCGs had introduced the Medical Interoperability Gateway (MIG) – a system which allowed patient records, held by the GP, to be viewed by other clinicians. She stated that the MIG was a practical step forward; it had agreement from the majority of GP practices. The MIG initially enabled consultants from East Kent Hospitals University NHS Foundation Trust (EKHUFT) and local pharmacists to view a summary of care for each patient. She noted that pharmacists' use of the MIG was increasing. The MIG was being introduced to Kent and Medway NHS and Social Care Partnership Trust (KMPT) followed by Kent Community Health NHS Trust (KCHT) and South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

(6) RESOLVED that:

(a) there be on-going engagement between NHS South Kent Coast CCG, NHS Thanet CCG and HOSC as plans are developed

(b) NHS South Kent Coast CCG and NHS Thanet CCG present a report to the Committee in six months.

5. East Kent Hospitals University NHS Foundation Trust: Clinical Strategy
(Item 6)

Liz Shutler (Director of Strategic Development and Capital Planning, East Kent Hospitals University NHS Foundation Trust), Rachel Jones (Director of Strategy & Business Development, East Kent Hospitals University NHS Foundation Trust), Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG) and Bill Millar (Chief Operating Officer, NHS Ashford CCG and NHS Canterbury & Coastal CCG) were in attendance for this item.

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

- Challenges and pressures faced by the Trust
- Future care models
- Consultation and engagement
- Proposed next steps

(2) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about engagement with hard to reach groups such as people who are housebound, homeless, part of the gypsy and traveller community and have speech and language difficulties. Ms Jones explained that the Trust was working with Healthwatch Kent to engage with hard to reach groups. She acknowledged that there was not one model for engagement and the Trust was using a variety of methods. Mr Inettt stated that he welcomed the opportunity to work with the Trust following Healthwatch Kent's concerns with the outpatients' consultation. Healthwatch Kent had been involved early on with the strategy. The Trust was working with local people to help them understand the challenges and develop options for

the local population. He noted that hard to reach groups would be identified in the Equality Impact Assessment and Healthwatch Kent would utilise existing support groups to target them.

(3) The Chairman invited a local Member, Mr Bowles, to speak. Mr Bowles stated that the Faversham Local Engagement Forum would be keen to engage with the Trust regarding their clinical strategy.

(4) A number of comments were made about the recruitment of GPs and medical staff. Ms Shutler explained that three GP practices would be based at the new Buckland Hospital. The co-location of acute and primary care services would make it more attractive for training and new GPs as they would be able to work alongside acute physicians. She noted that there was a shortage of junior doctors and nurses; the Trust had had to use specialist doctors to fill vacant junior doctor and nurse positions. The Trust was continuing to recruit and was moving towards a more sustainable position. She stressed the importance of utilising the current workforce as there were pressures in the system. Ms Carpenter stated that the development of Integrated Care Organisations in Thanet and the South Kent Coast would be attractive to future GPs.

(5) A Member enquired about a press release regarding proposals for 60 recovery beds to be located on the new Buckland Hospital site. Ms Shutler explained that the Trust had not made a decision about building recovery beds on the site; they were exploring options with CCGs, social services and stakeholders. Ms Carpenter stated that the CCG was not looking at a specific number of beds rather they were focusing on accommodation.

(6) In response to a specific question about demographic growth in the new Chilmington Green development in Ashford, Mr Millar explained that the CCG had been working together with local practices, the community network and the planning authorities. He noted that there was an opportunity for practices to bid for a tranche of the Primary Care Infrastructure Fund which was being used to accelerate improvements in GP premises and infrastructure. Ms Shutler stated that the Trust worked closely with the planning authority with regards to new housing developments and population growth. She acknowledged that the Trust needed to ensure they were providing for the correct capacity.

(7) A number of comments were made about Monitor and the Trust's marketing. Ms Shutler stated that the Trust had agreed an action plan with Monitor which was updated and published on the website. The Trust had a monthly meeting with Monitor, CQC and CCGs; she stated that the Trust had appointed an Improvement Director and progress was being made against the plan. She explained that the local press were not always keen to publish good news stories.

(8) RESOLVED that:

(a) there be on-going engagement between East Kent Hospitals University NHS Foundation Trust and HOSC as plans are developed.

(b) East Kent Hospitals University NHS Foundation Trust presents a report to a meeting of the Committee in April.

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

(1) The Committee received a report from South East Coast Ambulance Service NHS Foundation Trust (SECAmb) which provided an update on the Trust's plans to develop two new Emergency Operations Centres in Kent and West Sussex.

(2) RESOLVED that the report be noted and SECAmb be requested to provide a written update to the Committee in six months.

7. Kent Community Health NHS Trust: Community Dental Clinics (Written Update)
(Item 8)

(1) The Committee received a report from Kent Community Health NHS Trust which provided an update on the Trust's implementation of changes to its community dental service.

(2) RESOLVED that the report be noted.

8. Faversham MIU (Written Update)
(Item 9)

(1) The Committee received a report from NHS Canterbury and Coastal CCG which provided an update on Faversham MIU.

(2) The Chairman invited the local Member, Mr Bowles, to speak. Mr Bowles stated that he welcomed the report and the final outcome. He thanked the Committee for their support.

(3) RESOLVED that the report be noted and NHS Canterbury and Coastal CCG be requested to keep the Committee informed with progress.

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Item 4: CQC Inspection Report: Maidstone and Tunbridge Wells NHS Trust

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 March 2015

Subject: CQC Inspection Report: Maidstone and Tunbridge Wells NHS Trust

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

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

The CQC Inspection Summary Report was circulated to Members on 18 February 2015.

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1. Introduction

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

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

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

(c) The Chief Inspector of Hospitals, Professor Sir Mike Richards, has introduced a new approach to inspection in acute hospitals. The new inspections involve larger inspection teams and take longer. The teams involve Experts by Experience (people who have experience of using care services) as well as clinical and other experts (CQC 2014).

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

1. A&E
2. Acute medical pathway (including frail elderly)
3. Acute surgical pathway (including frail elderly)

4. Critical care
5. Maternity
6. Paediatrics
7. End of life care
8. Outpatients.

(e) Public listening events are held before each inspection and after the inspections, Quality Summits will be held. HOSCs have the opportunity to play a role in these summits (CQC 2014).

(f) An enhanced Intelligent Monitoring tool has been developed that identifies risk to service quality, and directs inspection. The tool is based on 150 indicators, which supports the five key questions all inspections will seek to answer. These questions are asked of every service (CQC 2014):

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

(g) Under the new inspection model, acute trusts are awarded a new 'Ofsted style' ranking (CQC 2014):

- Outstanding
- Good
- Requiring improvement
- Inadequate

2. Recommendation

RECOMMENDED that the report be noted and the Trust be invited to attend a meeting of the Committee in six months.

Background Documents

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

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

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Maidstone and Tunbridge Wells NHS
NHS Trust

HEALTH OVERVIEW AND SCRUITY COMMITTEE

6th MARCH 2014

CARE QUALITY COMMISSION INSPECTION, OCTOBER 2014

Report from: Avey Bhatia – Chief Nurse

Summary

This report details findings following Care Quality Commission (CQC) inspection in October 2014. The overall rating for Maidstone and Tunbridge Wells NHS Trust is Requires Improvement. The Quality Improvement Plan is under development with our external stakeholders and will be submitted to the CQC by 16 March 2015.

1. Introduction

The Care Quality Commission (CQC) published the reports of their October 2014 inspection at the Trust on 2nd February 2015. The separate inspection reports for Maidstone Hospital and Tunbridge Wells Hospital have been issued to all staff, and are available on the Trust's website, at www.mtw.nhs.uk/about-the-trust/cqc-reports.asp.

A Quality Summit was held at the Trust on 29th January to discuss the reports and the actions being taken. A wide range of bodies were represented, including West Kent and High Weald Lewes Havens Clinical Commissioning Groups, Kent County Council, Social Services, Healthwatch Kent, the NHS Trust Development Authority, NHS England and Health Education England.

The CQC's recommendations are welcome, particularly the endorsement of the care we give. Actions to address the areas requiring improvement are underway. A detailed action plan is being developed in conjunction with all levels in the Trust and external stakeholders. An action plan will be submitted to the CQC by 16th March.

2. Key achievement

There are a number of areas where the CQC recognised good and outstanding practice. These areas are:

- Caring 'good throughout' – Staff were caring and compassionate and treated patients with dignity and respect.
- Patient Experience – Overall scored better than national average in Friends and Family test
- Nursing levels – generally found to be good
- Collaborative working with partners
- Our staff – praised by the CQC for using this process to help identify and drive through improvements

Outstanding practice

- Maidstone Birth Centre
- Maternity services at Tunbridge Wells
- Mercer ward (Maidstone) and Ward 20 (Tunbridge Wells) focus on Dementia care
- Breast care service provided very good care

3. Key areas for improvement

Trust wide issues

There are key themes within the report that are organisation wide and therefore have impact in many different way and areas. These key themes are described below:

- Patient Flow - (in, through and out of the hospital), we are looking at how patients move through our services and how we manage capacity. We are working with our clinical commissioning Group colleagues to look at ways in improving utilisation of acute beds and community provision.
- Communication – we need to improve our communication systems including access to clinical guidelines and improve record keeping standards
- Leadership – we need to develop and ensure consistent and effective leadership across the organisation
- Culture – we need to ensure staff feel fully engaged and heard within the organisation and continue work on developing and open and transparent supportive culture
- Patient Safety and Governance – we need to review and develop improved systems for reporting incidents, sharing learning and proactively managing risks
- Inconsistency – whilst there were examples of high standards, effective systems, good multidisciplinary working, appropriate behaviours and good care these was not felt to be consistent across the organisation.

Specific issues

There are areas and services identified as needing urgent improvements (compliance actions) and within these areas actions are already underway to address these concerns. The areas of immediate focus are:

- Critical Care
- Organisational governance
- Privacy and dignity
- Translation services
- Children and Young person's services

4. Next steps

The draft plan is being finalised within the organisation and with external stakeholders and will be submitted within the agreed timeframe to the CQC. We shall continue to work at pace to make the changes we need to deliver improved services to our patients.

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

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 March 2015

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

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

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

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1. Introduction

(a) Maidstone and Tunbridge Wells NHS Trust has attended HOSC on two occasions to present their developing clinical strategy and provide an update on stroke services: 18 July 2014 and 28 November 2014. At the end of the discussion on 28 November 2014, the Committee agreed the following recommendation:

- *RESOLVED that:*

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

(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.

2. Stroke Services

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

Ischaemic – where a blood clot blocks an artery carrying blood to the brain(this accounts for 85% of all cases);

Haemorrhagic – where a burst blood vessel bleeds into the brain (intracerebral haemorrhage) or into the surrounding area (subarachnoid haemorrhage).

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

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

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

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

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

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

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

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

3. Recommendation

RECOMMENDED that there be ongoing engagement with HOSC as the Trust's five year clinical strategy and strategy for stroke is developed.

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

Background Documents

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

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

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

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (28/11/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=30458

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

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

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

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Maidstone and Tunbridge Wells NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

6 MARCH 2015

MAIDSTONE AND TUNBRDIGE WELLS NHS TRUST

CLINICAL STRATEGY and STROKE SERVICE

Report from: **Dr Paul Sigston, Medical Director**

Summary

This paper provides an update on the strategy of the Trust and the work to improve the stroke service.

