HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th April, 2016

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th April, 2016, at 10.00 am	Ask for:	**Lizzy Adam**
Council Chamber, Sessions House, County Hall, Maidstone	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 - 14)	

4. SECAmb: Forensic Review of Red 3 Pilot and Review of Ambulance Quality Indicators (Pages 15 - 28) 10:05

5. Better Care Fund (Pages 29 - 44) 10:45

6. King's College Hospital NHS Foundation Trust: Outpatient Services at Sevenoaks Hospital (Pages 45 - 52) 11:30

7. Kent and Medway NHS and Social Care Partnership Trust (Written Briefing) (Pages 53 - 82)

8. Five Year Forward View for Mental Health and the implications for Kent (Written Briefing) (Pages 83 - 94)

9. Date of next programmed meeting – Friday 3 June 2016

    - East Kent Strategy Board
    - Kent and Medway NHS and Social Care Partnership Trust
    - Kent and Medway Sustainability and Transformation Plan
    - Review of winter preparedness in Kent 2015/16
    - North and West Kent Neurorehabilitation Service

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

31 March 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, 4 March 2016.

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

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

UNRESTRICTED ITEMS

13. Membership
(Item 1)

(1) Members of the Health Overview and Scrutiny Committee noted that Mr Bowles replaced Mr King as a member of the Committee.

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

(1) There were no declarations of interests by Members in items on the Agenda for this meeting.

15. Minutes
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken since 29 January 2016:

(a) Minute Number 7 – North Kent: Adult Community Services. Following the discussion on 29 January, Mr Brookbank and Miss Harrison were contacted by a member of the public and one of the bidders regarding the extended standstill period. The CCGs were asked to provide a response which was circulated to the Committee on 29 February. The CCGs stated that "On the 22nd December 2015 all four bidders were advised of the outcome of the process and were told in confidence who the preferred bidder was. This was followed by the 10 day standstill in line with best practice where any of the bidders were able to raise queries or question the outcome of the evaluation. During this time the CCG received a response from one of the providers which resulted in the standstill period being extended by a further five days so that the CCG could respond to the query, which it did so to that bidders

satisfaction. The standstill period was lifted on 12th January 2016 and the public announcement made on 13th January 2016." It was also noted that a "complaint from Dartford & Gravesham NHS Trust/Medway Community Healthcare (the third placed bidder) was made to Monitor on 15 January 2016."

A further statement from the CCGs was provided to the Committee on 25 February which stated that the CCGs had "received notice of the issue of proceedings by an unsuccessful bidder in the Technology and Construction Court (part of the High Court of Justice). The challenge has been brought under the Public Contracts Regulations 2006. This triggers an "automatic suspension" under Regulation 47G of the Public Contracts Regulations 2006 which requires the CCGs to refrain from entering into a contract in respect of the services until the proceedings are determined, discontinued or otherwise disposed of". As the CCGs were now involved in legal proceedings, they have been advised not to comment further at this point.

(b) Minute Number 7 – NHS Swale CCG: Review of Emergency Ambulance Conveyances. During the discussion on 29 January, a Member enquired if the closure of the A249 (Sheppey) had had an adverse impact on SECAmb; Patricia Davies stated that she had not been made aware of any adverse impact but undertook to check with SECAmb and provide the information to the Committee. A response from SECAmb was awaited.

(c) The JHOSC scheduled for Friday 26 February was postponed at the request of NHS England South (South East) and the Kent and Medway CCGs. A new date in April would be scheduled in due course. A written briefing to update the JHOSC was circulated to the JHOSC Members on 26 February.

(2) Miss Harrison expressed a view that the Committee had been kept fully informed regarding the extended standstill period.

(3) The Scrutiny Research Officer committed to circulating the actions that had been taken since 29 January 2016 by email to the Committee.

(4) RESOLVED that the Minutes of the meeting held on 29 January are correctly recorded and that they be signed by the Chairman.

