HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 29th January, 2016

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 29th January, 2016, 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 (2):	Mr H Birkby and Mr A D Crowther
Labour (3):	Mrs P Brivio, Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor J Howes, Councillor M Lyons, Councillor M Peters and Councillor M Ring

Webcasting Notice

Please note: this meeting may be filmed for the live or subsequent broadcast via the Council's internet site or by any member of the public or press present. The Chairman will confirm if all or part of the meeting is to be filmed by the Council.

By entering into this room you are consenting to being filmed. If you do not wish to have your image captured please let the Clerk know immediately.

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

4. CQC Inspection Report: East Kent Hospitals University NHS Foundation Trust (Pages 7 - 10) 10:05

5. Kent & Canterbury Hospital: Emergency Care Centre (Pages 11 - 16) 10:30

6. SECAmb: Update (Pages 17 - 34) 11:00

7. North Kent: Adult Community Services (Pages 35 - 46) 11:30

8. North Kent: Emergency and Urgent Care Review and Redesign (Pages 47 - 52) 12:00

9. NHS Swale CCG: Review of Emergency Ambulance Conveyances (Pages 53 - 56) 12:30

10. East Kent Strategy Board (Written Briefing) (Pages 57 - 68)

11. Date of next programmed meeting – Friday 4 March 2016 at 10:00

    Proposed items:

    - CQC Inspection Report: Medway NHS Foundation Trust
    - East Kent Strategy Board
    - Kent and Medway NHS and Social Care Partnership Trust: Update
    - North and West Kent Neurorehabilitation Service

BREAK (13.00 - 14.00)

12. Patient Transport Services (Pages 69 - 80) 14:00

13. NHS West Kent CCG: Diabetes Services (Pages 81 - 106) 14:15

14. Emotional Wellbeing Strategy for Children, Young People and Young Adults (Pages 107 - 126) 14:45

MOTION TO EXCLUDE THE PRESS AND PUBLIC FOR EXEMPT ITEM

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

15. Emotional Wellbeing Strategy for Children, Young People and Young Adults (Exempt Appendices to Item 14) (Pages 127 - 252)

**Timings are approximate*

Peter Sass
Head of Democratic Services
03000 416647

21 January 2016

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.

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Item 4: CQC Inspection Report: East Kent Hospitals University NHS Foundation Trust

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

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

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

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

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1. Introduction

(a) CQC is the regulator of all health and adult social care services in England. Its purpose is to make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. Its role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish what it finds, including performance ratings to help people choose care (CQC 2015).

(b) East Kent Hospitals University NHS Foundation Trust was originally inspected in March 2014 and led to an overall rating of inadequate and as a consequence the Trust was placed into special measures by Monitor. Monitor appointed an Improvement Director to provide support to the Trust and hold it to account for making progress against the Improvement Plan. The Committee considered the Trust's initial response to the inspection findings on 5 September 2014; the Trust's Improvement Plan on 10 October 2014 and an update on progress since the inspection on 5 June 2015.

(c) The CQC was re-inspected the Trust in July 2015 and the inspection report was published in November 2015. The CQC rated the Trust as Requires Improvement but recommended that the Trust should remain in special measures for a further six months. The inspection reports can be viewed here:

- East Kent Hospitals University NHS Foundation Trust
- Buckland Hospital
- Kent and Canterbury Hospital
- Queen Elizabeth The Queen Mother Hospital
- Royal Victoria Hospital
- William Harvey Hospital

2. Recommendation

RECOMMENDED that the report be noted and the Trust be requested to provide an update to the Committee in six months.

Background Documents

CQC (2015) *'CQC Annual Report and Accounts 2014/15 (21/07/2015)',* http://www.cqc.org.uk/content/annual-report-201415

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 (10/10/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5400&Ver=4

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (05/06/2015)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5840&Ver=4

Contact Details

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East Kent Hospitals University NHS
NHS Foundation Trust

Health Overview and Scrutiny Committee

Care Quality Commission Update Report January 2016

Background

The Trust had an initial Care Quality Commission (CQC) Inspection in March 2014 and was rated, overall, as "inadequate" broken down by:

- Safe – inadequate
- Effective – requires improvement
- Caring - good
- Responsive - requires improvement
- Well led – inadequate

The key highlights of the report were as follows:

- There was a concerning divide between senior management and frontline staff;
- The governance assurance process and the papers received by the Board did not reflect our findings on the ground;
- The staff survey illustrated cultural issues within the organisation;
- Patient safety incidents were not always identified and reported and;
- Patients had excessively long waits for follow-up appointments.

At this time the Trust was also placed into special measures, a Director of Improvement was appointed by Monitor and the improvement journey began.

Current Situation

The second CQC inspection took place in July 2015 and the Trust was rated, overall as "requires improvement" broken down by:

- Safe – requires improvement
- Effective – inadequate
- Caring - good
- Responsive - requires improvement
- Well led – requires improvement

The key highlights of the report are as follows:

- The Trust is no longer rated "inadequate" and has now improved to the next grade up ("requires improvement") which is the same rating as the majority of NHS Trusts in England;
- Two of the Trust's five hospitals have been rated as "Good" with the other three being rated "requires improvement";
- There is a well-developed approach to the management of learning from complaints and care is rated as "good" across the whole Trust;
- There has been significant improvement in the culture and processes surrounding the reporting of incidents;
- Infection control policies and procedures were in place and adhered to and the environment was clean;
- A suitable Board structure is in place which is underpinned by a governance structure that has been revised following external review and;
- Despite recruitment challenges staffing levels had improved.

In addition to the overall Trust rating the CQC report gives an individual rating to each of the Trust's five hospitals.

- The William Harvey Hospital in Ashford is now rated as "requires improvement" but critical care and outpatient and diagnostic imaging are rated as "good".
- The Kent and Canterbury Hospital in Canterbury is now rated as "requires improvement" but children's services, critical care and outpatient and diagnostic imaging are rated as "good".

- The Queen Elizabeth the Queen Mother Hospital in Margate is now rated as “requires improvement” but again critical care and outpatient and diagnostic imaging are rated as “good”.
- Buckland Hospital in Dover and the Royal Victoria Hospital in Folkestone are now rated as “good”.

The main areas of improvement between the 2 inspections are much improved leadership in many areas, improving staff engagement, strengthened governance arrangements and demonstrably better working relationships with external partners. The report also recognised areas that were outstanding including our Outpatient Improvement Plan which has significantly improved services for patients, the positive impact Quality Improvement and Innovation Hubs have made and the added value to outcomes delivered by the pre-operative joint clinics.

Further areas for improvement

The CQC report, published on 18th November, also noted some important areas for improvement including:

- Ensuring there are sufficient numbers of suitably qualified, skilled, and experienced staff available to deliver safe patient care;
- The development of robust systems to monitor the safe management of medicines;
- Ensuring suitable arrangements for patients with mental health issues whilst awaiting assessment;
- Replacing the Liverpool Care Pathway and;
- The need for sufficient, well maintained equipment.

In addition, following helpful CQC comments, the Trust is giving particular attention to improving the exceptionally busy Emergency Departments across all three acute sites and is working with its health and social care partners to improve the overall emergency pathway across the Trust.

In order to both support and ensure the delivery of the improvements required the Trust has a High Level Improvement Plan which is reported on monthly to Monitor. On Friday 27th November 2015, the Improvement Plan Delivery Board (IPBD) held an away day. Seventy members of the organisation attended with multidisciplinary membership and representation from all levels. This away day was used to populate the detail of the Improvement Plan in addition to exploring those cultural issues that inhibit or delay change within a complex organisation. On Friday 4th December 2015, we invited our partnership stakeholders to a half day session to gain commitment around cross organisational solutions to the high level actions contained in the plan.
The Trust has also mapped the five priorities in our Quality and Improvement Strategy to the CQC core domains and identified 30 high level actions grouped into 12 work streams.

- End of Life Pathway
- Emergency & Urgent Care Pathway
- Maternity Pathway
- Children & Young People
- Mental Health
- Access & Operations
- Patient Safety
- Workforce & Culture
- Environment & Equipment
- Patient Experience
- Clinical Strategy
- Leadership & Governance

From January 2016 the Trust has put in place a Programme Management Office (PMO) to drive, challenge and track delivery of the Improvement Plan. This is being led by Dr David Hargroves who is a Stroke Consultant and offers the clinical leadership to drive forward the improvements. There is Executive leadership in place to support the PMO and Divisions.

The Trust welcomes the new plan and the refreshed focus that the latest inspection reports have provided. The work undertaken within the Trust in the last eighteen months and the new plan provide a platform to achieve our goal of getting to a rating of “good”, working in partnership with our staff, our partners and of course our patients.

Item 5: Kent & Canterbury Hospital: Emergency Care Centre

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

Subject: Kent & Canterbury Hospital: Emergency Care Centre

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

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

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1. Introduction

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

2. Health Education England

(a) Health Education England (HEE) is a Non-Departmental Public Body (NDPB) and is responsible for promoting high quality training and education, undertaking national planning and leadership, allocating financial resources, monitoring outcomes and securing the required supply of qualified staff (Department of Health 2013).

(b) At a local level, education and training is co-ordinated by 13 local education and training boards (LETBs) including Health Education Kent, Surrey & Sussex. The LETBs are statutory committees of HEE and act as the bodies for all providers and professionals to work collectively to improve the quality of education and training outcomes within their local area – in order to meet the needs of patients, the public and service providers. Each LETB covers a geographical area and develops comprehensive plans, considering existing workforce data, what healthcare services will be needed in the future and the demographic of the local population. HEE allocates funding for LETBs to spend on the education and training required in their local area and provides support to LETBs (Department of Health 2013).

(c) Health Education Kent, Surrey & Sussex (HEKSS) is responsible for a population of 4,000,000 (Health Education England 2015). As part of its quality management process, HEKSS undertakes visits to Local Education Providers (LEPs) to assess the quality of education and training in Kent, Surrey and Sussex. The objectives of LEP visits are to (Health Education Kent, Surrey & Sussex 2015):

- Ensure that General Medical Council (GMC) standards for the delivery of postgraduate medical education are being met;
- Investigate any matters of concern against the GMC standards

- Improve the quality of education and training by identifying issues and ensuring they are rectified;
- Identify areas of notable practice across the specialties

(d) A programme of routine visits is planned annually. KEKSS also undertake exception visits, which are held at short notice in order to explore specific, serious issues. Follow-up visits are undertaken when there is a specific need to follow up on issues raised in previous visits, to ensure issues are being addressed. All HEKSS visits include trainee representatives and lay representatives on the visiting teams. Exception visits always include external representation, and will also include representation from the GMC where necessary (Health Education Kent, Surrey & Sussex 2015).

3. Recommendation

RECOMMENDED that:

(a) the report be noted;

(b) East Kent Hospitals University NHS Foundation Trust and East Kent CCGs be requested to keep the Committee updated as a new model of care is developed.

Background Documents

Department of Health (2013) *'Guide to the Healthcare System in England (03/05/2013)'*, https://www.gov.uk/government/publications/guide-to-the-healthcare-system-in-england

Health Education England (2015) *'Annual Report and Accounts 2014/15 (16/07/2015)*', https://hee.nhs.uk/news-events/news/health-education-england-annual-report-accounts-2014-2015

Health Education Kent, Surrey & Sussex (2015) *'Quality management visits (28/10/2015)',* https://hee.nhs.uk/hee-your-area/kent-surrey-sussex/our-work/planning-commissioning/quality-management/postgraduate-medical-education/quality-management-visits-0

Contact Details

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Report to Kent HOSC re Kent & Canterbury Hospital Emergency Care Centre

1. Introduction

1.1. The purpose of this report is to inform members of the Kent HOSC about the current and emerging situation at Kent and Canterbury Emergency Care Centre regarding core medical trainee doctors and the potential impact this may have on the public accessing emergency services at east Kent Hospitals.

2. Background

2.1. On 20th October 2015, EKHUFT received a report from Health Education Kent Surrey and Sussex (HEKSS) following a review of the Trust's core medical training at Kent and Canterbury Hospital. The visiting review team was headed up by Professor Graeme Dewhurst, Postgraduate Dean of HEKSS.

2.2. The review team met with junior doctor trainees in the Department of Medicine from the full spectrum of training grades, as well as consultant physicians, the Trust's Clinical Tutor and the Director of Medical Education.

2.3. The main issues identified by the review team were that in their view:

- the ECC receives patients presenting with acute abdominal pain. Patients presenting with acute abdominal pain can have either a medical or surgical problem and can require a general surgical opinion. General Surgeons are not available at K&CH and whilst the numbers are small trainees do not feel equipped to manage patients presenting with acute general surgical problems;

- out of hours (nights and weekends) the medical on call teams cover both the ECC and the rest of the hospital. The ECC subsumes a vast amount of medical trainees' time which they believe to be to the detriment of patient care in the rest of the hospital;

- the trainees perception is that the ECC is an A&E by any other name without the benefit of A&E doctors and they are apprehensive at being required to fulfil an A&E doctor role in the ECC; particularly with respect to mental health patients and severely inebriated patients;

- paediatric and obstetric services are not available 24/7 at K&CH. On the rare occasions these patient do attend the ECC the medical trainees have had to see and transfer the patients. Again they feel vulnerable seeing these patients;

- in general induction needs to be more robust; and

- juniors were being asked to 'act up' without adequate supervision from consultants.

3. HEKSS Recommendations and implications

3.1. As a result of this visit the Trust received a letter from HEKSS insisting that immediate changes were made to the ECC model of care by 1st December 2015 and that a new emergency model of care which removed trainees from the ECC was implemented for K&CH by August 2016, ahead of any permanent clinical strategy changes.

3.2. A failure to undertake this would result in the removal of medical trainees from the K&CH site. This action could destabilise acute hospital services within east Kent and in particular would mean the closure of the ECC and removal of the unselected medical take on the site. This would result in the loss of acute medical support for other services on the site and the immediate physical movement of all in-patient vascular surgery, high risk urology, inpatient renal, haematocology and neurology services from the site leaving only a few low risk medical patients.

3.3. Clearly the Trust had neither the capital nor the capacity at the other two sites to effect these changes by 1st December. This remains the case for the August 2016 deadline. As such a short term solution needed to be agreed by HEKSS

3.4. Interim arrangements that have been put into place as of 1st December were to:

- provide consultant physician presence 12 hours a day 7 days a week;
- provide senior surgical review for patients presenting as acute general surgical emergencies 08.00 – 18.00 Monday to Friday with network surgical advice out of hours; and
- minimise the risk of non-medical patients being taken to K&CH.

4. Current Position

4.1. It is acknowledged that these interim arrangements are fragile, as they are reliant on the use of locum staff and overtime to provide the senior clinical input required by HEKSS and especially challenging as the winter period is one of high pressure; therefore there is some urgency to design and implement a sustainable model ahead of the permanent clinical strategy.

4.2. One of the immediate changes the Trust has been asked to implement is to ensure medical trainees that work in the ECC are only required to assess patients with medical problems. They should not be expected to be the initial doctor assessing patients with non-medical presentations (e.g. paediatric, surgical and other specialty presentations). The Trust has explored all possible solutions to this issue and has concluded that the only way to implement this change is to work with South East Coast Ambulance Services NHS Foundation Trust to revise the admission criteria for the ECC at K&CH.

4.3. The current criteria were agreed ten years ago when the ECC model was first introduced and the unit accepts patients with a wide range of conditions including cardiac, renal, respiratory, elderly care, vascular, urology and medicine. At the time the model was first introduced the ECC's majors' model was considered to be innovative and forward thinking.

4.4. Over the years there has been a growth in the breadth of the criteria and as a result we have seen a gradual change in the patients that are taken to and self- present to

the Department. Consequently, doctors that work within the ECC have to assess and treat a very wide range of conditions over and above those initially included in the criteria including surgical emergencies, children and other complex specialty patients. Over the same period of time there have been changes in sub-specialisation of doctors and changes in training requirements nationally which we need to ensure the ECC is consistent with. Until now the Trust has responded to these exigencies and provided care for these patients' needs but we are now at a stage where HEKSS believes that this it is no longer acceptable for medical trainees to be confronted with acute medical problems they are not equipped to manage and a change is required to address this.

4.5. As a consequence, with the full support of our Commissioners, the Trust is now working closely with South East Coast Ambulance NHS Foundation Trust to cease the referral of all patients with acute abdominal pain, alcohol intoxication and patients with a primary mental health problem to the ECC at K&CH. In total there are approximately 3000 patients that attend the ECC & MIU with non-medical conditions a year; Around 2000 of these present to the MIU and will continue to present in the way that they would at MIUs in other locations. This is in part related to the university population and the available 'nightlife'. 476 of the remaining 1000 patients are brought in by ambulance to the ECC with abdominal pain, alcohol intoxication and a primary mental health condition. This equates to approximately 9 patients a week. Instead, these patients will be taken to either the William Harvey Hospital, Ashford (WHH) or to Queen Elizabeth the Queen Mother Hospital, Margate (QEQMH). Patients that self-present to the ECC will still be assessed and if they require on-going care they will be stabilised and transferred. Our intention is to work closely with Healthwatch to inform the public how best to access the most appropriate health care service for their needs.

4.6. The Trust is doing everything possible to continue to address the issues raised by HEKSS and to provide all of the trainees with a quality experience. However, there is still a very real risk that HEKSS continue to feel that the training experience provided by EKHUFT for medical trainees at K&CH is unsatisfactory and they would then require the General Medical Council (GMC) to review the situation. Should the GMC concur with the HEKSS programme board's views then all medical trainees would be removed from K&CH site. The Trust would then be forced to implement the emergency measures detailed earlier in paragraph 3.2. This would not only affect many of the services provided from K&CH, it would also inevitably have an impact on the provision of emergency services at WHH, Ashford and QEQMH, Margate.

4.7. Given the fragility of the interim model and the resulting unacceptable risk of the emergency transfer of large number of patients from K&CH to WHH and QEQMH, the Trust are seeking to design and implement the model preferred by HEKSS and NHS England; a Primary Care Urgent Care Centre (minor injuries and minor illness unit) and an Acute Medical Admissions Unit as part of services at the K&CH site. The Trust would like to gain agreement from commissioners and the Kent HOSC that this new model is implemented by the end of June 2016

5. Conclusion

5.1. The December 2015 solution is not sustainable and the Trust wants to work with commissioners to develop a more robust approach and develop a new model of care by the end of June 2016.

5.2. The Trust feels it is important to be clear with the Kent Health Overview and Scrutiny Committee that services remain very fragile at the Kent and Canterbury Hospital site and will continue to keep the committee informed of the progress.

Item 6: SECAmb: Update

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

Subject: SECAmb: Update

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

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

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1. Introduction

(a) The South East Coast NHS Ambulance Service NHS Foundation Trust (SECAmb) was formed on 1 July 2006 through the merger of Trusts in Kent, Surrey and Sussex. SECAmb achieved Foundation Trust status on 1 March 2011 - one of the first ambulance service NHS foundation trusts (SECAmb 2015).

(b) SECAmb responds to 999 calls and NHS 111 calls to a population of over 4.6 million across 3,600 square miles in Kent, Surrey, Sussex and parts of North East Hampshire and Berkshire. It also provides non-emergency patient transport services in Surrey and Sussex. In 2014/15 the Trust attended 690,277 emergency calls and answered 1,137,390 NHS 111 calls (SECAmb 2015).

(c) Response times are set nationally and apply to all ambulance services in England and Wales (SECAmb 2014):

Red 1 - life-threatening conditions where speed of response may be critical in saving life or improving the outcome for the patient: heart attack, trauma, serious bleeding

- 75 % of all Red 1 patients must be reached in 8 minutes
- 95 % of all Red1 patients must be reached within 19 minutes

Red 2 - serious but not the most life threatening

- 75 % of all Red 2 patients must be reached in 8 minutes
- 95 % of all Red 2 patients must be reached within 19 minutes

Category C - conditions where the patient has been assessed as not have immediately life threatening condition but does require an assessment by an ambulance clinician or transport to hospital.