1 Strategy

1.1 Introduction

A comprehensive clinical and business review has been undertaken by the Trust with involvement from both clinicians and other stakeholders which has led to a new strategic direction for the trust.

The trust recognises that the full implications of NHS England '5 Year Forward View', other key reports and the forthcoming General Election will further shape the approach of the trust.

1.2 Mission, Vision and objectives

The new strategic mission, vision and strategic objectives are

Mission 'Our purpose is to provide safe, compassionate and sustainable health services'.

Vision To provide the highest, consistent, quality care to our patients, whether in or outside hospital setting.

Objectives

1 To transform the way we deliver services so that they meet the needs of patients

2 To deliver services that are clinically viable and financially sustainable

3 To actively work in partnership to develop a joint approach to future local health care provision

1.3 Clinical strategy

A number of strategic clinical opportunities have been identified including

- Emergency care: integrated front end for both hospitals, linking GP out of hours, A&E and rapid response services together in line with West Kent CCG commissioning intentions. This service initially to be delivered by a partnership of MTW with IC24 the GP out of hour's provider.
- Stroke: enhanced service
- Maternity: Total births forecast to increase by around 8.5% reflecting an increased catchment area through the Crowborough Birthing Centre. Service to be integrated with the locality community midwives enabling best use to be made of the facility.
- Paediatric A&E: Strategically the development of a separate Paediatric A&E at TWH is well developed. The establishment of this unit and the associated beds will increase the capacity of the inpatient paediatric unit for further expansion.
- Orthopaedics: There is a large market for elective orthopaedics in the area with increasing demand. The Trust will seek to take a lead role in a West Kent MSK contract when that happens.
- Paediatric orthopaedics: This is an area where the Trust has a major competitive advantage. It already provides a service to West Kent and Medway and a partial service for East Sussex. The appointment of a 3rd consultant would give the Trust the critical mass to provide the service to the whole of East Sussex with a centre of excellence.
- Surgery: The future of Upper GI surgery lies in collaboration with a major centre. This process is on-going.
- Gynae oncology: Currently the Trust provides a specialist service in Maidstone for West Kent and Medway with outreach to the other acute hospitals locally. The strategic aim is to consolidate a Kent-wide service incorporating the surgical unit at QEQM Margate in line with best practice for this service. This will involve collaboration with East Kent to facilitate this.
- Critical care: The directorate is moving towards a significant increase in consultants and a commensurate reduction in trust doctors to provide a more efficient, consultant provided service.
- Pain service: There is an increased demand for our pain service which has a hub at Maidstone with spokes into the community. Current trends for growth and GP requirements together with increasing the number of spokes will give a 10% increase in referrals.

- Pathology: The Trust has entered into an agreement with EKHT forming a joint venture for Pathology Services. This involves pooling both Trusts' assets into a new organisational team called Kent Pathology Partnership.

1.4 Collaborative working

The Trust has already responded to the needs of Swale CCG with regard to services they have commissioned from Medway NHS Foundation Trust.

The Trust is also in discussion with Brighton and Sussex University Hospitals NHS Trust, East Sussex Healthcare Trust and Queen Victoria Hospital NHS Foundation Trust regarding possible collaborative working.

1.5 Moving forward

The strategic focus for the Trust moving forward is

- To do the things we currently do more efficiently and effectively, with an emphasis on Emergency Care
- To grow the population we serve, particular in collaboration with Swale CCG and Lewes, Hastings and the Havens CCG.
- To collaborate and complete, on a 'case by case' basis with other partner providers.

2 Stroke Service

2.1 Performance

The results for the last four quarters show that both sites improved their overall score (as measured by SSNAP for clinical teams) and that Maidstone missed being level C (A highest, E lowest) by half of one point.

	Oct to Dec 2013	Jan to Mar 2014	Apr to Jun 2014	Jul to Sep 2014
Maidstone	E (34.4)	D (44.2)	D (42.4)	D (59.5)
Tunbridge Wells	E (33.3)	E (38.7)	D (41.4)	D (50.3)

The Maidstone score was adjusted from B to D as a result of a D rating for audit compliance.

Actions plans are in place to continue to improve the service at both sites.

2.2 Engagement with stakeholders

The Trust recognises and is committed to ensuring that there is strong public and patient engagement (first of the Government 4 tests for major service change) throughout the stroke improvement programme.

The approach to stakeholder engagement is led by the Clinical Strategy Joint Engagement Group (that includes Kent Healthwatch and the South East CSU).

Recent stakeholder engagement includes gaining an understanding from stakeholders on their views of the current service and also what model of care and associated quality standards should be considered.

This has involved recent attendance at the West Kent PPG Chairs meeting, Maidstone and Malling GP Patch meeting and High Weald GP Locality meeting. Future events include community meetings in early March in Maidstone, Tonbridge, Tunbridge Wells and Crowborough.

2.3 Kent and Medway Stroke review

The Trust is working closely with the Project Director of the Kent and Medway Stroke review to ensure that the best outcomes for the patients seen by the Trust are achieved.

Item 6: Patient Transport Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 March 2015

Subject: Patient Transport Services

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

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

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1. Introduction

(a) HOSC has considered the subject of PTS on seven occasions since the beginning of 2013:

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

(b) At the end of the discussion on 28 November 2014, the Committee agreed the following recommendation:

- *RESOLVED that the report be noted and that CCG colleagues be invited to attend the March 2015 meeting of the Committee.*

2. Potential Substantial Variation of Service

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

(b Where the HOSC deems the new service specification as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the CCG.

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

3. Recommendation

If the new service specification is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the new service specification to be a substantial variation of service.

(b) West Kent CCG be invited to submit a report to the Committee in six months.

If the new service specification is *substantial*:

RECOMMENDED that:

(a) the Committee deems the new service specification to be a substantial variation of service.

(b) West Kent CCG be invited to attend a meeting of the Committee in three months.

Background Documents

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

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

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

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

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

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

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (28/11/2014)'*, *https://democracy.kent.gov.uk/mgAi.aspx?ID=30459*

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Patient Transport Services – update on procurement

Background

- The contract for patient transport services (PTS) is hosted by NHS West Kent CCG on behalf of all Kent and Medway CCGs.

- Historically PTS services were provided by a range of providers in Kent and Medway.

- The previous PCT cluster re-procured the service in 2011/2012 and NSL Care Services were appointed as a new provider for the whole of Kent and Medway.

- NSL took over the contract in July 2013. The contract is for three years with the option to extend by up to two years.

- Contract performance since July 2013 has been poor.

- The contract ends in June 2016 and Kent and Medway CCGs have agreed to re-procure a new provider from that date and not extend the current contract.

Objectives of procurement

The aim procurement is to ensure provision of a service to provide routine (not emergency or urgent) transport for eligible Kent and Medway patients with a medical need for transport, between their places of residence and providers of NHS funded healthcare (services traditionally provided in hospital), in reasonable time and comfort without detriment to their medical condition.

- Patients will be transported in safe and timely manner in a vehicle appropriate to their needs
- Patients will not spend an unreasonable amount of time on vehicles
- Patients will be collected promptly, in reasonable timescales following their appointment
- Patients will be treated with courtesy, dignity and respect at all times
- There will be no detriment to patients' health and wellbeing during their journey
- The specified requirements of how these outcomes will be met are set out in the Service specification.

Service for patients – eligibility criteria

The DH published national eligibility criteria in August 2007 (Attachment 1). The current contract uses the South East Coast Eligibility criteria for NHS funded Patient transport (Attachment 2) that have been in use for many years. The South East Coast Eligibility criteria set out in more detail how the national criteria are to be interpreted locally; they do not restrict the national criteria.

The revised specification does not change either of these.

The revised service specification strengthens the requirement for a provider to meet these criteria.

Service specification

An updated service specification is being produced for the procurement. The specification is being jointly developed with CCGs and Trusts

Although the service for patients has not been changed the requirements for providers have been significantly improved from the one used to procure the current service. Specific changes are:

- **Darent Valley Hospital**
  Darent Valley hospital has been excluded from the procurement as they are intending to take the service in-house. This is to better enable them to manage transports into and out of London.

- **Reintegration of call centre function**
  The original service specification separated the contract into two lots, the call centre and provision of journeys. This could have resulted in two providers! In the new specification these are not separated and the same provider will be sought for both functions. This will allow greater integration between the call centre and planning and day control.

- **Renal transport**
  The new contract will be tendered in two lots. One for Renal services one for the rest. Renal transports are a stable and predictable set of journeys and providing a ring-fenced service will enable improved service standards for these patients.

- **Improved liaison with trusts**
  The new specification requires a much greater level and seniority of liaison and day to day planning control with individual provider trusts.

- **Improved performance standards**
  Performance standards for patient discharges are being tightened up so that all patients are collected within 2 hours of the hospital advising the PTS provider that the patient is ready to be collected. The current contract allows between 2 and four hours.

  Automatic penalties or reductions to payment are being introduced for failure to meet Key Performance indicators.

- **Accurate activity data**
  The specification includes activity data from the current provider and from trusts for journeys they have had to arrange themselves. This data is considerably more accurate than the information used in the previous tender.

- **Improved clarity**
  Lessons learnt over the last 18 months have been built into the specification to significantly improve clarity and reduce ambiguity.

The service specification includes much clearer operational descriptions of the interface with other transport providers (SECAMB, the Cardiac transport provider, the intensive care transport provider)

Patient Engagement

There have been a number of local events to discuss PTS provision with local people:

- 12 January Canterbury and Coastal CCG CPRG(12 attendees)
- 13 January South Kent Coast HRG (12) plus two locality chairs meetings: Deal (10) – and Shepway (16)
- 13 January West Kent Chairs meeting – (24 public)
- Ashford locality chairs PPG received information virtually
- 27 January Thanet PPG – (40 patients, carers and VCS)
- 28 January Swale Patient liaison Group – (10 public)
- 29 January DGS chairs – (11 public)
- TBC - Medway

The outcome from the work has been pulled together into the attached report setting out the views of local people about the services (attachment 3).

The key themes were:

- Delayed journeys and waiting time for transport (punctuality), long journey times
- Eligibility criteria
- Low awareness of PTS (as well as other transport options, including voluntary and community schemes)
- Confusing, lengthy and difficult to access booking procedures
- The need to strengthen the links between PTS and other NHS services especially mental health and hospital trusts
- Staff attitudes: showing a lack of understanding and consistency in dealing with the transport of carers/escorts, failure to inform families/care homes of progress, particularly in case of delays
- Lack of capacity and suitable range of vehicles
- Instances of poor level of care provided

Patients from each clinical commissioning group area have volunteered to join the Patient Transport Service working group and will meet together to test the patient experience standard and turn it into a charter, they will also comment on any subsequent iterations of theService Specification and Key performance Indicators. They will also receive training and support in the spring to take part in the formal assessment and evaluation of any bids and the prospective contractors.