16. East Kent Strategy Board
(Item 4)

Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury & Coastal CCG) and Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Hazel Carpenter began by outlining the new national planning guidance which requires the NHS to develop five year Sustainability and Transformation Plans (STPs) by June 2016. She explained that there would be a STP for Kent and Medway and the East Kent Strategy Board would oversee the development of the plan for the

East Kent population which would align and link to the Kent and Medway STP. She noted that the reviews of stroke and vascular services in Kent and Medway were key elements of work already underway. She stated that there would be public consultation on the strategy for East Kent following the submission of the STP in June 2016. She noted that complex work was being undertaken in East Kent around the emerging clinical models and the development of service options including the co-location of adjacent services; prior to the submission of the STP, the plan would be sent to the Kent, Surrey & Sussex Clinical Senate for approval. She reported that a public engagement group had been established which was chaired by Clive Hart, Lay Member for Public Engagement, NHS Thanet CCG.

(2) Members of the Committee then proceeded to make a number of comments about the inclusion of growth in the STP and presenting updates to local Health and Wellbeing Boards (HWBs). Ms Carpenter stated that the CCGs were beginning to proactively work with borough and district councils to understand and influence new developments. Mr Perks reported that the new developments provided a unique opportunity, which must be taken advantage of, to integrate health and social care in the community through provision in patients' homes or in local facilities such as Whitstable Medical Practice led by Dr Ribchester. A Member requested that elected Members be kept informed about health's role in new housing developments. Mr Perks noted that a briefing paper had been circulated to local HWBs but it would timely to present an update. He stated that local HWBs and Community Networks provided a valuable opportunity for the CCGs to share their thinking and gain insight from their local community.

(3) In response to a specific question about the Committee's role in the timeline, Ms Carpenter explained that the Case for Change would be finalised by the end of Easter and highlight the financial and quality challenges in each locality; the emerging options and detailed content would be developed by the end of April.

(4) RESOLVED that the report be noted and the East Kent Accountable Officers be requested:

(a) to submit a written update detailing the Case for Change for the Committee's meeting on 8 April;

(b) to liaise with colleagues and arrange for a verbal presentation on the Kent and Medway Sustainability and Transformation Plan to be presented to the Committee on 8 April;

(c) to arrange an informal meeting with Members in early May and present a formal update to the Committee on 3 June about the strategy for East Kent.

17. Kent & Medway NHS & Social Care Partnership Trust: Update
(Item 5)

Malcolm McFrederick (Executive Director of Operations, Kent & Medway NHS & Social Care Partnership Trust) and Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr McFrederick began by giving a general update to the Committee about the Trust's financial and staffing position, the CQC inspection and the Trust's plans and support for integration.

(2) Mr McFrederick explained that the Trust had a planned deficit for this financial year and was in contract negotiations and sign-off with the CCGs and NHS England for the next financial year. He reported that the Trust has a rolling programme of recruitment and was working towards a more therapeutic model of staffing with therapists, psychologists and psychiatrics which had helped to decrease the ward staffing deficit by half in East Kent. He noted that it was challenging to recruit in North Kent particularly in Dartford as bordering Trusts paid a London weighting allowance. He reported that a sustainable model for the East Kent Liaison Psychiatry Service had been developed with the East Kent Hospitals University Foundation Trust (EKHUFT) which had led to a reduction in the hours of operations; NHS West Kent CCG and NHS Dartford & Gravesham CCG were looking to introduce a Liaison Psychiatry Service. He stated that the Trust was in discussions with Kent Community NHS Foundation Trust (KCHFT) about using the Knole Centre, Sevenoaks as a stepdown facility. The Trust had withdrawn from providing the specialist neurological rehabilitation inpatient services at the Knole Centre as it predominately provided physical health services.

(3) Mr McFrederick stated that the CQC published its report in July 2015 following an inspection in March 2015. He noted that there were a number of outstanding services and a number of areas in which the Trust needed to improve including the variable quality of care particularly for older adults. The Trust had developed a quality plan which was monitored by the Trust Development Authority, the Care Quality Commission and local CCGs. The plan was divided into three areas for action: internal operational activities such as the embedding of medicine management to be completed by April 2016; capital spend to make improvements to estates regarding Section 136 suites and seclusion rooms by October 2016; and increasing bed capacity for younger adults and Psychiatric Intensive Care Units (PICU). He noted that the Trust was in discussions with East and West Kent commissioners about commissioning additional young adult and PICU bed capacity.

