HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 4th March, 2016

10.30 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 4th March, 2016, at 10.30 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 A H T Bowles, Mr N J D Chard, 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

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UNRESTRICTED ITEMS

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

Item Timings*

1. Substitutes

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

3. Minutes (Pages 5 - 16)

4. East Kent Strategy Board (Pages 17 - 30) 10:35

5. Kent & Medway NHS & Social Care Partnership Trust: Update (Pages 31 - 40) 11:00

6. CQC Inspection: Medway NHS Foundation Trust (Pages 41 - 48) 11:30

7. Emotional Wellbeing Strategy for Children, Young People and Young Adults (Pages 49 - 64) 12:00

8. Date of next programmed meeting – Friday 8 April 2016

   - Review of winter preparedness in Kent 2015/16
   - Better Care Fund

EXEMPT ITEMS

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

**Timings are approximate*

Peter Sass
Head of Democratic Services
03000 416647

25 February 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.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 29 January 2016.

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

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Mr A Scott-Clark (Director of Public Health)

UNRESTRICTED ITEMS

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

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

(2) Cllr Lyons declared an Other Significant Interest as a Governor of East Kent Hospitals University NHS Foundation Trust.

2. Minutes
(Item 3)

(1) The Scrutiny Research Officer updated the Committee about the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC). She reported that the first meeting of the JHOSC was held on 8 January 2016 and the Minutes of the meeting would be shared with the Committee on 4 March 2016. She noted that the next JHOSC would take place on Friday 26 February 2016.

(2) RESOLVED that the Minutes of the meeting held on 27 November are correctly recorded and that they be signed by the Chairman.

3. CQC Inspection Report: East Kent Hospitals University NHS Foundation Trust
(Item 4)

Matthew Kershaw (Chief Executive, East Kent Hospitals University NHS Foundation Trust) and Rachel Jones (Director of Strategy and Business Development, East Kent Hospitals University NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee and introduced Mr Kershaw who had recently been appointed as the Chief Executive of the East Kent Hospitals University NHS Foundation Trust. Mr Kershaw began by outlining the background to the inspection. He explained that inspection took

place in July 2015 as a re-inspection following the initial inspection in March 2014 which had led to the Trust being placed into special measures. He reported that there had been significant improvements across the Trust since the original inspection; the Trust was now rated as Requires Improvement but would remain in special measures for a further six months. He stated that the Trust's objective was to get out of special measures as soon as possible; the Trust would be inspected again in 2016 but this would not take place before May 2016. There were a number of areas for improvement including the emergency care pathway and cultural change across the Trust. He noted that an Improvement Plan had been developed to support and ensure the delivery of improvements which was being led by Dr David Hargroves, a stroke consultant, as the clinical lead in conjunction with the Chief Nurse Dr Sally Smith.

(2) Members of the Committee then proceeded to make a number of comments about recruitment and well maintained equipment. Mr Kershaw explained that the provision of high quality staffing was key for safe and effective patient care. He noted that the inspection report acknowledged staffing levels had improved despite recruitment challenges. He reported that there were a number of gaps in staffing including emergency consultants, middle grade posts and on some wards. He noted that a report was going to the Trust's Board on 8 February which showed that 90 – 95% of shifts were covered with the use of agency staffing; the Trust was looking to move away from temporary to substantive posts as agency staffing was expensive and the temporary staff were not part of the organisation. Ms Jones explained that following the inspection a centrally managed equipment library had been developed so that all equipment could be recorded and have its condition checked before being released for use. She noted that the Trust had a specific budget for replacing equipment.

(3) The Chairman invited Mr Inett to speak. Mr Inett stated that Healthwatch Kent had been working with the Trust since the initial CQC inspection in March 2014 including quarterly meetings with the Chief Nurse. He reported that Healthwatch Kent had recently carried out follow-up visits to the Accident & Emergency departments and Outpatient services. The reports had been submitted to the Trust for comments and would be shared with the Committee once published.

(4) RESOLVED that the report be noted and the Trust be requested to provide an update to the Committee in six months.

Cllr Lyons, in accordance with his Other Significant Interest as a Governor of East Kent Hospitals University NHS Foundation Trust, withdrew from the meeting following Matthew Kershaw's presentation and took no part in the discussion or decision.

4. Kent & Canterbury Hospital: Emergency Care Centre
(Item 5)

Matthew Kershaw (Chief Executive, East Kent Hospitals University NHS Foundation Trust), Rachel Jones (Director of Strategy and Business Development, East Kent Hospitals University NHS Foundation Trust) and Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Kershaw began by outlining the background to the Emergency Care Centre. He explained that when the Emergency Care Centre model was developed 10 years ago, it was considered innovative with its specific criteria for accepting patients including cardiac and minor injuries. He reported that there had been a growth in the breadth of the criteria and doctors now were assessing and treating a very wide range of condition over and above those included in the original criteria. He noted that Health Education England Kent, Surrey and Sussex undertook visits to assess the quality of education and training by Local Education Providers; during a review of the Trust's core medical training at the Kent and Canterbury Hospital junior doctors raised concerns about the creep of criteria. Health Education England Kent, Surrey and Sussex concluded that it was no longer acceptable for medical trainees to be confronted with acute medical problems they were not equipped to manage and a change was required. He reported that if changes were not made to the Emergency Care Centre it could result in the removal of medical trainees from the Kent and Canterbury site by Health Education Kent, Surrey and Sussex and the General Medical Council which would destabilise acute hospital services with East Kent and result in the closure of the Emergency Care Centre and removal of other services on the site.

(2) Mr Kershaw stated that the Trust was proposing to reiterate the criteria for accepting patients and was working with South East Coast Ambulance NHS Foundation Trust to cease the referral of all patients with acute abdominal pain, alcohol intoxication and patients with primary mental health problems to the Emergency Care Centre. He reported that this equated to approximately nine patients a week and those patients would be taken to the William Harvey Hospital, Ashford or the Queen Elizabeth Queen Mother Hospital, Margate. Patients that self-presented to ECC would still be assessed and if they required ongoing care, they would be stabilised and transferred. He noted that if patients were seriously comatosed due to alcohol, as opposed to being drunk, they would be transferred to a site with an Accident & Emergency site.

(3) Mr Kershaw noted that the proposal had the full support of the Trust's Commissioners. The Trust would be presenting the proposal to Health Education Kent, Surrey and Sussex in March as part of a re-inspection and the reclarified model of care implemented by the end of June 2016. Mr Kershaw stated that he was looking for the Committee's support to the reclarified model of care - ceasing the referral of all patients with acute abdominal pain, alcohol intoxication and patients with primary mental health problems to the Emergency Care Centre. He noted that the new model of care needed to be implemented before there was a wider discussion ahead of the permanent clinical strategy for East Kent.

(4) Members of the Committee then proceeded to ask a series of questions and make a number of comments. In response to a specific question about communicating the reclarified model of care to the public particularly to students, Ms Jones explained that two-thirds of patients self-presented to the Emergency Care Centre and the Trust would be working with Healthwatch Kent, Public Health and Commissioners to develop an information and awareness campaign. Steve Inett confirmed that Healthwatch Kent would be raising awareness of this issue and was looking to increase its number of volunteers as part of the communication and engagement for the wider

strategy for East Kent. Andrew Scott-Clarke stated Public Health would be leading on discussions with the universities about the impact of alcohol on public services and with Canterbury City Council as the licensing authority.

(5) A Member enquired about the number of patients who currently self-presented with acute abdominal pain, alcohol intoxication and primary mental health problems and if the reclarified model of care would have a significant impact on junior doctors. Mr Kershaw explained that there were a similar number of patients who self-presented and arrived by ambulance with acute abdominal pain, alcohol intoxication and primary mental health problems – approximately 20 per week in total. Mr Kershaw stated that the revised model of care would reduce the number of patients to a level similar to other hospitals; it would not take away the element of surprise associated with emergency care which was encountered by all medical trainees nationally.

(6) A number of comments were made about sustainability. Mr Kershaw noted that the reclarified model of care had the full support of the Commissioners. He stated that there was a significant risk of destabilisation across the Trust if medical trainees from the Kent and Canterbury Hospital site were removed. He recognised that there would be an ongoing issue of stability until a sustainable long term strategy for East Kent was developed through the East Kent Strategy Board.

(7) RESOLVED that:

(a) the Committee is supportive of the decision to take urgent action by the East Kent Hospitals University NHS Foundation Trust as set out in the Trust's paper;

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

Cllr Lyons, in accordance with his Other Significant Interest as a Governor of East Kent Hospitals University NHS Foundation Trust, withdrew from the meeting following Matthew Kershaw's presentation and took no part in the discussion or decision.

5. East Kent Strategy Board
(Item 10)

Matthew Kershaw (Chief Executive, East Kent Hospitals University NHS Foundation Trust), Rachel Jones (Director of Strategy and Business Development, East Kent Hospitals University NHS Foundation Trust) and Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Carpenter began by explaining that the written briefing included in the Agenda pack was requested by the HOSC group representatives following a meeting with the East Kent CCGs' Accountable Officers Hazel Carpenter and Simon Perks on 25 November 2015. She stated that the East Kent Strategy Board was established to look at how to provide health and social care services to the East Kent population in the future. She explained that the Board was CCG led but was working collaboratively with providers to oversee the work

programme. She noted that NHS South Kent Coast CCG and NHS Thanet CCG had already presented their initial plans for Integrated Care Organisations to the Committee. She reported that the East Kent Strategy Board was looking forward to working with the HOSC and a further update would be presented to the Committee on 4 March.