Next steps timeline

The current timeline is as follows, this is not finalised:

Issue PQQ	April/May 2015
Shortlist and issue ITT	May/June 2015
Bids received and evaluation	June/July 2015
Contract award recommended	Aug/Sept 2015
Contract Award	Sept/Oct 2015
Contract Commences	1st July 2016

Appendix1

Eligibility Criteria for Patient Transport Services (PTS)

Eligibility Criteria for Patient Transport Services (PTS)

PTS eligibility criteria document

Prepared by
DH Ambulance Policy

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working

Document Purpose	Best Practice Guidance		
ROCR Ref:		**Gateway Ref:**	8705
Title	Eligibility Criteria for Patient Transport Services (PTS)		
Author	Department of Health		
Publication Date	23 Aug 2007		
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, Directors of Finance, PTS provider representative organisations and groups		
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, Directors of Finance, PTS provider representative organisations and groups. It will also be available on the internet for any interested parties.		
Description	Following responses to a thirteen-week consultation this document provides revised eligibility criteria for non-emergency patient transport services		
Cross Ref	Chapter 20 of the NHS Finance Manual		
Superseded Docs	PTS Guidance 'Ambulance and other patient transport service – Operation, use and performance standards' (1991)		
Action Required	To take account of the revisions in PTS eligibility		
Timing	Immediate		
Contact Details	Ambulance Policy 11th Floor New Kings Beam House 22 Upper Ground SE1 9BW emergencycare@dh.gsi.gov.uk www.dh.gov.uk/consultations/fs/en		
For Recipient's Use			

First published date

Published to DH website, in electronic PDF format only.
http://www.dh.gov.uk/publications

Contents

Document Purpose

1. ‘Ambulance and other Patient Transport Services: Operation, Use and Performance Standards’ [HSG 1991(29)] was published in 1991. This set out guidance for the NHS on the operation, use and performance standards for emergency and urgent ambulances. It also set out criteria for establishing which patients were eligible for non-emergency patient transport services (PTS).

2. The White Paper (‘Our health, our care, our say: a new direction for community services’, January 2006) made a commitment to extend eligibility for the Hospital Travel Costs Scheme (HTCS) and PTS to procedures that were traditionally provided in hospital, but are now available in a community setting. This will mean that people referred by a health care professional for treatment in a primary care setting, and who have a medical need for transport, will also receive access to PTS and HTCS.

3. This extension to PTS, as outlined in this document, is expected to come into force in 2007/08, although Primary Care Trusts (PCTs) can of course amend local eligibility criteria for PTS in line with the White Paper before that date, should they wish to do so.

4. This document therefore updates and replaces the 1991 guidance and applies to both NHS and independent service providers contracted to the NHS.

What is PTS?

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

Who is eligible for PTS?

6. PTS should be seen as part of an integrated programme of care**.** A non-emergency patient is one who, whilst requiring treatment, which may or may not be of a specialist nature, does not require an immediate or urgent response.

7. Eligible patients should reach healthcare (treatment, outpatient appointment or diagnostic services i.e. procedures that were traditionally provided in hospital, but are now available in a hospital or community setting) in secondary and primary care settings in a reasonable time and in reasonable comfort, without detriment to their medical condition. Similarly, patients should be able to travel home in reasonable comfort without detriment to their medical condition. The distance to be travelled and frequency of travel should also be taken into account, as the medical need for PTS may be

affected by these factors. Similarly, what is a "reasonable" journey time will need to be defined locally, as circumstances may vary.

8. Eligible patients are those:
   - Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
   - Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
   - Recognised as a parent or guardian where children are being conveyed.

9. PTS could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with a physical or mental incapacity, vulnerable adults or to act as a translator. Discretionary provision such as this would need to be agreed in advance, when transport is booked.

10. A patient's eligibility for PTS should be determined either by a healthcare professional or by non-clinically qualified staff who are both:
   - clinically supervised and/or working within locally agreed protocols or guidelines, and
   - employed by the NHS or working under contract for the NHS

Who provides PTS?

11. For simplicity, the text of this guidance will refer to PCTs when discussing the role of the commissioner. There is an expectation that over time, where it is not already the case, PCTs should take on responsibility for PTS contracts and commissioning.

12. PCTs are responsible for commissioning ambulance services (which could include patient transport services) to such extent as the PCT considers necessary to meet all reasonable requirements of the area for which they are legally charged with providing services. It is for the PCT to decide who receives patient transport services in their area. PCTs should therefore apply the principles outlined in this document either to consider each case on its merits or to develop more detailed local criteria for PTS use. PCTs may lawfully ask other bodies to assist in the exercise of their commissioning functions. Yet where they make such arrangements, it is still the responsibility of the PCT to ensure that appropriate services are being provided at an appropriate cost and standard.

13. A range of different providers may provide PTS - for example the local NHS ambulance trust, independent sector providers, or a combination of providers.

14. PTS eligibility has not been extended to include patients who do not fit the criteria outlined above e.g. those who have a social need for transport. Local transport plans should address issues of access to health services to enable integrated transport provision and PCTs have been encouraged to engage in this process through accessibility planning guidance and the NHS Modernisation Agency's 'Driving Change – Good Practice Guidelines for PCTs on Commissioning Arrangements for Emergency

Ambulance Services and Non-Emergency Patient Transport Services' best practice material.

15. The White Paper ('Our health, our care, our say: a new direction for community services') made clear that PCTs and local authorities should be working together to ensure that new services are accessible by public transport. Existing facilities should also work closely with their PCTs and with accessibility planning partnerships (in those areas that produce local transport plans) to ensure that people are able to access healthcare facilities at a reasonable cost, in reasonable time, and with reasonable ease.

Who pays for PTS?

16. Eligible patients are not charged for patient transport services provided by the NHS. PCTs are ultimately responsible for the costs of PTS.

17. The cost of providing PTS is for PCTs to negotiate for their registered population, dependent on local needs and priorities. It will vary depending on the nature of services provided, distance to be travelled and is a matter for local agreement.

18. The cost of PTS remains within the scope of Payment by Results as an integral part of the relevant tariffs and will remain within tariff during 2006/07 and 2007/08. If it is agreed locally that the acute trust should not be responsible for providing PTS then locally agreed adjustments should be made to the tariff to facilitate the PCT contracting for PTS directly with providers.

Duty of care to patient

19. The provider of the transport service owes a duty of care to the patient (and any accompanying escort or carer) being transported, from the time they collect the patient to the time they hand them over. However, during patient transfer, the NHS will still owe a duty of care to a patient, regardless of whether there is an escort in attendance. The PCT will still be responsible to the patient being transported in so far as the PCT must exercise reasonable care to ensure that the arrangements it makes for provision of PTS ensure that PTS will be provided to a safe and adequate standard. See Chapter 20 of the finance guidance for more detail on quality standards.

Out of area

20. Patients are now being offered a choice, through the extended care network, over where they receive treatment when they are referred for elective care. Therefore, it is likely that the number of out of area PTS journeys will increase. The principle that

should apply is that each patient should be able to reach hospital in a reasonable time and in reasonable comfort, without detriment to their medical condition. Distance to be travelled should actively be considered when assessing whether the patient has a medical need for transport.

21. In terms of funding arrangements, the general principle should be that a patient's home PCT would be expected to bear the cost of their PTS journeys.

22. See Chapter 20 of the finance manual for more detail on charging for out of area journeys.

Private patients

23. If a private patient is treated as such by a NHS Trust, any requirement for PTS will generally be provided under the PCT service agreement. However, the NHS Trust will recover the cost from the patient rather than the patient's home PCT by reflecting the cost of the transport provided in the private patient rates it charges and, if necessary, by supplementing those charges to allow for the cost of any additional PTS activity. It will then reimburse the PCT.

24. If a private patient is treated in a private hospital, any PTS supplied by an NHS PTS provider will be charged to the private hospital, which will make its own arrangements for recovering the cost from the patient.

25. A private patient transferred as an NHS emergency case is liable for the cost of transport only if the patient, or a person acting on the patient's behalf, opts for private treatment and signs an undertaking to pay charges.

Escorts

26. PTS could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with physical or mental incapacity, children or to act as a translator. Only one escort should travel with a patient under such circumstances. Such discretionary provision would need to be agreed in advance, when transport is booked.

27. The eligibility criteria for PTS have not been extended to include visitors.

28. Where, exceptionally, a friend or relative accompanies a patient to hospital or for treatment, return transport provision is at the discretion of the provider.

Carriage of wheelchairs

29. There is currently no regulation covering the carriage of wheelchairs: the Department for Transport (DfT), Local Government and the Regions (DTLR) document VSE 87/1 Code of Practice: "The Safety of Passengers in Wheelchairs on Buses" remains the main guidance available.

30. Some patients have wheelchairs with special seating or controls. Such patients have the right, wherever possible, to be transported in or with their wheelchair for reasons of comfort and mobility. In deciding how best to meet requests for wheelchair transport, purchasers/providers will, however, need to adhere to the requirements produced by the DfT and guidance provided by the Medical Devices Agency, which is referenced at the end of this document.

Setting standards

31. *Our Health, Our Care, Our Say* sets out the Department's intention to provide national standards for what people can expect from patient transport services, as well as exploration of options for accrediting independent sector providers of PTS, to ensure common minimum standards.

32. In the meantime, PCTs should ensure that whatever arrangements are adopted for the provision of PTS are underpinned by an effective transport management quality assurance, and health and safety system.

Social needs for transport

33. The NHS can use income generation powers to charge patients for the provision of transport for 'social', rather than 'medical' needs.

34. PCTs do not have to provide transport for social reasons however Section 7 of the Health & Medicines Act 1988 allows a charge to be levied for the provision of transport to patients with a social need. The main provisos for income generating schemes are:

    a) The scheme must be profitable as it is unacceptable for it to be subsidised from NHS funds;
    b) The profit must be used for improving the health services; and
    c) Income Generation schemes must not in any way interfere with the provision of NHS services to patients.

35. Guidance is contained in National Health Service income generation – 'Best practice: Revised guidance on income generation in the NHS', February 2006.

Help with travelling expenses and travelling arrangements for patients on low incomes – Hospital Travel Cost Scheme (HTSC)

36. The Hospital Travel Costs Scheme provides financial assistance to those patients who do not have a medical need for ambulance transport, but who require assistance in meeting the cost of travel to and from their care. Reimbursement of travel fares are provided for services that must be:

    - Currently under the care of a consultant (such as a surgeon or rheumatologist, but not a GP)

    - for a traditional hospital diagnostic or treatment, (i.e. non-primary medical services or non-primary dental services), regardless of where the treatment is carried out

    - paid for by the NHS, regardless of whether it is carried out by an NHS care professional or an independent one

37. Benefits and allowances that entitle patients (and their dependents) to full or partial reimbursement of travel expenses under HTCS are means-tested and include Income Support, Income-based Jobseeker's Allowance, Pension Credit Guarantee Credit, Child's Tax Credit, Working tax credit with Child's Tax Credit, Working Tax Credit with a disability element, or the NHS Low Income Scheme.