- Target agreed locally - the patient should receive an emergency response in 30 or 60 minutes depending on the clinical need.

Hear & Treat – conditions assessed as not requiring an ambulance service response, but could more appropriately be assessed or treated by an alternative healthcare provider

- Target agreed locally - where an ambulance service clinician provides advice, a call back should be made within two hours of the original 999 call depending on clinical requirement.

(d) Following briefings provided by the Trust about the Red Three project and the use of defibrillators in reporting ambulance response time performance and the Committee's consideration of winter resilience in Kent on 27 November 2015, the Chairman requested the Trust attend on 29 January 2016 to give an update on winter resilience, the Red Three project and the use of defibrillators in reporting ambulance response time performance.

2. Recommendation

RECOMMENDED that the report be noted and SECAmb be requested to share the findings of the Forensic, Patient Impact and Governance Reviews, commissioned by Monitor, to the Committee at the appropriate time.

Background Documents

SECAmb (2014) *'Response time targets (28/10/2014)',* http://www.secamb.nhs.uk/about_us/our_performance/response_time_targets.aspx

SECAmb (2015) *'Annual Report and Accounts: 1 April 2014 - 31 March 2015 (19/10/2015)',* http://www.secamb.nhs.uk/about_us/idoc.ashx?docid=becd2ec4-f5ba-4ac7-b134-f29c5cc0c667&version=-1

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South East Coast Ambulance Service NHS
NHS Foundation Trust

Kent HOSC

29 January 2016

Geraint Davies,
Director of Commissioning

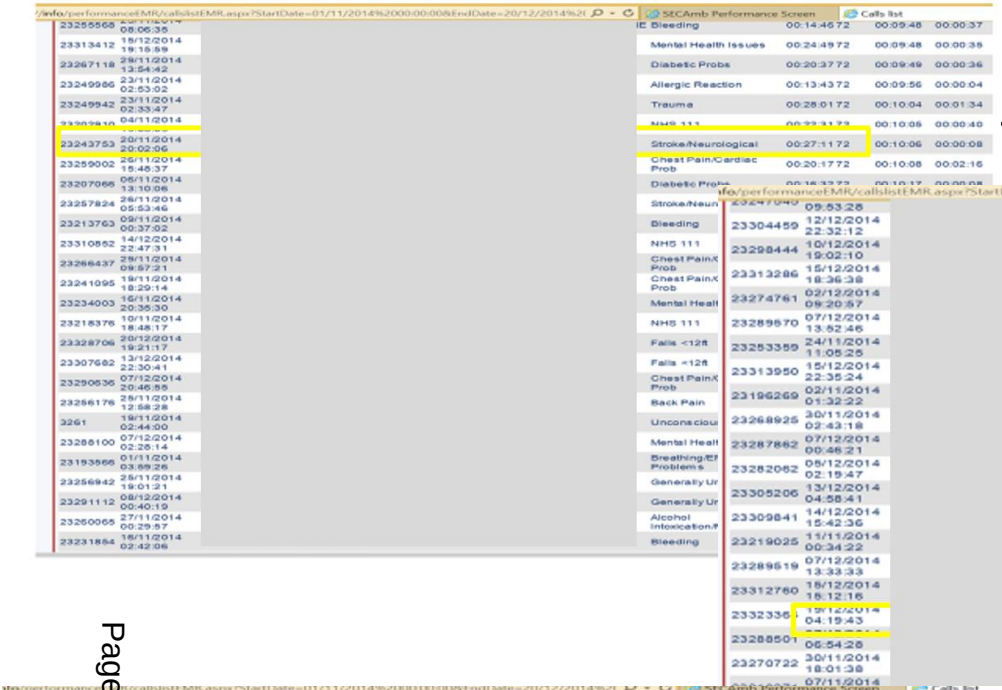
Your service, your call

Agenda

- Re-triage process
- Performance up-date & challenges:
  - 999
  - NHS 111
- Preparing for winter
- Performance reporting – defibrillators
- Key developments

Re-triage process

- Introduced during Winter 2014/15
- Background of significant system pressures & real risks to patient care
- Process saw clinicians taking up to an extra ten minutes to ‘re-triage’ calls that had come across from 111 to 999 as requiring an emergency response, during a period when we simply did not have sufficient resources available to respond to the demand.
- It allowed the clinicians to spot immediately life-threatened patients (Red 1s) amongst these, who needed a very quick response, as well as those calls that could wait a little longer for a response.


SECAmb Performance Screen
Calls list
Mental Health Issues 00:24:49 72 00:09:48 00:00:35
Diabetic Probs 00:20:37 72 00:09:49 00:00:36
Allergic Reaction 00:13:43 72 00:09:56 00:00:04
Trauma 00:28:01 72 00:10:04 00:01:34
Stroke/Neurological 00:27:11 72 00:10:06 00:00:08
Chest Pain/Cardiac Prob 00:20:17 72 00:10:08 00:02:16


SECAmb Performance Screen
Calls list
Assault 00:18:10 72 00:13:25 00:00:11
Chest Pain/Cardiac Prob 00:16:50 72 00:13:26 00:01:13
Breathing/ENT Problems 00:18:02 72 00:13:27 00:00:08
Minor Ailment/Injury 00:20:58 72 00:13:45 00:01:40
999 HCP 00:26:52 72 00:14:02 00:00:02
Chest Pain/Cardiac Prob 00:19:19 72 00:14:13 00:00:26
Falls <12ft 00:25:03 72 00:14:17 00:00:10
Allergic Reaction 00:25:25 72 00:14:18 00:00:05
NHS 111 00:26:22 72 00:14:21 00:00:04
Chest Pain/Cardiac Prob 00:17:23 72 00:14:22 00:00:32
Abdominal/Flank Pain 00:20:13 72 00:14:26 00:01:11
Unconscious/Faint 00:25:38 72 00:14:34 00:00:00
NHS 111 00:19:59 72 00:14:49 00:02:29
Generally Unwell 00:31:34 72 00:14:52 00:00:13
Stroke/Neurological 00:23:45 72 00:15:03 00:02:07
Maternity Issues 00:43:42 72 00:15:07 00:00:48
Bleeding 00:47:20 72 00:15:10 00:00:05
Prob 00:15:21 00:00:15
999 HCP 00:19:45 72 00:15:22 00:00:06
Stroke/Neurological 00:19:33 72 00:15:38 00:00:43
Chest Pain/Cardiac Prob 00:16:23 00:00:42
Chest Pain/Cardiac Prob 00:38:12 72 00:16:33 00:06:20


Assault 00:18:10 72 00:13:25 00:00:11
Chest Pain/Cardiac Prob 00:16:50 72
Breathing/ENT Problems 00:18:02 72
Minor Ailment/Injury 00:20:58 72
999 HCP 00:26:52 72
Chest Pain/Cardiac Prob 00:19:19 72
Falls <12ft 00:25:03 72
Allergic Reaction 00:25:25 72
NHS 111 00:26:22 72
Chest Pain/Cardiac Prob 00:17:23 72
Abdominal/Flank Pain 00:20:13 72
Unconscious/Faint 00:25:38 72
NHS 111 00:19:59 72
Generally Unwell 00:31:34 72
Stroke/Neurological 00:23:45 72
Maternity Issues 00:43:42 72
Bleeding 00:47:20 72
Prob
999 HCP 00:19:45 72
Stroke/Neurological 00:19:33 72
Chest Pain/Cardiac Prob
Chest Pain/Cardiac Prob 00:38:12 72
Overdose/Ingestion - Accidental 00:37:55 72
Headache
Minor Ailment/Injury 00:29:53 72


Headache 00:21:08 72 00:16:55 00:00:06
Minor Ailment/Injury 00:29:53 72 00:17:02 00:01:45
Back Pain 00:44:35 72 00:17:21 00:00:04
Back Pain 00:56:55 72 00:17:45 00:00:05
Alcohol Intoxication/Related 00:31:01 72 00:17:56 00:00:05
Breathing/ENT Problems 00:21:01 72 00:18:17 00:00:54
Fitting 00:44:51 71 00:19:43 00:00:20
Generally Unwell 00:23:06 72 00:19:54 00:00:14
999 HCP 00:33:36 72 00:19:58 00:05:37
Chest Pain/Cardiac Prob 00:39:51 72 00:21:33 00:00:17
Headache 00:41:22 72 00:22:28 00:00:48
999 HCP 00:34:11 72 00:22:38 00:01:55
Unconscious/Faint 00:32:25 72 00:22:41 00:01:07
Bleeding 00:32:21 72 00:22:52 00:02:56
Back Pain 00:25:06 72 00:23:33 00:00:05
Breathing/ENT Problems 00:34:08 72 00:24:19 00:00:45
Stroke/Neurological 00:56:34 72 00:31:14 00:00:05
Falls <12ft 01:05:32 72 00:31:32 00:00:12
Breathing/ENT Problems 01:02:38 72 00:39:52 00:00:05

23288104	07/12/2014 02:29:41	Headache	00:21:08 72	00:16:55	00:00:06
23328680	20/12/2014 19:09:59	Minor Ailment/Injury	00:29:53 72	00:17:02	00:01:45
23244691	21/11/2014 08:17:51	Back Pain	00:44:35 72	00:17:21	00:00:04
23247713	22/11/2014 10:49:54	Back Pain	00:56:55 72	00:17:45	00:00:09
23273770	01/12/2014 21:21:08	Alcohol Intoxication/Related	00:31:01 72	00:17:56	00:00:09
23316446	16/12/2014 19:26:26	Breathing/ENT Problems	00:21:01 72	00:18:17	00:00:54
23198881	02/11/2014 23:42:02	Fitting	00:44:51 71	00:19:43	00:00:20
23[illegible]540	15/12/2014 19:57:54	Generally Unwell	00:23:06 72	00:19:54	00:00:14
23[illegible]615	24/11/2014 12:49:03	999 HCP	00:33:36 72	00:19:58	00:05:37
23218453	10/11/2014 19:14:44	Chest Pain/Cardiac Prob	00:39:51 72	00:21:33	00:00:17
23290072	07/12/2014 17:04:59	Headache	00:41:22 72	00:22:28	00:00:48
23323300	19/12/2014 03:08:17	999 HCP	00:34:11 72	00:22:38	00:01:59
23311187	15/12/2014 02:42:52	Unconscious/Faint	00:32:25 72	00:22:41	00:01:07
23254872	24/11/2014 21:58:57	Bleeding	00:32:21 72	00:22:52	00:02:56
23257322	25/11/2014 22:12:37	Back Pain	00:25:06 72	00:23:33	00:00:09
23313984	15/12/2014 22:50:28	Breathing/ENT Problems	00:34:08 72	00:24:19	00:00:46
23304539	12/12/2014 23:08:56	Stroke/Neurological	00:56:34 72	00:31:14	00:00:09
23213876	09/11/2014 01:40:12	Falls <12ft	01:05:32 72	00:31:32	00:00:12
23314355	16/12/2014 02:37:43	Breathing/ENT Problems	01:02:38 72	00:39:52	00:00:05

Review process

- Reviews undertaken to date have recognised that the pilot was undertaken to ensure that the right response was provided to patients
- During the pilot period, 26,000 calls were transferred from the 111 service to 999
- As part of the review:
  - 899 incidents were reviewed
  - 25 incidents were identified, that were linked to the Red 3 process in some way
  - 7 Serious Incidents reported
- No identifiable patient harm attributable to the pilot has been identified to date
- But reviews have also revealed that the pilot was not well implemented and we did not use our own internal governance processes properly to manage it = serious findings.

Review process – contd./

- Action plan in place & reviewed with CCGs via contractual route
- Process with Monitor underway, includes:
  - **Forensic Review** - undertaken by Deloittes during November & December 2015, looking to establish the 'how, why, who & when' facts
  - **Patient Impact Review -** to be led by SECAmb Medical Director, Dr Rory McCrea and supported by Dr Andy Carson from WMAS. This has already commenced, with a likely timescale of four to six months, due to report in April 2016.
  - **Governance Review** – a wide-ranging review, covering all aspects of the Trust's governance arrangements. This will be shaped by the outcome of the Forensic Review and therefore will not start until the end of January/February 2016. It is likely to take circa three months to complete.

999 Performance

- Current performance – challenges around achieving Red 1, Red 2 and A19 targets

	December 2015		YTD (April to Dec 15)	
Indicator	**SECAmb**	**Kent**	**SECAmb**	**Kent**
Red 1	74.6%	75.0%	73.6%	72.5%
Red 2	71%	71.6%	73.4%	72.7%
A 19	95.4%	96.1%	95.0%	96.2%

- Performance remedial plan agreed with commissioners:
  - Focus on call answer time – aim to get to 95% within 5 seconds by year end
  - Focus on improving allocation of resources – forecasting, operational hubs, new management structure
  - Transition to Operating Units

999 Performance – key challenges

- Volume of hours lost to handover & turnaround delays = over 3,800 in December 2015
  - The position has worsened considerably in the first two weeks of January 2016
  - Handover delay is an issue at most sites but key priorities in Kent are Darent Valley, William Harvey, Pembury & Medway
  - For SECAmb overall, year to date delays are 50% up on same period in 2013 (impact on our response capacity and patient safety & experience)
- OOH GP capacity pressures causing severe impact on 111 and 999
- On-going recruitment pressures – front-line staff
- Finite capacity to recruit & train required additional EMA and EOC staff (rate-limiting step) required

NHS 111 Performance

- Current YTD performance – improving but challenges around call answer times & abandonment rate, especially at weekends
- Performance reviewed through contractual process
- Key internal challenge – recruitment/retention of Health Advisors (call handlers)
- Failure of OOH services, especially at weekends = significant risk

Winter

- Detailed action plans developed for 999, PTS & 111
- Key focus period – 1 December to 12 January
- 999 :
  - Maximise availability of front-line resources – on the road & EOC:
    - Managers, Private Providers, CFRs & Co-responders (ESFRS)
    - Reduce leave & other abstractions
    - Offer enhanced overtime for ‘hard to fill’ shifts
  - Ensure availability of support services – fleet, logistics, operational hubs
  - Logistic preparations – winter tyres, 4x4s, back-up systems
  - Includes escalation options – regional & national

Preparing for winter – contd./

- NHS 111:
  - Maximise availability of Health Advisors (call-takers) & Clinical Advisors
  - Identification of key 'pinch points'
  - Identification of 'surge' options e.g. front-end message
- Key risks (across all service areas):
  - System issues:
    - Availability/accessibility of other health & social care services
    - System capacity – hospital handover/OOHs
- Good performance over Christmas and New Year across 999 and 111
- Key pinch points/system pressures during January

Performance reporting - defibrillators

- We believe passionately in the widespread availability of Public Access Defibrillators (PADs) across our area
- 789 PADs currently in Kent & 2,227 across our region as a whole
- Defibrillators & national performance reporting – the current position:
  - The Association of Ambulance Chief Executives (AACE), the representative body for all English ambulance services, provides guidance on interpretation of Ambulance Quality Indicators (AQIs) to ensure they are applied consistently and correctly by everyone in all ambulance trusts
  - We carefully consider how to define whether a defibrillator is available at an incident location and we have detailed rules governing this

Performance reporting - defibrillators

- For Red 1 patients, the ‘clock stop’ only counts if the defibrillator is actually by the patient’s side.
- For Red 2 patients, the clock will only stop if there is someone able to collect the defibrillator and bring it to the patient and that the AED is accessible at the time of the call. Red 2 calls include incidents where there is a chance of cardiac arrest so there is a potential need for a defibrillator but it is not immediately required
- This process was used for approximately 5,000 calls in 2014/15 and should be seen in the context of the more than 850,000 total calls we received (which includes more than 200,000 Red 1 and Red 2 calls)
- We believe have been compliant with guidance - independent review currently underway to ensure
- Wider discussions underway, locally & nationally, on whether national reporting needs to change in this area - some changes made already

A key role in supporting & delivering system change

- Key enabler = professionalisation of clinical workforce
  - Development & utilisation of Paramedics & Paramedic Practitioners
  - Broader utilisation of range of clinicians including nurses, pharmacists, mental health professionals
- Sustainability & Transformation Plans
  - Integration of emergency & urgent care including 999, 111, GP OOH, Care Navigation & system support
- Development of integrated Community Paramedic role
  - Whitstable pilot

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Item 7: North Kent: Adult Community Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

Subject: North Kent: Adult Community Services

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 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) On 6 March 2015 and 5 June 2015 the Committee considered update reports on proposals for adult community services. At the end of the discussion on 5 June, the Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the Committee does not deem the changes to Adult Community Services to be a substantial variation of service.

  (b) North Kent CCGs be invited to submit a report to the Committee in six months

2. Community Services

(a) Community services are provided outside of hospitals in community settings, including in people's homes and in community clinics. Community services have a number of objectives, including promoting health and healthy behaviours, supporting people to manage long-term conditions, and providing treatment in a person's home or in the community to avoid hospital or residential care where possible (Monitor 2015).

(b) Prior to 2009, the vast majority of Primary Care Trusts (PCTs) both commissioned and provided community health services. From 2009 to 2011, as part of the Department of Health's Transforming Community Services (TCS) programme, PCTs transferred their community services provider arms to existing providers or created new providers including NHS providers (community trusts, acute trusts and mental health trusts); independent providers (private companies, GP practices and hospices); and third sector (charities, community interest corporations, social enterprises and voluntary sector organisations) (Monitor 2015).

(c) Community health services continue to be provided by a range of different providers and are a focus of several of the New Models of Care set out in the Five Year Forward View (particularly multispecialty community providers (MCPs) and integrated primary and acute care systems (PACS)).

(d) The Health and Social Care Act 2012 established Clinical Commissioning Groups (CCGs) which replaced PCTs on 1 April 2013; CCGs took responsibility for commissioning many community services. Local authorities became responsible for commissioning certain community-based public health services including alcohol and drug use prevention and treatment and sexual health services. NHS England also became responsible for commissioning certain public health services provided in the community, such as immunisations and national screening programmes (Monitor 2015).

3. Recommendation

RECOMMENDED that the report be noted and NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG be requested to provide the Committee with an update on the development of a new service model at the appropriate time.

Background Documents

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 (10/10/2014)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5400&Ver=4

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (06/03/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5838&Ver=4

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (05/06/2015)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5840&Ver=4

Monitor (2015) 'Commissioning better community services for NHS patients (22/01/2015)', https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/397429/Improving_community_services.pdf

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NHS Dartford Gravesham and Swanley and NHS Swale CCGs
Adult Community Services Procurement

HOSC Briefing – January 2016

Introduction

1. On 13 January 2016 NHS Dartford, Gravesham & Swanley (DGS) and NHS Swale Clinical Commissioning Group's (CCG's) confirmed the award of the contract for adult community services to Virgin Care Services Limited (Virgin Care).

2. The decision was made following a year-long procurement process which saw Virgin Care assessed as the best provider following thorough evaluation involving local clinicians, patients, commissioners and other subject matter experts. Virgin Care has a strong track record of running NHS community healthcare services over the last ten years, free at the point of need, to many people across the country. The CCGs are confident that Virgin Care will be able to provide the services and meet the needs of local people both now and in the future.

3. DGS and Swale are now working with Virgin Care and the current providers, Kent Community Health NHS Foundation Trust and Medway Community Healthcare, to ensure a seamless service transfer by early April 2016.

4. As previously discussed with the HOSC in March and June 2015, the procurement has been undertaken on 'an-is' basis: patients will continue to receive the same range of adult community services as is currently available. This is a seven year contract with the potential to extend a further three years. From the outset, the CCGs specified that the successful organisation would need to be responsive to any future changes in local health requirements over the period of the contract. However, any change in future service provision would need to follow formal due process as appropriate, including public consultation where required (in discussion with HOSC).

5. All staff currently employed by the existing providers who provide the applicable adult community services will be able to transfer to Virgin Care from April 2016, carrying with them their continuous services and the same terms and conditions of employment.