(2) Members of the Committee then proceeded to make a number of comments about population growth, the commitment of the Board and public consultation. Ms Carpenter explained that the CCGs were very aware of new housing developments and associated population growth. Mr Kershaw noted that modelling work was being undertaken to look at the impact of housing developments and aging population and how health services could be provided innovatively in the future. Ms Carpenter stated that all four CCGs were completely committed to and determined for the work of the Board to be a success. Mr Kershaw stated that he endorsed Ms Carpenter's comments; he noted that one of the reasons he had returned to East Kent was to get involved with the work of the Board. He reported the consultants in the Trust were keen for decisions to be taken as soon as possible as the current model of services was unsustainable. Ms Carpenter noted that health and care systems were required to work together to draft Sustainability and Transformation Plans by June 2016. She reported that once the plans had been developed, the Board would go out to public consultation. She explained that it was not possible at this stage to say if a single or multiple consultations would be required; she stated that there would be an ongoing dialogue with the HOSC as plans were developed.

(3) RESOLVED 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.

(4) The meeting was adjourned at 11.10 and reconvened at 11.15.

6. SECAmb: Update
(Item 6)

Geraint Davies (Director of Commissioning, SECAmb) and Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swale CCG and NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Davies began by outlining the background to the retriage pilot which was introduced during Winter 2014/15. The pilot saw clinicians taking up to an extra ten minutes to retriage calls that had come across from 111 to 999 as requiring an emergency response. An initial review into the pilot by NHS England found that there was no detrimental impact to patients but there had been a failure in the Trust's internal governance processes. He noted that three further reviews, Forensic Review, Patient Impact Review and Governance Review, were being undertaken by Monitor and he would be happy to come back and share the findings of the review with the Committee.

(2) Mr Davies also outlined the background to the use of defibrillators in performance reporting. He explained that SECAmb followed national guidance on performance reporting; under the current guidance for Red 2 patients, a

clock stop could take place if there was someone able to collect a defibrillator and bring it to the patient and a defibrillator was accessible at the time of the call. He stated that SECAmb was lobbying for this guidance to change so that defibrillators had to be by the patient's side before a clock stop was applied. He noted that an independent review was underway to ensure the Trust had been compliant with the guidance and he would be happy to come back and share the findings of the review with the Committee

(3) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about pinch points and surge options. Mr Davies explained that a key pinch point was delays in the transfer of care within 15 minutes of arriving in hospital; for every 1000 hours lost in delayed transfers of care resulted in 0.4% impact on the Trust's performance. The Trust was working with commissioners in Kent to make improvements to ambulance handover performance particularly with Darent Valley Hospital which was the worst performing hospital for transfer in Kent. The key challenge for 111 performance was the difficulty in referring patients to out-of-hour services particularly at the weekend which had resulted in some patients being inappropriately referred to an ambulance or an emergency department. He explained that surge options included playing a message during peak periods explaining that there may be a delay in answering the 111 call.

(4) A number of questions were asked about vandalism of Public Access Defibrillators, the outcomes of Public Access Defibrillators and the consultation on proposed blue light collaboration including joint control rooms between emergency services. Mr Davies noted that there were low levels of violence against the staff and fleet. He stated that the Trust supported the widespread availability of Public Access Defibrillators; the Trust was looking to develop outcomes for their use. He explained that the Trust and their staff saw themselves as part of the NHS, as a mobile health care system. The Trust wanted to be integrated into the NHS and had made representations to the Minister and Secretary of State. He noted that the Trust was involved in a project in Whitstable which had integrated a community paramedic into primary care; the project had enabled the Trust to understand patient demand and improve flow to the acute patient pathway.

(5) The Chairman invited Mr Inett to speak. Mr Inett stated that Healthwatch Kent had been aware of the concerns relating to the retriage process and the use of defibrillators in ambulance performance before they were reported in the press as it was a member of the Kent and Medway Quality Surveillance Group. Mr Davies stated that the Trust had collectively met with the six Healthwatchs in the areas where SECAmb provide services and was looking forward to engaging further with Healthwatch volunteers and officers in the future. The Trust was looking at how to incorporate Healthwatch representatives onto its boards and committees.

(6) RESOLVED that the report be noted and SECAmb be requested to share the findings of the Forensic, Patient Impact and Governance Reviews of the Retriage Pilot and the independent review into the use of defibrillators in performance reporting at the April meeting of the Committee.

7. North Kent: Adult Community Services

(Item 7)

Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG), Julie Hunt (Director of Performance Delivery and Programme Director for Adult Community Services, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG) and Michael Ridgwell (Programme Lead, Swale Blue Light Transfer, NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Members enquired about the period of formal standstill after the bidders had been advised of the outcome and the expected growth in the local area. Ms Davies thanked the Committee for the opportunity to provide feedback on the outcome of the procurement. She explained that there was a period of formal standstill which was extended whilst the CCGs answered a query from one of the bidders; once that query had been answered the bidder was satisfied with the outcome and the standstill was ended and the outcome of the procurement was announced.

(2) Ms Davies noted that there was an expected 26% population growth in Dartford, Gravesham and Swanley. She stated that the contract was let on an as-is basis but a key part of the tender was for bidders to explain how they could deliver innovation and transformation, be flexible to meet demand and integrate with primary and social care in the future. She explained that the CCG had submitted a bid with the Ebbsfleet Development Corporation and local councils for Healthy New Towns status for the Ebbsfleet development; they were one of sixteen bids which had been shortlisted from 150 submissions across the country. She explained that the Healthy New Towns status would not come with funding but would bring expertise and raise the national profile of the development at a government level. She explained that £310 million had been allocated to the Ebbsfleet development in the Autumn Spending Review which would be aligned for infrastructure as opposed to health services; upfront investment was required as CCGs were only paid on the number of patients registered with GP practices. She noted that the CCG was engaging with NHS England, local MPs and Healthwatch Kent to lobby for additional funding.

(3) The Chairman invited Mr Inett to speak. Mr Inett enquired if Virgin Healthcare Services would be required to reinvest any surplus into the service. Ms Davies stated that there had been an open and transparent procurement process. The tender was for an NHS contract which was awarded to a private company; the provider had to comply with NHS Terms & Conditions including the legal duty to breakeven reinvest a surplus into community services. Mr Inett noted that Healthwatch Kent was part of a panel which was looking at the mobilisation of services from the existing to the new provider.

(4) RESOLVED 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 about:

(a) the mobilisation of the contract and performance of the new provider in November;

(b) the development of any new service model at the appropriate time.

8. North Kent: Emergency and Urgent Care Review and Redesign
(Item 8)

Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG), Julie Hunt (Director of Performance Delivery and Programme Director for Adult Community Services, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG) and Michael Ridgwell (Programme Lead, Swale Blue Light Transfer, NHS Swale CCG) were in attendance for this item.

(1) The Committee received a report from NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG which provided an update on the Emergency and Urgent Care Review and Redesign in North Kent.

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

9. NHS Swale CCG: Review of Emergency Ambulance Conveyances
(Item 9)

Patricia Davies (Accountable Officer, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG), Julie Hunt (Director of Performance Delivery and Programme Director for Adult Community Services, NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG) and Michael Ridgwell (Programme Lead, Swale Blue Light Transfer, NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Davies began by outlining the background to the review of emergency ambulance conveyances for the NHS Swale CCG population. She explained in October 2014 NHS Swale CCG explored options of moving some elective services for Swale residents from Medway Hospital to Maidstone Hospital to reduce pressure on Medway NHS Foundation Trust. She reported the CCG had committed to a review, following concerns raised by the Care Quality Commission, local GPs and the public, into a potential change for some blue light conveyances to Maidstone Hospital. There would be a number of exclusions to transfers, if the changes were made, as Maidstone Hospital did not offer all of the same services as Medway Hospital. She stressed that it was a feasibility study to explore bed capacity at Maidstone Hospital; the types of patients who could be transferred; and the impact on patients and the wider community.

(2) Members enquired about repatriation of patients and bed capacity. She stated that it could be difficult to repatriate Swale residents discharged from Medway Hospital, who required social care services, as the hospital was located in a different local authority's area from where they lived. If Swale patients were in the care of a Kent acute provider it would enable a smoother transition from health to social care services. Mr Ridgwell explained that the feasibility study was being carried out to assess all possible impacts including bed capacity; services which were not available at Maidstone Hospital such as emergency surgery; and services which were well regarded at Medway Hospital such as obstetrics and gynaecology. He noted that NHS Swale CCG was working will all relevant partners to assess the practicality of the proposal. He stated that

the CCG was not looking to increase risk at other Trusts; the CCG's priority was to support Medway NHS Foundation Trust in being a viable high quality organisation.

(3) In response to specific questions about timelines and the closure of the A249, Mr Ridgwell explained that the CCG wanted to understand activity flow and test provider demand, before going out to public consultation, if the proposals to change conveyances were deemed feasible. He stated that the review would need to be part of a long term strategy which would take place over a longer timescale. Ms Davies reported that she had not been made aware of any adverse impact on SECAmb with the closure of the A249; she stated that she would check with Geraint Davies and provide this information to the Committee.

(4) RESOLVED that the report be noted and NHS Swale CCG be requested to keep the Committee updated as a long term proposal for emergency ambulance conveyances for the NHS Swale population is developed.

(5) The meeting was adjourned at 12.30 and reconvened at 14.00.

10. Patient Transport Services
(Item 12)

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

(1) The Chairman welcomed Mr Ayres to the Committee. Mr Ayres began by explaining as part of the tender evaluation, bidders were scored on a weighting of 65% for quality and 35% for value for money. He reported that the service was split into three separate contracts: renal patient transport; transport to and from Dartford and Gravesham Hospital Trust and Kent and Medway patient transport. Bidders were evaluated on their full written submissions, site visits, presentations and interviews with the providers and their existing commissioners. The site visits included observing call handling, the processes and systems used by bidders to manage operations and ride on journeys to observe patient care. A member of the Project Board included an experienced manager of Patient Transport Services who provided advice on staffing rotas and fleet plans. He stated that G4S was awarded all three contracts; he noted that the three separate contracts may be brought together in the future. He explained that key performance indicators and automatic penalties had been strengthened in the new contract and the contract would be reviewed and rebalanced if required within the first six months. He noted that preparatory work for the mobilisation phase was being undertaken.