38. PCTs are ultimately responsible for payment of the scheme. However, in practice and for convenience, patients claim their expenses from the NHS trust where they receive their treatment, and that trust reclaims the expenses from the responsible PCT. Guidance on the operation of the scheme is available from the Department of Health's website

39. http://www.dh.gov.uk/assetRoot/04/12/77/39/04127739.pdf

Complaints

40. From 1 September 2006, changes to the NHS complaints regulation came into force. The changes were designed to make the complaints procedure clearer and easier to access for those who need it. Purchasers of emergency ambulance services and PTS should ensure that local arrangements and procedures for investigating complaints conform to the requirements of that guidance. Guidance is available through the DH website:

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/ComplaintsPolicy/NHSComplaintsProcedure/fs/en

41. Independent Complaints Advocacy Service (ICAS) provides support to people in England wishing to complain about the treatment or care they received under the NHS. ICAS delivers a free and professional support service to clients wishing to pursue a complaint about the NHS.

42. Patient Advice and Liaison Services (PALS) provide confidential advice, support and information on health-related issues to patients, their families and carers.

43. A more general complaints leaflet is available for the public, available on the DH website: www.dh.gov.uk/assetRoot/04/02/00/39/04020039.pdf

References

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- *Our health, our care, our say: a new direction for community services*, The White Paper, Department of Health, January 2006. www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

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- Code of Practice: *The Safety of Passengers in Wheelchairs on Buses* Department for Transport (DfT), Local Government and the Regions (DTLR) document VSE 87/1

- *Guidance on the Safe Transportation of Wheelchairs (MDA DB2001(03) June 2001)*, the Medical Devices Agency. www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dDocName=CON007343&RevisionSelectionMethod=LatestReleased.

- *Guidance of the Safe Use of Wheelchairs and Vehicle-mounted Passenger Lifts (MDA DB2003(03) March 2003)*, the Medical Devices Agency. www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dDocName=CON007320&RevisionSelectionMethod=LatestReleased

- *Medical Devices Regulations 1994 (SI 1994 No 3017)* www.opsi.gov.uk/SI/si1994/Uksi_19943017_en_1.htm

- *Manual Handling Operations Regulations 1992 (SI 1992 No 2793)* www.opsi.gov.uk/SI/si1992/Uksi_19922793_en_1.htm

- *The Health & Medicines Act 1988*, Section 7, ISBN 0105449881 www.opsi.gov.uk/ACTS/acts1988/Ukpga_19880049_en_1.htm

- *National Health Service income generation - best practice : revised guidance on income generation in the NHS,* Department of Health, February 2006 www.dh.gov.uk/assetRoot/04/13/06/68/04130668.pdf

- *The Hospital Travel Costs Scheme Guidance*, Department of Health, May 2005 www.dh.gov.uk/assetRoot/04/12/77/39/04127739.pdf

Attachment 2 - South East Coast Eligibility Criteria

1. Introduction

A non emergency patient is defined as a patient who, whilst requiring treatment, does not need the skills of an ambulance paramedic or technician, but may require trained personnel to undertake a journey to or from a health facility.

The NHS expects patients to make their own way to and from outpatient and inpatient appointments unless there is a clearly defined medical reason why they can not use conventional transport options including:

- walking
- cycling
- public transport including bus, train, community transport schemes, voluntary transport schemes, taxi
- private transport including lifts by friends, carers, neighbours, relatives, or the patient's normal network of support
- Or a combination of the above.

The revised process and protocols for the eligibility criteria will be rolled out from April 2010 on all new and existing contracts across the South East Coast Strategic Health Authority to provide non emergency transport only to those patients who have a medical need.

Patient Transport Services (PTS) will continue to offer ambulances and care vehicles for eligible patients and will continue to provide appropriate transport where the medical need and entitlement criteria are applicable.

2. Principles

Not all patients attending a health facility will be entitled to non emergency PTS.

The Principle for the entitlement to non emergency PTS is defined as:

- The patient having a medical condition such that they require the skills of ambulance staff or appropriately skilled personnel on, or for the journey

And/or

- Following a documented clinical decision, it has been determined that the medical condition of the patient is such that it would be detrimental to the patient's condition or recovery if they were to travel by any other means

- Where the entitlement to PTS is clear the patient will be offered PTS regardless of distance and circumstances.

- An agreed assessment tool will be used to determine the patient's entitlement to PTS services and the type of PTS services that are available for patients to travel in, to and from their place of treatment

3. <u>Patients who are entitled to Patient Transport Services (PTS)</u>

- For mental health and learning disability patients -

    1. All community patients and some in-patients (*identified below) should exercise all means available to them to reduce reliance upon health provided transport. This will include, walking, cycling, driving, utilising public transport, lifts from care home staff/partner/carer/family/friends or using a public taxi where affordable to access

healthcare services and appointments.

2. If none of the above means of transport are available/accessible/appropriate on health grounds, people will be eligible to access health provided transport for the duration of their treatment if it is assessed as being required by an individual's care co-coordinator/care manager and it forms part of a care plan subject to regular review. This may be a car or ambulance type vehicle dependent upon assessed need.

3. For people receiving treatment for mental ill health/learning disability as an in-patient, health funded transport (this may be in the form of a vehicle retained at the hospital for patient transport) will be available for people detained under the mental health act 1983 (revised 2008) who will be escorted by at least one staff member for the duration of the journey.

4. *People receiving in-patient treatment on a voluntary basis and needing to access alternative healthcare services or appointments where transport is necessary if for whatever reason 2 above is not appropriate then 3 above shall apply.

    - Patients with an intravenous infusion that requires medical supervision
    - Patients requiring oxygen.
    - Patients with a chest drain or morphine pump.
    - Patients attending renal dialysis sessions two or more times per week (for the duration of treatment).
    - Patients attending radiotherapy/chemotherapy sessions two or more times per week (for the duration of treatment).
    - Patients where independent travel presents a clinical risk such as low immunity patients or patients with a reasonable possibility of an event occurring during transport that requires skilled assistance i.e. Epilepsy
    - Patients who have a clear need to travel in a wheelchair (providing they do not have a specially adapted vehicle, a mobility allowance or are unable to use public transport)
    - Patients who cannot walk without continual physical support (not including the use of aids such as walking sticks or Zimmer frames)
    - Patients who cannot use public transport (bus, train, community transport schemes, voluntary transport schemes, taxi) because they:
        - Have a medical condition that would compromise their dignity or cause public concern.
        - Have severe communication difficulties which routinely prevent them using public transport.
    - Patients who are Blind, profoundly deaf or have speech (not language) difficulties which mean they are unable to travel alone.

5. <u>Assessment criteria</u>

The following assessment criterion has been developed to ensure PTS is provided to patients who are entitled to it and to determine the type of vehicle they need. A series of questions is proposed to enable those assessing a patient's entitlement to make a clear decision and to be able to give those asking for patients transport an understanding why they are not entitled to receive PTS and what alternatives exist.

Stage 1 Assessing entitlement

FULFILLING ANY OF THE ETITLEMENT CRITERIA IN SECTION 3 WILL MAKE THE PATIENT ELIGIBLE TO PATIENT TRANSPORT SERVICES

If the MEDICAL reason is not detailed in the entitlement criteria the assessment team will use the next series of questions

Part 1

- What medical condition does the patient have that requires skilled assistance to transfer to and from a vehicle?
- What disability or condition does the patient have that makes it impossible or medically undesirable to travel by Public transport?
- What medical condition does the patient have that means there is a likelihood that an event could occur during transit that would require skilled assistance?
- What medical condition or disability does the patient have that may result in a risk to themselves or others?

Part 2

- How would the patient usually travel to see their GP?
- Does the patient routinely (at least monthly) get into a

If patients do not have a medical reason listed or are assessed as not eligible for booking Patient transport Service the following advice should be offered.

- **Patients should be reminded that Hospital transport is only provided for those people with a medical need.**
- **Advise Patients of alternatives i.e. Volunteer Car Bureau (48 hours notice required, charges apply, approximately half price of Taxi cost)**
- **Train and bus time tables along with maps and routes to hospitals can be found at (input local information websites)**
- **Patient may be able to get Travel Expenses (HTCS) reimbursed if eligible.**
- **HCI forms for future help or HC5 form for refunds**

Stage 2: Assessing the type of patient transport

Does the Patient need to travel lying down on a stretcher?	For Patients up to 18 stone in weight, book as a Normal Stretcher (NS) Mobility Note: - HCT address assessment required
	For Patients over 18 stone in weight, book as a Bariatric Stretcher (BS) Mobility (State number of Assistants required to transfer, 2, 3, 4, 5 or 6) Note: - HCT address assessment required
	For Patients able to transfer to a seat for transit? Book as Wheelchair Assist (WA) Mobility (State number of Assistants required to transfer 1, 2, 3 or 4 and if oxygen required)
Does the Patient need to use a wheelchair or more than one assistant to walk?	For Patients unable to transfer to a seat for transit, book as a Wheelchair In-situ (WI) Mobility (State number of Assistants required to transfer 1, 2,

Patients and Carers

ESCORTS AND CARER'S WILL BE PROVIDED OR ALLOWED

- **When transferring a patient to/from a secure area (i.e. under Mental Health Section).**
- **For all persons under 16 years of age.**

If a patient requests an escort or carer to assist them, and they do not fit into the categories above the following information will be sought to ensure a carer/escort is only considered in the appropriate cases:

- **The patient's condition is such that they require constant attention or support, as confirmed by clinical assessment.**
- **The patient has severe communication difficulties for example, Blind, profound deafness or speech (not language) difficulties, and therefore is routinely unable to travel alone.**

Proposed assessment weighting linked to questions

Part 1

- What medical condition does the patient have that requires skilled assistance to transfer to and from a vehicle?
- What disability or condition does the patient have that makes it impossible or medically undesirable to travel by Public transport?
- What medical condition does the patient have that means there is a likelihood that an event could occur during transit that would require skilled assistance?
- What medical condition or disability does the patient have that may result in a risk to themselves or others?

Part 2

- How would the patient usually travel to see their GP?
- Does the patient routinely (at least once a week) get into a normal car by themselves and travel as a passenger?
- Does the patient use public transport (at least once a week)?

Assessment score for entitlement +5

Part 1

- Medical Condition/Disability is such that further assessment is not needed + 5
- Medical Condition/Disability is such that further assessment is needed + 3

Part 2

- Patient uses public transport, taxi, own car or walks to see GP - 3
- Patient only receives home visits from GP + 2
- Patient routinely travels in a car as a passenger - 3
- Patient routinely uses public transport - 3

Attachment 3 – Patient Insight report

1 Introduction

In preparation for the re-procurement of the non-emergency Patient Transport Service, South East Commissioning Support Unit engagement and insight staff have worked with each clinical commissioning group and their regular patient reference/PPG chairs groups, as well as previously collating and analysing four years of evidence from across Kent and Medway about patients' experience of the current service. This was drawn from the 2010 Kent Link report, 2013 and 2014 Kent Healthwatch meetings, NSL complaints, media reports, information reported through the seven health networks over the last two years, and performance and quality reports.

During January 2015, the engagement and insight teams met with the five regular patient forums which work with the clinical commissioning groups for: Canterbury and Coastal, Dartford Gravesham and Swanley, South Kent Coast, Swale, and West Kent; whilst Ashford PPG received the information electronically. Some of the groups cascaded the information to their GP practices and the patient participation groups, their wider virtual health network members, or specific service user groups with an interest in patient transport; who in turn fed back their views which were then collated together in this report The engagement team also held a workshop with Thanet health network members and there is another booked for Medway in February. So far, 125 patients, carers and service users have been involved in direct discussions on this topic, with many more feeding in their views through their extended networks.