(4) Mr McFrederick reported that the Trust was engaging with and supporting local heath economies' plans for integration; the Trust was adjusting their community models to fit with local requirements. He noted that the Trust was benefiting and improving its relationship with Kent County Council (KCC) under a joint working Section 75 agreement; 250 KCC staff had been seconded to the Trust to provide an integrated mental health service in Kent.

(5) 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 the

CQC Inspection Report and Quality Improvement Plan. Mr McFrederick stated that the Trust was rated as 'requires improvement' under the effective and responsive measures due to an increased demand for acute inpatient care, which was exceeding the 174 beds commissioned by the CCGs, resulting in a number of patients being placed outside Kent and Medway. He reported that the CCGs and the Trust were involved in remodelling the demand on beds and a proposal for 16 additional beds was being considered by the CCGs. He noted that the Trust was rated as 'requires improvement' under the safe measure due to the size of 136 suites and seclusion rooms not meeting the latest size regulations. Other actions to be taken to improve safety included reducing the caseload to at or below recommended level for the community team of nurses and social workers in Dartford, Swale and Thanet and developing relationships between psychologists, psychiatrists, nurses and GPs in South Kent Coast to improve referral into and discharge out of the Trust's services.

(6) Mr McFrederick reported that the Single Point of Access Service, a single telephone contact number which enabled clients, carers and those experiencing mental health crisis to access mental health care, would from April 2016 be staffed by clinically trained staff who would be able treat and facilitate the onward coordination of care and accept urgent referrals from patients, carers, 111 service, GPs and the Police. He noted that as part of the Trust's internal assurance process, CCGs had carried out CQC style inspections which had been useful particularly in North Kent. He confirmed that the additional locum consultant in the Liaison Psychiatry Service had been made permanent subject to the Royal College of Psychiatry approval.

(7) In response to a specific question about inpatient mental health capacity, Ms Carpenter explained that commissioners in East and West Kent were looking to commission additional bed capacity, in the short to medium term, to reduce the number of patients being placed out of county. She noted that a long term strategy would be included within the Kent and Medway Sustainability and Transformation Plan. Mr McFrederick reported that since the 174 beds currently commissioned by CCGs were modelled, there had been an increase in demand; there were currently 23 patients placed outside of Kent and Medway. He stated that the Trust was working with CCGs to look at the effectiveness of inpatient care using national benchmarks; the Trust was at or below average for the length of stay and delayed transfer of care and was under commissioned for adult inpatient beds. He noted that the Trust also had a Crisis Resolution Home Treatment Service which provided an alternative to inpatient admission for individuals who were suffering with acute mental ill health. He reported that the Trust was working with the Police to reduce the number of Section 136 detentions under the Crisis Concordat; Kent and Medway had more Section 136 detentions than Birmingham and only 20% of detentions resulted in inpatient admissions. He highlighted the importance of preventing service users who were known to the Trust going into crisis.

(8) A Member enquired about provision for young people, transition and young people in care. Mr McFrederick stated that the Trust provided services for younger adults aged 18 – 65 and older adults aged over 65. He noted that the CCGs had offered a Commissioning for Quality and Innovation (CQUIN) payment to the Trust and Sussex Partnership NHS Foundation Trust to

improve transition between the two services. Ms Carpenter reported that the requirements of vulnerable groups such as Looked After Children and Unaccompanied Asylum Seeking Children was being developed as part of the service specification for the NHS Children and Young People's Mental Health Service.

(9) A number of comments were made about morale and engagement with KCC. Mr McFrederick explained that there had been a major improvement in staff satisfaction last year which had been maintained in the current year. He reported that staff were disappointed when improvements were out of their control such as capital investment and the IT system. Mr Scott-Clark stated that KCC's Public Health team was working with the Trust to become smoke free; there was a high prevalence of smoking amongst mental health service users. Mr McFrederick noted that through the Section 75 agreement with KCC, a dedicated Approved Mental Health Professional (AMPH) service had been developed to deliver a 24/7 service which had been recognised by the CQC as an area of innovation and good practice. He stated that he welcomed the opportunity to present an update to the Committee and looked forward to engaging with the Committee more frequently in the future. He noted that the Five Year Forward View for Mental Health had recently been published and there was an expectation that there would be a higher profile and additional targets for mental health.