6. A copy of the briefing that was circulated to key stakeholders on 13 January and Frequently Asked Questions is attached to this paper for information.

Background

7. The challenge for health and social care both nationally and locally is predominantly:

- Long-standing health inequalities across the population

- A year on year increasing number and complexity of morbidities, particularly within the elderly population. This is however, true for all age groups with long term conditions

- Resources, both financial and human are finite and require further efficiency gains

8. How to respond to these challenges is central to the CCG's five year commissioning strategies and operational plans. These strategies are designed to tackle the above issues alongside the expected demographic changes linked to the planned and significant housing growth in both CCG areas.

9. It is widely acknowledged that in order to respond to the increasing requirements in the community there needs to be greater flexibility, improved responsiveness and closer integration between all health & social care providers. Models of care need to reflect a joint response with all parties needing to work together around the service users and centred on promoting health, independence and safety, thus reducing dependence on hospitals and long term care. Core to the successful delivery of the CCG plans are adult community health services.

10. As a result the CCG agreed to 'test the market' for a suitable provider of adult community services, given the view that the quality and flexibility of the existing service provision needed to be improved and that there were a range of providers who should be given the opportunity to bid for the contract. This would provide the CCG's with the opportunity to ensure that the best provider was engaged to support delivery of the strategic and operational plans.

The process

11. The CCGs undertook a 'competitive dialogue' procurement process, working with potential providers to understand their delivery proposals over a number of dialogue stages. In particular, the CCGs were keen to understand how the bidders would deliver high quality, flexible and financially sustainable services, and be able to develop innovative solutions to deliver integrated care to meet the long term needs of the local communities.

12. The procurement was advertised and conducted in line with EU, UK Government and NHS requirements. The process was also raised and discussed at CCG public Governing Body meetings, Health and Well Being Board meetings and with the HOSC. Local events were also held to ensure current and potential stakeholders were aware of the process.

13. Seven bids were originally received. Five of these organisations went through to the final stages. One organisation subsequently withdrew. Four high-quality final bids were received and thoroughly evaluated by the CCG. The contract was awarded based on a combination of quality and cost effectiveness. The four organisations leading each bid were:

    - Dartford and Gravesham NHS Trust
    - Kent Community Health NHS Foundation Trust
    - South Essex Partnership University NHS Foundation Trust
    - Virgin Healthcare Services Limited

14. During each stage of the procurement process, provider submissions were thoroughly reviewed by commissioners, clinicians, patient representatives and subject matter experts through a detailed evaluation process. These evaluations were then 'moderated' and 'super-moderated' by other independent individuals to ensure consistent assessment and scoring. The procurement process was supported throughout by NHS Commercial Solutions and, in the latter stages, by the CCGs legal representatives.

15. Finally, the procurement process was considered and approved by the two CCG Governing Bodies in December 2015. All four bidders were advised of the outcome of the process on 22nd December 2015, and following a period of formal 'standstill' (where any of the four providers were able to query the outcome), the outcome of the procurement was announced on 13th January 2016.

Conclusion

16. The HOSC are asked to note the outcome of the DGS and Swale adult community services procurement.

January 2016

STAKEHOLDER BRIEFING

Dartford Gravesham and Swanley Clinical Commissioning Group

Swale Clinical Commissioning Group

Accountable Officer
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Kent, DA12 1AU

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13 January 2016

Adult Community Services Procurement in North Kent

Dear Colleagues/Partners

You will already be aware that the above procurement to provide the majority of community services for adults in the north Kent CCG areas of Dartford, Gravesham and Swanley and Swale has been undertaken over the last twelve months. Following a rigorous process involving clinical and patient representatives, the north Kent CCGs will today announce the award of the contract to the preferred bidder, Virgin Care Services Limited (Virgin Care).

Whilst the announcement is being made today, this is subject to final due diligence and contract signature which is expected to be completed shortly.

We are confident that Virgin Care will be able to meet the diverse health needs of the people we serve, not just now, but in the future.

A change of provider will **not** mean a change in the services that patients currently access: the procurement has been carried out on an 'as-is' basis. The evaluation panel looked at a wide range of criteria that will contribute to the sustainable delivery of community based services that will meet the rapidly changing health needs of people in north Kent and most importantly reduce existing health inequalities in the area.

The decision comes after a year-long procurement process, which saw Virgin Care assessed as the best provider following thorough evaluation involving local clinicians, patients, commissioners and other subject matter experts. Virgin Care has a strong track record of running NHS community health services over the last ten years, free at the point of need, to more than a million people across the country.

Seven organisations participated in the initial tender process, with five of these organisations going through to the final stages. One organisation subsequently withdrew. Four high-quality final bids were received and thoroughly evaluated. The contract was awarded based on a combination of quality and cost effectiveness.

The new contract is worth approximately £18 million a year over seven years, with the potential to extend by three years.

Services included in the procurement

The majority of community health services for adults across Dartford, Gravesham, Swanley, Sittingbourne and the Isle of Sheppey will see a change of provider including:

- Community hospital services
- Community nursing and intermediate care services
- Community neuro rehabilitation
- Speech and language therapy
- Continence service
- Community podiatry
- Community specialist nursing

A small number of adult community services are excluded and will continue to be provided by the existing provider. These include:

- Physiotherapy
- Learning Disability services
- Epilepsy
- Lymphoedema.

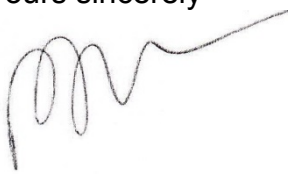
Other exclusions include children's community services, maternity services, Minor Injury Units and out of hours GP services, which will also continue to be provided by the existing providers.

As part of our commitment to ongoing patient and stakeholder feedback, with the assistance of a panel of patient representatives, we will continue to work closely with all parties to ensure a smooth and seamless transition for patients.

All affected adult community services staff currently employed by the existing providers, Kent Community Health NHS Foundation Trust and Medway Community Healthcare, will be able to transfer across to Virgin Care from 1 April 2016, carrying with them their continuous service, with the same terms and conditions of employment.

Some frequently asked questions and the answers to these are attached for your information.

Yours sincerely



Patricia Davies
Accountable Officer
NHS Dartford, Gravesham and Swanley and NHS Swale CCGs

NHS
Dartford Gravesham and Swanley Clinical Commissioning Group

NHS
Swale Clinical Commissioning Group

ADULT COMMUNITY SERVICES PROCUREMENT IN NORTH KENT FREQUENTLY ASKED QUESTIONS

What services are included in this procurement?

Most community health services for adults across Dartford, Gravesham, Swanley, Sittingbourne and the Isle of Sheppey are included, such as:

- Community hospitals
- Community nursing
- Intermediate care services
- Community neuro rehabilitation
- Speech and language therapy
- Continence service
- Community podiatry
- Community specialist nursing

Exceptions

A small number of adult community services are excluded such as physiotherapy, learning disability services, epilepsy and lymphoedema. Other exclusions include children's community services, maternity services, Minor Injury Units and out of hours GP services, which will continue to be provided by the existing providers.

Which hospitals are affected by this procurement?

This change in provider applies to services commissioned at the following community hospitals:

- Sittingbourne Memorial Hospital
- Sheppey Hospital, Isle of Sheppey
- Gravesham Hospital, Gravesend
- Livingstone Hospital, Dartford

Are you cutting any services?

There are no plans to cut services. Patients will continue to receive the same range of community services as is currently available.

From the outset, commissioners specified that the successful organisation would need to be responsive to any future changes in local health requirements and the expected growth in the local population over the duration of the contract. Any potential change in future service provision, however, would need to follow formal due process as appropriate, including consultation where required.

Will money be saved as a result of these changes?

The NHS is working within a very challenging funding environment and as commissioners we are looking to maximise value for money alongside improving service provision. The successful bid will attract some savings across the life of the contract and these will be reinvested into local frontline services.

Will you be moving any services?

No. Community-based services will continue to be provided from a range of community settings and in patients' homes. The locations of community hospitals are **not** part of this procurement process and the buildings and properties will continue to be owned by NHS Property Services.

How can you ensure that the quality of care will not slip?

Performance will be regularly reviewed as part of a robust contract management process by DGS and Swale CCGs, to ensure that patients have access to high quality services. As with all contracts between commissioners and providers, the contract will contain penalties for poor performance and all services will continue to be regularly inspected by the Care Quality Commission.

Who were the other bidders?

Seven bids were originally received. Four high-quality bids were evaluated as part of the final shortlisting process. The four organisations leading each bid were:

1. Dartford and Gravesham Hospitals NHS Trust
2. Kent Community Health NHS Foundation Trust
3. South Essex Partnership University NHS Foundation Trust
4. Virgin Healthcare Services Limited

Why do commissioners procure services?

Procurement of services is a recognised element of good commissioning, and is part of best practice to ensure commissioners access and understand the options available for the best possible service provision. The process helps CCGs understand how different healthcare providers deliver high quality, effective and timely care to patients, which represents good value, meeting the needs of the people they serve.

How did you conduct this particular procurement?

The procurement of Adult Community Services in Dartford, Gravesham and Swanley CCG and Swale CCG areas was led by the two organisations through a dedicated project team composed of clinical, commissioning and subject matter experts. Procurement process support was provided by NHS Commercial Solutions.

The tender for Adult Community Services was advertised publicly in accordance with EU, UK government and NHS requirements. The commissioners' intentions were also highlighted in public meetings, including the Governing Bodies and Annual General Meetings of both CCGs, and through other local events to ensure current and potential stakeholders were aware of the process.

Ends

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Item 8: North Kent: Emergency and Urgent Care Review and Redesign

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

Subject: North Kent: Emergency and Urgent Care Review and Redesign

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

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

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1. Introduction

(a) On 10 October 2014 the Committee considered proposals to reconfigure and recommission emergency and urgent care services in North Kent. The Committee's deliberations resulted in agreeing 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.

(b) NHS Swale CCG and NHS Dartford, Gravesham and Swanley CCG requested to postpone the item until 29 January 2016 meeting following the publication of national commissioning standards and procurement guidance for an integrated GP Out-of-Hours and 111 service by NHS England in September 2015; the Chairman agreed to this request.

2. Recommendation

RECOMMENDED that the report be noted and NHS Swale CCG and NHS Dartford, Gravesham and Swanley CCG be requested to keep the Committee updated as the urgent care programme is developed.

Background Documents

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (10/10/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5400&Ver=4

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NHS
Swale Clinical Commissioning Group

NHS
Dartford Gravesham and Swanley
Clinical Commissioning Group

Briefing to Kent County Council HOSC Friday 29th January 2016

Subject: Emergency and Urgent Care Review and Redesign – North Kent

Date: 18th January 2016

1. Purpose of report

This report provides the Committee with an update on the planned reconfiguration of urgent and emergency care services by NHS Swale Clinical Commissioning Group (CCG) and by NHS Dartford, Gravesham and Swanley CCG. This follows on from local review of recently published national guidance on future requirements for integrated services, and has implications for future procurement of NHS 111 and primary care Out-of-Hours services.

2. Introduction

In October 2014, Simon Stevens NHS England Chief Executive published his Five Year Forward View for the NHS. In relation to emergency services this states that across the NHS, urgent and emergency care services will be redesigned to improve integration between A&E departments, GP Out-of-Hours (OOH) services, urgent care centres, NHS 111 services, and ambulance services. In response to this, the North Kent CCGs established a programme to review and redesign urgent care services across the three CCG areas. This led to a series of CCG specific patient and clinical reference groups, arriving at a recommended solution within each CCG area. Due to the potential impact of large-scale developments including Ebbsfleet and resultant population increase across the DGS area, the scope of the DGS programme was changed to a re-procurement of primary care OOH services only.

For Swale, the proposal was a stand-alone Urgent Care Centre (UCC) incorporating OOH, Walk-In and Minor Injuries. The Medway proposal was a 24/7 co-located Urgent Care Centre (UCC) incorporating OOH and Walk-In provision. In all cases, the proposals were based on having a separate 111 service.

In July 2015 all CCGs received a letter from NHS England (NHSE), describing the future publication of new commissioning standards for an Integrated OOHs and 111 Service. The letter stated that, in order to allow the completion of the consultation on the standards, all further procurements of NHS 111 and OOH services should be suspended (whatever stage of the procurement had been reached) until the end of September 2016. In response, the three North Kent CCGs adjourned all activities related to Urgent Care redesign and procurement.

3. NHSE guidance for Transforming Urgent and Emergency Care Services in England

NHS England held an Integrated Urgent Care Services workshop in London on 8th September, at which they set out some of the work they were doing to develop national standards for future procurement of an integrated model for 111 and Out of Hours Primary Care.

Following this, a variety of national commissioning standards and procurement guidance for an integrated OOH and 111 service have been issued by NHSE.

The new commissioning standards (Commissioning Standards Integrated Urgent Care v1, September 2015) describe the requirements for a closely integrated urgent care service that is the 'front door' of the NHS, which will provide the public with 24/7 access to urgent clinical assessment, advice and treatment.

Central to this will be the development of a 'Clinical Hub' to provide clinical advice to patients contacting the 999 or 111 service, and to provide clinical support to clinicians, particularly ambulance staff such as paramedics and emergency technicians, so that no decision is made in isolation.

Other requirements are:

- Central to Integrated Urgent Care will be a 24/7 free to call number (111)
- The hub would have a range of clinicians including specialist or advanced paramedics with primary care and telephone triage competences, nurses, mental health professionals, prescribing pharmacists, dentists and senior doctors with primary care competences.
- The NHS 111 Directory of Services should include social care, mental health and voluntary sector services
- Commissioners are responsible for the procurement of a functionally Integrated Urgent Care service in line with the service standards described.

The guidance is not prescriptive on the contract model to be used, proposing that commissioners make an assessment of their current service provision and then plan what is required from the various contract options available taking their own legal advice in considering contract options and the procurement and competition implications of them.

4. Impact on reconfiguration of services in North Kent and Medway NHS

Potential local solutions to meet the guidance are being reviewed by the three CCGs. NHS 111 is currently provided in Kent, Surrey and Sussex by South East Coast Ambulance NHS Foundation Trust (SECAmb), working in partnership with Care UK. It is known that other CCGs in Kent, Surrey and Sussex are taking forward their own plans for 111 and OOH service provision. The North Kent CCGs are therefore considering procurement of a single 111 service across North Kent, functionally integrated with the three local Urgent Care Models in Medway, Swale and DGS, which would provide economy of scale in terms of the 111 service, whilst enabling local solutions for service configuration.

The three CCGs are now reviewing timescales for re-start of their respective redesign programmes, and are implementing programme governance structures to take the work forward. The contracts for existing NHS 111 services and Out-of-Hours providers are being extended to March 2018 in order to enable completion of the redesign programme, although it may be possible for new services to be procured and in place by Autumn 2017.

Now the pause has been lifted the CCGs intend to engage and consult with patients stakeholders in the review of current services and design of the urgent care system in line with the guidance.

In summary, the current actions for Swale and DGS CCGs are:

- Definition of scope of urgent care redesign within DGS, incorporating Ebbsfleet and Paramount developments in the area, in order to deliver 'clinical hub' requirements
- Relaunch the process for the review and design of urgent care in line with the published guidance;
- As part of this governance process to engage with patients, the public and key stakeholders in terms of any baseline review and in the design of the clinical hubs.
- Review of previously defined proposal for Swale urgent care provision, in light on NHSE guidance, to make sure that these co-designed provisional plans still hold true and are compliant with the published guidelines

5. Next steps

The CCGs will ensure the Committee is briefed on the developing urgent care programme.

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Item 9: NHS Swale CCG: Review of Emergency Ambulance Conveyances

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

Subject: NHS Swale CCG: Review of Emergency Ambulance Conveyances

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

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1. Introduction

(a) NHS Swale CCG has asked for the attached report to be presented to the Committee.

2. Recommendation

RECOMMENDED that:

(a) the report be noted;

(b) NHS Swale CCG be requested to keep the Committee updated as a long term proposal for emergency ambulance conveyances for the NHS Swale CCG population is developed.

Background Documents

None

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Briefing for HOSC

Review of Emergency Ambulance Conveyances for the Swale CCG Population

January 2016

Summary

A key priority for Swale CCG continues to be the improvement of patient experience and outcomes for the communities it serves.

Following a number of concerns raised by the Care Quality Commission, local GPs and the public in relation to care being provided at Medway Foundation NHS Trust (MFT), Swale CCG has committed to review a potential change in blue light conveyance.

This possible change in the emergency care pathway, will only cover the Swale population and will look at the feasibility of aligning *some* ambulance conveyances to a Kent provider at Maidstone Hospital (part of Maidstone and Tunbridge Wells NHS Trust).

The feasibility study supports existing strategic intentions that seek to develop a more integrated approach across health and social care, in order to enable seamless services and avoid unnecessary organisational bureaucracy.

The review will assess all possible impacts and more specifically, look at how additional bed capacity might be made available at Maidstone Hospital. The CCG is working with all relevant partners including Kent County Council and MFT to assess the practicality of this proposal.

Once this preliminary feasibility work has been undertaken, any long-term change in the destination of ambulances from Swale, would require formal public consultation, with any proposed change unlikely to be implemented until the summer of 2016.

Briefing note

1. Swale CCG is considering a potential change in the emergency care pathway for the population for whom it has commissioning responsibility. As part of the development of commissioning intentions the CCG is considering whether some emergency ("blue light") ambulance conveyances for its population should transfer from Medway Foundation NHS Trust to Maidstone Hospital (part of Maidstone and Tunbridge Wells NHS Trust).
2. This change is being considered for a number of reasons:
    i. Strategically the CCG is considering the future development of accountable care organisations (i.e. integrating the commissioning and provider functions). As an enabler to this the CCG believes there is a strategic argument to align Swale with a Kent acute hospital provider, which will facilitate the delivery of integrated care with the local authority by streamlining the emergency care pathway. Kent County Council are responsible for the social care needs of the Swale population and whilst they work with Medway Foundation NHS Trust, this provider is not in their area. Transferring conveyances for the Swale population would potentially align health and social care and facilitate the development of accountable care organisations.

ii. In response to issues identified by the Care Quality Commission at Medway Foundation Trust, a number of actions were identified in collaboration with NHS England to support the hospital. This included actions to reduce demand on the hospital so as to provide an opportunity for the organisation to review its operational practices and support staff training. One action was to consider a possible transfer of blue light ambulances for the Swale population from Medway Foundation NHS Trust to Maidstone Hospital.

iii. Concerns around the care provided at Medway Foundation NHS Trust have been raised by local GPs and the public, including at the CCG's recent Annual General Meeting. In response to these concerns Swale CCG has committed to review a potential change in blue light conveyance.

3. Swale CCG has now initiated a project to review this potential change in conveyances. This focuses on emergency medical patients and the following categories of patients are not being considered as part of this work (i.e. if changes are made these patients would continue to be transferred to Medway Foundation Trust):

   - All suspected maternity, obstetric and gynaecological patients
   - All paediatric patients under 16 years of age with any condition
   - All suspected vascular emergencies (including AAA and ischemic limbs)
   - All major trauma (Adult major trauma tree stages 1-4)
   - All cardiac arrests, imminent cardiac arrest (patients at high risk of cardiac arrest based on the clinical assessment of the ambulance clinician); and
   - All suspect surgical patients.

4. The main rate limiting step, which would delay any change being implemented should a decision be taken to proceed. is likely to be identifying additional bed capacity at Maidstone Hospital. This is mostly likely to be achieved through improving the flow of patients at Maidstone Hospital, through actions such as reducing the number of Delayed Transfers of Care and delivering internal operational efficiencies.

5. Any long-term change in the destination of conveyances from Swale, as part of the CCGs regular, ongoing review and development of commissioning intentions, would require formal public consultation, with any change unlikely to be implemented until the summer of 2016. However, Swale CCG reserves the right to take any appropriate and immediate commissioning action it deems necessary if there are significant concerns regarding patient safety.