All of the CCG patient groups were able to discuss the procurement process, the lessons learned from the first Kent and Medway procurement and the South East CSU report which collated and analysed the key themes from a variety of sources of Kent and Medway patients' experience of the current and previous Patient Transport Services. The key themes were:

- Delayed journeys and waiting time for transport (punctuality), long journey times
- Eligibility criteria
- Low awareness of PTS (as well as other transport options, including voluntary and community schemes)
- Confusing, lengthy and difficult to access booking procedures
- The need to strengthen the links between PTS and other NHS services especially mental health and hospital trusts

- Staff attitudes: showing a lack of understanding and consistency in dealing with the transport of carers/escorts, failure to inform families/care homes of progress, particularly in case of delays
- Lack of capacity and suitable range of vehicles
- Instances of poor level of care provided

Many of those present at the recent discussions confirmed the key themes from this research concerning difficulties understanding the eligibility criteria and assessment process, difficulties over long waits or long journeys to incorrect destinations. There were many questions to establish the scope of the PTS contract: whether it was 24/7, whether a range of suitable vehicles were specified, and if the new contractor would have sufficient capacity to deliver contract effectively, if it covered GP practices and so on.

- *"From my experience the service is very difficult to use, nobody explains the service or how it works unless requested"*
- *"People wait all day to be taken home, so once discharged they have to sit for several hours, often late into the night time"*
- *"No updates are given to keep the patient informed"*
- *"Nobody explains that the service is "round the houses" and has multiple drop-offs, and is not direct for the individual patient, and therefore may take several hours - obvious to some, but not to others"*
- *"Many patients were very stressed by it, especially elderly patients who were often very distressed indeed." DGS patient*
- *"I think their main problem is communication as the booking service is in Shrewsbury who would know nothing about the local areas and hospitals, the drivers are all very good and helpful it is not their fault when they turn up late if they are given wrong addresses and details. I am sorry for going on but I have experienced a lot of problems with them."*

2 Measures of success to inform the service specification

The patients groups were then asked to discuss how they would frame measures of success which could be included in the service specification, either through the key performance indicators in the draft service specification, or by inserting a patient experience quality standard (a sample version was shared with them from some London boroughs, together with some statements suggesting what patients want from a high quality service). The patients also looked at the current eligibility criteria and how to make them clearer, or

suggested questions which the contractor could use to make the assessment process easier by using simple questions which elicit the patients' needs and capabilities in plain English. These questions could be used to frame staff training, improving the assessment process and the description of the eligibility criteria themselves.

2.1 Issues which were brought up during the discussions and virtual feedback were:

2.1.2 Location or disposition of vehicles

In our experience some South East Coast Ambulance vehicles were in the wrong places and then had to travel further to pick up patients. How will management of vehicles be written into the service specification to ensure fit with area and high patient need?

The current provider spent money on their fleet of vehicles but were blind to the requirements (for instance too many ambulances and not enough cars). When the contract goes to tender, would the new company change the makeup of vehicles to suit the needs of the population? Are they willing to spend the money?

The commissioners seem to be making the service cover an increasingly large geographical area. Why can we not have a local service with local knowledge?

2.1.3 Poor performance over time keeping, better contracts or penalties

Patients were well aware of the poor performance and bad time keeping issues with the current provider, and so were anxious to know how this can be avoided within the next service specification and contract. Patients discussed the key performance indicators and some of the thresholds and asked whether there would be penalties for missed discharge times. (See Appendix1 and the specific notes on KPIs)

- The current time slots for collection are generally considered too generous, and still feature most frequently in complaints to NSL. Patients suggested promotion of better time keeping, possibly by using the national benchmarking confidence levels to ensure the contractor is in the top quintile of performers. Incentivise the performance levels which would make the most difference to patients, possibly between an acceptable performance and a good performance: 80 per cent of costs paid for acceptable performance, 90 per cent if meet target, 100 per cent if in top quintile over three consecutive quarters; rather than the alternative which is to penalise poor performance on similar sliding scale set out?

- Could commissioners retain a portion of the overall contract payment for snagging issues when new contractors take over to incentivise smooth transition between incoming and outgoing providers?

- Patients felt there should be more onus on the service provider to arrange alternative vehicles if it could not make the pick up within the agreed time. There should be contingency plans which are put into place rather than just letting time lapse and patients wait unduly.
- Most importantly the service should be proactive about contacting or communicating with patients and/or staff caring for the patients, so that they know the service has been delayed and how much longer it will be.
- Patients felt there should be better planning by hospital trusts of when inpatients being discharged will be ready to leave hospital, taking into account potential causes of delay such as provision of medication.
- The contractor should recognise the patients with time imperatives such as very specific appointment times, and act accordingly to ensure swift journeys to meet specific appointments, differentiating from patients with more approximate time slot.
- It is important that when the hospital cancels appointments at short notice this is passed on to the PTS provider. When appointments are rescheduled, PTS should also be informed by the NHS service provider.
- Patients should not be returned home late at night or only if due consideration and care is taken to ensure they are able to return home safely, with friends/family or care givers contacted to assist.
- Patients in Swale have complained of too many patients being carried in one vehicle and being asked to “budge up to squeeze in another one” when mobility needs suggest careful carriage and assistance rather than rough and tumble of public bus service.
- When vehicles carry several patients, the delay with one patient can subsequently affect the journeys and appointments of several patients. So capacity needs to be considered and there needs to be communication about the knock-on impact and mitigating actions taken, if possible, to divert colleagues/other types of vehicle to collect some of the passengers.

2.1.4 Eligibility criteria

Patients agreed the eligibility criteria need greater clarity, and have worked on questions to assist in making the assessment process friendlier and easier for both parties.

There were calls for clarity, especially around whether carers can travel with patients. An example given by a member of the patient reference group is that of a patient who requires help with toileting needs. They were told they could not take a carer and that the driver could not help with this.

The eligibility criteria looks as if it will take quite a bit of time to go through. Questions were asked about the flexibility within the criteria, and how sensitively they are applied.

The criteria around senses, do they recognise only registered blind people or varying visual problems? A suggestion was made that neurological conditions should also be recognised, particularly if people are likely to have seizures or fits during journeys.

A question was raised about whether assistance dogs can travel in PTS vehicles with their master/mistress. If a patient is ineligible, would the provider be able to suggest a suitable alternative, such as volunteer transport schemes?

Patients recognise the hardship some people have in affording suitable transport, so think it is very important to provide information to those on low income who do not meet the hospital transport criteria about how they can reclaim hospital transport costs. "*We have experience of those who have appointments out of area, who do not meet the eligibility criteria and do not have the funds to pay for public transport. They are not accessing the follow up medical care they need."*

The criteria state those undergoing radiotherapy/chemotherapy are eligible – "*in my experience with our Volunteer Transport Scheme patients have not been eligible for hospital transport solely for this reason – we have many of our clients asking to use our scheme for this reason who have been turned down by the current system".*

2.1.5 Staff

It is important that call handlers are educated to converse clearly, especially if they have any accents. People with hearing disabilities will have difficulty understanding any dialects they are not used to.

All the staff should be friendly, polite and courteous as this behaviour can make people feel welcome and capable under difficult circumstances. Several people commented favourably on the ambulance drivers and support staff.

Patients would like to have seen more about quality requirements within the service specification to ensure better service delivery and client satisfaction. They would like the requirements of and training of the transport and control room staff to be stipulated within the final specification.

2.1.6 Differentiating between certain patients

Patients requiring chemotherapy were suggested as a potential group of patients which could be separated out, like renal patients, as requiring a contract of their own.

One CCG manager suggested those being taken home following a trip to A&E or ambulatory care should be prioritised to ensure smooth working of the urgent care system.

Renal patients and staff fed back their views on the current service to inform a service specification which would address their particular needs as patients who are regular users of the Patient Transport Service. These are noted in Appendix 1 at the end of this report, many of the suggestions are consistent with the needs of all patients using Patient Transport Services..

2.1.7 Difficulties with public transport

Patients reminded commissioners and providers that difficulties with public transport, particularly in rural areas, and at bank holidays, or in the evening, make attending hospital or returning home difficult. This should be seriously considered and taken into account when planning service contracts. They also highlighted the importance of alternatives such as volunteer car driver schemes – which have a cost attached, which can sometimes put patients off.

Publicising and supporting volunteer driver schemes: "*In my experience some patients choose alternatives before approaching hospital transport, it usually means a more direct route A to B and they are waiting around less before and after appointments. I think it is important that this information is available to the public so patients have choice."*

2.1.8 Integrating services and contracts

The services should work effectively together so that when patients receive information about their appointment they also get information about booking non-emergency transport and about alternative transport services. (For trust/service providers to action)

3 Detailed examination of the measures for success

Forty members of the Thanet health network attended a workshop to discuss three topics in detail: the key performance indicators (KPIs) from the current draft service specification, improving the eligibility criteria, and drafting a standard for high quality patient experience of a Patient Transport Service which could be embedded in the service specification and influence any additional work on the KPIs.

3.1 Key Performance Indicators

The participants were asked to rank whether they agreed with the indicators and suggest alterations if they felt could be improved and if so, how.

For instance:

Patients arrival time: Patients should arrive within an hour of their appointment time.

The performance indicator suggested: 95% no more than 60 minutes prior to appointment

Patients suggestions:

☺ can we reduce payment/increase penalty to only pay 50 per cent of cost?

☹ **the** consequences not clear enough, how it is worked out.

😐 an hour is too long, 30 minutes would be better.

😐and ☹ as were split 60 minutes being realistic pending number of patients included in one vehicle and distance/times etc. and split about breach rate being too low. Plus, does not feel provider will be truthful.

The patients had a chance to comment on every key performance indicator and threshold in the draft specification and many of their views and the language describing what they expect from the service has been carried through into the most recent version of the service specification.

3.2 The Eligibility Criteria

The patients discussed this in small groups and suggested that:

- Patients who regularly use the Patient Transport Services should be registered with Patient Transport Services.
- GP surgery or practice staff should undertake the eligibility assessment process: asking questions to assess patients' eligibility, and make sure this assessment process could be recorded on patients practice records. It could also record if the booking is to be made by patient.
- If GP makes decision, it would take out interpretation by provider.
- Make sure eligibility is written in easy-read format for people who can't read or have limited English.
- Also when treatment/care starts in hospital then medical practitioner could make the decision and likewise mark the records, and who assessed the patient.
- Eligibility questions are too detailed.
- Too many statements – no more than six are needed.

- At the booking staff need to get a clear idea of what kind of appointment, as well as the practicalities of the distance and location within the facility, as these requirements have a bearing on the amount of support needed for patients to arrive at point of treatment.

3.3 Questions which have been suggested as a means to assess someone's need and eligibility for the Patient Transport Service:

3.3.1 General assessment

- Have you attended before and how did you get there?
- How would you usually travel to hospital given your needs?
- Have you got someone that can take you?
- Have you got transport?
- Who is your GP? Where is your appointment?
- Are you receiving hospital treatment currently?
- Have you been advised by a health worker to use Patient Transport?
- Do you need support to go to hospital?
- Do you have anyone that could take you?
- Can you travel on public transport?
- Return journeys: Do you live alone? Do you have any dependants who should be told of your return?