(2) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A number of comments were made about capacity, discharge and contract signing. Mr Ayres explained that a triangulation activity had been tested and data had been more accurately recorded and captured for capacity. Mr Ayres stressed the importance of G4S in engaging and building the trust of the acute providers to improve discharge. As part of the service specification, G4S were required to have more senior management on each site, working closely with nursing and care homes and using a much better IT system to record data. He noted that there were stricter

key performance indicators about collection within a specific time period. Mr Ayres stated that the contracts would be signed in February; all contentious issues had been resolved but the CCG and G4S were working through the smaller details of the contract such as using NSL bases and vehicles. G4S were developing a flexible fleet with vehicles that could be adapted to carry wheelchairs and trollies. He noted that the previous provider's frontline staff were found to be very caring and compassionate and would be TUPEd to the new provider.

(3) In response to a specific question about contract management, Mr Ayres explained that the North Kent CCGs would manage the Dartford and Gravesham Hospital Trust contract and West Kent CCG would managed the renal and the rest of Kent and Medway contract. He noted that the two contract management teams had and would continue to work together as they were transformed into mobilisation teams.

(4) RESOLVED that the report be noted and NHS West Kent CCG be requested to provide an update to the Committee about the mobilisation phase in September 2016 including details about patient experience.

11. NHS West Kent CCG: Diabetes Services
(Item 13)

Ian Ayres (Accountable Officer, NHS West Kent CCG), Dr Sanjay Singh (Chief GP Commissioner, NHS West Kent CCG) and Naz Chauhan (Commissioning Manager – Long Term Conditions, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Ayres began by explaining that the current pathway was fragmented and delivered by separate providers. The new model of care would provide a whole system approach by decommissioning the current secondary care level three diabetes service and recommissioning the same in the community under an integrated level two and three service between the hospital, GP practices, community and mental health support. Dr Singh noted that the service specification included access and clinical quality outcomes and performance including individual care plans. He stated the importance of patient education, access to psychological services and meeting the rising demand.

(2) A number of comments were made about patient education, patient experience and the involvement of Diabetes UK. Dr Singh explained that patient experience would be improved through the new service model. Ms Chauhan noted that Diabetes UK was part of the Diabetes Clinical Reference Group which met quarterly. Dr Singh stated Diabetes UK was keen to promote patient empowerment and self-care.

(3) RESOLVED 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 January 2017.

12. Emotional Wellbeing Strategy for Children, Young People and Young Adults
(Item 14)

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

(1) The Committee discussed participating in a small working group, chaired by Graham Gibbens, Cabinet Member for Adult Social Care & Public Health. This working group would look at the Universal & Targeted Emotional Health & Wellbeing Specification and the Children & Young People's Mental Health Specification in more detail before the Committee made a determination at the 4 March 2016 meeting on whether the service specification was a substantial variation of service and if it was happy to support the procurement.

(2) Mr Ayres stated that he would welcome detailed oversight of both specifications by a working group. He acknowledged that although this Committee could only make a determination on the NHS service specification, there was a single overarching vision and the two service specifications were interrelated. He noted that the procurement would need to commence in March but could be halted if required following the Committee's discussions on 4 March.

(3) The following Members expressed an interest in being part of the working group: Mrs Allen, Mr Birkby, Mr Chard, Mr Crowther, Mr Daley, Ms Harrison and Cllr Lyons.

(4) RESOLVED that:

(a) members of the HOSC participate in a working group chaired by Graham Gibbens, Cabinet Member for Adult Social Care & Public Health to look at the Universal & Targeted Emotional Health & Wellbeing Specification and the Children & Young People's Mental Health Specification in more detail.

(b) the Committee defer making a determination on whether the NHS service specification is a substantial variation of service and whether it is happy to support the procurement on 4 March 2016.

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Item 4: East Kent Strategy Board

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 March 2016

Subject: East Kent Strategy Board

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

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

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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. On 29 January 2016 Hazel Carpenter presented an initial report on the work of the Board to the Health Overview and Scrutiny Committee. The Committee agreed the following recommendation:

- *RESOLVED 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.*

2. Recommendation

RECOMMENDED that the report be noted and the East Kent Accountable Officers be requested to present an update to the Committee at the appropriate time.

Background Documents

Kent County Council (2016) *'Agenda, Health Overview and Scrutiny Committee (29/01/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6256&Ver=4

Contact Details

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East Kent Strategy Board

HOSC Update

4 March 2016

Sustainability and Transformation Plan (STP)

- New planning guidance published on 22 December 2015 – authored by the six national NHS bodies
- Clear list of national priorities and longer-term challenges for local systems

"We are asking every health and care system… to create its own ambitious local blueprint for accelerating its implementation of the Forward View…We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years."

"Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors and local government through health and well-being boards."

Sustainability and Transformation Plan

- Health service regulators require health economies to produce a five year sustainability and transformation plan to drive the *Five Year Forward View* and place based care.
- It involves five things:
  - Local leaders working as a team
  - A shared vision
  - A coherent programme of activities
  - Execution against the plan
  - Learning and adapting.

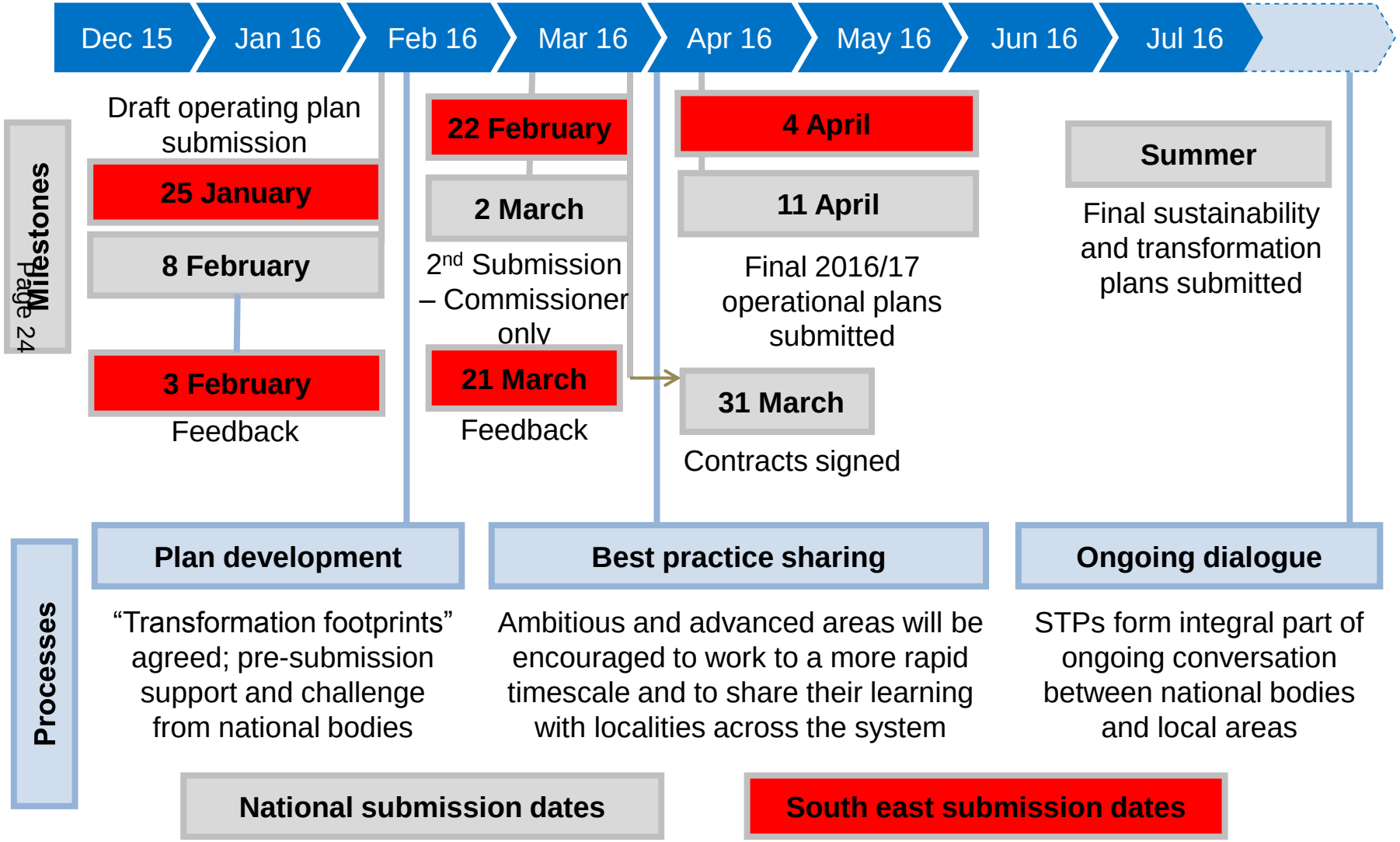
Sustainability and Transformation Plan

- The plan will cover the population of Kent and Medway and will be submitted to NHS England at the end of June 2016.
- The planning process will have significant central money attached and the most compelling plans will secure the earliest additional funding (from April 2017).
- Further guidance has been issued and we are working with NHS England to ensure the plan will cover:
  - Closing the health and well-being gap
  - Driving transformation to close the care and quality gap
  - Closing the financial and efficiency gap.

Sustainability and Transformation Plan

- Sustainability and transformation plans will cover a range of key services and population groups, defining future need, identifying gaps to close and scope for improvement.
- Model of care to implement these changes will be identified.
- Work-streams might include:
  - Prevention and self-care
  - Long term conditions, frailty and end of life care
  - Maternity and paediatrics
  - Mental health and learning disabilities
  - Planned and specialist care
  - Urgent and emergency care

South east timetable



Developing the plan

- The East Kent Strategy Board will oversee the development of the sustainability and transformation plan for the east Kent population - this will be aligned with our partners in north Kent, west Kent, Medway and Swale
- Several key elements of work already underway in Kent and Medway, specifically reviews of vascular and stroke services
- The EKSB work to date and the development of the sustainability and transformation plan will now come together to meet the national timetable.