January 2016

Item 10: East Kent Strategy Board (Written Briefing)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

Subject: East Kent Strategy Board (Written Briefing)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the East Kent Strategy Board.

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.

---

1. Introduction

(a) On 25 November 2015 the group representatives met with the East Kent Accountable Officers to discuss the work of the East Kent Strategy Board and requested a written briefing and verbal presentation at a formal meeting of the Committee.

(b) East Kent Hospitals University NHS Foundation Trust was due to return to the Committee with an update on their clinical strategy 'Delivering Our Future' on 29 January 2016. As the strategy has become part of a wider programme across East Kent which involves all the healthcare partners in the area working together; a written briefing about the East Kent Strategy Board has been submitted for the 29 January 2016 meeting and the East Kent Accountable Officers will attend the Committee on 4 March 2016 to give a verbal presentation about the work and programme of the Board.

2. Recommendation

RECOMMENDED that the report be noted and the East Kent Accountable Officers be requested to provide a verbal presentation on the work and programme of the East Kent Strategy Board on 4 March 2016.

Background Documents

None

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East Kent Strategy Board – briefing paper for HOSC

Meeting:	Kent County Council Health Overview and Scrutiny
Date of Meeting:	29 January 2016
Subject:	East Kent transformation – an update on the work of the East Kent Strategy Board
Action Required:	This paper is for information.
Purpose:	To update Health Overview and Scrutiny Committee representatives on developments following the establishment of the East Kent Strategy Board.

1. Introduction

This paper notes the meeting between HOSC Group representatives on 25 November 2015 and CCG Accountable Officers Hazel Carpenter and Simon Perks.

2. The East Kent Strategy Board

The East Kent Strategy Board was established in September 2015 by local health and care commissioners to spearhead a new drive to determine how best to provide health and care services to the population of east Kent. By the time of this meeting, the Board had met three times.

Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS and care services. The Board will oversee a work programme and advise local health and care commissioners whose role it is to plan the future pattern of services across east Kent.

A communication to stakeholders announcing the establishment of the Strategy Board and its remit was circulated in November 2015 (see Appendix A - stakeholder communications) and recipients included HOSC members. This paper includes the key points from that communication.

3. Relationship with HOSC

The HOSC was formally briefed about the establishment of the Board, its purpose, method of working and aims on 9 October 2015. This informal meeting was an opportunity for the Group Representatives to have a more in-depth briefing directly from the relevant CCG Accountable Officers with some context about the ambitions and work of the Board, and the subsequent programme of activity that it will oversee. It was acknowledged that while its work was in its early stages meaning that there were many unanswered question around changes to models of care and service patterns, there was a strong commitment to keeping

the HOSC updated and informed at every step of the way, a fact reflected in high-level programme planning.

4. Making the case for change – the context for transformation in east Kent

The Accountable Officers set out the context for the work of the Board.

- While staff and organisations work hard to provide local people with the best care, the quality and range of services which patients currently receive vary significantly according to the area of the county where they live. There are variations in the quality of some services, in health outcomes, in access to services and in key aspects of diagnosis and treatment. For example, some areas record much lower numbers of patients with long-term health conditions, such as heart disease or diabetes, than national trends suggest: indicating that people's illnesses may not have been diagnosed. For those who have a diagnosis, the quality of care doesn't always meet national quality standards. These variations are unacceptable and we believe that everyone in east Kent deserves to receive the very best care, wherever they live.
- The NHS is under increasing strain and must look at ways to transform the way care is delivered if we are to give the best care within available funding and resources. The reasons for this are plain: the NHS is operating with an unprecedented – and changing - demand for services, with fewer available specialists, in an acutely challenging financial environment.
- We have an ageing population with high levels of multiple long term conditions needing complex care and treatment from different organisations. This can be difficult for patients and their families and carers to navigate. It is time that care became more personalised, coordinated and community based, with sufficient focus on prevention as well as treatment.
- In addition, we are seeing a rise in long-term health problems such as diabetes as a result of lifestyle choices. It takes time, effort and new approaches to keep people with these conditions well and out of hospital.
- We in east Kent are not alone in needing to change. At a national level, the *NHS Five Year Forward View* (published in October 2014) made a compelling case for the need to transform if the NHS is to meet the needs of the population. This includes new ways of working and providing more services out of hospitals and in local communities.

New approaches to delivering care are already underway (examples below) and it is the responsibility of the Board to make sure these approaches are joined up, coherent and working to support each other, as part of an overall strategy for delivering care in the future for the people of east Kent.

- Hubs in Folkestone and Dover provide GP appointments 8am-8pm seven days a week, thanks to funding from the Prime Minister's GP Access Fund. Patients are referred by their practice or NHS 111.

- Primary care mental health specialists in a number of GP practices across east Kent support people who are acutely mentally unwell so they are less likely to need care

from secondary mental health services (provided by Kent and Medway NHS and Social Care Partnership Trust).

- A new 'multi-speciality community provider' model is being tested in the Canterbury, Faversham and Whitstable areas, with £1.6million from the NHS England Transformation Fund. It plans extended practice opening hours, paramedic practitioners who will visit housebound patients, an integrated nursing service involving both community and practice nurses and an increase in the number of outpatient services provided through specialist GPs – indeed, much of this is already taking place.

5. Next steps

There is a pressing need to tackle service pressures at the same time as developing a future model of care for the people of east Kent that meets changing needs. The Board will oversee the development of a model of care that works in a joined up way across primary, community, mental health and acute services, and with social care partners for the longer term. In the shorter term, individual organisations will continue, as now, to ensure they are delivering safe services day to day and will make any necessary immediate changes to fulfil this duty as required and in accordance with due process.

The Board will oversee a programme of design work over the coming months that will set out proposals for a new pattern of services across east Kent. The work will be clinically led, working closely with staff, patients, carers and the local community to co-design solutions to meet the challenges we face.

The Board has not yet considered or tested any options for change and no decisions about how services might be organised in the future have been made. Any decision-making on the future pattern of services remains with the commissioning bodies (the four clinical commissioning groups, NHS England and Kent County Council) who have the statutory responsibility to take decisions about what health and care services should be provided for their local populations.

6. Working with HOSC

The Group Representatives were asked to advise how they could work with the East Kent Strategy Board as its work develops and Representatives expressed an interest in the need for appropriate communications and engagement support for the Board's work. The Accountable Officers acknowledged that the programme is wide-ranging, involving as it does, all health and care organisations within east Kent and will take a 'whole system' approach to transforming the local health economy – a landscape which has a diverse and widespread mix of stakeholders and audiences all of whom will want or need to be engaged as the programme develops.

With this in mind, it was agreed that input from Representatives as the programme develops over 2015/16 and 2016/17 would be invaluable. Specifically it was agreed that reviewing plans for any formal consultation in due course and the consultation document would be welcome and helpful. It was acknowledged that regular updates to HOSC would both ensure Representatives were kept briefed and up-to-date as the programme progresses, and in itself would help to support the wider communications and engagement around the programme's work. The Accountable Officers also committed to updating the HOSC before the formal consultation, once the independent analysis has been published and after the formal decision by all Boards.

It is understood that a verbal update to the HOSC at the 4 March 2016 meeting has been requested by the Chairman.

Authors: Hazel Carpenter, Accountable Officer, NHS Thanet and NHS South Kent Coast CCGs and Simon Perks, Accountable Officer, NHS Ashford and NHS Canterbury and Coastal CCGs.

Ends

NB: The East Kent Strategy Board member organisations include:

NHS South Kent Coast CCG; NHS Canterbury and Coastal CCG (encompassing the Whitstable multi-specialty community provider vanguard); NHS Ashford CCG; NHS Thanet CCG; East Kent Hospitals University NHS Foundation Trust; Kent Community Health NHS Foundation Trust; Kent & Medway NHS and Social Care Partnership Trust; South East Coast Ambulance NHS Foundation Trust; and Kent County Council.

Appendix A – stakeholder communications

A letter to stakeholders announcing the establishment of the East Kent Strategy Board was circulated on 30 November. A supporting statement from the Board was also developed to sit alongside this letter and for partner organisations to use in their own communications about specific organisational transformation objectives. The letter and the statement are set out below for HOSC members' information.

East Kent health and care transformation programme – letter to stakeholders

30 November 2015

Dear colleague,

As the Accountable Officers for the four clinical commissioning groups covering east Kent and the Clinical Chair for the East Kent Strategy Board, we are writing to tell you about the latest developments regarding the future of local health and care services as we know you have an interest in this area.

We have recently established the East Kent Strategy Board to spearhead a new drive to determine how best to provide health and care services to the population of east Kent in the future.

Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS and care services. The Board will oversee a work programme and advise local health and care commissioners whose role it is to plan the future pattern of services across east Kent.

This letter aims to provide you with some context about the ambitions and work of the Board, and the subsequent programme of activity that it will oversee. We don't yet have answers to all the questions, but will seek to keep you regularly involved and updated as we progress with our work.

Why do we need to make changes?

While staff and organisations work hard to provide local people with the best care, the quality and range of services which patients currently receive vary significantly according to the area of the county where they live. There are variations in the quality of some services, in health outcomes, in access to services and in key aspects of diagnosis and treatment. For example, some areas record much lower numbers of patients with long-term health conditions, such as heart disease or diabetes, than national trends suggest: indicating that people's illnesses may not have been diagnosed. For those who have a diagnosis, the quality of care doesn't always meet national quality standards. These variations are unacceptable

and we believe that everyone in east Kent deserves to receive the very best care, wherever they live.

The NHS is under increasing strain and must look at ways to transform the way care is delivered if we are to give the best care within available funding and resources. The reasons for this are plain: the NHS is operating with an unprecedented – and changing - demand for services, with fewer available specialists, in an acutely challenging financial environment.

We have an ageing population with high levels of multiple long term conditions needing complex care and treatment from different organisations. This can be difficult for patients and their families and carers to navigate. It is time that care became more personalised, coordinated and community based.

In addition, we are seeing a rise in long-term health problems such as diabetes as a result of lifestyle choices. It takes time, effort and new approaches to keep people with these conditions well and out of hospital.

We in east Kent are not alone in needing to change. At a national level, the *NHS Five Year Forward View* (published in October 2014) made a compelling case for the need to transform if the NHS is to meet the needs of the population. This includes new ways of working and providing more services out of hospitals and in our local communities.

New approaches to delivering care are already underway

The East Kent Strategy Board recognises that some of this work has already begun. For example:

- Hubs in Folkestone and Dover provide GP appointments 8am-8pm seven days a week, thanks to funding from the Prime Minister's GP Access Fund. Patients are referred by their practice or NHS 111.

- Primary care mental health specialists in a number of GP practices across east Kent support people who are acutely mentally unwell so they are less likely to need care from secondary mental health services (provided by Kent and Medway NHS and Social Care Partnership Trust).

- A new 'multi-speciality community provider' model is being tested in the Canterbury, Faversham and Whitstable areas, with £1.6million from the NHS England Transformation Fund. It plans extended practice opening hours, paramedic practitioners who will visit housebound patients, an integrated nursing service involving both community and practice nurses and an increase in the number of outpatient services provided through specialist GPs.

- In addition, East Kent Hospitals University NHS Foundation Trust is developing a new clinical strategy, working closely with Healthwatch and clinicians to shape services to

meet the needs of patients and talking directly to patients and the public about their views and experiences.

But we now need to make sure that these new approaches are joined up, coherent and working to support each other, as part of an overall strategy for delivering care in the future for the people of east Kent.

Where will the Board focus its work?

It is clear that we need to tackle service pressures at the same time as developing a future model of care for the people of east Kent that meets changing needs. We need to develop a model of care that works in a joined up way across primary, community, mental health and acute services, and with social care partners.

The Board is committed to developing and delivering a comprehensive and cohesive transformation programme that improves health and wellbeing, delivers high quality and safe care both in and out of hospital settings and puts the services that so many people value on the path to a bright and sustainable future. The Board will oversee a programme of design work over the coming months that will set out proposals for a new pattern of services across east Kent. The work will be clinically led, working closely with staff, patients, carers and the local community to co-design solutions to meet the challenges we face.

The Board has not yet considered or tested any options for change and no decisions about how services might be organised in the future have been made. Any decision-making on the future pattern of services remains with the commissioning bodies (the four clinical commissioning groups, NHS England and Kent County Council) who have the statutory responsibility to take decisions about what health and care services should be provided for their local populations.

Transforming services around the interests of patients is at the heart of our ambition and we are committed to engaging with and consulting all those who provide, deliver – and most importantly of all – use health and care services. We have shared this letter with a range of local stakeholders but please feel free to update your own colleagues about our ambition for the future health and care system in east Kent, as described in this letter.

We look forward to working with you to turn our ambitions into a reality.

Yours faithfully

Dr Sarah Phillips	**Hazel Carpenter**	**Simon Perks**
Clinical Chair	**Accountable Officer**	**Accountable Officer**
East Kent Strategy Board	**NHS Thanet CCG**	**NHS Ashford CCG**
		NHS Canterbury and Coastal

Statement from East Kent Strategy Board regarding the future of health and care services

November 2015

The East Kent Strategy Board has been established by local health and care commissioners to spearhead a new drive to determine how best to provide health and care services to the population of east Kent in the future.

Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS and care services. The Board will oversee a work programme and advise local health and care commissioners whose role it is to plan the future pattern of services across east Kent.

While staff and organisations work hard to provide local people with the best care, the quality and range of services which patients receive vary significantly according to the area of the county where they live. These variations include key aspects of diagnosis and treatment. For example, some areas record much lower numbers of patients with long-term health conditions, such as heart disease or diabetes, than national trends suggest: indicating that people's illnesses may not have been diagnosed. For those who have a diagnosis, the quality of care doesn't always meet national quality standards. These variations are unacceptable and we believe that everyone deserves to receive the very best care, wherever they live.

The NHS is under increasing strain and must look at ways to transform the way care is delivered if it is to give the best care within available funding and resources. The reasons for this are plain: the NHS is operating with fewer available specialists in an acutely challenging financial environment with an unprecedented demand for services.

While it is great news that people are living longer, our ageing population often has multiple long term conditions needing complex care and treatment from different organisations. This can be difficult for patients and their families and carers to navigate. It is time that care became more personalised, coordinated and community based.

In addition, many of us are developing long-term health problems such as diabetes as a result of our lifestyle choices. It takes time, effort and new approaches to keep people with these conditions well and out of hospital.

We in east Kent are not alone in needing to change. At a national level, the *NHS Five Year Forward View* (published in October 2014) made a compelling case for the need to transform if the NHS is to meet the needs of the population. This includes new ways of working and providing more services out of hospitals and in our local communities.

The Board recognises that some of this work has already begun in east Kent. Examples include:

- Hubs in Folkestone and Dover providing GP appointments 8am-8pm seven days a week, thanks to funding from the Prime Minister's GP Access Fund. Patients are referred by their practice or NHS 111

- Primary care mental health specialists in a number of GP practices across east Kent, supporting people who are acutely mentally unwell so they are less likely to need care from secondary mental health services (provided by Kent and Medway NHS and Social Care Partnership Trust)

- New multi-speciality community provider model being tested in the Canterbury, Faversham and Whitstable areas, with £1.6million from the NHS England Transformation Fund. It plans extended practice opening hours, paramedic practitioners who will visit patients at home, an integrated nursing service involving both community and practice nurses and an increase in the number of outpatient services through specialist GPs.

In addition, East Kent Hospitals University NHS Foundation Trust has started a programme of developing a new clinical strategy, working closely with Healthwatch and clinicians to shape services to meet the needs of patients and talking directly to patients and the public about their views and experiences.

We should be proud of much of what we have already achieved but we need to tackle undeniable service pressures at the same time as developing a future model of care for the people of east Kent that meets changing needs. The time is right for us to do this together and the Board is committed to developing a comprehensive and cohesive transformation programme that improves health and wellbeing, delivers high quality and safe care both in and out of hospital settings and puts the services that so many people value on the path to a bright and sustainable future.

The Board has not yet considered or tested any options for change and no decisions about how services might be organised in the future have been made. Transforming services around the interests of patients is at the heart of our ambition and we are committed to consulting and engaging with all those who provide, deliver – and most importantly of all – use health and care services.

Ends
Notes for editors

- The membership of East Kent Strategy Board is: NHS South Kent Coast Clinical Commissioning Group; NHS Canterbury and Coastal Clinical Commissioning Group; NHS Ashford Clinical Commissioning Group; NHS Thanet Clinical Commissioning Group; East Kent Hospitals University NHS Foundation Trust; Kent Community Health NHS Foundation Trust; Kent and Medway NHS and Social Care Partnership Trust; South East Coast Ambulance Service NHS Foundation Trust; the Kent Health & Wellbeing Board; and Kent County Council.

- The East Kent Strategy Board is an advisory board chaired by GP clinical Chair Dr Sarah Phillips and comprising the chief executives and most senior clinicians of East Kent's NHS and care services. Any decision-making on the future pattern of services within east Kent remains with the commissioning bodies (the four clinical commissioning groups, NHS England and Kent County Council) who have the statutory responsibility to take decisions about what health and care services should be provided for their local populations.

Item 12: Patient Transport Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

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) The Committee has considered reports on patient transport services in Kent on 1 February 2013, 11 October 2013, 31 January 2014, 11 April 2014, 18 July 2014, 5 September 2014, 28 November 2014 and 6 March 2015.

(b) At the end of the discussion on 6 March 2015, the Committee agreed the following recommendation:

- *RESOLVED 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 on Patient Transport Services in six months.

(c) In July 2015 NHS West Kent CCG requested to postpone the item until after the public notification of the contract award on 22 December 2015 in order to prevent the disclosure of confidential information during the procurement process. The Chairman agreed to the request and the Patient Transport Services item is now scheduled for 29 January 2016.

2. Recommendation

RECOMMENDED that the report be noted and NHS West Kent CCG be requested to provide an update to the Committee about the mobilisation phase at the appropriate time.

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*

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (06/03/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5838&Ver=4

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NHS
West Kent
Clinical Commissioning Group

Non-emergency Patient Transport Service re procurement project Contract Award report

21 December 2015

Patient focused, providing quality, improving outcomes

1. Project Background

1.1 Service definitions

Non-Emergency Patient Transport is an eligibility based service that provides transport and care to individuals that due to their medical needs, would otherwise be unable to travel to or from the point at which they receive health care services. Eligibility criteria are set at a national level by the Department of Health.

The current Non-Emergency Patient Transport Service (PTS) contract for Kent and Medway expires on 30 June 2016.

The new service includes transport for eligible patients with a medical need that:

- Reside in Kent, Medway, Bromley or Bexley and are registered with a Kent, Medway, Bromley or Bexley GP.
- Reside in Kent, Medway, Bromley or Bexley and are not registered with a GP.
- Do not reside in Kent, Medway, Bromley or Bexley but are registered with a GP within Kent, Medway, Bromley or Bexley.
- Do not have a registered address and are not registered with a Kent, Medway, Bromley or Bexley GP and wish to be transported to an address within Kent, Medway, Bromley or Bexley following treatment within Kent or Medway.

1.2 The Procurement Project

Having made the decision to re procure the Kent and Medway PTS service the eight Kent and Medway Clinical Commissioning Groups (CCGs) established a project to ensure delivery of the required outcomes. The lead commissioning CCG for the Kent and Medway PTS is NHS West Kent Clinical Commissioning Group. South East Commissioning Support Unit was commissioned in March 2015 by the eight Kent and Medway CCGs to deliver the procurement project. Delivery is overseen by a Project Board that consists of membership representing the eight CCGs and key stakeholders.

The commencement of the project began with a thorough review of current services and the methodology used to procure the service in 2012. A number of lessons learnt were taken from this review and embedded in the project. These included the need for:

- Greater clarity and transparency in the required service standards
- Accurate activity data
- Detailed service standards and key performance indicators
- Patient focused key performance standards that include contract penalties for non-performance within certain thresholds.
- Provision of service that meets the individual needs of specified cohorts of patients.