3.3.2 General health

- Are you disabled or do you have a long term condition?
- Are you on any medication that restricts you from driving? Or will you receive treatment at your appointment that restricts you afterwards?

3.3.3 Mobility:

- How far can you walk? Between two lamp posts (75 metres)?
- Can you use public transport? If so – how far is it from home?

- Do you require or use a walking aid? Wheelchair? Mobility scooter? Stretcher?
- Do you receive attendance/mobility allowance?
- Do you use aids to support you?
- Do you use public transport on your own?
- Do you walk well on your own?
- Do you find walking hard?
- Do you have any walking aids like a stick, or zimmer/walking frame?
- Can you walk unaided or do you need help?
- Are you able to step up into a bath/public bus?
- Do you have difficulty stepping up into some cars such as people carriers/black cabs or minibuses?
- Do you need to travel with a wheelchair?
- Can you walk 83 steps or more unaided? (This measurement is based on an average step being 0.76 m/2.6ft – defined on pedometers, so someone with reduced mobility might have a step length reduced to 0.6m or 2 feet, therefore 83 steps equates to fifty meters.)
- Can you walk the length of two coach buses without assistance?

3.3.4 Carer accompanying patient

- Do you have a carer who accompanies you to your appointments?
- Do you need a carer to accompany you?
- Do you need someone to come with you? If so why?
- When you go out do you usually get someone to pick you up?

3.3.5 Senses

- Do you find communicating difficulties?
- Do you have any problems hearing or seeing

- Should be a way to check whether patient has regular seizures or fits such as neurological condition: Do you regularly have fits or seizures?

The exercise reveals to the patients taking part exactly how interrogatory an assessment process could easily become through volume of personal questions, and so recommend a minimum number is used to ascertain someone's needs.

4 Patient Experience Standard

Patients recognise that service standards must be realistic and achievable and that, in any contract, risks must be fairly shared and true partnerships developed. 'Working in partnership with the NHS' should not be a slogan on the side of an ambulance or other transport but a commitment on both sides. Otherwise disputes are inevitable and patients are then let down. The Patient Transport Service needs to work as an effective component of a patient's care and connect well with the NHS service it is taking the patient to and from as well as the patient and any family or carers involved in their care.

The engagement staff shared a sample of a patient experience quality standard based on previous discussions with patients in Kent and an example created by patients and the voluntary and community sector organisations from several London boroughs. This was shared with the patients involved in the workshop and they agreed that this was a useful way to set out clearly the standard quality of service which they felt should govern how the service worked, inform the training of staff, and influence the monitoring and measurement of any contractors' performance.

The majority of the draft standard was agreed with reservations about the wording specifically those with time-related standards, which the patients felt needed more detailed work to be realistic and ensure consistency with any of the key performance measures.

See draft standard below.

4.1 Service Standards describe how a service provider does what they agree to do. One measure of the quality of services, or *how well* a service provider does what they agree to do, is shown and measured by patients' experience of those services.

Patient experience includes their whole experience of services (healthcare, social care and the third sector) from beginning to end. It spans the whole patient journey, from knowing what services are needed and how to access them, continuing with the first contact such as telephone call, or appointment letter; it includes interactions with both clinical and support staff as well as smooth transfers between services and/or care providers; and it includes experiences of care in all settings such as home, community, hospital and all phases of care including preparation for care, acute care, continuing care and after care.

Patient experience is broader than satisfaction. You could be satisfied with the outcome of your care if for instance your hip was replaced, but you may have had a bad experience during your stay in the hospital because you experienced a lot of pain. Similarly, you may not be satisfied with the outcome of your journey to hospital if your journey is delayed so you miss an episode of care if for instance you were three hours late for your chemotherapy. This experience of poor care could be made easier through good communication: receiving the bad news about the delay to the journey could become a 'good experience' if you were kept informed by friendly staff, and your appointment was rearranged for you by the booking service, so that you felt cared for despite the difficult circumstances.

From a patient's perspective when I have a **'good experience'** of care, I feel:

- Confident of receiving an accurate timely care
- Positive about receiving high quality service
- Respected, safe, comfortable, and cared for
- Listened to and understood
- Informed and involved in decision making
- Able to take responsibility for and contribute to my own health as a partner in my care
- Assured of having full access to all available resources

A ***'good experience'*** of care is enabled when:

- My care is planned with me and centred on my needs and is inclusive of my family and carers
- My care is co-ordinated across health, social and any voluntary services
- Equipment and resources are available to meet my needs and requirements
- Staff are effective at communicating and sharing information with me and also with other staff within and across health, social and third sector services
- The vehicle/environments where I receive care are appropriate, accessible, clean, welcoming and enable my privacy and dignity to be maintained

Staff:

- Are professional, honest and accountable

- Are approachable, kind, compassionate and cheerful
- Maintain my confidentiality, privacy and dignity and treat everyone with respect
- Are prepared and informed about me, my care needs and other services
- Have the right knowledge, attitude and skills and adhere to policies
- Work in partnership with me, my family and carers and other professionals

4.2.1 Booking

Joined up services mean that when I get the information about my appointment I also get information about booking non-emergency patient transport and any alternative transport services. (For trust/service provider)

When I call to make a booking I will be able to get through in a minute or less, to a person, not an automated system and I will be given a clear explanation of the eligibility criteria.

When I call to make a booking, the person responding will ask if I have any specific communication needs (for example, I may want them to speak more loudly or slowly or repeat things)

I will be able to choose to make a booking on-line

On the day before my booking, I will get a reminder

I will be able to choose to get a reminder by text message, confirming estimated time of arrival

4.2.2 **Eligibility criteria** will be used to assess my need for non-emergency patient transport and make sure I get the right type of vehicle and support on my journey

Before asking me any detailed questions, the person I speak to will ask if I have received information on the eligibility criteria

Please use simple examples to help me to explain my mobility and care needs, in terms of distance I can easily walk, or the type of aid I require.

If I don’t meet the eligibility criteria, please provide me or my carer with contact details of suitable alternatives types of transport, such as volunteer transport schemes

When my booking is confirmed, please tell me who to contact if something changes or if I have a problem and how to cancel a booking. Then, if I need to cancel my booking, I will be able to make a new one in the same way that I made my original booking

4.3 My Outward Journey

I will be given a clear time, or time slot in which to expect my transport to collect me. I can expect that my transport will **almost always** arrive within 30 minutes of the time slot that I have been given

If there is a problem with my transport, I will be contacted and told about it. If my transport is delayed by more than 30 minutes I will be given a new time or time slot, and everything I would usually expect from a booking will happen for the new (revised) time or time slot

I will be given a **realistic** estimation of my journey time, taking into account the type of vehicle, any other passengers, the time of day, any road works and diversions, weather conditions and usual traffic flow on that route

The service will get me to my appointment **on time**, taking into account what kind of appointment I have and any procedure-related instructions that came with my appointment letter

My journey time and arrival for my appointment will be **reasonably** similar to that of someone using their own personal vehicle

Collection

When my patient transport arrives at my address, the driver or any escort will make every effort to let me and/or my family or carer(s) know that they have arrived to collect me. This should include following any directions made at my booking (for example, I may need someone to knock very loudly or contact a warden by interphone)

The driver and/or escort will have a suitable photo ID, or wear uniform or branded clothing so the patients can easily recognise them. They will check with me that the journey they are collecting me for is the journey I have booked, and they will ask me if I have any belongings and/or equipment that I need to take with me

I will be asked respectfully and positively about my needs in a manner that encourages me to say what sort of assistance is best for me (for example, the driver and/or escort might use an open ended question, “Is there anything else I can do to make you more comfortable?”)

The driver and/or escort will give me enough time to **safely** and **comfortably** settle into the vehicle, as independently as I am able to

At all times during collection, the journey, drop-off and return the driver and/or escort will be considerate of my **comfort** and **wellbeing** and be mindful of my **dignity**

4.5 Drop-Off

The driver and/or escort will give me enough time to **safely** and **comfortably** leave the vehicle as independently as I am able to

When we arrive at the healthcare facility, the driver and/or any escort will make every effort to let staff know that they have arrived to drop me off. This will include following any instructions added to my booking (for example, I may need to borrow equipment or wait for a porter)

If I need assistance from carers, staff or family, the driver will check that someone knows this and can assist me.

4.6 My return/homeward journey

"Please remember I have had treatment and so will be feeling frailer than usual, please plan a swift journey by the most direct route and keep me informed of any delays"

Please give me a clear time or time slot in which to expect my transport to collect me.

I expect that my transport will **almost always** arrive within 60 minutes of the time slot that I have been given, and if there is a problem with my transport I will be contacted and told about it.

If my transport will be delayed for more than one hour, I will be given a new time or time slot, and everything I would usually expect from a booking will happen for the new (revised) time or time slot.

I will be given a **realistic** estimation of my journey time, taking into account the type of vehicle, any other passengers, the time of day, any road works and diversions, weather conditions and usual traffic flow on the most direct route.

My estimated journey time will be **reasonably** similar to the same journey if a person used their personal vehicle.

If my transport is unable to make the journey for whatever reason I, and/or my family or the staff caring for me will be informed, and contingency arrangements made.

When my transport arrives at my home/resident address the driver and/or any escort will make **every effort** to let my family, staff or carer(s) know that they have arrived to drop me off; following any instructions added to my booking (for example I may need someone to knock very loudly or contact a warden by interphone)

4.8 Quality of care (For frail/vulnerable patients)

If I am to be transported home between 8pm and 8am, please inform my family or those who provide care for me and check that measures will be put in place to ensure any care needs I have are met in full.

All my needs will be considered, not just my journey, so that if I have specific medical or social care needs they are known and noted, and extra care is taken to contact and work with the family, staff or care support I receive at either end of my journey to ensure all my care is joined up.

> "I expect the staff to treat me as they would their own family: with kindness, care, and consideration. As a person deserving dignity and respect at all times"

Next steps

A summary of this work and the progress with the procurement will be shared with all of the patient forums which have contributed.

Patients from each clinical commissioning group area have volunteered to join the Patient Transport Service working group and will meet together to test the patient experience standard and turn it into a charter, they will also comment on any subsequent iterations of theService Specification and Key performance Indicators. They will also receive training and support in the spring to take part in the formal assessment and evaluation of any bids and the prospective contractors.

Appendix 1

Renal patients have to regularly receive treatment which means they are regular users of the Patient Transport Service. As patients with a chronic condition, they are often frail and concerned about the hygiene of their environments, due to an increased risk of infection. Those patients receiving dialysis have very specific bookings to use the equipment and cannot afford to miss their appointment/treatment times; which is why the key performance indicators have shorter time differentials in the draft service specification.

In gathering the views of renal patients and the staff who treat them, we have worked with East Kent NHS Hospitals University Foundation Trust and reviewed the findings of the national renal transport audits 2008, 2010 and 2012, along with the National Institute of Health and Care Excellence guidance on management of chronic kidney disease.