East Kent Strategy Board Update

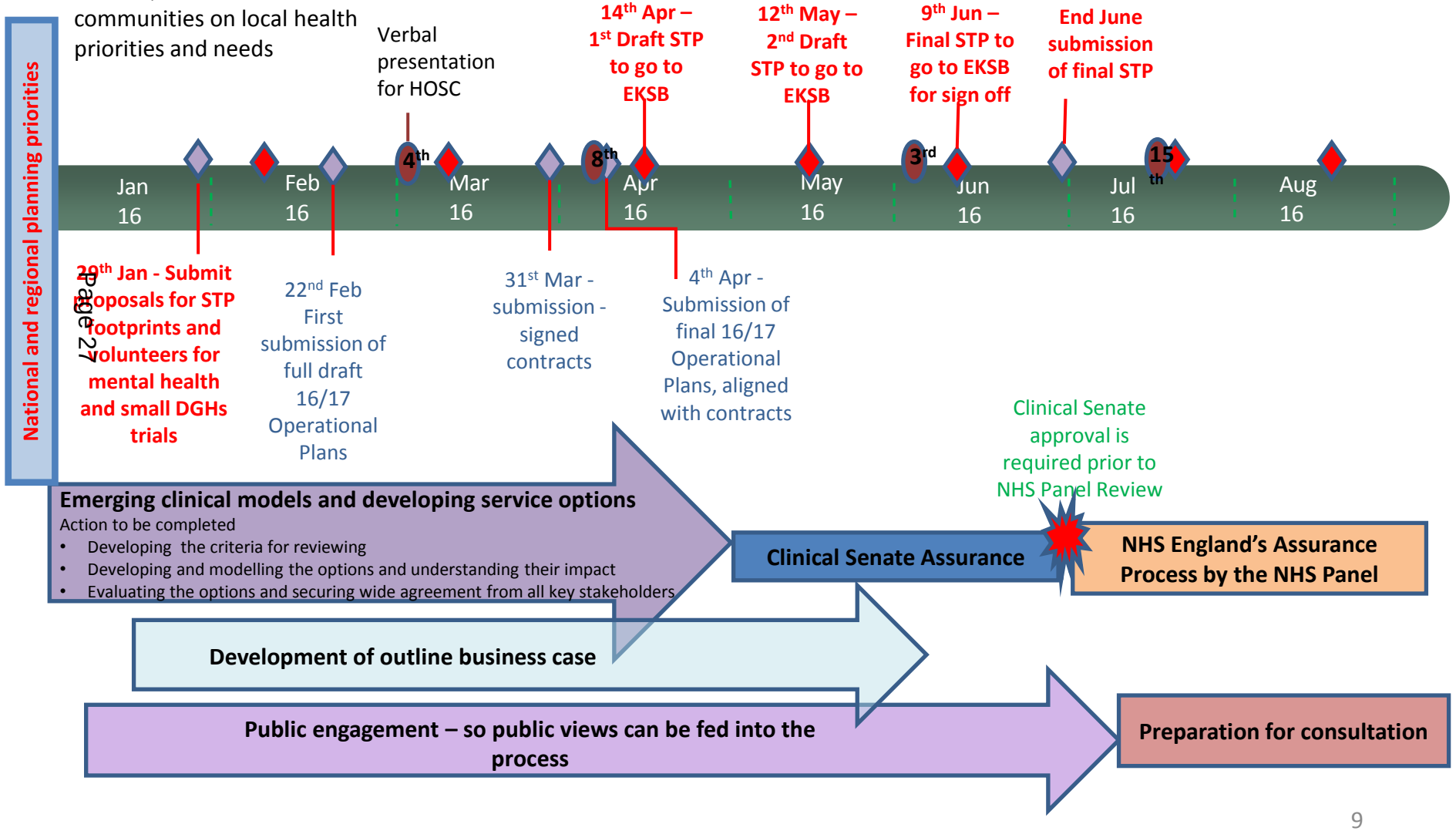
- Through the autumn the Board has been focussing on:
  - Forming a coalition of local health and social care leaders and developing a shared vision
  - Understanding the map of current and planned reviews and initiatives in place across the economy
  - Developing a robust Kent Integrated Data set (formerly Year of Care) which allows us to really understand flow across the health and social care system, and
  - Working with colleagues across Kent and Medway to understand the impact in east Kent of the vascular and stroke reviews.

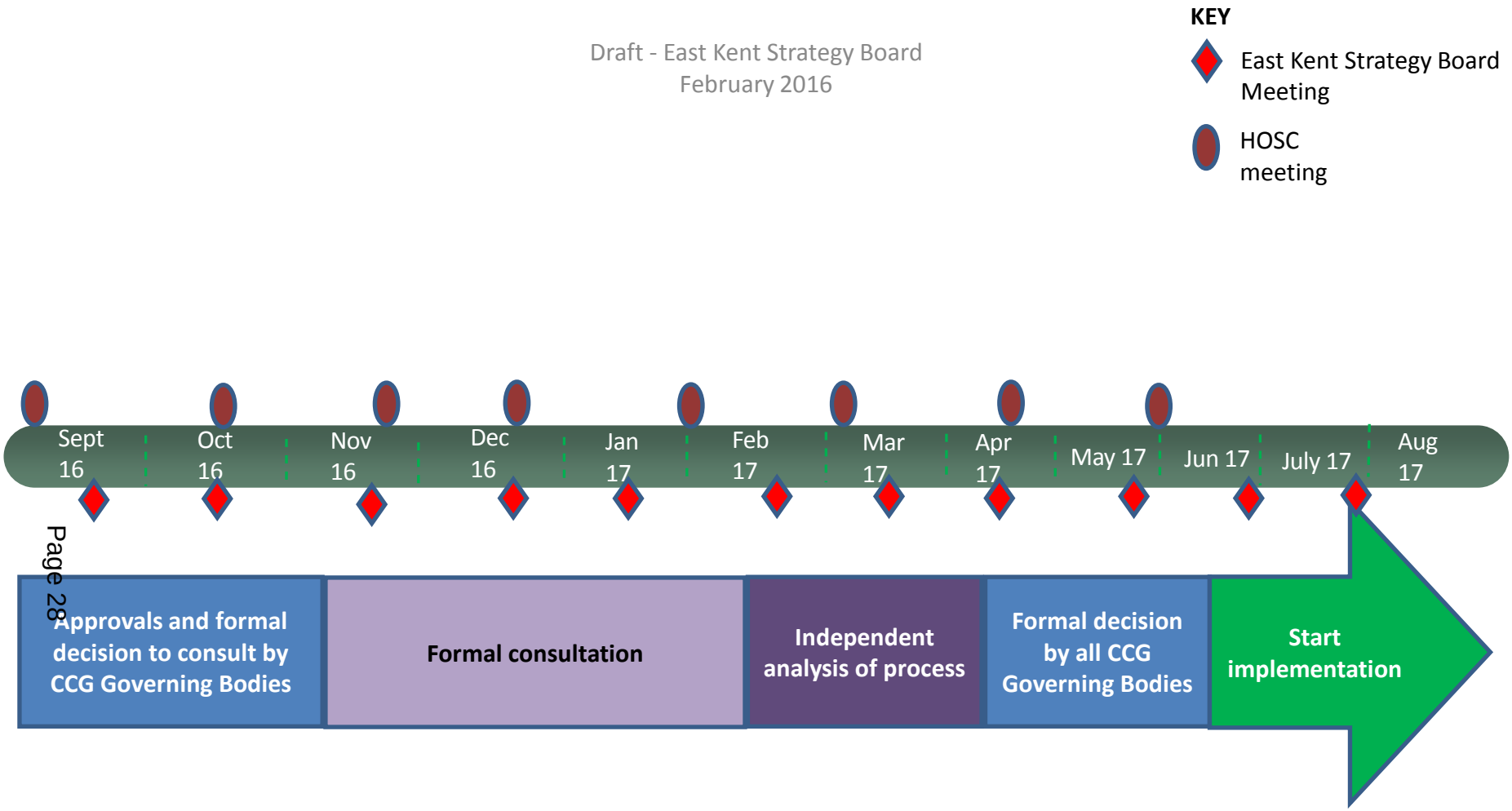
Work is well underway to set the strategic context

- Development of JSNA, joint H&WB strategies and commissioning plans
- Clinical working group
- Continuous dialogue with H&WBs, HOSC and local communities on local health priorities and needs

KEY

- East Kent Strategy Board Meeting
- HOSC meeting




KEY
East Kent Strategy Board Meeting
HOSC meeting
Sept 16
Oct 16
Nov 16
Dec 16
Jan 17
Feb 17
Mar 17
Apr 17
May 17
Jun 17
July 17
Aug 17
Approvals and formal decision to consult by CCG Governing Bodies
Formal consultation
Independent analysis of process
Formal decision by all CCG Governing Bodies
Start implementation

Future Timetable

By Easter:

- Governance arrangements and an agreed process in place
- The east Kent 'Case for Change' agreed
- Key priorities for the gaps identified

By end April:

- Description of the emerging clinical models for the key priorities
- Development of the evaluation criteria by which those models will be assessed
- Ongoing engagement with key stakeholders, including HOSC and the public to feed into the process

Future Timetable

By end May:

- A well developed draft sustainability and transformation plan with clear description of the models of care to meet key priorities
- Clear ambitions, using a prioritised approach, for the future health and social care system in east Kent
- Clarity on how we plan to meet the nine ‘must dos’ in the planning guidance

By end June:

- We will submit our plan as part of our long-term ongoing work to improve health and care in east Kent.

Item 5: Kent and Medway NHS and Social Care Partnership Trust (KMPT): Update

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 March 2016

Subject: Kent and Medway NHS and Social Care Partnership Trust (KMPT): Update

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway NHS and Social Care Partnership Trust.