(10) RESOLVED that:

(a) the report be noted;

(b) KMPT be requested to submit a written briefing about CQC style inspections carried out by the CCGs; the timescale for the six key areas of improvement and which area of the Quality Improvement Plan they sit under; and the number of out-of-county placements for the Committee's meeting on 8 April;

(c) KMPT be requested to present an update to the Committee in June;

(d) Ms Carpenter be requested to liaise with colleagues and arrange for a written briefing on the Five Year Forward View for Mental Health and the implications for Kent to be submitted to the Committee for its meeting on 8 April.

18. CQC Inspection: Medway NHS Foundation Trust

(Item 6)

Lesley Dwyer (Chief Executive, Medway NHS Foundation Trust) and Shena Winning (Chairman, Medway NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Dwyer began by outlining the background to the inspection. She explained that the Trust had been subject to many inspections and the latest inspection in August 2015 had resulted in the Trust maintaining the inadequate rating and remaining in special measures; prior to the inspection the Trust had self-rated itself as inadequate. She noted that the Trust accepted the report in its entirety. A

quality summit was held on 8 January with over 90 stakeholders who were asked to make a positive commitment to help the Trust improve. She stated that the Trust had been rated good in the caring measure which was a strong foundation for improvement. She highlighted that areas of outstanding practice had been found during the inspection including maternity services which had been noted as having strong leadership and a focused team to improve results; wider learning from these services would be shared across the organisation.

(2) Ms Dwyer reported that the Trust had 28 days to submit an improvement plan to the CQC which was aligned to the Trust's existing 18 month recovery plan; 73 'must do' and 'should do' actions were identified including the modernisation and expansion of the emergency department. She noted that the Trust had put in place a specialist team, including staff from the buddy Trust at Guy's and St Thomas' NHS Foundation Trust, to coordinate and drive the improvement plan. She stated that there were a number of key milestones in the next few weeks including a new medical model which would reduce the number of handovers for patients; the opening of a new waiting area in the emergency department; and the launch of an in-house bank of locum nurses. She highlighted that the Trust was criticised by the CQC for its reliance on agency staffing; up to 50% of A&E staff and 25% of nurses across the Trust were agency. She reported that the Trust had held a number of events and open days which had led to the recruitment, subject to checks, of 70 – 80 nurses. The Trust was also looking to make joint appointment with Trusts in London where staff would rotate between sites and was working with the local universities to attract university students to the Trust. She noted that for the fourth month in a row more staff were arriving than leaving the Trust which was a significant improvement.

(3) 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 when the Trust would be removed from special measures, Ms Dwyer stated that she was confident that the Trust now had the right level of clinical leadership to step up and take responsibility for change and improvement at the Trust. She noted that the Trust was developing positive relationships with its partners. She stated that the improvement plan set out what needed to be done and the Trust was required to report weekly on how it was achieving against the plan.

(4) A Member enquired about the variability of services and support from NHS Swale CCG. Ms Dwyer identified areas of good practice including the maternity team, neonatal unit and the frailty pathway. She stated that the Trust understood the potential impact if something went wrong. She noted that there were indications of sustained improvement at the Trust; the Trust was no longer an outlier for mortality rates. She reported that reviews were undertaken after every death and serious incident to learn from and make changes. She highlighted that both the Chair and Accountable Officer from NHS Swale CCG attended the Quality Summit. The Trust recorded data about why patients chose to go to the emergency department which was shared with the CCG; she noted that 25% of attendances to the emergency department were referred to the onsite GP centre. She stated that the Trust was working closely with GPs to make changes to the medical model including improved access for GPs to speak with consultants, the development of drop-in and wellness centre and geriatricians working in the community.