Patients and staff said that the main problems were:

1. Patients left waiting unacceptably long time for return transport post-dialysis
2. Patients booked to travel with others who may be finishing much later/earlier.
3. Afternoon patients brought in long before their booked appointment time and having to wait for a machine to be ready.
4. Difficulty in contacting NSL staff to discuss issues – especially after 5pm and at weekends
5. Being informed transport is 'nearly with you' and then finding, once it eventually arrives, that it was still a long way off when the call was made.
6. There is an inadequate service on a Saturday – just one car for all the patients here, and sometimes patients are completely forgotten.
7. It is often our most vulnerable patients, in wheelchairs requiring more help and specific transportation, that are left waiting. They become very anxious about getting home for their carers as they may miss their evening meal.

Suggested improvements:

1. Give the crews the "ready times" on the day in good time
2. Answer the phone sooner (the control line)
3. Tell the truth about where vehicles are and what time to expect them
4. Sort your regular bookings first (as being left waiting three times a week is not fair).
5. Speak to the renal unit if you know in advance there is going to be a problem, as we may be able to work around it
6. Learn the local areas and distances (suggest control team/planners go out riding shot gun, for a few hours each, with the crews, to see what the job involves)
7. Turn down the volume (or get rid of the horrible and irritating and painfully loud 'music' that is played when one is on hold. It doesn't help).
8. Control/planners should have a rough understanding of the way the renal units work, with timed slots, no spare machines, knock on effect when patients are late, no food available, closing times, staffing levels, cutting treatment times etc.

9. Try and get patients here at the right time and collect them on time, or is that too obvious?
10. Individual renal units should set their own time standards, taking into account local conditions but these should not result in more than 75% of patients waiting more than 30 minutes before or after dialysis
    Note – despite the first (Thanet) patient group rejecting the idea, there is a suggestion that journey times in a private vehicle be taken into account when setting these standards, that is when identifying acknowledged exceptions that would trigger single occupancy protocol
11. Where it is acknowledged that waiting times may be close to, and sometimes in excess of 30 minutes (especially with transport from rural areas or in zones of known traffic congestion), multiple pick up and drop off points should be avoided
12. Multiple vehicle occupancy should be rationalised and planned to give the closest approximation to a single occupancy direct route and should take into account timing of dialysis slots and length of session
    Note – this has an impact on technical vehicle specs as it presumes satellite navigation' equipped vehicles and efficient, real-time, dispatch to vehicle communications
13. Monitoring against time standards should be ongoing and separate from 'overall experience / satisfaction' surveys
14. Patient collection times should be closer to fixed times rather than longer 'windows' or time slots
15. Dispatch and vehicles should be able to communicate directly with renal unit staff to allow for more effective management of start times for dialysis and minimise waiting once patients arrive, or when planning their return journey

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Item 7: East Kent: Out of Hours Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 March 2015

Subject: East Kent CCGs: Out-of-Hours Services

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Ashford CCG, NHS Canterbury & Coastal CCG, 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) On 11 April 2014, the Committee considered an update on the procurement of East Kent's Out-of-Hours services as part of the urgent care programme. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that the report be noted and the Chairman seek written clarification in regards to the additional costs resulting from the contract variation with the current provider, the working group and a timescale for procurement.*

(b) The Scrutiny Research Officer circulated a response from the East Kent CCGs on 23 May 2014.

(c) The East Kent CCGs have requested the opportunity to bring the attached report to the attention of the Committee.

(d) Out-of-hours cover may include some or all of the services below (NHS England 2013):

- GPs working in A&E departments or minor injuries units (MIUs);
- Teams of healthcare professionals working in primary care centres, A&E departments, MIUs or NHS walk-in centres;
- Healthcare professionals (other than doctors) making home visits, following a detailed clinical assessment;
- Ambulance services moving patients to places where they can be seen by a doctor or nurse, to reduce the need for home visits.

2. Recommendation

RECOMMENDED that the report be noted and the East Kent CCGs be requested to keep the Committee informed with progress.

Background Documents

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

NHS England, *Out-of-hours services (28/01/2013)'*, http://www.nhs.uk/nhsengland/aboutnhsservices/doctors/pages/out-of-hours-services.aspx

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Meeting: Health Overview and Scrutiny Committee

Date of Meeting: 6th March 2015

Subject: Briefing Paper: Out-of-hours procurement

Action Required: This paper is for information

Purpose: To update the Health Overview and Scrutiny Committee on the pending procurement of east Kent CCG's out-of-hours (OOH) GP service as part of the urgent care programme.

1.0 Overview

1.1 This paper seeks to update a paper presented to the Health Overview and Scrutiny Committee in April 2014 which outlined key issues and proposals for transforming the existing Out of Hours model in East Kent. Urgent Care services continue to be under the national spotlight. East Kent CCGs recognise the need to simplify and integrate health and social care provision in order to reduce pressure on our local system.

1.2 Patient feedback about the current service model indicated the need to have improved access to primary care along with greater integration of front line staff and clearer signposting and navigation through services.

- ***"If you are ill and trying to get help having to tell your condition to every single person can be confusing and often makes the situation worse."***

- ***"I have been very frightened for my husband's deteriorating health – I need reassurance otherwise I panic. Compassion is essential."***

- ***"It is not clear what NHS 111 should be used for and when"***

- ***"It is not clear how other services align with NHS 111"***

- ***"It is not clear what is available in the community"***

- ***"There are a number of barriers to get into services (e.g. door entry and lack of signage at sites)"***

- ***"We just don't know where to go…."***

2.0 Progress to date

2.1 Since April 2014 East Kent Clinical Commissioning Groups led by GP clinical leads have been working with existing providers to enhance existing services in line with the CCGs strategic commissioning plans. A number of key developments have been introduced in the East Kent

area. The aim is to support better integration in response to patient feedback.

These are:

2.2 Agreed a contract variation with our existing out of hours providers, enabling better integration with the local Accident and Emergency service, improving overall productivity and maintaining cost neutrality

2.3 Recognising the current fragmentation between the NHS 111 and existing Out of Hours service, aligned contract cycles to facilitate the development of this new integrated service

2.4 Successfully launched 7 day working pilots in South Kent Coast, Canterbury and Coastal and Ashford CCG areas

2.5 Launched an advanced care navigation pathway through a local referral unit, established in Ashford and Canterbury and Coastal CCGs

2.6 Worked with the local Ambulance service to develop pathways enabling more patients to be seen and treated closer to home

3.0 Channels of Development

3.1 Under the guidance of the Out of Hours working group, a proposed model has been designed (see figure 1). Both individual and group sessions have been held and progress on the service model development has been reported through the Urgent Care and Long Term Condition Integrated Care Board and CCG Clinical Strategy and Investment Committees. It will also be presented to all CCG Governing Bodies in March 2015.

3.2 Utilising patient feedback and working with clinical and operational stakeholders the proposed model has been worked in to a draft service specification which will (subject to CCG Governing Body approval following recommendation from clinical committees) then be taken through a procurement process continuing to engage local stakeholders and potential providers, as well as the public through regular updates and inclusion of patient representatives on the evaluation panel.

3.3 In addition to this, expertise from PriceWaterhouseCoopers has been commissioned to help bring national learning and best practice and to provide additional oversight and scrutiny to the service specification design.

4.0 Next Steps of the Out of Hours Procurement

4.1 It has been recognised that whilst the Out of Hours element of the Urgent Care system is critical to the wider functionality, the 111 service and Out of Hours services should be procured together and include care navigation (formerly known as Local Referral Units).

4.2 The proposed service model will deliver for those people with urgent but non-life threatening needs highly responsive, effective and personalised services. The successful provider will be required to manage fragmentation between the formerly separate services and maximise efficiency encouraging use of local pathways to avoid attendance at hospital wherever possible.

4.3 As part of the development, CCG's have undertaken an element of *soft market testing* by meeting with existing and potential suppliers of the future service. Discussions with all existing providers and a sample of national providers has indicated that there is a competitive market for a locally provided integrated 111/out of hours and care navigation service.

4.4 Key requirements have been identified by both providers and commissioners to deliver the future service vision for East Kent:

4.4.A **A patient-centred service** that demonstrates the best possible clinical outcomes and improved patient experience.

4.4.B **Greater integration between front line services and seamless working** to promote efficient interaction from the patients perspective

4.4.C Note: The new integrated NHS 111, GP OOH and Care Navigation Service should work seamlessly with the developing Integrated Urgent Care Centres co-located within the Accident and Emergency departments within the locality

4.4.D **Greater responsiveness of services and reduced duplication**. It is proposed that by re-configuring existing services, the health economy will:

- improve health outcomes for patients
- increase the number of Out of Hours treatments undertaken in a patients home / place of residence
- reduce the need for acute admission to hospital
- reduce the length of stay in hospital when an admission is required
- change the traditional accident and emergency service, to co-locate Primary Care, Social Services and Community services within an Integrated Urgent Care Centre
- improve the overall experience for patients.

4.4.E **Delivered for and within East Kent** making best use of local skills, knowledge and services

4.4.F **Flexible** to meet future pathway development

4.4.G **Safe, cost effective** (affordable)

4.5 It is anticipated that the procurement process will commence in April 2015

5.0 Other key milestones delivered as part of the overall Urgent Care Transformation Process

5.1 Community geriatricians – This service provides a care of the elderly consultant working within the local community area to support frail patients who are at risk of falling. This is currently in place for Ashford, Canterbury and Coastal and South Kent Coast. This service provides geriatric support to patients within the local community under a shared care service plan.

5.2 Streamlining discharge processes to improve care home and residential home discharge pathways to hospital at weekends. 7 day Social Care assessment services have been introduced as part of the Integrated Discharge Team model within each Hospital site in East Kent.

Discharge profiles at weekends have increased as a direct result of this service.

5.3 Primary care hubs in A&E – These are currently in place on each Hospital site and are subject to review. These provide primary care expertise to support patients arriving in A&E.

5.4 A new approach to health economy systems pressure management. A live Urgent Care Dashboard, enabling providers to use data analysis to forecast local hotspots and plan to mitigate service pressures is due to be launched as part of the perfect week exercise being undertaken by the local health economy from 3 – 10 March.