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

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1. Introduction

(a) Kent and Medway NHS and Social Care Partnership Trust provides mental health and social care services in Kent. The Trust was formed in April 2006 after the merger of East Kent NHS and Social Care Partnership Trust and West Kent NHS and Social Care Trust. The Trust's services are commissioned by the eight local Clinical Commissioning Groups (CCGs) in Kent and Medway, Kent County Council and NHS England. The Trust covers a population of 1.7 million across 1,500 square miles. The Trust has an annual revenue of £178 million and employs 3,318 staff and 228 seconded staff who are located in 83 buildings on 47 sites.

2. Recommendation

RECOMMENDED that the report be noted and KMPT be requested to provide an update at the appropriate time.

Background Documents

KMPT (2015) *' Kent and Medway NHS and Social Care Partnership Trust Annual Report 2014-15' (04/06/2015)',* *https://www.kmpt.nhs.uk/downloads/Who-we-are/KMPTAnnual-report-201415-web-opt.pdf*

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Kent & Medway NHS & Social Care Partnership Trust [KMPT]

Update

Report prepared for:

Kent County Council [KCC]
Health Overview and Scrutiny Committee [HOSC]
04 March 2016

Version: 3.0

Reporting Officer: Malcolm McFrederick
Executive Director Operations, KMPT

Date: 23 February 2016

Report Compiled By: Sarah Day
Programme Management Office [PMO]
Project Manager, KMPT

1. Introduction

1.1 This report has been prepared at the invitation[1] of Kent County Council [KCC]'s Health Overview and Scrutiny Committee [HOSC] to provide a general update about the Trust.

1.2 This report will provide a comprehensive update on four areas as identified by the Committee, namely:

i. The Trust's financial and staffing position following media reports about reductions to liaison psychiatry in East Kent and the closure of the Knole Centre in Sevenoaks.

ii. 2015 Care Quality Commission [CQC] Inspection.

iii. Implementation of the Kent and Medway Adult Inpatient Mental Health Services Review – Inpatient Mental Health Capacity.

iv. Plans and support for integration.

1.3 The Committee is asked to note the content of the report.

2. The Trust's financial and staffing position following media reports about reductions to liaison psychiatry in East Kent and the closure of the Knole Centre in Sevenoaks

2.1 Liaison Psychiatry

2.1.1 The purpose of the Liaison Psychiatry Service is to meet the needs of people with mental health problems in acute hospitals. Liaison Psychiatry Services provide an urgent mental health assessment service to service users over the age of eighteen with mental health problems who attend the Accident and Emergency Department [A&E] and who may be admitted to a district general (acute) hospital. These service users often have complex assessment needs resulting in longer waits and stays. The service ensures mental health assessments are undertaken in a timely manner and to facilitate effective discharge planning, reduce unnecessary hospital admissions and reduce the length of stay where appropriate. In addition the service helps raise awareness of the importance of mental health, improves early detection of illness and its impact on physical health and recovery in a general hospital setting and ensures that people with mental ill health have their needs appropriately met whilst under the care of the general hospital. The Liaison Psychiatry Service covers all areas of the acute hospital, not just A&E.

2.1.2 The East Kent Liaison Psychiatry Service operates across three sites, namely, the William Harvey Hospital (Ashford), the Kent and Canterbury Hospital (Canterbury), and the Queen Elizabeth the Queen Mother [QEQM] Hospital (Margate). The service currently operates during the day, 08.00 – 16.00 hours seven days a week. This reduction to the previous hours of operation (09.00 – 00:00 hours) across all sites was implemented in October 2015 to meet safe staffing guidelines, an ability to provide a whole hospital service matched to demand and an inability to safely staff the additional hours.

2.1.3 Outside of these operational hours, and in the event of a mental health need that requires urgent assessment and intervention, the Crisis Resolution Home Treatment [CRHT] Service[2] covers A&E on a case by case basis.

[1] KCC (02 February 2016) Robert Brookbank (Chairman, KCC HOSC) letter to Angela McNab (Chief Executive, KMPT)

[2] The purpose of the CRHT service is to provide an alternative to inpatient admission for individuals who are suffering with acute mental ill health to the extent that without CRHT involvement, admission would be indicated.

2.1.4 In addition to the CRHT and Liaison Psychiatry Services, the Single Point of Access [SPoA] Service[3] provides a single telephone contact number (0300 222 0123) to enable clients, carers and those experiencing mental health crisis to access mental health care and advice 24/7.

2.1.5 The current commissioned contract for the East Kent Liaison Psychiatry Service is for one band 7 team manager at each site, two consultant psychiatrists and one speciality doctor across the three sites, and 15.54 whole time equivalent [wte] nurses (currently divided as 5.00 wte per site). In addition the service is supported by one administrator and one administrative assistant located centrally who work with each of the three teams across the three sites. This number of staff allows for eight operational hours per day across the three sites.

2.1.6 Over the winter period an additional locum consultant has joined the team, allowing for a consultant at each site. This is not a substantive arrangement and will cease on 31 March 2016.

2.1.7 Note that by 2020 it is expected that a core 24/7 liaison psychiatry service will be commissioned for all acute hospitals nationally.

2.2 Knole Centre

2.2.1 The Specialist Neurological Rehabilitation Inpatient Service for people of North and West Kent and Medway who have experienced an acquired or traumatic non-progressive neurological illness previously provided at the Knole Centre (Sevenoaks) closed in December 2015. This followed the Trust's decision to serve notice in March 2015 in response to a decision by local Clinical Commissioning Groups [CCGs] to commission these services differently going forward. The new model sees a move away from and the de-commissioning of a specialist inpatient model to one that provides service users requiring neurological rehabilitation with bespoke packages of care in a variety of settings (community care and generic NHS rehabilitation wards) appropriate for each individual service user and across a range of NHS and private provider organisations.

2.2.2 The impact of this closure has had a positive impact on the Trust's financial and staffing position. Ongoing pressures in recruiting and retaining staff in the Sevenoaks locality (with its close proximity to London and the attraction of London weighting allowances) meant the unit had a high rate of agency workforce.

2.3 Finance

2.3.1 The Trust's financial position as reported at month 9 is on track for a year end income and expenditure [I&E] deficit of £4.3m after technical adjustments.

2.3.2 The Trust continues to implement a number of proactive and corrective actions to improve this position.

2.3.3 The total headcount for December 2015 was 3,256 with a total of 2,925.13 wte. Headcount has exceeded the last four years position apart from 2011-12. The largest workforce is within the registered nursing staff group.

The CRHT team is multi-disciplinary, and includes registered nurses and occupational therapists [OTs], consultant psychiatrists, speciality doctors, nurse prescribers and support time recovery [STR] workers.

[3] The SPoA has been operational since 2014 and until April 2016 this service only provides a routing and signposting function enabling clients to be transferred to a mental health professional within the locality based services. From April 2016 the SPoA will be staffed by clinically trained staff who have a ready treat principle and can facilitate onward co-ordination of care.

2.3.4 The rolling twelve months turnover rate at December 2015 sits at 16.24%, a little above the NHS national average of 12-14%. The highest turnover was experienced within the Forensic and Specialist Service Line [FSSL]. The closure of the Specialist Neurological Rehabilitation Inpatient Services (which sits within the FSSL) had a direct impact.

2.3.5 High vacancy rates remain in acute and older adult inpatient services linked to the challenges of recruiting in North and West Kent (bordering Trusts pay a London weighting allowance). This is mirrored in the community recovery services that include a high level of KCC staff vacancies, turnover and absence. The robust focus on reducing sickness absence across the Trust has seen a significant improvement in sickness absence rates in year. The rolling twelve month year to date figure of 4.05%.

2.3.6 The Trust continues to implement a rolling programme of recruitment.

3 2015 CQC Inspection

3.1 On 30 July 2015 the CQC published its Quality Report[4] following an inspection of the Trust's services between 17 and 20 March 2015. The overall inspection summary concluded the Trust requires improvement against four of the five objectives measured. The table below provides a summary of these ratings.

Key CQC Question	CQC Inspection Rating
Are services safe?	Requires improvement (amber)
Aer services effective?	Requires improvement (amber)
Are services caring?	Good (green)
Are services responsive to people's needs?	Requires improvement (amber)
Are services well-led?	Requires improvement (amber)

3.2 The CQC talked to 219 service users, carers and family members; observed how staff were caring for people; looked at the personal care or treatment records of over 224 service users and interviewed over 329 individual frontline members of staff.

3.3 Of the nine core services inspected, one was outstanding, three were good and five required improvement. The table provided below provides a summary these findings.

Service	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units [PICU]	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Long stay / rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Forensic inpatient / secure wards	Requires improvement	Outstanding	Outstanding	Good	Outstanding	Outstanding
Wards for older people with mental health problems	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Wards for people with a learning disability or autism	Requires improvement	Outstanding	Outstanding	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Mental health crisis services and health based places of safety	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Community mental health services for people with a learning disability or autism	Good	Good	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	[5]Requires improvement

3.4 The CQC noted that KMPT had kind, caring, compassionate and passionate staff who treated people with dignity and respect, want to deliver good quality care and want to improve. They noted evidence of good leadership and sharing a common purpose. They

[4] CQC (30 July 2015) *Kent and Medway NHS and Social Care Partnership Trust Quality Report*
[5] Overall provider: Requires improvement (amber)

found a clear strategy based around driving clinical improvements. In addition, the CQC found some outstanding care and practice in forensic and learning disability services where they were "overwhelmed by volume of evidence of innovative practice to support and include patients in their care".

3.5 However, there were a number of areas in which KMPT needed to improve, namely:

- The CQC had serious concerns about care in older adult continuing care wards, warning notices were issued to which KMPT responded immediately.
- Some concerns over systems not embedded consistently (medicines management, Deprivation of Liberty Safeguards [DOLs], Mental Health Act [MHA] use and recording).
- Estates issues regarding section 136 suites and seclusion rooms.
- High bed occupancy levels in acute and PICU wards and community caseloads.
- Physical health checks not being carried out consistently.
- The quality of care planning was variable, in some areas outstanding, requiring improvement in others.

3.6 The Trust responded by developing and agreeing a Quality Improvement Plan [QIP], the implementation of which is being monitored monthly by meetings chaired by the Trust Development Authority [TDA] and NHS England [NHSE].