The aim of the project is to procure a non-emergency patient transport service for Kent and Medway patients from July 2016 to a specification co-designed with stakeholders, that delivers a twenty four seven service with:

- A high level of reliability
- A quality service for patients, service providers and commissioners
- Efficient booking and control
- Value for money.

The high-level objectives supporting these aims are to:

- Specify service requirements to ensure delivery of the stated project objectives and improve patient experience.
- Ensure that the service redesign maximises the opportunities for partnership working and was congruent with the whole system and the specific local health economies of West Kent, East Kent, North Kent and Medway including other PTS service providers.
- Ensure that governance, assurance and decision making processes, are transparent and effective.
- Re-procure and mobilise the service with the new operating model effective from the end of the current contract.

In order to deliver these objectives the project has sought to:

1. Engage stakeholders in agreeing the specification and scope of the service and in particular resolving issues that might occur at the interfaces.
2. Develop and articulate service objectives that clearly express the desired level of performance. This includes whole system working arrangements that ensure effective communication and engagement across the health care economy and continuous improvement and service development.
3. Encapsulate these service objectives in key performance Indicators (KPIs)
4. Identify those performance indicators that will have sanctions for unacceptable performance.
5. Define the quality standards expected of this service and identify those that are to be reported through performance indicators.
6. Define the eligibility criteria for PTS in such a way that they can be applied and understood by patients, commissioners, clinicians, and the booking service.

7. Ensure the development and delivery of an effective mobilisation plan to ensure that the appointed service provider is ready to commence service delivery no later than 1st July 2016.
8. Establish and plan for effective contract performance management to commence immediately the contract starts.
9. Ensure that all relevant stakeholders, patient groups and the wider public are engaged with the project, its aims, and the status of the project at any time during its life. This will include (as far as is possible within procurement rules so as not to prejudice the procurement), providers of PTS services in Kent and Medway.

During the project commissioners have taken the opportunity to review and reorganise the way that these services are provided. The outcome will be contracts that specify services in a much more detailed and patient focused way and have significantly improved contract performance requirements. In addition to the inclusion of transport to and from points of healthcare in Kent and Medway, transport to and from London sites has also been included. This means that wherever a patient lives in Kent and Medway they can be confident that if they are eligible for transport they will receive the same consistent, good quality service wherever that transport may be required to and from. The contracts also includes the transport of patients home from hospital after an in-patient stay.

1.3 The Procurement Process

A Prior Information Notice (PIN) was published **3rd December 2014** alerting the market that a procurement process and market engagement event was to be undertaken.

A market engagement event was held in Tonbridge on 23rd March 2015 advising potential providers on the process, timeframes and drivers behind the whole project.

The OJEU advert Ref 2015/S 087-157440 was placed in 17th April 2015.

The service will be divided by three separate contracts in the following way.

- Lot 1: Kent and Medway patient transport excluding the transport of renal patients and transport to and from Dartford and Gravesham Hospital Trust (DGH)
- Lot 2: Renal patient transport
- Lot 3: Kent and Medway patient transport to and from Dartford and Gravesham Hospital Trust (DGH) sites.

The decision to divide the provision in this way was made to ensure that the needs of specific cohorts of patients were met in the most effective way and that the service was congruent within each health economy system.

All three contracts run for six years with the option to extend by another three. The total value of the contracts over six years is approximately £90million. It is expected there will be around 316,000 patient journeys in the first year and nearly two million

during the six years covered by the contracts.

The Pre-Qualification Questionnaire (PQQ) closed 1st June 2015 with 20 companies expressing an interest and 13 completing the PQQ.

The top scoring six companies in each Lot were invited to the tender stage.
The ITT followed a restricted procurement process.

The Contracting Authority issued the Invitation to Tender ("ITT") in connection with a competitive procurement conducted in accordance with the Restricted Procedure under EU Directive 2014/24/EU and Public Contracts Regulations 2015 on 17th July 2015. The opportunity closed on 1st September 2015. The effective period of each contract will be six years from the date of commencement. The effective period may be extended for a further 3 years but will not be extended beyond nine years.

- Four bids were received for Lot 1
- Four bids were received for Lot 2
- Five bids were received for Lot 3

This equated to a total of six different bidders.

1.4 Service Specifications

The service specifications for each of the three Lots will ensure that the service meets the needs of three distinctly separate cohorts of patients.

The service specifications for each the three Lots were co designed with key stakeholders including patients and acute and community trust providers. The service specifications have been improved to ensure:

- Greater clarity of requirements
- Significantly improved service standards and key performance indicators
- The inclusion of patient focused key performance standards that include contract penalties for non-performance within certain thresholds.
- Provision of service that meets the individual needs of specified cohorts of patients

Process maps have also been developed to underpin the requirements of the specification.

1.5 Tender evaluation

The Invitation to Tender (ITT) was evaluated on both technical/quality questions (65% weighting) and commercial score (35% weighting).

In addition to the evaluation of written submissions, site visits, presentations and interviews with bidders also took place. The site visits formed an essential element in validating the content of bidder submissions. During the site visits interviews were undertaken with commissioners of the service in the area that the site was based. Other activities that took place during site visits included observing call handling, the processes and systems used by bidders to manage operations and ride on journeys to observe patient care.

All bidders that submitted tenders were invited to attend interview and give a presentation for each of the Lots for which they had submitted a bid. Separate presentations that were prepared on the day by the bidder and interviews sought to further validate the content of written submissions.

Finally a moderation session was held for each Lot to reach the final scores on 19th October 2015.

1.6 Patient Involvement

Patients and service users have been engaged throughout the procurement phase in various different ways. The involvement of patients has included:

- Development of service specifications
- Involvement in bidder interviews
- Development of a Patients Charter.

The Patient Charter is a document that illustrates to the service provider the expected standards of service from a patient perspective. The charter is embedded in the service specifications.

Patients will continue to be involved throughout the mobilisation phase.

2. Contract Award

The Kent and Medway CCGs have considered the recommendations made by the Project Board and decided to award the contracts for Lot 1, Lot 2 and Lot 3 to G4S.

G4S have consistently shown a great understanding for the needs of the customer and the requirement to deliver this service in each Lot.

The award of these contracts is based on an evaluation process that combined technical / quality capability and commercial costs. The weighting was allocated on a 65/35 basis in favour of technical capability/quality.

The technical/ quality score was broken down into the following key areas and weighted accordingly.

Section 1 – Service Delivery 25% weighting
Section 2 – Management Process 22% weighting
Section 3 – Patient Experience & Safety 18% weighting.

The maximum score that could be achieved was 65 for the technical/quality questions and 35 for the commercial offer.

Lot 1 – Kent and Medway patient transport excluding renal patients and transport to and from Dartford and Gravesham Hospital Trust (DGH)

Bids for Lot 1 were received from:

- E-zec
- Medical Transport Services Limited
- G4S and
- NSL.

G4S achieved 77% of the total marks available for their technical and quality score compared to the nearest closest bidder who scored 60%.

G4S scored 31 for their commercial submission. The lowest commercial submission was given a maximum score of 35 and all other commercial submissions were measured against this as a percentage deviation.

Overall G4S scored a combined total of 82% compared to 74% for the bidder in second place.

Lot 2 – Renal Patient Transport

Bids for Lot 2 were received from:

- E-zec
- G4S
- NSL and
- Thames Ambulance Service.

G4S achieved 68% of the total marks available for their technical and quality score compared to the nearest closest bidder who scored 60%.

G4S scored full marks of 35 for their commercial submission. The lowest commercial submission was given a maximum score of 35 and all other commercial submissions were measured against this as a percentage deviation.

Overall G4S scored a combined total of 79% compared to 64% for the bidder in second place.

Lot 3 - Kent and Medway patient transport to and from Dartford and Gravesham Hospital Trust (DGH)

Bids for Lot 3 were received from:

- Dartford and Gravesham NHS Trust
- G4S
- Medical Transport Services Ltd
- NSL and
- Thames Ambulance Service.

G4S achieved 87% of the total marks available for their technical and quality score compared to the nearest closest bidder who scored 65%.

G4S scored full marks of 24 for their commercial submission. The lowest commercial submission was given a maximum score of 35 and all other commercial submissions were measured against this as a percentage deviation.

Overall G4S scored a combined total of 81% compared to 70% for the bidder in second place.

All three contracts run for six years with the option to extend by another three. They are worth close to £90million in total over the six years. It is expected there will be around 316,000 patient journeys in the first year and nearly two million during the six years covered by the contracts.

3. Next steps

Key activities that will take place over the next few weeks to commence the formal mobilisation process are set out below.

Start	Finish	Activity
22nd December 2015	22nd December 2015	Formal contract award notice to successful bidder
22nd December 2015	1st February 2016	Public Notification of contract award including papers to part 1 CCG Governing Body meetings
22nd December 2015	8th January 2016	Mobilisation submissions to be provided by G4S

14th January 2016	14th January 2016	First full meeting of mobilisation group to include NSL and G4S
22nd December 2015	1st February 2016	Contract award

The timetable below illustrates the high level key activities that will take place during the mobilisation phase.

Key Gateway Activities	09/12/15 to 01/01/16	Jan 16	Feb 16	Mar to Jul 16	Jul to Sep 16	Oct 16
Service launch						
Mobilisation submissions to be provided by winning bidder						
First full meeting of mobilisation group to include NSL and winning bidder						
Public Notification of contract award including papers to part 1 CCG Governing Body meetings						
Approve mobilisation plans						
Finalise revisions to pricing and operational structure						
Contract award						
Provider to enact mobilisation plan						
Exiting provider to enact exit plans						
Assure mobilisation and exit plan delivery						
Mobilise						
Monitor mobilisation						
Project evaluation						

4. Summary

G4S provided a detailed and well written tender response for each of the three Lots showing an in-depth understanding covering all the requirements for this tender. It was clear from their documentation that they have a dedicated well balanced team as well as a large vehicle fleet. G4S offer flexibility to increase the number of vehicles as and when required. G4S have good regional presence and effective plans to expand bases. The provider also has a tried and tested vehicle tracking, monitoring and management system, effective booking system and established organisational processes to provide a good management process. The documentation submitted by G4S also covered Risk

and Issues.
The organisation and management structure is clear and a detailed mobilisation programme was provided that shows an in-depth understanding of what is required.

The award of each of the three separate contracts to G4S based on the improved service specifications will ensure that Kent and Medway patients receive an improved level of service.

The three contracts will run for six years with the option to extend by another three. The total value of the contracts over six years is approximately £90million. It is expected there will be around 316,000 patient journeys in the first year and nearly two million during the six years covered by the contracts.

The mobilisation process will be detailed and through and will ensure that there is as smooth a transition as possible from the current provision. Key stakeholders will be involved throughout this process. The mobilisation phase will be overseen by the Project Board.

The contracts will mobilise on 1st July 2016.

Item 13: NHS West Kent CCG: Diabetes Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

Subject: NHS West Kent CCG: Diabetes Services

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

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

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1. Introduction

(a) On 4 September 2015 the Committee considered the proposed model of care, patient engagement report and GP membership engagement report for specialist community-based diabetes services in West Kent. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that the report be noted and NHS West Kent CCG be requested to present the service specification to the Committee at the appropriate time.*

2. Potential Substantial Variation of Service

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

(b) Where the HOSC deems the 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 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 service specification is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the service specification for Diabetes Services in West Kent to be a substantial variation of service.

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

3. Recommendation

If the service specification is *substantial*:

RECOMMENDED that:

(a) the Committee deems the service specification for Diabetes Services in West Kent 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 (2015) '*Agenda, Health Overview and Scrutiny Committee (04/09/2015)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5842&Ver=4

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NHS
West Kent
Clinical Commissioning Group

Specialist Community Based Diabetes Service Diabetes care for adults with diabetes mellitus

29 January 2016

Patient focused, providing quality, improving outcomes

1. Introduction

This report is to brief Members of the Kent Health Overview and Scrutiny Committee (HOSC) with the proposed new service specification for improvements to diabetes services in West Kent.

This follows an earlier briefing in September 2015.

2. Background

At the 4 September 2015 HOSC meeting, NHS West Kent Clinical Commissioning Group (CCG) briefed Members on proposals to reconfigure /recommission diabetes services.

As part of the CCG's Commissioning Intentions 2015/16 and 2016/17, diabetes services and care have been identified as a key priority for improvement to meet the future challenges that will come with the predicted rise in prevalence.

The current pathway is fragmented, with services delivered by separate organisations (hospital, community, GP practices) with no overarching care planning across the system. There is scope to deliver more holistic care for patients and to develop a more 'joined-up' pathway between hospital, GP practices, community and mental health support.

The successful management of patients with diabetes requires a whole system approach, with support for self-care and care in the community as key elements that can have a major impact on outcomes across all care settings. Through delivering more integrated care, NHS West Kent CCG anticipates that it will improve both the quality of care and also make better use of resources.

The proposal is to decommission the current secondary care level three diabetes services for NHS West Kent CCG and to recommission the same in the community under an integrated level two and three service.

During May and June 15, NHS West Kent CCG led a joint patient and stakeholder engagement programme to seek views on improvements in diabetes care, covering both local health care professionals and patients.

The September 2015 briefing provided a summary on the results and outcomes of the engagement.

Members noted the report and asked NHS West Kent CCG to present the service specification to the Committee at the appropriate time.

3. The service specification

Service Specification No.	
Service	**Specialist Community Based Diabetes Service** **Diabetes care for adults with diabetes mellitus**
Commissioner Lead	**Dr Sanjay Singh, Chief GP Commissioner** **West Kent CCG**
Provider Lead	
Period	
Date of Review	

1. Population Needs
1.1 National/local context and evidence base

Background

Diabetes is a common long-term condition caused by too much glucose in the blood. There are two main types of diabetes, Type 1 diabetes and Type 2 diabetes. It is estimated that 10% of people with diabetes have Type 1 diabetes and 90% have Type 2 diabetes.

Type 1 diabetes (T1DM) develops if the body cannot produce any insulin. It usually appears before the age of 40 years, especially in childhood. It is the less common of the two types of diabetes. It cannot be prevented and it is not known why exactly it develops. Type 1 diabetes is treated by daily insulin doses by injections or via an insulin pump.

Type 2 diabetes (T2DM) develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). Type 2 diabetes is treated with a healthy diet and increased physical activity. In addition, tablets and/or insulin injections can be required.

1.2 National context and evidence base

Diabetes care is one of the major challenges facing the NHS in the coming years and the quality of care provision varies throughout the country. Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year[1] and the number of people in the UK with diabetes is increasing and is projected to rise from 3.1 million to 3.8 million by 2020[2]. Due to the increasing obesity levels in the UK it is expected that the incidence of T2DM (which accounts for approximately 90% of diabetes in the UK[3]) will increase and as a result it is estimated the number of people with diabetes in the UK will rise to 4.6 million by 2030[4]. This makes it the long term condition with the fastest rising prevalence[4]. If diabetes is not managed properly it can lead to serious life-threatening and life-limiting complications, such as blindness and stroke. An individual may also have diabetes and any other number of other long-term conditions, like, for example, chronic obstructive pulmonary disease (COPD). The NHS needs to rise to the challenge of multi-morbidity through proactive and comprehensive disease management, placing the

individual firmly in the centre of their care. This sort of effective management of individuals, as described in this service specification, will impact positively on indicators across the five domains of the NHS Outcomes Framework (see below).

Diabetes care in the UK has improved significantly over the past 15 years[5, 6] and the levels of premature mortality in the UK are lower than in 18 other wealthy countries[5]. In spite of these developments there is still room to improve the service delivery.

Currently, only around one in five people with diabetes are achieving all 3 of the recommended standards for glucose control, blood pressure and cholesterol[2]. Moreover, the complications relating to diabetes are wide reaching, including:

- The most common reason for renal dialysis and the second most common cause of blindness in people of working age[4,7]
- Increases the risk of cardiovascular disease (heart attacks, strokes) by two to four times[8]
- Increases the risk of chronic kidney disease, from an incidence of 5-10% in the general population to between 18% and 30% in people with diabetes[4]
- During 2011-14, 21,125 patients with diabetes underwent an amputation equating to an average of 135 per week. 14,367 people lost a toe or part of their foot in minor amputations and 6,758 had a foot or part of a leg cut off[9]

1.3 Local Context[10]

The resident population of West Kent CCG is 467,500 and 86,000 of those people are aged 65 or over, a higher proportion than across England as a whole. In the CCG, 2.5% of people live in the most deprived fifth of areas in England. In 2013/14 a total of **20,485** patients (17 years and over) were recorded to have diabetes which is significantly lower than neighbouring CCGs. There were an estimated **4,800** people who remain undiagnosed suggesting the total number of adults with diabetes in the CCG was around **25,300**. Between 2013/14 and 2019/20, the crude prevalence rate of diabetes in adults is expected to increase from 5.5% to 6.8% and the undetected prevalence rate is expected to increase from 1.3% to 2.6%.

People with diabetes are at a higher risk of having a heart attack or stroke. In this area, people with diabetes are 88.5% more likely than people without diabetes to have a heart attack. This is lower than the figure for England which is 108.6%. People with diabetes are also 103.2% more likely to have a stroke. This is higher than the figure for England where there is an 81.3% greater risk. West Kent CCG spent £320 on prescribing per person with diabetes which is higher than the England average of £285. The total spend on prescribing for anti-diabetic items between April 2013 and March 2014 was £6,550,000. Prescriptions to treat diabetes accounted for 9.1% of the total CCG prescribing budget.

The National Institute for Health and Care Excellence recommends nine care processes for diabetes. These are five risk factors (body mass index, blood pressure, smoking, glucose levels (HbA1c) and cholesterol) and three tests to identify early complications (urine microalbumin, creatinine, and foot nerve and circulation examination). Eye screening is recommended but not included in the data presented. Controlling the risk factors helps a person with diabetes reduce his or her future risk of developing diabetic complications. There are also recommended targets for HbA1c, cholesterol and blood pressure. West Kent CCG 2012/13[11] (most recent data available) is listed below:

Indicator	Local	Comparator CCGs	England
People with diabetes who have had 8 recommended care processes	48.6%	56.7%	59.5%
People with diabetes whose last HbA1c was equal to or less than 58mmol/mol	64.2%	68.6%	62.4%
People with diabetes meeting blood glucose, blood pressure and cholesterol targets	35%	34.8%	36%

For West Kent CCG there have been 1,216 episodes of care for diabetic foot disease between 2011/12 and 2013/14, accounting for 10,847 nights in hospital. The annual rate of episodes of care for diabetic foot conditions per 1,000 adults with diabetes is significantly higher than the national average. There were 41 major amputations performed during the three years, giving an annual rate of 0.7 major amputations per 1,000 adults with diabetes, which is not significantly different from the national average. 549 different patients were admitted for foot disease. 51.2% of these had more than one episode of care in the three years, which is significantly lower than the national average. Of the 549 patients, 13.5% had more than four periods of care, which is significantly lower than the national average.[12]

Using national data from 2011, Type 2 diabetes can be estimated to cost West Kent CCG £13 million from its treatment and management, as well as a further £51 million from diabetic complications. For 2019/20, a cost of nearly £21 million to the local health economy is projected using the crude prevalence of diabetes for treatment and management.

It has been shown in studies that good diabetic management in the first 10 years of diagnosis has the maximum impact on morbidity and mortality hence timely diagnosis and appropriate initial management of the disease is crucial to a Patient's clinical outcomes.