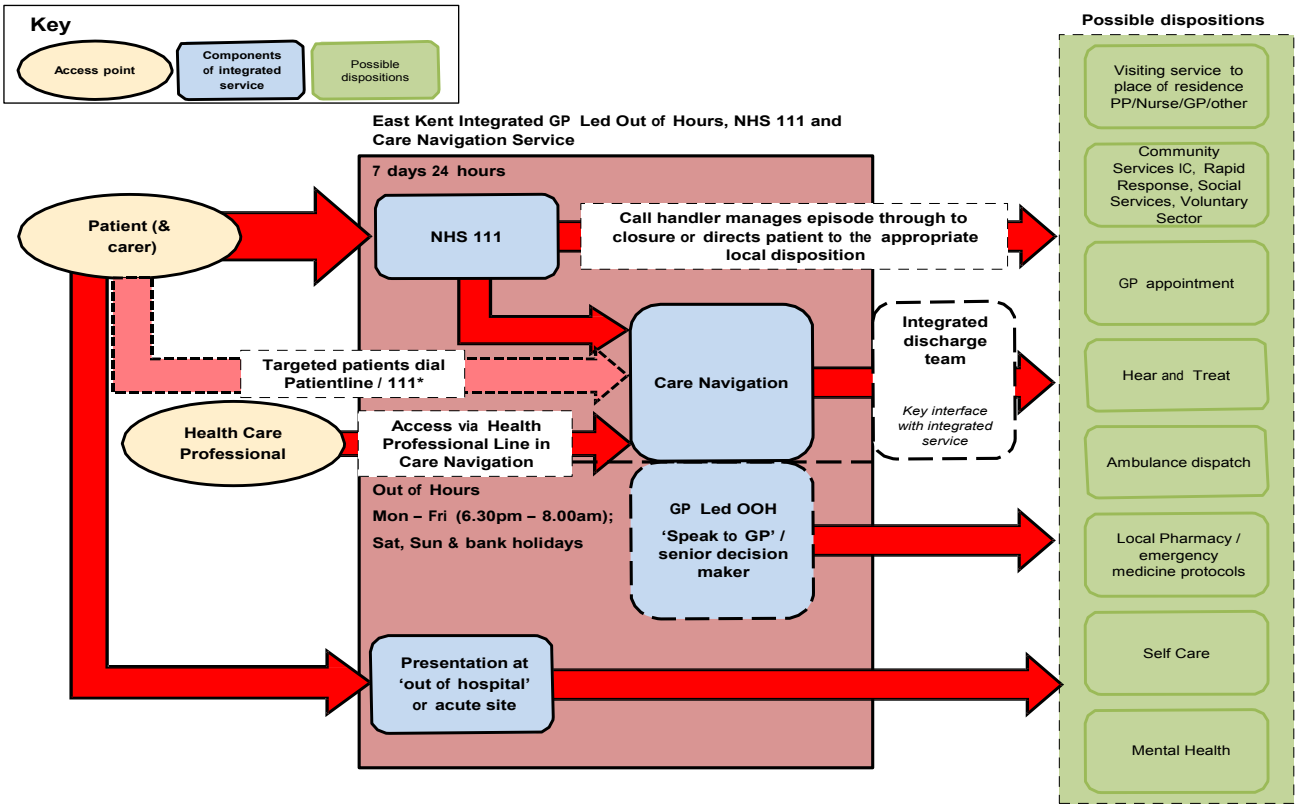

Figure 1: Proposed Integrated GP Led Out of Hours, NHS 111 and Care Navigation Service

6.0 Recommendation:

Members of the Health Overview and Scrutiny Committee are asked to note the contents of this briefing paper.

For any questions relating to this paper, please contact:

Bill Millar – Chief Operating Officer, NHS Ashford and NHS Canterbury and Coastal CCGs

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Item 8: NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG: Adult Community Services (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 March 2015

Subject: NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG: Adult Community Services (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Dartford, Gravesham and Swanley CCG and NHS Swale 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) On 11 April 2014, the Committee considered the redesign of community services and out-of-hours services in the NHS Swale CCG area. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that the Committee determines the proposed service change as a substantial variation of service and that a timetable for consideration of the change would be agreed between the HOSC and NHS Swale CCG after the meeting.*

(b) On 10 October 2014, the Committee considered an update on the out-of-hours proposals as part of the wider reconfiguration and recommissioning of emergency and urgent care services by NHS Medway CCG, NHS Swale CCG and NHS Dartford, Gravesham, Swanley CCG. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that:*

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

  (b) the guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and that they be invited to attend a meeting of the Committee in six months

(c) NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG have asked for the attached update report, on proposals for adult community services, to be submitted to the Committee.

2. Community Services

(a) Community health services cover a range of services provided by a variety of organisations and staff including:

- Community nurses;
- Health visitors;
- Community dentistry;
- Podiatry;
- Physiotherapy;
- Speech and language therapy;
- Family planning services;
- Community rehabilitation.

(b) Prior to 2009, the vast majority of Primary Care Trusts (PCTs) both commissioned and provided community health services. By 2009, PCTs had to organisationally split their commissioning and provider arms.

(c) A wide range of options for the future organisational form of provider arms was set down in the 2009 Transforming Community Services programme. The “most likely options” were given as integration with an NHS acute or mental health provider; integration with another community-based provider; or a Social Enterprise.

(d) By April 2011 PCTs had to divest themselves of their provider arms. A number of Community Health Trusts were created following the merger of community-based providers.

(e) The Health and Social Care Act 2012 established Clinical Commissioning Groups (CCGs) which replaced PCTs on 1 April 2013. CCGs are now responsible for the planning and commissioning of health care services for their local area including community services; whilst NHS England is responsible for directly commissioning primary care and specialised services.

(f) Monitor approved the Foundation Trust applications of Derbyshire Community Services NHS Trust and Bridgewater Community Healthcare NHS Trust on 30 October 2014. They became the first community health trusts to achieve foundation trust status.

2. Kent Community Health NHS Trust

(a) Kent Community Health NHS Trust was formed on 1 April 2011 from the merger of Eastern and Coastal Kent Community Services NHS Trust and West Kent Community Health.

(b) It is one of the largest NHS community health providers in England, serving a population of two million; 1.4 million living in Kent and 600,000 people in areas outside of Kent. The Trust employs 5,500 staff including community nurses, physiotherapists, dietitians and many other healthcare professionals. The Trust’s budget was £229 million in 2013/14.

(c) The Trust provides wide-ranging NHS care for people, in their community, in a range of settings including people's own homes; nursing homes; health clinics; community hospitals; minor injury units; a walk-in centre and in mobile units. The Trust has three million contacts with patients a year.

(d) The Trust is working towards becoming a foundation trust. The NHS Trust Development Authority discussed the Trust's application in July 2013 and agreed that it was ready to be assessed by CQC. The CQC carried out inspections across the Trust in June 2014 and rated it as 'Good'. The CQC has agreed that the Trust is now ready to be assessed by Monitor. The assessment by Monitor is the final stage in becoming a foundation trust.

3. Recommendation

RECOMMENDED that the report be noted and NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG be invited to attend the June meeting of the Committee.

Background Documents

Department of Health (2013) '*Transforming community services transformational guides (08/02/2011)*', https://www.gov.uk/government/publications/transforming-community-services-transformational-guides

Kent Community Health NHS Trust (2014) *'About (01/01/2014)*', http://www.kentcht.nhs.uk/home/about-us/

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (11/04/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27880

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (11/04/2014)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5400&Ver=4

NHS Trust Development Authority (2014) *'Monitor approves 3 FT applications (30/10/2014)'*, http://www.ntda.nhs.uk/blog/2014/10/30/monitor-approves-3-ft-applications/

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Dartford Gravesham and Swanley Clinical Commissioning Group

Swale Clinical Commissioning Group

Briefing to Kent County Council HOSC Friday 6th March 2015

Subject: Update on actions taken by NHS Dartford, Gravesham and Swanley (DGS) Clinical Commissioning Group (CCG) and NHS Swale CCG regarding adult community services

Date: 24th February 2015

Introduction

During 2013/14, NHS DGS CCG and NHS Swale CCG undertook a benchmarking and engagement exercise, to better understand key stakeholder (including GP) and wider public and patient experience of community services. This process was conducted to help inform the CCGs 2 and 5 year planning process.

An outline business case was produced as one of the outputs of this engagement work, seeking CCG Governing Body approval to undertake a review of the current adult community services with a view of taking these services out to tender. As part of this review process, both CCGs have been working with the current providers of adult community services, Kent Community Health Trust (KCHT) and Medway Community Health (MCH) to more appropriately align these services around clinically meaningful groups (or clusters) of general practices to form what we call Integrated Primary Care Teams (IPCT). This commenced in November 2014 and will be fully implemented by April 2015. As part of the Pioneer work with Kent County Council, we are also aligning social care staff, mental health services and voluntary sector services into these Integrated Primary Care Team structures to improve the coordination of care for patients particularly those with long terms conditions. There is a great deal of emerging clinical evidence demonstrating the benefits of such professionals working together in this way.

The Governing Bodies have approved the outline business case and a project has been initiated to oversee the process.

Current Position

Key individuals have been appointed to carry out the review project and governance processes have been established. The project steering group has, as an integral part of its membership, lay representatives drawn from the CCGs Patient Participation forums, who are actively engaging with their respective communities to impart messages from the project and to bring comments and views back for inclusion and consideration. An NHS procurement agency (NHS Commercial Solutions) has been appointed to provide relevant legal, process and governance expertise.

The Project Steering Group was formed in November 2014 with the aim of overseeing the implementation and learning from the IPCT work, providing advice on future contracting models and the process for contracting going forward based in the future.

For contracting and commissioning purposes, the Project Group defined the following services to be included within the umbrella of “Adult Community Services”:

- Community Hospitals
- Community Liaison
- Community Nursing (including matrons)
- Community continence service
- Intermediate Care service
- Community physiotherapy service
- Community podiatry
- Speech and language therapy
- Community specialist nursing including but not exclusively; neuro rehab, cardiac, pain therapy, respiratory, diabetic, epilepsy

The procurement is underway and it is the current expectation that the contract will be let in autumn 2015 with an expected contract commencement in April 2016. The current value of services within the tender is in the order of £26m per annum (combined for NHS DGS CCG and Swale CCG).

The intention is to let the contract on the same service specification as exists currently. The CCGs do not intend, at this point, to design a new model of community care or re-configure services. The CCGs are engaging in a competitive dialogue process, working with potential providers to understand their proposals and solutions to the local health issues; and to establish the credentials of the prospective providers to deliver high quality, financially sustainable services. By openly engaging with the market and local communities we hope to engender more innovative approaches to deliver care in a joined up way that is consistent with meeting the long term health needs of both communities.

Attached is a timetable of the procurement process. As a first step in that process a 'market engagement' event was held on 11th February to engage potential providers in discussion about ways to deliver the services in the future. We were keen to understand their concerns, issues with the approach and general interest in working with us to deliver the improvements. It also provided an opportunity for them to make connections with each other and to possibly form alliances or consortia to put forward joint bids which may strengthen their offering. The event was well attended with 38 different organisations and 80 individuals present. Initial feedback has been positive with a number of comments and suggestions made on the day. Follow up feedback forms have been circulated to all attendees with a view to securing further comments and suggestions. These will be collated and will be used to inform how the CCG's proceed. A further event is being scheduled later in the Spring to further discuss our approach based on the feedback and further thinking within the CCG.

The CCG would welcome the opportunity to return to the HOSC at its June meeting to provide further updates on progress and following further engagement with potential providers.

Revised Outline Procurement timetable 6th February 2015

Procurement Process - Stages	Due Date
Prior Information Notice (PIN) Published	9th January 2015
Initial Potential Bidders Launch Event	11th February 2015
Issue PQQ	Spring 2015
Bidder Event	Spring 2015
PQQ Closes / Selection of participants	Spring 2015
Bidder notification of PQQ Outcome	Spring 2015
ITPD	Summer 2015
The Dialogue – successive stages (tbc)	Autumn 2015
Optional Bidder Presentations / Site Visits	Autumn 2015
ISFT - Final tender process	Autumn 2015
Evaluation of Tenders	Winter 2015
Final Bid Clarification	December 2015
Contract Award	December 2015
Standstill	December 2015
Mobilisation/Transition	January – March 2016
Service Commencement Date	1st April 2016 to be confirmed

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