(5) A number of questions were asked about staff retention and morale, the buddy trust and the modernisation of the emergency department. Ms Dwyer explained that the Trust was working with local universities and developing its apprenticeship scheme to improve recruitment. She noted that she met with all new staff for lunch after three months and nine months at the Trust to find out about their experiences and if they were being supported within the organisation. She reported that there had been less than positive articles about the Trust in the press which impacted on staff; she stated that half of all comments received by the Trust were praise and half were complaints. Ms Dwyer stated that the Trust was responsible for improvement but required additional support. She reported that Guy's and St Thomas' NHS Foundation Trust were very committed to the Trust; the Trust had recently appointed the medical director and the nursing director who had been recruited from that Guy's and St Thomas' NHS Foundation Trust. Ms Dwyer explained that the new waiting area in the emergency department was one part of the modernisation. She noted that the minor injuries unit, which was being refurbished during the CQC inspections, now had a shared triage desk and the new paediatric emergency department had opened. The next area of refurbishment was the major trauma and resuscitation area which was due to be completed by the end of 2017.

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

19. Emotional Wellbeing Strategy for Children, Young People and Young Adults
(Item 7)

Ian Ayres (Accountable Officer, NHS West Kent CCG), Dave Holman (Head of Mental Health Programme Area, NHS West Kent CCG) and Samantha Bennett (Consultant in Public Health, Kent County Council) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Ayres began by stating that the working group, attended by a small group of Members and representatives from NHS West Kent CCG and KCC Public Health, was very useful and the Members comments had been incorporated into the paper submitted by the CCG.

(2) Members of the Committee made a number of comments about transition, provision for children who attended private schools, partnerships with the universities and joint commissioning. Mr Holman explained that in the second year of the new contract the 0 – 25 model would be clarified; at present Kent and Medway NHS and Social Care Partnership Trust (KMPT) and Sussex Partnership NHS Foundation Trust were subject to Commissioning for Quality and Innovation (CQUIN) payment for 14 – 21 joint pathway. He reassured the Committee that under the new model that there would ne one payment for 0 – 25 services. Mr Ayres stated that any child in Kent could access NHS services for free at the point of the delivery; public health services would cover all state funded schools and academies. Mr Ayres noted that as part of the procurement they would look at providers who would have the capability to work in partnership with the universities. Mr Ayres reported that the Kent

Emotional Wellbeing Strategy for Children, Young People and Young Adults would be one of the first jointly commissioned contracts by the NHS and Public Health and it had been an interesting challenge with lots of learning. Mr Scott-Clark stated that NHS West Kent CCG and Public Health had been having discussions about developing specifications together and incorporating prevention into pathways. He noted that Public Health was a member of the East Kent Strategy Board to provide advice about improving population health and ensuring public health commissioning aligned to the strategic plans.

(3) RESOLVED 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 six months;

(d) a working group be established to monitor the performance of the new contract and provider at the appropriate time.

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Item 4: SECAmb: Forensic Review of Red 3 Pilot and Review of Ambulance Quality Indicators

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 8 April 2016

Subject: SECAmb: Forensic Review of Red 3 Pilot and Review of Ambulance Quality Indicators

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

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

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1. Introduction

(a) On 29 January 2016 the Committee considered an update on South East Coast Ambulance Service NHS Foundation Trust (SECAmb) which included details about a retriage pilot 'Red 3' during Winter 2014/15 which saw clinicians take up to an extra ten minutes to retriage calls that had come across from 111 to 999 as requiring an emergency response and the use of defibrillators in performance reporting. The Committee agreed the following recommendation:

- *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.*

(b) A forensic review of Red 3 pilot commissioned by Monitor and an independent review of ambulance quality indicators commissioned by the Trust were published on 15 March 2016. The reports can be viewed here:

- Deloitte Forensic Review of Red 3 Pilot
- RSM Review of Ambulance Quality Indicators

(c) SECAmb and NHS Swale CCG have asked for the attached reports to be presented to the Committee:

SECAmb Report	pages 17 - 26
NHS Swale CCG	pages 27 - 28

2. Recommendation

RECOMMENDED that the report be noted and SECAmb be requested to share the findings of the Patient Impact Review at the Committee's July meeting.