The current status of service provision and strategy around diabetes prevention and management within West Kent has much scope for improvement and is also ill-placed to meet the future challenges that will come with the predicted rising prevalence:

- There is a lack of a comprehensive obesity strategy to slow the rise in the expected number of diabetics in West Kent
- The current programmes (e.g. NHS health checks) for early detection of diabetes has had variable impact with much room for improvement especially in the deprived and 'hard to reach' populations.
- There is a lack of comprehensive local strategy or pathway to deal with patients with 'Impaired Glucose Regulation' in terms of identification, registers and clinical management
- Primary care capability is variable leading to variable standards of care delivered to patients
- Primary care capacity has not risen with the rise in prevalence due to resource constraints which has affected patient care and outcomes
- There has not been any 'workforce planning' for diabetes in West Kent leading to patchy and variable provision of services based on historical commissioning (e.g. dietetics and podiatry)
- Services like specialist nursing, diabetic podiatry and dietetics are predominantly secondary care based, which is both expensive and fails to reach patients who need their services in the community
- Diabetic related preventable non-elective admissions are on the rise and consuming a significant level of resources
- Most secondary care based diabetic services are based on activity rather than outcomes

- The financial risks to West Kent CCG related to the above points are worsening each year in rising planned, unplanned and prescription costs
- It is estimated that nationally only 15% of diabetic patients meet the 3 'Best Practice Targets' (Hba1c: 6.5% or 48mmol/mol, Cholesterol: <4mmol and BP: <135/80)

West Kent CCG aim to address the current issues facing primary, secondary and community care by developing a Prevention and Obesity Strategy to slow down the expected rise in prevalence. A primary care diabetes prevention programme is in place to support earlier diagnosis of diabetes and improvement in control of the main risks associated with diabetes, namely blood pressure, cholesterol and glycaemic control.

References

1. National Diabetes Audit Mortality Analysis 2007-2008 – NHS Information Centre, 2011
2. The management of adult diabetes services in the NHS - National Audit Office; 2012 in POSTNote Number 415 Preventing Diabetes, July 2012
3. Diabetes in the UK 2009: Key statistics on diabetes, Diabetes UK, 2009
4. Commissioning Excellent Diabetes Care: an at a glance guide to the NHS Diabetes Commissioning Resource – NHS Diabetes and Diabetes UK, February 2012, Second edition
5. Murray, Christopher JL, et al. (2013) UK health performance: findings of the Global Burden of Disease Study 2010. *The Lancet*
6. Lind, M., et al. (2013) Mortality trends in patients with and without diabetes in Ontario, Canada and the UK from 1996 to 2009: a population-based study. *Diabetologia*: 1-8
7. State of the Nation, England - Diabetes UK, 2012
8. Stamler J, Vaccaro O, Neaton J, Wentworth D. (1993) Diabetes, other risk factors, and 12-yr cardiovascular mortality for men screened in the multiple risk factor intervention trial Diabetes Care
9. The Guardian: Diabetes UK, record number of people undergoing amputations because of diabetes, 15 July 2015
10. Kent & Medway Public Health Observatory: NHS West Kent CCG Diabetes, June 2015
11. Public Health England: Cardiovascular Disease Profile: Diabetes, March 2015
12. Public Health England: Diabetes foot-care activity profile, June 2015

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Domain 1	**Preventing people from dying prematurely**	**Yes**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**Yes**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**Yes**
Domain 4	**Ensuring people have a positive experience of care**	**Yes**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**Yes**

2.2 Local defined outcomes

The Provider will operate a prioritisation system to triage referrals. In cases where the standard waiting times would be too detrimental to the Service User's condition or safety their assessment should be

undertaken as soon as possible. The Provider may therefore need to fast track the Service User into specialist services. This will:

- Ensure all services achieve the high quality care as described in Diabetes National Service Framework, NICE guidance and NICE quality standards
- Increase the uptake of structured patient education programmes to facilitate the independent management of their condition
- Improve self-esteem and ability to self-manage their condition
- Improve equality of access to specialist diabetes services including podiatry, dietetics and psychological support
- Reduce anxiety and depression of patients with diabetes
- Improve access and uptake of primary care and non-specialist hospital staff education in diabetes
- Improve primary care diabetes reviews and annual reviews
- Reduce diabetes related referral rates to secondary care for routine care
- Reduce number of new and follow up diabetes appointments
- Reduce average prescribing and monitoring costs related to diabetes when compared to comparable CCGs and national averages
- Reduce minor and major amputations
- Reduce average HbA1c levels from current baseline
- Reduce cardiovascular morbidity and mortality over a 5 year period
- Reduce length of stay for admissions of patients with diabetes
- Reduce hospital bed days incurred by patients with diabetes
- Reduce the frequency of emergency admission for service user's with diabetes, including episodes of diabetic ketoacidosis, hypoglycaemia and hyperosmolar hyperglycaemic state (HHS) by 20% in 3 years
- Lead to individualised care plans for 90% of patients in Level 2-4 services
- Increase the proportion of service users with diabetes reporting positive experiences of diabetic care to 90% in 5 years
- Reduce the average years of life lost due to Type 2 diabetes from 6 to 4 in 10 years
- Reduce the average years of life lost due to Type 1 diabetes from 15 to 12 in 10 years
- Reduce diabetes related partial or total blindness by TBC%

3. Scope

3.1 Model of Care

The community based diabetes service (the 'Service') will provide clinical management of diabetes in adults in line with the agreed model of delivery shown below.

Diabetes Pathway (Final).docx

The service will be provided by a comprehensive diabetes skilled multidisciplinary team which will require all professionals involved in the patient's care to work in partnership, including GPs, consultants, specialists, other health care professionals and support staff, with the patient and his/her family/carer.

3.2 Aims and objectives of service

NICE have produced a Quality Standard for Diabetes Care QS6 (Appendix A), to help describe what constitutes high quality care for people with diabetes. This service specification integrates this standard into pathways of care for people with diabetes with the aim of improving outcomes. This specification details the whole pathway including episodes of specialist care.

The key aims and objectives of the service are to:

Provide an integrated, evidence based service with a single point of access/referral. The community based service will act as a single point for all referrals (Levels 2 to 4) received and will be triaged by an appropriate clinician. The triage system will offer support, advice and guidance via telephone and electronic contact (without the need to see the patient) on how to best manage a patient where primary care management is deemed appropriate or triage onto the appropriate specialist community based service i.e. the 'Hub' or 'Spoke' (Level 2/3) or hospital care (Level 4). The professional advice line will be available as a minimum during the hours of Monday-Friday, 09.00-17.00; this will be subject to ongoing review with the Commissioner. Professional queries through the advice line will be responded to by the next working day via telephone or secure email.

The majority of diabetes care will occur in a primary care setting. If an optimum level of diabetes care is to be achieved for patients in West Kent CCG, good standards of fundamental diabetes care needs to be delivered by all GP Practices. In order to optimize primary diabetes care, the community based diabetes service needs to be fully integrated with all GP practices and develop collaborative relationships that share expertise via the 'spokes'.

SPOKE - The mainstay of specialist diabetes care in West Kent CCG will be undertaken within the spokes, which will be situated in GP practices across the patch. There will be 10-12 spokes aligned to an average population size of 40,000-50,000 registered patients though it will vary separately depending on geography and any other local factors. The spokes will operate on a 'roving model' with teams visiting host practices with the spoke catchment on an agreed rotational basis. These will consist of fortnightly or monthly clinical sessions and care will be delivered by a team of accredited Level 2/3 practice clinicians, GPwSIs, dietitians and DSNs (Diabetic Specialist Nurses) supported by Consultant Diabetologists. Consultants are expected to spend at least 1 clinical session at each spoke per month to provide support and supervision, see patients, interact with GP colleagues and undertake complex case reviews. The spoke will be responsible for the first stage of stepped up care from routine GMS diabetes care. Increasingly this will be the vehicle through which most patients with complex or severe diabetic presentations are managed. Once the issues presenting are resolved, the patient will be discharged to the referring GP for ongoing monitoring (in line with a jointly agreed care plan). The spokes will:

- Develop and implement a defined integrated pathway with clinical triage, onward referral and management protocols embedded into the diabetes pathway consistent with current NICE guidance
- Provide a multi-disciplinary team (MDT) from the point of diagnosis, whether practice or community based
- Deliver individualised care planning agreed in partnership with patient, carers and health care professional and once achieved (considered stable), the patient will be discharged back to the referring GP
- Undertake Insulin and GLP1 initiation and stabilisation of Type 2 diabetes patients

- Management of unstable Type 2 with poor glycaemic control despite best efforts in primary care. Depending on complexity of the case these may be patients delegated from hubs after initial multidisciplinary assessment or direct referrals from Primary care
- Undertake integrated diabetic assessments for new patients
- Management of stable DAFNE trained Type 1 patients via virtual and face to face consultations till discharge to Primary care with patient consent
- Offer joint case notes reviews and MDT discussion sessions for all patients to offer advice/support and to educate primary care clinicians in the management of complex diabetic patients. In undertaking this joint case note review of complex patients on the diabetic list, GP practices and the Service can agree which patients may be suitable for review in joint consultation clinics, community clinics (if not referred already), or home visits. These case note reviews should take place on a quarterly basis as part of routine clinical sessions
- Provide practice based education in addition to signposting to or provision of formal structured education programmes
- Offer specialist pre-conception advice where control is good and for patients who have suffered from gestational diabetes in previous pregnancy, including direct referral to specialist (Level 4) antenatal services
- Targeted care coordinator role/function for non-engagers, hard to reach groups and for high risk patients
- Multidisciplinary clinics providing access to consultants, specialist practice nursing and dietetics
- Management of housebound patients on request by primary care and if fulfilling the criteria described below, in liaison with primary care and complex care nurses. It should include at least one annual review of diabetics on medications or poorly controlled against their individualized targets
- Management of patients discharged from the hub
- Monitor patients and discharge back to primary care were applicable
- Monitor/audit local practice performance
- Contribute to a reduction in the severity and frequency of acute episodes including episodes of diabetic ketoacidosis, hypoglycaemia and hyperosmolar hyperglycaemic state (HHS)
- Use a patient record system to ensure there is IT connectivity and interoperability for all providers across the integrated diabetes pathway. This shall include facilitating the use of national diabetes dataset standards for the exchange of electronic patient information between primary care, community and secondary care providers
- Provide direct and easy access to the MDT
- Sign-post patients to Health Trainers and lifestyle services

HUBS – as referred to above, the mainstay of specialist diabetes care will be delivered via spokes, however on occasions, the complexity or severity of the patient's diabetes will exceed the thresholds of care in the spokes. In these instances, a referral will be made to the hub. There will be 2 hubs aligned to an average GP population size of 240,000 registered patients. These will consist of (TBC) regular clinical sessions and care will be delivered by a Consultant Diabetologist or Endocrinologist as well as a community DSN and other healthcare professionals working within the multi-disciplinary team. The staffing level for each hub will comprise as a minimum Consultant Diabetologists, DSNs, dietitians, podiatrists and a psychologist. The hubs will:

- Undertake integrated diabetic assessments of complex patient cases (including new referrals) with development of a structured individualised care plan (TBA) with multidisciplinary assessment and

input. As a minimum this will include clinical, dietetics, psychologist and podiatry input where applicable

- Multidisciplinary clinics providing access to consultants, specialist nursing, dietetics and podiatry and specialist psychology
- Offer podiatry care, advice and support for increased risk patients with a history of active foot problems. Care for active complex podiatry (requiring liaison with specialist vascular consultants) will include direct referral to specialist (Level 4) podiatry services
- Insulin infusion pump management after initiation in secondary care
- Provide clinical psychology input within the MDT environment for appropriate patients
- Provide a Young Adults Clinic (16 – 25 years old) service to support and facilitate transition of patients into adult service
- Provide structured education for patients with Type 2 diabetes in line with NICE TA60
- Provide structured education for patients with Type 1 diabetes in line with NICE TA60
- Provision of structured diabetes education for primary care and healthcare professionals to update knowledge and awareness of diabetes management and to support shared learning
- Provide specialist Type 1 diabetes care within a multidisciplinary framework supported by a Consultant Diabetologist in line with NICE CG15
- Management of unstable Type 1 and Type 2 patients with poor glycaemic control despite best efforts in primary care
- Deliver individualised care planning agreed in partnership with patient, carers and health care professional and once achieved (considered stable), the patient will be discharged back to the spoke or primary care
- Provide specialist 'dietetics only' input to primary care as per an agreed referral criteria
- Offer an appointment to all diabetes ketoacidosis (DKA) non elective admissions to prevent further re-admissions

Domiciliary Care

The service will provide support and advice to primary care (GPs and Complex care nurses) by monitoring the diabetes management, treatment decisions, annual check-ups and education for those with complex needs in residential care settings or identified as housebound as per an agreed criteria and on request by the GP Practice. In such circumstances, the community service will make arrangements to undertake the equivalent consultation within the patient's home or residential setting. A referral request from GP would be required in each case.

Patients who can receive this service will meet one or more of the following criteria:

- The person is 'housebound' i.e. a person who, as a result of chronic physical or psychological disability, is unable to leave their home via regular or adapted transport and accesses GP services normally by home-visiting
- The patient is receiving end of life care
- The patient has very complex needs where an assessment visit to their home will help inform the management plan
- The patient lives in a registered nursing home and meets one or more of the above criteria

Patient Education

The community diabetes service will deliver structure patient education for patients with Type 1 and Type 2 diabetes in line with NICE TA60. The programmes will be delivered in a way that maximizes accessibility for eligible patients in terms of location, time, language, venue and style of delivery.

- Type 1 – please refer to Appendix A for full service specification
- Type 2 – please refer to Appendix B for full service specification

Healthcare Professional Training

Practice delivered structured patient education – practice nurses will deliver structured patient education when a patient is unable to attend the courses detailed above. The community service will provide appropriate training to practice staff and training must be fully completed before beginning to deliver formal structured education. A literature pack (approved by the Commissioner) will be provided by the community service for practices to talk through with patients.

Professional Education – the community service will support the up-skilling of GPs, Practice Nurses and allied health professionals in primary care. Strong emphasis on building competence and confidence to enact initial management and continued care for patients with diabetes including annual completion of the nine key processes of care as follows: HbA1c, Blood Pressure, Cholesterol, Creatinine, Micro-albuminuria, BMI, Eyes, Feet, Smoking.

Medicines Management

Drugs Budget

The Provider will receive from the Commissioner an agreed drugs budget to cover medications supplied on FP10 prescriptions by the community based diabetes service, based on available data and reviewed annually. The supply and acquisition of medicines must be made in accordance with the Medicines Act.

Medicines Management Audit

The Provider will work with the Commissioner to analyse on a quarterly basis prescribing from FP10 prescriptions and FP10 P-REC to ensure that it is prescribing and supplying medicines in line with NICE and local guidance, in a cost-effective manner.

The Provider will be required to undertake audits of prescribed medicines as requested by the Commissioner.

The Provider will be required to work with the Commissioner to identify and understand variances of unusual drugs prescribed outside the West Kent interface formulary or stock list, and if there is a cost variance of more than TBC% on the predicted FP10 prescribing budget, the Service will be expected to fund the difference. This will be on an on-going, minimum quarterly or more frequent exceptional basis. The provider will ensure supporting data is available e.g. non-identifiable patient consultations for review in order to validate audits and data provided.

The Provider should ensure that it has access (procured or directly employed) to appropriate professional support to ensure that it has the correct policies and procedures in place in order to meet the requirements

of the Medicines Act.

3.2 Service description/care pathway

The Service shall:

- Ensure that it is fully integrated across primary, secondary and community care
- Ensure the patient is provided with full access to all elements of the pathway when clinically appropriate.
- Ensure clinical staff are competent, qualified and/or trained in diabetes care
- Information is provided at the time of referral to enable the patient to make informed decisions regarding care and requirements
- Support, information and scheduled reassessments are provided at the time of first assessment.
- On-going support is provided where required
- Provide a responsive service that addresses patient's needs, provides service support and demonstrates that feedback is acted on and informs improved service delivery
- Provide a responsive service that regularly partakes in audit within and across all care settings, reviews data and uses it to inform and stimulate improvements in service delivery
- Provide education (in addition to the formal structured education courses) for patients in all settings, but particularly primary care, to promote self-management
- Ensure IT facilities allow the following:
  - Clinical notes read-only provision;
  - Clinician to clinician capability such as use of Kinesis;
  - Electronic transmission of patient communication;
  - Electronic contact between clinician and patient
- Ensure IT integration with primary care systems for seamless flow of information.
- Ensure patient services are delivered by a number of methods including electronic contact, telephone, video consultation and face to face consultations
- Offer a proportion of appointments times outside normal working hours to make it easier for working or commuting patients to access their services

Assessment and care planning/appointment

SPOKE – the service shall:

- Ensure all patients are offered an initial assessment and individualised care planning appointment with a member of their MDT within 4-6 weeks (2-3 weeks for antenatal) of referral
- Ensure that the representative MDT member undertaking initial assessment and care planning is appropriately trained and experienced.

The assessment must include:

- Referral for Retinal Screening
- Referral to appropriate psychological services where applicable
- The offer of an education programme
- Physical activity and dietary advice
- Foot inspection and ulceration risk assessment
- Insulin-treated patients – discussion about the self-management of their insulin

Recording of the nine care processes:

- HbA_{1C} levels
- Blood Pressure
- Cholesterol levels
- Serum Creatinine levels
- Urinary albumin to creatinine ratio
- Foot surveillance
- Body Mass Index
- Smoking Status
- Eye screening status

The service shall conduct a care planning cycle at least every 12 months if the patient remains within the service and are not discharged to primary care.

The service shall adhere to the NICE guidelines relating to these processes.

HUB – the service shall:

- Ensure that personalised care planning remains the mechanism of care delivery for and interaction with each patient with diabetes
- Ensure that structured education programs are consistent with NICE TA60 – diabetes (Types 1 and 2) patient education models
- Ensure that pre-pregnancy advice is consistent with NICE CG63
- Ensure that Service Users with Type 2 diabetes and poor glycaemic control will receive management consistent with NICE guidelines
- The service (only when supported by a Consultant Diabetologist) will ensure that patients with Type 1 diabetes will receive management consistent with NICE CG15
- Ensure clinical psychology support within the MDT environment for appropriate patients
- For all specialist services the service will arrange follow-up appointments at clinically appropriate intervals

Continuing care and assessment – the service shall ensure that:

- All patients have a designated health care coordinator who is accountable for the management of the patient's care
- All patients have direct access to a member of their MDT through the provision of emergency contact details during work hours, open access services in line with NICE CG15 and 87
- All patients can easily access a member of their MDT (via phone or email) who can review and alter their treatment in a timely manner
- All patients have regular reviews of their HbA_{1c} levels, at a minimum 6 monthly in line with NICE CG87
- All patients at risk of developing an ulcer undergo podiatry screening regularly in line with NICE CG10
- All patients who need to initiate insulin therapy are provided with an education package around insulin self-administration
- All patients who need to initiate other injectable therapies are provided with an education package

around drug self-administration

The hub shall refer patients to the hospital care service in the following circumstances:

- If there is doubt as to the type of diabetes – if there is difficulty differentiating Type 1 from Type 2 diabetes, or if a rarer form of diabetes, such as MODY or mitochondrial diabetes, is suspected
- Referral to the specialist antenatal diabetes team – following a confirmation of pregnancy
- Referral to a specialist foot care team – if ulcer present or suspicion of acute Charcot neuroarthropathy, then will need to be seen within 24 hours, Monday to Friday, by the foot MDT
- Referral to the specialist diabetes team – following assessment by the MDT and suspicion of diabetic kidney disease
- Referral to a specialist vascular/diabetic services where appropriate i.e. high risk foot clinic

3.3 Population covered

This specification covers the care of young adult and adult Service Users with diabetes (16 years and over) whose care is provided by a West Kent CCG GP member. This specification details the care of patients with diabetes for their adult lifetime or from registration with an in-area GP.

The service will triage all referrals and where the requirements of a patient are beyond the scope of the community team, the service will ensure the patient has a fast track referral into hospital care.

3.4 Any acceptance and exclusion criteria and thresholds

NOTE: Access to the NHS service will be governed by geographic location and eligibility for NHS treatment. The Commissioner shall define the geographic area to be covered in accordance with "Establishing the Responsible Commissioner" and the NHS Plan.