3.7 The plans divide into three areas:

i. The first relates to those operational issues that KMPT can solve internally, and these are on track to be completed by 1 April 2016.

ii. The second relates to the estate where capital spend is required. This is on track to be completed by October 2016.

iii. The third area relates to capacity issues with younger adult and PICU bed capacity, where CCGs would need to agree to commission additional capacity before anything else could be done.

4 Inpatient Mental Health Capacity

4.1 As the CQC found, due to increased demand for acute inpatient care, exceeding the 174 beds currently commissioned by CCGs, a number of individuals who require acute inpatient care are being placed in hospitals outside of Kent and Medway. This has an impact on the individual with regards to their recovery, ability to maintain social networks, friends and family and on KMPT and CCGs in relation to costs incurred.

4.2 CCGs and KMPT have been involved in remodelling the demands on beds. As well as additional physical bed capacity, investment in alternatives to admission is still required.

4.3 At the request of the CCGs, KMPT has submitted a proposal for the addition of 16 beds to the current bed stock (from autumn 2016) as part of a longer CCG commitment that will enable investment into building an additional younger adult acute ward and PICU. Once the CCGs have agreed to this commitment, the next hurdle of capital money provision can be addressed.

4.4 In the meantime, KMPT continues to work internally and with partners, KCC and CCGs, to minimise length of stay and reduce the need for admission.

5 Plans and support for integration

5.1 The Trust is actively engaged in the Kent Integration Pioneer Programme and has adopted a proactive approach to ensuring engagement in all groups and at all levels. The Trust has welcomed this whole system opportunity to work with a comprehensive range of stakeholders and agencies to deliver services in a way that improves outcomes, improves experiences of care, makes better use of resources and ensures the citizen is placed at the centre of health and social care.

5.2 The ethos behind the Integration Pioneers approach to helping health and social care services work together to provide support for people at home, to promote earlier treatment within an individual's community and reduce the number of people needing emergency care in hospital or care homes is one that reflects the revised key areas of action set out in the Trust's refreshed Clinical Strategy[6]. The table below provides a summary of these key areas of action:

Key areas of action
Developing and delivering a range of service models to support timely care in the least restrictive setting ensuring urgent and acute care needs can be met.
Ensuring service users have clear, integrated pathways to recovery including supported transfer to and from primary care.
Working with CCGs and other stakeholders where necessary to develop services that enable more service users with complex needs to be cared for within the Trust.
Developing and delivering high quality clinical environments, supported by the use of technology to provide quality and clinical effectiveness.

5.3 The Committee is reminded that Kent is one of fourteen national integration pioneers appointed by the Department of Health [DoH]. Kent's Integration Pioneer Programme is a partnership involving Kent's seven CCGs, adult social care, the community health trust, mental health, acute sector and district councils. The partnership also engages the voluntary sector and the public and seeks to ensure the citizen is placed at the centre of health and social care.

5.4 The Trust also continues to benefit from the joint working arrangements between the Trust and KCC for the provision of integrated mental health services in Kent and in accordance with the Section 75 Agreement of the NHS Act 2006. The table below provides a summary of the benefits of this arrangement, which has at its core an integrated approach to ensuring the individual is at the centre of all services provided and that these services focus on prevention, wellbeing and recovery.

Benefits of Section 75 Agreement
Ensuring a clear professional role for social workers to deliver the social care agendas through a person centred approach, delivering improved outcomes and working in partnership to the highest standards of practice.
KMPT through the Section 75 agreement has been delegated the responsibility to manage the newly developed dedicated Approved Mental Health Professional [AMHP] Service in which social workers and nurses who have qualified as an AMHP deliver a county-wide 24/7 service recognised by the CQC as an area of innovation and good practice.

[6] Due to be published in Quarter 4 2015/16

Integration ensures all professions are well coordinated and have equitable influence on care and support models to ensure a holistic services.
Social workers working in statutory mental health services can provide a vital counterbalancing view to clinical models of illness and disorder and where this is done well, can have a powerful impact on NHS culture and practice.
Social care in mental health can offer more than just Self Directed Support - there are a range of social interventions that support recovery and social care staff bring a different and vital perspective to multi-disciplinary working.

5.5 The five role categories for social workers in adult mental health support delivery and realisation of these benefits. The table below provides a summary of these categories.

Five Role Categories
Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of local authorities.
Promoting recovery and social inclusion with individuals and families.
Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity.
Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship.
Leading the AMHP workforce.

6 Conclusion and Recommendation

6.1 The KCC HOSC is requested to note the content of this update report in support of its discussion around the provision of mental health services.

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Item 6: CQC Inspection Report: Medway NHS Foundation Trust

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 March 2016

Subject: CQC Inspection Report: Medway NHS Foundation Trust

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

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

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1. Introduction

(a) The Health Overview and Scrutiny Committee has considered Medway NHS Foundation Trust on seven occasions (6 September 2013, 7 March 2014, 5 September 2014, 10 October 2014, 28 November 2014, 30 January 2015 and 5 June 2015) following the publication of Professor Sir Bruce Keogh KBE's review into the quality of care and treatment provided by 14 hospital trusts in July 2013.

2. Keogh Review

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

(b) Medway NHS Foundation Trust was one of 14 Trusts selected for the review on the basis of being outliers for two consecutive years on one of two measures of mortality: Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). (NHS England 2013a; NHS England 2013b; NHS England 2013c).

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

3. CQC

(a) Professor Sir Mike Richards, the Chief Inspector of Hospitals, prioritised full inspections of the 14 trusts that were in the Keogh

Review (including the 11 trusts in special measures) under CQC's new inspection model for acute hospitals (CQC 2014).

(b) The CQC initially inspected Medway NHS Foundation Trust in April 2014 and led to an overall rating of inadequate. Medway NHS Foundation Trust was the only Trust in special measures found to have failed in making significant overall progress. It was recommended that the Trust remained in special measures. Further inspections took place in July 2014, August 2014 and December 2014 (CQC 2014).

(c) The CQC re-inspected the Trust in August 2015 and the inspection report was published in January 2016. The CQC rated the Trust as Inadequate and recommended that the Trust should remain in special measures. The inspection reports can be viewed here:

- Medway NHS Foundation Trust
- Medway Maritime Hospital

4. Recommendation

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

Background Documents

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

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

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

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

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (10/10/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=30032

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (28/11/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5401&Ver=4

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (30/01/2015)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=30553

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (05/06/2015)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=32310

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

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

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

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Kent's Health Overview and Scrutiny Committee

4 MARCH 2016

UPDATE ON CARE QUALITY COMMISSION INSPECTION

Report from: Lesley Dwyer
CEO, Medway NHS Foundation Trust

Summary:

This report seeks to inform the Kent Health Overview and Scrutiny Committee on the summary of the main CQC findings findings detailed within the Care Quality Commission's Quality Report (published on 7th January 2016) following its' Comprehensive Inspection of Medway NHS Foundation Trust during August and September 2015 and the Trust's response to this, areas of improvements since the 2014 inspection and areas of improvements to be tackled now.

Background

Following a comprehensive inspection of Medway NHS Foundation Trust (MFT) by the CQC in April 2014, the trust was given an overall rating of inadequate and has been subject to further CQC inspections over the last 18 months, namely in May 2014 (Emergency Department and Surgical Services), July 2014 (Emergency Department and Surgical Services) and August 2014 (Emergency Department); as a result of those inspections the CQC undertook Enhanced Enforcement action and imposed conditions on the trusts registration which required us to undertake an initial assessment of all patients who presented to the emergency department within 15 minutes of their arrival.

In November 2014 MFT commenced an 18 month recovery plan in order to bring about a state of stability within the organisation. This plan was based around 5 key themes which covered the breadth of changes and improvements that were required within the hospital to ensure delivery of high quality care.

A further unannounced inspection in December 2014 (Emergency Department and Surgery), saw the Care Quality Commission reporting on some positive changes and noticing improvements.

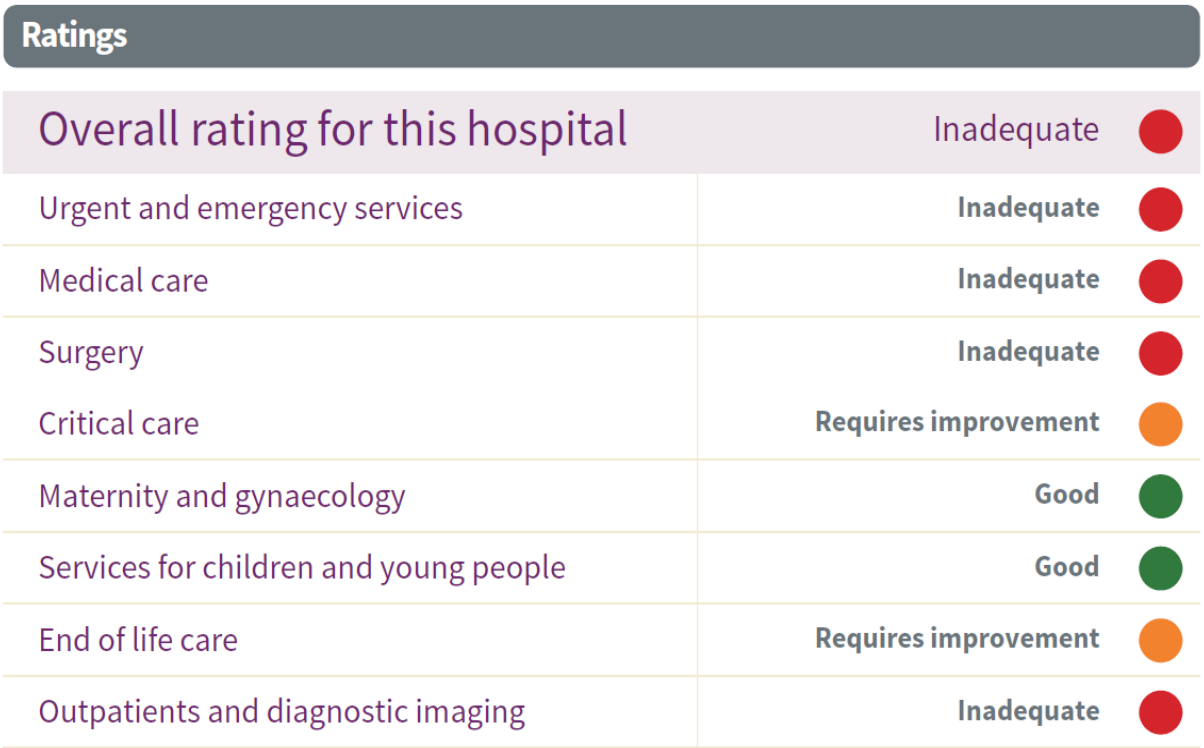
The Care Quality Commission (CQC) carried out a second Comprehensive Inspection of Medway NHS Foundation Trust on 25th - 27th August 2015, with further unannounced inspections taking place on 8th, 9th & 13th September 2015. During this most recent inspection the CQC were satisfied that the trust was meeting the condition imposed in August 2014 and has since removed this condition from the trusts registration.