Item 4: SECAmb: Forensic Review of Red 3 Pilot and Review of Ambulance Quality Indicators

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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South East Coast Ambulance Service NHS
NHS Foundation Trust

Deloitte Forensic Report into the Red 3/Green 5 Pilot & Defib Review

Key findings

Geraint Davies
Acting Chief Executive & Director of Commissioning

8 April 2016

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

R3/G5 Key Elements

- Re-Triage R2 “In the Stack”
- Up to 10 Minutes R2
- Clock stop

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Background

- Recognition of environment in which Trust was operating:
  - Difficult winter
  - High demand
  - Ebola outbreak

- Key findings from Deloitte Report (as outlined by Monitor):
  - Poor governance
  - Inadequate disclosure
  - Unclear clinical accountabilities
  - Non-unitary Board

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Poor Governance:

- Inadequate governance arrangements around the OSDG
- Project governance inadequate – no agreed timeframe, no benefit realisation identified, review criteria not agreed
- Failure to follow due process:
  - Decision of CEO to proceed despite concerns raised about the Pilot
  - Action taken by Chair of OPGWG
- Lack of timely and clear Board and Committees papers

Your service, your call

South East Coast Ambulance Service NHS
NHS Foundation Trust

Inadequate Disclosure

- Key Board Committees not fully informed of Pilot, unable to scrutinize
- Trust Board not fully informed of Pilot in detail
- Informal relationship with Commissioners
- Commissioners not fully appraised of all details of Pilot

Your service, your call

Clinical Accountability Unclear

- Clinical accountability confused between Medical and Clinical Director
- Medical Director disengaged from the development of the pilot
- No Quality Impact Assessment undertaken

South East Coast Ambulance Service NHS
NHS Foundation Trust

Non-unitary Board

- Non-Executive and Executive Directors did not work together effectively to create a Unitary Board
- Style of Chair
- Executive Directors failure to disclose to the Board
- Missed opportunities by NEDs to challenge & provide oversight
- Silo-based working amongst Executive Directors
- Board focus

Your service, your call

Next Steps

- Initial Actions:
  - Resignation of Chairman
  - CEO taking mutually agreed leave of absence while the Trust considers the findings of the report and determines the appropriate actions; Geraint Davies Acting Chief Executive
  - Interim Chair, Sir Peter Dixon, appointed by Monitor & started on 15 March 2016
  - Full Deloitte report published on 15 March 2016

South East Coast Ambulance Service NHS
NHS Foundation Trust

Next Steps

- Further Actions:
  - Joint Recovery Plan to be agreed with Commissioners/Monitor to address R3/Quality Concerns
  - Patient Impact Review to be completed by June 2016
  - Nature of any Governance Review to be agreed with Monitor
  - Process/timetable for appointing permanent Chair to be agreed with Monitor

Your service, your call

Defibrillator review

- Independent review undertaken by RSM (Internal Auditors) at Trust's request, following Daily Telegraph article
- Review confirmed not compliant with AACE additional guidance from 1/1/14 to 15/11/15
- Report discussed with commissioners and Monitor
- Actions addressed by Audit Committee and being taken forwards

Report to Kent HOSC on 8 April 2016 From NHS Swale CCG regarding South East Coast Ambulance Service NHS Foundation Trust (SECAmb)

Background information

Following an unauthorised call handling project carried out by NHS South East Coast Ambulance NHS Foundation Trust (SECAmb) between December 2014 and February 2015, the regulator Monitor requested a forensic review be undertaken into the circumstances, governance and decision-making surrounding the project. This review, undertaken by Deloitte UK, is now complete and was published on 15 March 2016, (available at www.secamb.nhs.uk). A further independent review, to identify the impact the project had on patients, is underway and due for completion later this year.

We, as the lead commissioner for Kent and Medway, will continue to stringently monitor SECAmb's progress and further support the Trust to strengthen internal governance arrangements, towards a safer and more effective ambulance service.

The Kent Health Overview and Scrutiny Committee have specifically asked three questions of commissioners:

1 The commissioners' response to the reviews and next steps

As lead commissioners of ambulance services across Kent and Medway, in conjunction with our colleagues in Surrey and Sussex, NHS Swale CCG's priority is to ensure a safe and high quality service for patients. We are working closely with the new Chair at SECAmb, and regulators, so that the Trust is fully supported to deliver the necessary improvements with pace, in line with the findings of the reports.