Acceptance criteria

- The Provider will accept referrals of patients (16 years and older) with diabetes, whether their condition is newly diagnosed or well established
- The Provider will accept referrals for patients whose care is provided by a GP member of West Kent CCG
- The Provider will ensure that it provides locally available information about the services it provides.

Exclusion criteria

The service will exclude but need to establish links with:

- Primary care diabetic care as per GMS regulations (Appendix C)
- Diabetic retinal screening
- Ophthalmology service
- Renal service
- Orthotics service
- Orthopaedics service
- Paediatrics and Adolescent (ages 14-17 years old)

Referral route

Access to the service will be by an agreed referral form as detailed in Appendix C via a single point of referral. The service will ensure the referral template is compatible with clinical systems operated by GP referrers.

Referral source

- West Kent General Practitioners
- West Kent Practice Nurses
- KCHT Community Nursing Teams
- Nursing and residential homes

Clinical triage and referrals

All routine referrals will be clinically triaged by an appropriate clinician within 2 working days and urgent referrals within 1 working day. Appointments will be confirmed in writing within a further 2 working days during the normal working week.

Incomplete referrals will be rejected and returned to the referrer with a written explanation within 3 working days.

Inappropriate referrals – the clinical triage system will offer support and advice/guidance via telephone and secure email (without the need to see the patient) on how to best manage a patient where primary care management is deemed appropriate. A letter will be sent to the referring GP with advice on the most suitable interventions within primary care within 3 working days.

Appropriate referrals – the clinical triage system will forward on to the most appropriate service i.e. the 'hub' or 'spoke' (Level 2/3) or hospital care (Level 4) within 3 workings days.

The professional advice line will be available as a minimum during the hours of Monday-Friday, 09.00-17.00. Professional queries through the advice line will be responded to by the next working day via telephone or secure email.

Waiting times

The service will comply to the following wait times:

- An urgent face to face appointment must be offered within 10-14 working days of the referral being received by telephone and letter to confirm details
- A routine face to face appointment must be offered within 6-8 weeks of the referral being received by telephone and letter to confirm details
- Patient choice will be respected where longer waits are requested and the date of referral must be recorded in the patient's notes
- The Service will have the flexibility to offer an appointment in an alternative spoke should the waiting list be shorter and in agreement with the patient.

Discharge

Patients will be discharged back to the care of the GP/Referrer when jointly agreed patient goals are met, the patient is considered stable or further management of the patient could be done in primary care with active advice to practice nurse or GP. An electronic discharge summary which details the 'Individualised care plan' should be sent to the GP within 72 hours of discharge. Hubs should actively transfer care to spokes after initial intervention where appropriate.

DNA Protocol

If the patient does not attend an appointment (with no notification), the patient will be rebooked and the

GP/Referrer advised for up to a maximum of 2 consecutive DNAs. Following 2 consecutive DNAs, the patient will be discharged back to the GP/Referrer confirming that re-referral will be required. A standard letter will be sent to the GP, and copied to the patient, requesting confirmation of acceptance of the management of the patient until the re-referral is received by the service.

3.5 Interdependence with other services/providers

The service will work together with all other providers of diabetes services for the covered population. In order to deliver integrated and seamless care, the service will work with:

- GP's and Primary Care Practitioners
- Generic nursing and therapy teams
- Specialist community teams and case managers
- Podiatry Services
- Local Acute Hospitals
- Diabetes Patient Forums
- Diabetes UK
- Diabetic Retinal Screening Services
- Palliative Care Services
- Orthotic Services
- Patient Transport Services

National and Local Clinical Audit

Participation in national audits is necessary to provide a means by which diabetes services in West Kent can be benchmarked against appropriate peers. The provider is required to participate in the following national audits:

- National Diabetes Audit
- National Diabetes Audit of Acute Trusts
- Patient Experience Surveys
- Patient Reported Outcomes Measures
- Annual local clinical audit of the service is required. Of particular importance will be the monitoring of prescribing against local pharmacotherapy guidance.

Staffing requirements

The minimum staffing requirements of some elements of the pathway are set out in Appendix D - TBC. The staffing establishment will ensure service coverage by all specialties 52 weeks a year.

The Provider shall ensure that policies and procedures are in place that ensures:

- All staff employed or engaged by the service are informed and aware of the standards of performance they are required to promote.
- Staff performance is routinely monitored and that any remedial action is taken where levels of performance are not in line with the agreed standards of performance.
- There are clear lines of responsibility and accountability for all members of staff.
- Conflicts of interest are resolved without impact on the service provision.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

This pathway specification is based on the NICE Quality Standard for Diabetes (QS6) and takes into consideration the guidance detailed below.

NICE Clinical Guidance:

- CG10 Type 2 diabetes – footcare (2004)
- CG15 Type 1 diabetes in children, young people and adults: NICE guideline (2005)
- CG62 Antenatal Care (2008)
- CG63 Diabetes in pregnancy (2008)
- CG87 Type 2 diabetes: full guidance (partial update of CG66) (2009)
- CG91 Depression with a chronic physical health problem: quick reference guide (2009)
- CG119 Diabetic foot problems - inpatient management: quick reference guide (2012)
- CG82 Schizophrenia – Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care (2009)

NICE Clinical Guidelines / Technology Appraisals in development:

Title	Wave	Anticipated publication date	Process
Diabetes in children and young people	R	Aug-15	CG
Diabetes in pregnancy	R	Feb-15	CG
Diabetic foot problems	0	TBC	SCG
Type 1 Diabetes (update)	R	Aug-15	CG
Type 2 diabetes	0	Aug-15	CG

Diabetic foot ulcers - new treatments [ID381]	TBC	MTA
Diabetic retinopathy - ruboxistaurin [ID382]	TBC	STA

NICE Technology Appraisals

- TA53 Diabetes (types 1 and 2) – long acting insulin analogues (2002)
- TA60 Guidance on the use of patient education models for diabetes (2003)
- TA151 Diabetes – Insulin pump therapy (2008)
- TA203 – Liraglutide (2010)
- TA248 – Exenatide (prolonged release) (2012)
- TA274 Macular oedema (diabetic) – ranibizumab: guidance (2013)
- TA288 – Dapagliflozin combination therapy (2012)
- TA315 – Canagliflozin combination therapy (2014)

Other:

- National Service Framework for Diabetes: Standards (2001)
- National Service Framework for Diabetes: Delivering Strategy (2002)
- Minding the Gap: The provision of psychological support and care for people with diabetes in the UK

– a report from Diabetes UK

- Emotional and Psychological Support and Care in Diabetes – a report by Diabetes UK
- Think Glucose – NHS Institute for Innovation and Improvement:

http://www.institute.nhs.uk/quality_and_value/think_glucose/welcome_to_the_website_for_thinkglucose.html

- Association of British Clinical Diabetologists:

  http://www.diabetologists-abcd.org.uk/Position_Papers/ABCD_DUK_Type_1_position_statement.pdf

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Royal college of Ophthalmologists

- Diabetic Retinopathy guidelines (Dec 2012)
- Diabetic Retinopathy Screening (DRSS) and the Ophthalmology Clinic set up in England (Sept 2010)

Royal College of Obstetricians and Gynaecologists

- Diagnosis and Treatment of Gestational Diabetes (Scientific Impact Paper 23)
- HbA1c monitoring in gestational diabetes - query bank

Royal college of Physicians

- Commissioning diabetes and endocrinology services [online]. Available at: http://www.rcplondon.ac.uk/projects/clinical-commissioning-hub/commissioning-diabetes-endocrinology-services

Royal College of Nursing

- Starting injectable treatment in adults with type 2 diabetes – RCN guidance for nurses (2012)
- The role of the link nurse in infection prevention and control (IPC): developing a link nurse framework (2012)

4.3 Applicable local standards

The service will:

- Improve the quality and effectiveness of diabetes care by integrating acute and community teams
- Improve the productivity of the workforce in equipping them with additional skills
- Enhance patient independence and supporting ability to cope with a long term condition
- Ensure that the Service operates within budgetary constraints and with appropriate regard to the management of resources with due consideration to local eligibility criteria and priorities
- 95% of routine referrals will be clinically triaged within 2 working day, urgent referrals within one working day
- 95% of urgent referrals will result in an urgent appointment offered within a maximum of 10 - 14 working days of the referral being received, offered by telephone and a letter to confirm details
- 95% of routine referrals will result in an appointment offered within 6-8 weeks of the referral being received, offered by telephone and a letter to confirm details

5. Applicable quality requirements and CQUIN goals

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

The submission of the monitoring report is a condition of service provision and the Commissioner will have the right to withhold payments due for provision of services if monitoring reports are not received. The provider will submit a quarterly report to the Commissioner containing the minimum data set as detailed in the contract, within this report providers will be expected to provide the following additional data:

Minimum Data Set (MDS)

Description	Reporting Method
Total number of patients seen at each Spoke and each Hub to include PID • Clinic Code / Venue • Number of patients seen by nurse • Number of patients seen by consultant • Number of patients seen by Dietetics • Number of patients seen by Podiatry • Source of referral (number incomplete, appropriate and number inappropriate) • Number of referrals (split routine/urgent) • Number of patients discharged (including reason) • Number of DNAs • Average waiting time for first appointment (split routine/urgent) • Number and % of patients and carers with discharge summary and ongoing joint Care Plan at point of discharge • Number of patient complaints and outcomes reported • 95% of all routine referrals will be clinically triaged within 2 working days and all urgent referrals within 1 working day • Incomplete referrals – 95% returned with written explanation within 3 working days • Inappropriate referrals – 95% returned with written explanation within 3 working days • Appropriate referrals - 95% forwarded to appropriate care setting with 3 working days	SUS + Unique local report as required

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Hubs – the premises will be located in 2 community locations across West Kent CCG. The service will ensure that the venues are accessible, local and suitable to undertaken this clinical function and must meet current DDA compliance.

The service will operate Monday to Friday 09.00 to 17.00 hours excluding weekends and Bank Holidays (hours subject to ongoing review with the Commissioner)

HUB 1	**HUB 2**
Venue - TBC	Venue - TBC
Clinic Times: TBC	**Clinic Times:** TBC

Spokes - the mainstay of specialist diabetes care in West Kent CCG will be undertaken within the spokes, which will be situation in GP practices across the patch. There will be 10-12 spokes aligned to an average population size of 40,000-50,000 registered patients though it will vary separately depending on geography and any other local factors. The spokes will operate on a 'roving model' with teams visiting host practices within the spoke catchment on an agreed rotational basis. The service will ensure that the venues are accessible, local and suitable to undertaken this clinical function and must meet current DDA compliance.

The service will operate Monday to Friday 09.00 to 17.00 hours excluding weekends and Bank Holidays (hours subject to ongoing review with the Commissioner).

SPOKE 1	**SPOKE 2**	**SPOKE 3**
TBC	TBC	TBC
Clinic Times: TBC	**Clinic Times:** TBC	**Clinic Times:** TBC
SPOKE 4	**SPOKE 5**	**SPOKE 6**
TBC	TBC	TBC
Clinic Times: TBC	**Clinic Times:** TBC	**Clinic Times:** TBC
SPOKE 7	**SPOKE 8**	**SPOKE 9**
TBC	TBC	TBC
Clinic Times: TBC	**Clinic Times:** TBC	**Clinic Times:** TBC
SPOKE 10	**SPOKE 11**	**SPOKE 12**
TBC	TBC	TBC
Clinic Times: TBC	**Clinic Times:** TBC	**Clinic Times:** TBC

7. Individual Service User Placement

N/A

8. Key Performance Indicators

Indicator	Threshold	Reporting Mechanism	Consequence of breach
Access: Waiting Times % of patients who have a record of being offered a routine appointment within 6-8 weeks of referral	95%	Quarterly report	Remedial action plan
Access: Waiting Times % of patients who have a record of being offered an urgent appointment within 10-14 working days of referral	95%	Quarterly report	Remedial action plan
Access: Discharge % of patients and carers with discharge summary and ongoing joint Care Plan at point of discharge	95%	Quarterly report	Remedial action plan
Patient satisfaction Provider should undertake an annual patient satisfaction survey with a sample size that should be at least 15% of the current service users	90% of patients surveyed report satisfaction with the services they receive	Annual report	Remedial action plan
Clinical All patients will have an 'Individualised care plan' developed electronically in consultation with the patient and given both to the patient and his/her GP	95%	Quarterly report	Remedial action plan
Clinical Reduction in emergency admission rate of Diabetes Ketoacidosis and Hypoglycemia by 10% in year 1 and 20% at year 3 from baseline year 2015/16	95%	Quarterly report	Remedial action plan
Clinical Reduction in emergency diabetic foot related conditions by 20% in year 3 (2018/19) and 40% in year 5 (2020/21) from baseline	95%	Quarterly report	Remedial action plan
Clinical 50% of diabetics referred to the service will have met the three individualised targets of Cholesterol, BP and target HbA1c within 12 months from referral date.	50%	Quarterly report	Remedial action plan

The NICE Quality Standard for Diabetes Care (Quality Standard 6)

Statement 1 People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education.

Statement 2 People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.

Statement 3 People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan.

Statement 4 People with diabetes agree with their healthcare professional a documented personalised HbA_{1c} target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an ongoing review of treatment to minimise hypoglycaemia.

Statement 5 People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.

Statement 6 Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.

Statement 7 Women of childbearing age with diabetes are regularly informed of the benefits of preconception glycaemic control and of any risks, including medication that may harm an unborn child. Women with diabetes planning a pregnancy are offered preconception care and those not planning a pregnancy are offered advice on contraception.

Statement 8 People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.

Statement 9 People with diabetes are assessed for psychological problems, which are then managed appropriately.

Statement 10 People with diabetes at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance.

Statement 11 People with diabetes with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.

Statement 12 People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.

Statement 13 People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.

Statement 14 People with diabetes who have experienced hypoglycaemia requiring medical attention are referred to a specialist diabetes team.

Diabetes QOF indicators for 2015/16

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Records		
DM017. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed NICE 2011 menu ID: NM41	6	
Ongoing management		
DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less *NICE 2010 menu ID: NM01*	8	53–93%
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less *NICE 2010 menu ID: NM02*	10	38–78%
DM004. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less	6	40–75%
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months *NICE 2010 menu ID: NM14*	17	35–75%
DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months	8	43–83%
DM009. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52–92%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months *NICE 2010 menu ID: NM13*	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register *NICE 2011 menu ID: NM27*	11	40–90%
DM018. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	55–95%

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 29 January 2016

Subject: Emotional Wellbeing Strategy for Children, Young People and Young Adults

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the Emotional Wellbeing Strategy for Children, Young People and Young Adults and to determine whether the NHS commissioned aspect of the new service specification constitutes a substantial variation of service.

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

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1. Introduction

(a) The Committee has considered reports on emotional wellbeing and mental health services for children and young people in Kent on 31 January 2014, 11 April 2014, 6 June 2014, 10 October 2014, 6 June 2015, 4 September 2015 and 9 October 2015.

(b) On 9 October 2015, the Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) NHS West Kent CCG be requested to provide the Committee at its November meeting with an Executive Summary of the specifications, key performance indicators within the contract and details of how these would be measured.

  (b) the Committee defer making a determination on whether the NHS service specification was a substantial variation of service until the November meeting.

(c) In November 2015 NHS West Kent CCG requested to postpone the item as further work was required on key performance indicators in the service specification which would not have been ready by 27 November 2015 meeting. The Chairman agreed to the request and the Emotional Wellbeing Strategy item is now scheduled for 29 January 2016.

(d) NHS West Kent CCG has asked for the attached reports to be presented to the Committee:

CCG Report		pages 111 - 118
Appendix 1	Universal & Targeted Emotional Health & Wellbeing Specification - Summary	pages 119 - 122
Appendix 2	Children & Young People's Mental Health Specification - Summary	pages 123 - 126
Appendix 3	Draft Universal & Targeted Emotional Health & Wellbeing Specification (EXEMPT)	pages 127 - 174
Appendix 4	Draft Children & Young People's Mental Health Specification (EXEMPT)	pages 175 - 252

2. Potential Substantial Variation of Service

(a) It is for the Committee to determine if the NHS commissioned aspect of the new service specification constitutes a substantial variation of service – the Draft Children & Young People's Mental Health Specification.

(b) Where the HOSC deems the NHS commissioned aspect of 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 NHS West Kent CCG.

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

3. Recommendation

If the NHS commissioned aspect of the new service specification is **not substantial:**

RECOMMENDED that:

(a) the Committee does not deem the new service specification in relation to the NHS commissioned aspect to be a substantial variation of service.

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

If the NHS commissioned aspect of the new service specification is ***substantial*** **and the Committee does support the procurement of the service specification:**

RECOMMENDED that:

(a) the Committee deems the new service specification in relation to the NHS commissioned aspect to be a substantial variation of service;

(b) the Committee supports the procurement of the new service specification;

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

If the NHS commissioned aspect of the new service specification is ***substantial*** and the Committee **does not support** the procurement of the new service specification:

RECOMMENDED that:

(a) the Committee deems the new service specification in relation to the NHS commissioned aspect to be a substantial variation of service;

(b) the Committee does not support the procurement of the new service specification for the following reasons [to be inserted during the meeting];

(c) NHS West Kent CCG be requested to respond to the Committee's recommendation in writing and attend an extraordinary meeting of the Committee.

Background Documents

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

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

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

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (10/10/2014)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=29245

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (05/06/2015)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=31953

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (04/09/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5842&Ver=4

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (09/10/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5843&Ver=4

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NHS
West Kent
Clinical Commissioning Group

Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years) (CAMHS)

Health Overview and Scrutiny Committee

29th January 2016

Patient focused, providing quality,

Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years)

Summary

This paper a provides a further progress report on the development of the Emotional Wellbeing and Mental Health Service for Children, Young People and Young Adults in Kent and provides summaries of the Public Health School-aged Universal and Targeted Emotional Health & Wellbeing and the NHS Children and Young People's Mental Health Service specifications, full draft copies of the service specifications along with proposed Outcomes, and KPI's and measurements for the KCC Public Health contract as requested by the Committee at the last meeting on 9th October 2015. The Health contract KPI's and measurements have not been provided as these will be developed throughout the procurement process with the Provider.

Kent County Council and the Kent Clinical Commissioning Groups have been working together since early 2014 to increase Universal provision to deliver a new whole system of support that extends beyond the traditional reach of commissioned services.

The new Model, which has been developed alongside the principles and approaches articulated within Future in Mind, outlines a whole system approach to emotional wellbeing and mental health in which there is a Single Point of Access, clear seamless pathways to support ranging from Universal 'Early Help' through to Highly Specialist care with better transition between services.

Following the final agreement of the draft specifications, the contract procurement process will commence in March 2016.

Recommendation

Members of the Kent Health Overview Scrutiny Committee are asked to note the contents of this report.

Due to legal obligations relating to the extension of the current contract, a procurement process is necessary in order to identify a new provider from 1st April 2017.

Members are reminded of their statutory duty to declare any conflict and have it properly resolved.

1.0 The Model

1.1 The detail required to deliver the model will be contained within the national specification guidance and the service specification will inform the future contracts and the contractual framework required. A contract technical group developed the Service Model in partnership with commissioners and clinicians.