Findings

In response to concerns raised by the CQC at the time of the inspection, the Trust developed 5 Remedial Action Plans (RAPs), and which are being progressed. These are related to Cancer, Imaging, the Emergency Department, Referral-To-Treatment (RTT) and Endoscopy.

The Care Quality Commission Quality Report was published on the 7th January 2016 which identified the overarching rating for the Trust as 'Inadequate'.

In addition to an overarching Trust level rating, each of the eight core services inspected received the following ratings:



Although we had already recognised many of the issues that the CQC identified as areas for improvement, and had action plans in place, it is clear that we need to accelerate significantly the pace of the work we are doing to turn around the Trust.
Notwithstanding this, we accepted the CQC's overall findings and expressed our regret that we were falling short of what the people of Medway and Swale deserve.

Quality Summit
We cannot improve the hospital without the support from a whole range of partners. In this context, it was very helpful that the day after the report, the CQC hosted a Quality Summit which brought together representatives from the Trust, other regulatory bodies and a range of other stakeholders, including Kent and Medway Councils.

Over 90 people attended the summit. In round table sessions, those present explored the key challenges facing the Trust, and the ways in which they can support us to address these. Everyone present made a pledge around the action they would take.

The event was extremely positive – although everyone recognised the scale of the work needed in improving the hospital, all participants committed to working with us to bring about the changes that are needed.

In presenting his summary of the key findings, Professor Sir Mike Richards did however report that the CQC saw several areas of improvement and outstanding practice including:

- The orthotics department, which had also been identified by NHS England as a service to benchmark against, because of the waiting times (90% of all patients seen the same day or next day).
- The maternity team for the multidisciplinary teamwork in providing support for women identified in the antenatal period as requiring an elective caesarean section.
- The Oliver Fisher Neonatal Unit

The report also identifies several examples of good practice:-

- The Intensive and Surgical High Dependency Care Units
- The leadership of the outpatient nursing team
- Overall, that our staff were caring and supportive with patients and those close to them, and that staff responded with compassion to patients in pain and to other fundamental needs.
- Staff treated patients with dignity and respect and people felt supported and cared for as a result.

Our improvement plan

We submitted our improvement plan to the CQC on 8 February. It is centred around six key activities:

- Modernising our Emergency Department, reducing the time it takes for patients to be seen and assessed
- Improving patient safety and care by minimising the number of different doctors that patients see during their stay in hospital
- Accelerating our recruitment drive to bring in the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interims and agency staff
- Continuing to improve our corporate and clinical governance, which will support both safe and high quality patient care and a productive working culture for staff
- Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional clinic appointments for patients to see specialists
- Working closely with our healthcare partners to ensure patients receive the right care in the community, when they are ready to leave hospital. This will free up beds for people coming into the hospital.

We have put in place a specialist team, mainly drawn from colleagues already working within the Trust and from our buddy Trust, Guy's and St Thomas', to co-ordinate and drive the plan, and the team has made a good start in mobilising and engaging staff to generate the improvements needed. It is critical that our staff are fully engaged to generate the improvements needed.

We have a number of key milestones ahead in the next few weeks, including the roll-out of a new way of treating patients that reduces the number of doctors they see and the amount of time they spend in the hospital, the opening of a new waiting area in the emergency department and the launch of an in-house bank of locum nurses and other staff groups which will mean we are less reliant on costly agency staff.

The plan is underpinned by a range of Key Performance Indicators which we have agreed with the CQC, including average length of stay in the hospital, mortality rates and time spent in the emergency department before being seen.

Next steps

Following the Quality Summit, Chief Inspector of Hospitals Professor Sir Mike Richards wrote to the Health Secretary, Jeremy Hunt, informing him that the Trust would remain in special measures for a further three months, that he was impressed by the progress that we were making but added that he would be monitoring our progress closely during this period. Whilst we are not expecting a re-inspection during this period, Professor Sir Mike Richards has stated that he will provide further advice to the Secretary of State regarding our progress.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 March 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, 9 October 2015 and 29 January 2016.

(b) On 29 January 2016, the Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) members of the HOSC participate in a working group chaired by Graham Gibbens, Cabinet Member for Adult Social Care & Public Health to look at the Universal & Targeted Emotional Health & Wellbeing Specification and the Children & Young People's Mental Health Specification in more detail.

  (b) the Committee defer making a determination on whether the NHS service specification is a substantial variation of service and whether it is happy to support the procurement on 4 March 2016.

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

Kent County Council (2016) *'Agenda, Health Overview and Scrutiny Committee (29/01/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6256&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

4th March 2016

Patient focused, providing quality, improving

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

Summary

A working sub-group of the Kent Health Overview Scrutiny Committee (HOSC) met on 17 February 2016, to discuss concerns raised at the previous HOSC meeting on 29 February 2016 relating to the universal/early help and health service specifications. The meeting was attended by a small group of committee members and representatives from NHS West Kent CCG and KCC Public Health.

It was agreed that a summary paper of the discussion would be written and submitted to the next HOSC meeting on 4 March 2016.

Recommendation

Members of the HOSC are asked to note the contents of this report and agreement is sought that, although the new service specifications do seek to significantly improve the way current provision of emotional wellbeing and mental health services are being delivered, they do not constitute significant change in terms of what is being delivered. Therefore, no further public consultation is required.

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 1 April 2017.

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

1.0 Service Specifications

1.1 The authors of the specifications were given the opportunity to briefly outline the aims and objectives of the services being proposed and the collaborative commissioning process being undertaken to deliver two separate services, but as a whole-system approach, ensuring a seamless pathway from universal support to specialist mental health care for the child/young person

1.2 Crucial to the improvement of the new whole-system approach is the development of an appropriate and clinically sound integrated Single Point of Access (SPA) which will ensure that qualified mental health practitioners will review all referrals received via the Early Help Notification process in order to identify the appropriate level of mental health need, therefore, ensuring children/young people are seen by the right person, in the right place at the right time and reducing demand for specialist services. The integrated SPA will have a single phone number, e-mail address and referral form to ensure ease of

access to support as well as real-time information for referrers about the availability of provision across Early Help, EWB and CAMHS services.

1.3 The development of a Kent-wide integrated outcomes based framework and data set will allow for closer scrutiny of service performance through system wide contract monitoring, ensuring the model remains aligned. This will continue to support evidence based improvements whilst ensuring value for money.

1.4 Two separate specifications have been developed, through consultation with children/young people, parents/carers and professionals and aligned to '*Future in Mind*', to meet the diverse needs outlined in Kent's '*The Way Ahead*' strategic framework and Emotional Health and Wellbeing Model.

1.5 One specification sets out the provision of the Public Health Secondary School-Aged Universal and Targeted Emotional Health and Wellbeing Service, working across the population of school aged children in primary, secondary and tertiary settings, 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.

1.6 Following public consultation, the contract will be split between primary and secondary/tertiary age groups to reflect the differing needs. Every state school in Kent will have a named professional who will provide advice and support to schools to improve the health outcomes for their children and face to face support for children and their families on health issues.

1.7 The Universal Service aims to build resilience (that is, individual, family and community capability to deal with adverse events) and support emotional wellbeing at an individual and whole school level. It will support mental health promotion across the school, provide advice and support to children with very mild emotional health problems, provide advice and support to school staff on supporting children with children with mild problems and identify and refer children with greater needs to the appropriate service.

1.8 The Targeted School Emotional Health and Wellbeing Service will be provided by the secondary/tertiary age school public health service providing in-reach to primary schools. This service will provide support for children with mild/moderate mental health needs and their families, staffed by mental health professionals. This could be provided via drop-in consultations or short term evidence-based programmes. This service will be accessed via self-referral, referral by school staff members, or from professionals outside the school, e.g. GPs, via the Single Point of Access. This service will also have a

role in supporting those children accessing more specialist mental health services to support their recovery and provide advice to the school.

1.9 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 across the three health economies (North, East and West Kent).

1.10 Targeted mental health services are for those children/young people who are experiencing mild to moderate mental ill health. This provision ensures timely access to assessment and treatment delivered by mental health professionals using a range of time-limited evidence-based interventions with successful resolution or management of the difficulty within their local education setting or social setting. This element of the service is for children/young people whose needs do not meet the higher level mental health threshold but cannot be supported by Universal services or by the Emotional Health and Wellbeing service.

1.11 Specialist mental health services will be for those children/young people presenting with the highest level of risk to self and others who have complex, severe and enduring psychological, psychiatric and behavioural problems. This medium – to long-term level of treatment will be delivered by highly specialist staff using evidence-based interventions in line with NICE guidance. The provision will include access to crisis care and will respond to the needs of children/young people with neurodevelopmental conditions (ADHD/ASC), eating disorders, victims of child sexual exploitation and those demonstrating harmful sexual behaviour, learning disabilities, psychosis, offending and substance misuse.