1.2 *Figure 1* demonstrates how the whole system will work together:

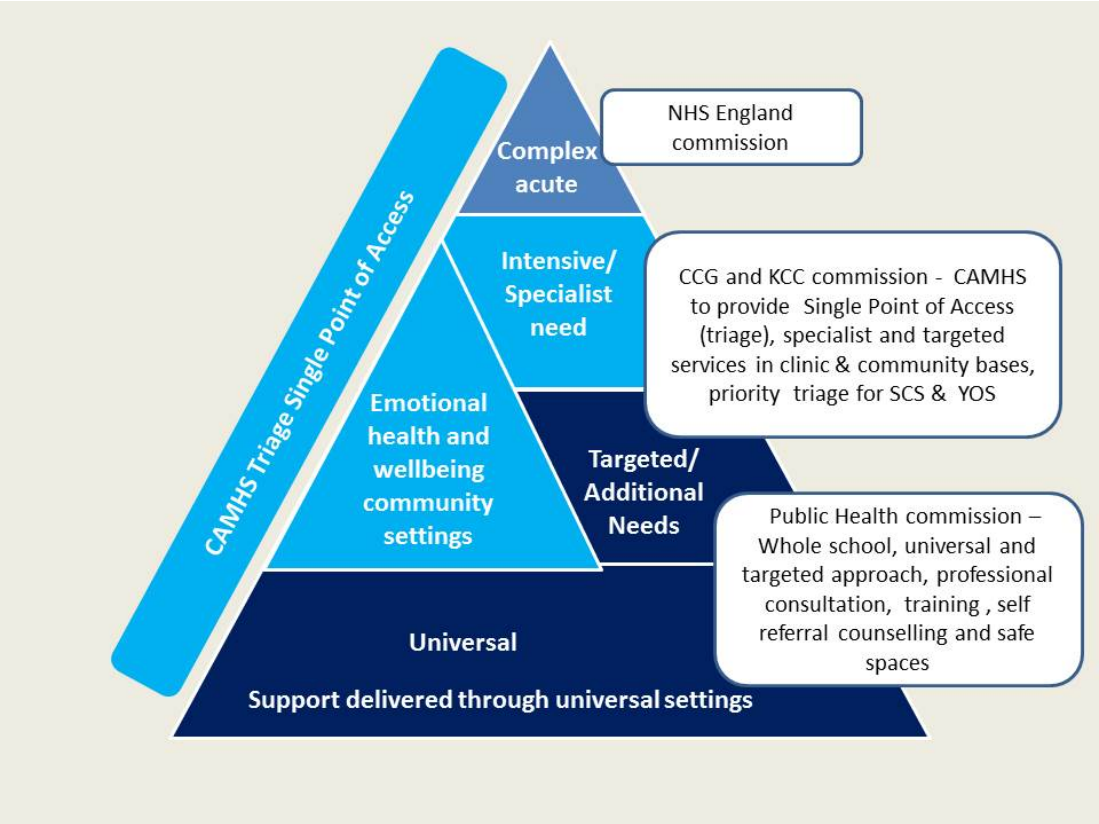

Figure 1: the whole system model

1.3 *Table 1* outlines the differences in service provision between the current Model and the new Model which fundamentally improves navigation of the totality of support services available to children and young people and allows Commissioners to better hold the Provider to account:

How things are now	**The new model**
Decision about resource allocation made in silos	Understanding of the totalling of resource and how it aligns across the system.
Lack of CYP voice in current service design inconsistent approach within services.	Ensure CYP and their families are involved in the design and commissioning of services especially technology
Lack of family approach	Think Family
Tiered approach to commissioning is not	Focus on children wherever they are in the

supporting children adequately	system
Services do not consider sufficiently family dynamics.	Responding to family dynamics with support
Thresholds unclear and inappropriate referrals	Multi-agency decisions about resource allocation. Information sharing protocols in place.
Inappropriate referrals and long waiting lists.	Single point of access. Referrals directed to right provision sooner through integrated model.
Rising demand for self- harm not met	Focus on self- harm
Not enough capacity in system - EHWB belongs to one service	Delivery and support through universal hubs with a focus on schools.
Insufficient strategic links between other critical pathways and transition protocols	Clear relationship for LD and neurodevelopmental pathway
CAMH service used as a "catch all"	Smooth transition to adult mental health for CYP 14-25 who require long term support.
Does not build capacity or support others to develop their understanding sufficiently. Lack of sufficient and flexible provision for emotional wellbeing.	Consistent approach to promote good emotional wellbeing and resilience including upskilling workforce.
Lack of clarity about eligibility	Deliver a consistent service reducing transfer between services ensuring CYP have named worker for continuity of care.
Lack of clarity in relation to LD and neurodevelopmental pathways	Clear pathways for assessment and treatment of CYP with neurodevelopment difficulties.
Insufficient evidence around outcomes being achieved. Inconsistent performance monitoring methods for different services.	Kent wide outcomes based framework and dataset to enable effective monitoring across the system. Systematic contract monitoring to ensure model remains aligned
No clear model for reporting performance data that is child related.	Child related performance data informing model of adult services

Table 1: The differences between the current and new Models

1.4 Key points of the model include the following:

- Promoting emotional wellbeing – how to embed this in all the work that we do this will include a multi-agency communications strategy.

- A single point of access/triage pathway model across emotional wellbeing early intervention and mental health services and delivery and support through universal hubs with a focus on schools.

- A clear focus on the child wherever they are in the system, enabling children and young people to receive timely access to support; development of drop-ins or safe spaces in schools.

- Increased availability of consultation from specialist services, upskilling of workforce and a named worker for every child and young person.

- A 'whole family' approach, responding to family dynamics, defining how parents and carers will be involved and identifying and responding to the wider needs of the family within assessments of the child's emotional wellbeing as well as the continued design and commissioning of services, especially technology.

- Effective implementation of multi-agency tools and protocols to identify children and young people who have been affected by Child Sexual Exploitation (CSE), and rapid access to specialist post-abuse support as well as a focus on reducing self-harm

- An understanding of the totalling of resource and how it aligns across the system, multi-agency decisions about resource allocation, information sharing protocols and an emphasis on continued improvement of performance to agreed contract requirements across the system

- Smoother transition between services, particularly from children's to Adult's mental health services and additional support for those aged 14-25 and leaving care. Clear links to critical pathways such as LD and appropriate assessment and treatment for neurodevelopmental disorders.

2.0 Service Specifications

2.1 Two separate specifications have been developed to meet the diverse needs of the Emotional Health and Wellbeing Model.

2.2 The first specification sets out the provision of the Public Health School-aged Universal and Targeted Emotional Health and Wellbeing Service which promotes positive emotional wellbeing and provides a lower level service in Universal settings such as schools. The goal of this service is to ensure that children and young people and their

families are supported at the earliest opportunity, to prevent their needs escalating and requiring the intervention of specialist mental health services (see Appendix 1 & 3)

2.3 The purpose of the second specification is to specify the provision of the NHS Children and Young People's Mental Health Service at the Targeted and Specialist level of provision, previously referred to as Tier 2 and Tier 3 of Child and Adolescent Mental Health Services (CAMHS) (see Appendix 2 & 4).

2.4 The final drafts of both the Public Health and NHS provision will be presented to the Collaborative Commissioning and Procurement Board on 8 February 2016 for sign off.

2.5 These documents will remain in draft format throughout the procurement process in order to be developed in partnership with Providers.

3.0 Procurement Process and Contracting

3.1 A Contract Procurement Board has been established, co-chaired by Andrew Ireland (KCC) and Ian Ayres (WK CCG).

3.2 Commissioners have agreed to pursue a competitive dialog procedure, developed utilising the expertise of the South East Clinical Support Unit (SECSU).

3.3 The procurement process is set to begin in March 2016 and will be completed by 31 October 2016 for the Universal & Early Help contract and by 31 March 2017 for the Health contract.

3.4 For the remainder of the current Children & Young People's Mental Health contract, work is already being undertaken to deliver aspects of the new service through contract variation with Sussex Partnership Foundation Trust.

3.5 In parallel with the re-procurement of the Children and Young People's Mental Health service, the Kent Transformation Plan is also being delivered. This involves a suite of projects aimed at increasing provision and improving specific pathways across the system in relation to, for example, Eating Disorders, Unaccompanied Asylum Seekers, Crisis Care and reducing waiting lists.

3.6 Governance structures, in the form of the Collaborative Commissioning and Procurement Board, local Transformation Implementation Groups in each of the 3 health economies and the Transformation Board, are in place to oversee the delivery of both programmes of work and to ensure alignment of interdependencies. Both of these Boards report to the Children's Emotional Health & Wellbeing Board.

4.0 Next steps:

- Sign off of draft service specifications
- Refinement of a Outcomes, KPI's and Measurements
- Finalise workforce development plan
- Governance approval to begin procurement
- Implement procurement

5.0 Recommendations

Members of the Kent Health and Overview Committee are asked to

(i) NOTE the contents of this report.

6.0 Appendices

Appendix 1	Universal & Targeted Emotional Health & Wellbeing Specification - Summary
Appendix 2	Children & Young People's Mental Health Specification - Summary
Appendix 3	Draft Universal & Targeted Emotional Health & Wellbeing Specification - Full
Appendix 4	Draft Children & Young People's Mental Health Specification - Full

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APPENDIX 1 – Summary of School-aged Universal and Targeted Emotional Health and Wellbeing Services

1. Introduction

1.1. This briefing provides an overview of the universal and targeted emotional health and wellbeing services for school aged children which will be commissioned by KCC Public Health. The annexes include the draft specification for the adolescent health and emotional wellbeing service, the draft KPI framework and safeguarding matrix.

2. Universal Emotional Wellbeing Services

2.1. Tier one universal emotional health and wellbeing services will be provided by the school public health service for primary age children and the adolescent health and targeted emotional wellbeing service (working in secondary and tertiary settings). Both services are currently going through a procurement process, with contracts due to start in October 2016. The universal intervention will build resilience and support emotional wellbeing at a whole school level.

2.2. The key differences of this service to the previous service are:

- A split of the school aged public health provision into primary and secondary/tertiary age groups. This will enable specific responses to the different needs of the age groups.
- A greater focus on a multidisciplinary workforce, particularly in the adolescent health and targeted emotional wellbeing service.
- Improved visibility of the service and working relationships with schools.
- Key assessment points.

2.3. The key features of this service are:

- A visible and well promoted presence in educational settings which enables young people, parents and carers to build trusted relationships and self-identify their health and wellbeing needs.
- Holistic health assessment for young people who are referred to the service, who enter the educational setting from outside of the UK and in Year R, Year 6 and Year 10.
- Formal and informal one to one tier 1/universal health and emotional wellbeing interventions including building self-efficacy, self-management and advocacy.
- Whole setting health improvement including the delivery of some elements of PSHE.
- Training for school staff and Governors in whole school health improvement, emotional and physical health.

- Support to parents to build their health literacy and support the health and wellbeing of their children including their emotional health and wellbeing.
- Development of publicity and resources which young people, parents and educators can access and which promote self-management and health literacy.

3. Targeted Emotional Wellbeing services

3.1. The adolescent health and emotional wellbeing service will also deliver targeted tier 2 interventions in both secondary/tertiary settings. In addition, the service will also provide targeted emotional health in reach services for primary age children working alongside the primary school public health service with a particular focus on supporting transition.

3.2. The draft service specification for the adolescent health and targeted emotional wellbeing service is attached at annex 1with both the universal and targeted elements of emotional wellbeing provision highlighted. The sections relating to universal provision are replicated in the primary school age service specification.

3.3. This is a new service providing targeted tier 2 support in schools to meet an identified need. It will work with schools to ensure there is no duplication in provision from what is provided from within the school itself to ensure there is additional benefit.

3.4. This service will link closely with CAMHs providers. This relationship will have number of benefits. These will include sharing information about children who are accessing CAMHs service and require support in school and those children who are moving from one service to the other.

3.5. The key features of the service are:

- Tier 2 emotional health and wellbeing interventions for children and young people in primary, secondary and tertiary educational settings who have identified themselves, have been identified by schools, GP's and referred by the SPA or other services as needing targeted support.

- An offer in school settings of ensuring that children and young people with early help and specialist needs are able to maintain their resilience throughout recovery.

4. Key Performance Indicators

4.1. The key performance indicators relating to the universal and targeted emotional wellbeing service are attached at annex 2. Targets will be set for each indicator in partnership with the provider. Where comparable measurements were taken for the community predecessor organisation, Young Healthy Minds, their performance will be set as a minimum achievement level to ensure no capacity is lost in the short term.

4.2. A safeguarding matrix is attached at annex 3.

5. HeadStart Kent

5.1. HeadStart Kent is already testing some early intervention approaches in early adolescence with the aim of preventing the onset or escalation of mental health issues. The adolescent health and emotional wellbeing service will proactively learn from and embed the approach to resilience and emotional health which is tested by HeadStart Kent. Going forward a suite of specific interventions will be agreed by an expert group and will be promoted for children and young people in Kent.

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APPENDIX 2

SUMMARY - Kent Children and Young People's Mental Health Service Specification

Period of contract 1st April 2017 – 31st March 2022

1.0 Introduction:

1.1 This specification is based on the national CAMHS service specification template and has been developed in line with recommendations in '*Future in Mind*', the local strategic framework set out in Kent's '*The Way Ahead*' as well as the *Kent Children and Adolescent Mental Health Service Needs Assessment*' .

1.2 The purpose of this specification is to specify the provision of mental health services at the Targeted and Specialist level, previously referred to as Tier 2 and Tier 3 of Child and Adolescent Mental Health Services (CAMHS) across the 3 health economies of Kent (East, North and West). This specification describes the scope of these services and the role, function and responsibilities of the Provider.

2.0 Service Delivery:

2.1 **Targeted services** (Tier 2 CAMHS) - Children and young people (and their families) resident in Kent who experience emotional wellbeing needs or low level mental health illnesses, have timely access to an assessment (if appropriate) and time limited intervention (typically 6 – 8 sessions) with successful resolution or management of the difficulty within their local educational setting and social setting. This part of the service is for children and young people whose issues cannot be met by Universal services or by the Emotional Wellbeing Service. The needs of these children and young people will not meet the higher level mental health threshold.

2.2 **Specialist services (Tier 3 CAMHS)** - Children and young people resident in Kent and their families who require medium (up to 6 months) or longer term (over 6 months) interventions have timely access to assessment and treatment services which result in the successful resolution or management of the difficulty. A multi-disciplinary/agency response to significant and sustained difficulties often with a number of other factors increasing their vulnerability.

2.3 As well as the above service levels, this specification also relates to delivery of care in relation to:

- **Emergency Response** - Children and young people resident in Kent who present a risk to self or others receive an immediate response, within the same working day, which ensures safety, provides initial intervention where necessary and ensures support is provided.

- **Transition Service** – Children and Young people who meet the criteria for an adult mental health service, experience a smooth transition from one mental health service to the other.

- **Children in contact with Specialist Children's Services** - The Provider will assess and provide intervention for vulnerable children and young people, including looked after children, disabled children, young offenders, children in need, and children on the child protection register. Intervention could be needed as a result of attachment and relationship difficulties; child sexual exploitation; sexual abuse or for children who exhibit harmful sexual behaviours.

- **Single Point of Access** – The purpose of the single point of access is to ensure that qualified mental health practitioners review the referrals received via the Early Help Notification process to determine the appropriate service response in light of awareness of the level of mental health need and involvement of other services. They will also provide advice, support, consultation and guidance to staff working in Targeted level services and other health professionals working in the community.

2.4 The services described in this speciation are part of a whole-system pathway designed to meet the emotional wellbeing and mental health needs of children and young people within the context their family. The Provider is expected to deliver services under equalities duty and the levels referred to are in relation to the child and young person's mental health needs rather than any disability or other need.

2.5 The services in this specification will be delivered by staff with relevant mental health skills and qualifications based in:

- the KCC Early Help units (22 workers across 44 units)
- the providers mental health hubs
- within/attached to the KCC Early Help Triage, which will form the Single Point of Access (SPA) for mental health referrals.

3.0 The Pathway:

3.1 All new referrals for a mental health service at either Targeted or Specialist services must be routed through the Single Point of Access (SPA) and must adhere to the Early Help Notification process. Screening will be completed within a maximum of 2 days. Vulnerable groups such as Looked After Children, Children in Need, Youth Offending service will be given priority access to screening via the SPA after which the referral will be sign-posted on to the relevant service and treatment will be based on clinical need along with all other referrals.

3.2 Specialist services within the mental health service:

- Neurodevelopmental Disorders(ADHD/ASC)
- Early Intervention in Psychosis
- Eating Disorders
- Crisis Care
- Young Offenders
- Harmful Sexual Behaviour/Post Sexual Abuse
- Challenging Behaviour/Learning Disability
- Looked After Children – including unaccompanied asylum seeking children

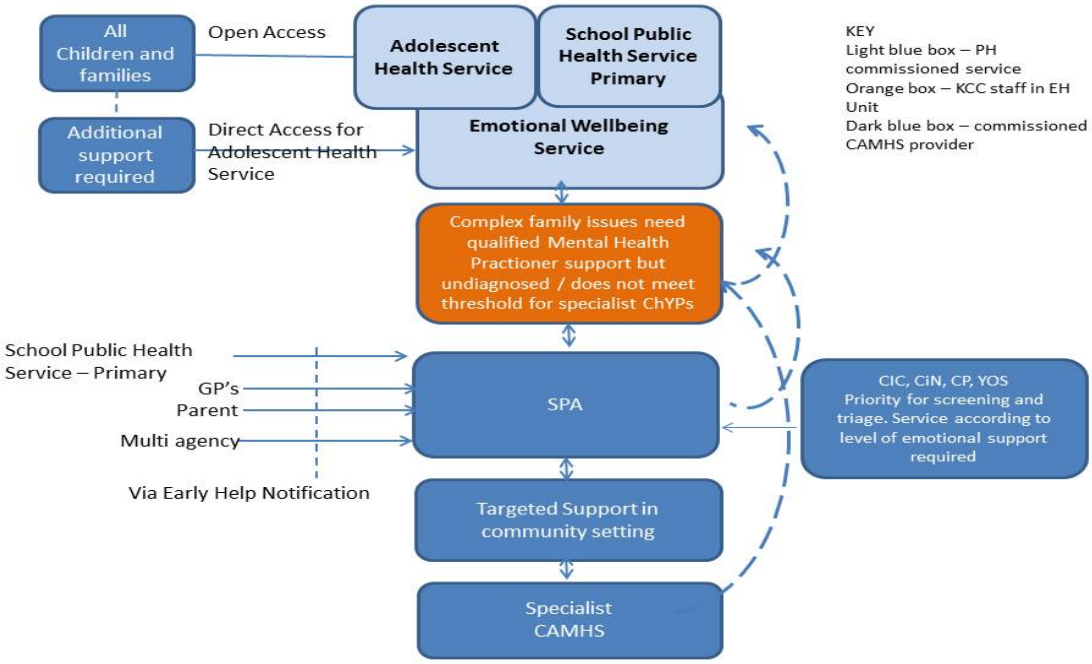

Figure 1: The Emotional Wellbeing and Mental Health Pathway

4.0 Key Features of the mental health service:

- Age/developmentally-appropriate evidence-based model of delivery to support children, young people and families
- A child-centred/whole-family approach to care
- A community-based service delivered in a range of appropriate settings, including assertive outreach
- Use of innovative and clear engagement techniques
- Up-skilling of support staff working in Universal settings as well as providing advice and consultation to the wider workforce
- Recovery focussed

5.0 Requirements of the whole service:

5.1 Over the lifetime of the contract, the Provider will work with commissioners and other providers to implement the transformation agenda.

5.2 Provide sufficient resources and capacity to deliver safe and effective pathways whilst meeting agreed targets, including an appropriately trained/supervised workforce.

5.3 Work collaboratively with commissioners and other service providers and promote a whole-system approach.

2.6 Accept appropriate referrals, via the SPA, for children and young people residing in Kent aged 0 – 18th birthday, with a view to expanding this service to 0 – 25 years over the lifetime of the contract.

5.4 Ensure that where young people do not meet the criteria for a secondary adult mental health service that they are given information about other providers and referred as necessary.

5.5 Utilise evidence-based validated tools to record, track and report on progress against outcomes (both clinical and service delivery)

5.6 Provide clear and accessible information to children, young people and families about the services and interventions available and how to access them.

5.7 Support the Early Help Notification process and follow the Care Programme Approach

5.8 Adhere to legislation, guidance, standards and protocols.

6.0 Report Author:

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