1.12 Clarity has been sought around the requirements of vulnerable groups (Children in Care/Looked After Children, Children in Need, Young Offenders, disabled children, children on the child protection register and Unaccompanied Asylum Seeking Children) and how best to meet their needs including prompt access to assessment and treatment via the SPA process.

1.13 There are clear requirements across the system to improve transition between services, including adult mental health services, through the development of a 0 – 25 year old provision after the first year of the five year contract.

1.14 The final drafts of both the Public Health and NHS provision will be presented to the Collaborative Commissioning and Procurement Board on 4 March 2016 for sign off. 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 Commissioning 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 and 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 three 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 Points raised by Members

4.1 How do you measure outcomes? The specifications require clear KPI's for access/waiting times for key points in the referral pathway – A *set of provisional outcomes and KPI's have been developed (Appendix 1 and 2) and these will form part of the competitive dialogue with Providers and will be agreed by commissioners as part of the procurement process.*

4.2 Concerns were raised around the complexity of the services being proposed and how realistic is to deliver them? - *Despite being a complex structure of services in terms of commissioning, a clear pathway had been developed which would allow children/young people and parents/carers to navigate the whole system from Universal to Specialist services where these had previously worked in silo, therefore, ensuring no child/young person could fall between the gaps in provision. Providers are required to work in*

partnership with other providers (including the voluntary sector) so that the demands are shared across the totality of services therefore reducing duplication of effort and improving efficiency.

4.3 How do you achieve 'collaborative commissioning'? – *As part of the procurement process, a joint commissioning strategy is being written up to identify a clear structure against which the procurement process will be aligned both in relation to KCC and CCG governance structure and timetables.*

4.4 The difference in language between local authority and health has caused some confusion - *Authors of these documents continue to work towards a common language and have agreed to provide a glossary of terms to provide some clarity to readers.*

4.5 Providers should be required to work with research bodies to embed evidence-based improvements in provision - *An element of research has now been written into the specifications via links with The National Institute for Health Research (NIHR) and Academic Health Science Networks (AHSN) which are affiliated with higher education institutions, patients and researchers and aim to translate research into practice.*

4.6 Is there a way to measure progression of an individual year on year? – A*s well as the system-wide data dictionary being developed within KCC, the health provider will be asked to submit a comprehensive data set to the South East Commissioning Support Unit who are able to identify individuals by NHS number – this could form an audit requirement*

4.7 Does the school public health service cover KCC funded schools and academies? - *Yes the funding covers all state funded schools and academies but not privately funded schools*

4.8 0-25 age banding, how does this work in practice when 20-25 year olds might not consider themselves in young people's services? - *The Providers will be required to develop an age appropriate service, including 18 -25 by year 2 of the contract, and to work in partnership with other service providers. Patients' have a choice as to what service they receive, providing it is clinically sound, so if someone wants to be seen by another services and this is deemed appropriate then they should be allowed to do so.*

4.9 The specifications must consider the full spectrum of people with learning disabilities (LD)? – *There is already an established close working relationship between LD health and social care which is very effective.*

4.10 How will these services be easily accessed? *In addition to referrals from Universal Service's and GP's, the integrated Single Point of Access will accept referrals from all other partners and members of the public, including self-referral. The specifics of this process are to form part of the Competitive Dialogue with Providers during the procurement process to develop an appropriate and clinically sound early help response and approach.*

5.0 Next steps of the contract process:

- 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.

6.0 Recommendations

Members of the Kent Health and Overview Committee are asked to

(i) NOTE the contents of this report.

(ii) agreement is sought that, although the new service specifications do seek to significantly improve the way current provision of emotional wellbeing and mental health services are being delivered, they do not constitute significant change in terms of what is being delivered, therefore, no further public consultation is required.

7.0 Appendices

Appendix 1 Universal/Early Help Outcomes and KPI's
Appendix 2 Mental Health KPI's

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APPENDIX 1

KCC Public Health Commissioned Service

District Key Performance Indicators

No.	Indicator
Service Outcomes for Children and Young People - emotional health and resilience (refined once the integrated outcomes framework is finalised)	
1	Children and young people 's emotional health and resilience is improved as a result of the Tier 1 (including across the resilience domains)
2	Children and young people 's emotional health and resilience is improved as a result of the Tier 2 intervention(including across the resilience domains)
3	Children and young people's voices are heard
4	Children and young people are confident that they can access resources and employ strategies to support their emotional health in the future
5	Children and young people are satisfied with the service that has been provided
6	Parents and carers are confident that they can access resources and employ strategies to support their child's or young person's emotional health in the future
7	Parents and carers are satisfied with the service that has been provided
8	Educational staff and governors are able to identify and support children and young people with emotional health and mental health needs
9	Educational staff and governors are confident that they can access resources and employ strategies to support their child's emotional health in the future
Agreements	
10	Number of schools who have a signed communication agreement in place with the SNS - signed off by the Head Teacher or Deputy Head
	Proportion of schools who have communication agreement signed by Head Teacher or deputy
11	Proportion of GP practices with a named link worker
Whole District and School Plans	
12	% of districts with District Public Health Plans
13	% of schools with School Health Plans
Assessments/ Screening and Tier 1 intervention including Tier 1 emotional health intervention	
14	Percentage of year R children who are offered a health questionnaire - cumulative
15	Proportion of Year R who have a follow up intervention for emotional health post health questionnaire - cumulative
16	Percentage of Year 6 children who are offered a health questionnaire -

	cumulative
17	Proportion of Year 6 who have a follow up intervention for emotional health post health questionnaire - cumulative - include type of interventions.
18	Percentage of Year 10 children you are offered a health questionnaire - cumulative
19	Proportion of Year 10 who have a follow up intervention for emotional Health post health questionnaire - cumulative - include type of interventions
Provision of an accessible service which can access referrals and self referrals	
20	Number of referrals for Tier 1 emotional health
21	Number of self referrals for Tier 1 emotional health
22	Number of referrals for Tier 2 emotional health (primary)
23	Number of self referrals for Tier 2 emotional health (primary)
24	Number of referrals for Tier 2 emotional health (secondary)
25	Number of self referrals for Tier 2 emotional health (secondary)
26	Number of drop in sessions delivered including in safe spaces
Packages of Care at Tier 1 and Tier 2 including emotional health and resilience	
Packages of Care at Tier 1 to children and young people	
27	Number of new packages of care started (Emotional Health and wellbeing) - (primary)
28	Number of new packages of care started (Emotional Health and wellbeing) - (Secondary)
Packages of Care at Tier 2 to children and young people	
29	Number of new packages of care started (Emotional Health and wellbeing) - (primary)
30	Number of new packages of care started (Emotional Health and wellbeing) - (secondary)
Training for parents, carers, staff and governors	
31	Number of parents and carers in Universal services trained to support children and young people's emotional health and resilience (primary)
32	Number of parents and carers in Universal services trained to support children and young people's emotional health and resilience (secondary)
33	Number of school staff and governors in Universal services trained to support children and young people's emotional health and resilience (primary)
34	Number of school staff and governors in Universal services trained to support children and young people's emotional health and resilience (secondary)
Referrals and Service Interfaces	
35	Number of children who are supported in their transition from Health Visiting into primary school
36	Number of children who are supported in their transition from Public Health School Service Primary/primary school into the Adolescent Health Service/ secondary tertiary school

37	Number of children who are referred to SPA for Early Help Additional Service
38	Number of children who are referred to SPA for Specialist Tier 3 CAMHS Service
39	Number of A and E attendances that are followed up
Whole School Health Improvement	
40	No. of schools supported to implement and review whole school health improvement around emotional health
41	% of schools in Quartile 1 who over the period of the contract adopt a whole school approach to health improvement around emotional health and resilience
42	No. of children and young people supported to participate in whole school health improvement

APPENDIX 2

Mental Health KPI's

Under Service Condition 2 of the national NHS contract, the Provider is mandated to comply with the registration and regulatory compliance guidance of any relevant regulatory or supervisory body. Under Service Condition 3 of the national NHS contract, the Provider is mandated not to breach thresholds in respect of operational standards and national quality requirements. Specific to children and young people, the national standards apply to access and waiting times in relation to eating disorders, perinatal mental health, early intervention in psychosis and liaison psychiatry.

The following KPI's link to the strategic outcomes specified in *'The Way Ahead'* - a strategic framework for Kent's children and young people's emotional wellbeing and mental health.

Access/Waits –

- 60% of routine assessments completed within 2 weeks of accepted referral
- 95% of routine assessments completed within 4 weeks of accepted referral
- Vulnerable groups – 100% assessments completed within two weeks of accepted referral
- Vulnerable groups – 100% commence treatment within 2 weeks of assessment
- Vulnerable groups – reduce DNA's to 4% from current baseline
- 100% of children screened for CSE
- 60% of routine treatment commenced within 4 weeks of assessment
- 95% of routine treatment commenced within 6 weeks of assessment
- No appointments cancelled by the Provider
- 100% of emergency referrals assessed within 24 hrs of accepted referral
- 100% of urgent referrals assessed within 5 working days of accepted referral
- 100% of MH S136 admissions assessed with 2 hrs of accepted referral

Whole Family –

- 100% of complaints responded to within 4 weeks
- 30% of patients/parents/carers discharged provided a survey response regarding their involvement in the care planning process
- 75% of those who responded to the care planning survey stated that they felt happy with the level of their involvement in their care planning
- 100% of multi-disciplinary care plans must be agreed by the patient and shared with parents/carers

Recovery and Transition –

- 100% of patients to have a multi-disciplinary care plan in place by 1st treatment, agreed and signed by the patient and parent/carer
- baseline of Tier 4 admissions reduced by 25%
- 75% of patients at point of leaving the service will have completed an appropriate pre- and post- patient reported outcome tool
- 90% of patients will have demonstrated statistical change in moving towards recovery at the end of their treatment using a recognised clinical tool
- 50% of patients will have achieved recovery (below caseness) at the end of their treatment as measured using a recognised clinical tool.
- 100% of patient's transitioning to other services to have a multi-disciplinary care plan shared with onward services