We have written to the Trust to formally require a Remedial Action Plan to address the governance issues in the report, and to also ensure that Response Performance is improved and that the actions to improve quality and safety are all delivered within one overall prioritised plan. This plan is being finalised at the time of writing this report.

This plan will be scrutinised by commissioners through regular review meetings at executive level, detailed investigations into specific areas and ongoing testing to check that changes have been put into practice at an operational level. Overall accountability will be part of the formal contract and performance management will be carried out by the accountable officers in the Strategic Partnership Group as described below.

2 The commissioners' plans to improve oversight

Since the initial review last year, the commissioners have improved the oversight and assurance processes for managing Trust performance. The actions include:

- Locally focussed contract management arrangements to ensure closer scrutiny from co-ordinating commissioners and their respective local commissioning associates in for each contract area:
    - Kent and Medway
    - Surrey
    - Sussex
- Formal governance for the lead commissioners for each of those contracts to collaborate and ensure a single focus for the Trust on areas which require consistency. This is established through a formal Strategic Partnership Group at Accountable Officer level, and a joint Clinical Quality Review Group and is supported by a clear process to facilitate clarity of decision-making
- Visibility of all proposed Trust projects and pilots with a process of ensuring that projects and pilots requiring formal approval are scrutinised and decisions are recorded
- Co-ordination of contract management processes to enable a consistent focus on key issues, with improved use of contractual mechanisms in holding the Trust to account
- Review of Performance Review Meetings' structure and delivery to ensure clarity of decision-making.

3 The commissioners' plans to develop Trust/Commissioner engagement

The commissioners recognise that senior executive engagement with the Trust needs to be broader, ensuring the wider Trust Executive Team is involved in performance management. This has already been improved and will be developed further through the Remedial Action Plan process. Current progress is outlined below:

- The Trust Executive Team is invited to the Strategic Partnership Group with the commissioners' accountable officers
- Clinical executive directors are involved in the Clinical Quality Review Group
- Board to Board meetings have been held to engage the Trust's non-executives with the NHS Swale CCG Governing Body
- The Chief Operating Officer for the Trust has been leading the R1 and R2 response Remedial Action Plan
- The commissioners' quality leads (including Surrey and Sussex colleagues) have been working with the relevant Trust leads to undertake detailed reviews of the changes that have been put in place.

Item 5: Better Care Fund

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 8 April 2016

Subject: Better Care Fund

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

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

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1. Introduction

(a) The £5.3bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to enable a transformation in integrated health and social care. The Better Care Fund (BCF) is seen as one of the most ambitious programmes across the NHS and local government. It has created a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services (Department of Health and the Department for Communities and Local Government 2016).

(b) In 2015-16, the Government committed £3.8 billion to the Better Care Fund with many local areas contributing an additional £1.5 billion, taking the total spending power of the Better Care Fund to £5.3 billion (Department of Health and the Department for Communities and Local Government 2016).

(c) In 2016-17, the Better Care Fund will be increased to a mandated minimum of £3.9 billion to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups (CCGs). The local flexibility to pool more than the mandatory amount will remain. NHS England will set eight conditions, which local areas will need to meet through the planning process in order to access the funding in 2016-17. The conditions require:

1. That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and CCGs;
2. A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.
3. Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;
4. Better data sharing between health and social care, based on the NHS number;

5. A joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
7. That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement;
8. Agreement on a local action plan to reduce delayed transfers of care (NHS England 2016).

(d) From 2017-18, the government will make funding available to local authorities, worth £1.5 billion by 2019-20, to be included in the Better Care Fund (Department of Health and the Department for Communities and Local Government 2016).

2. Recommendation

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

Background Documents

Department of Health and the Department for Communities and Local Government (2016) *'2016/17 Better Care Fund Policy Framework (08/01/2016)'*, https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

NHS England (2016) '*Technical Guidance Annex 4:Better Care Fund Planning Requirements for 2016-17 (01/02/2016)',* https://www.england.nhs.uk/wp-content/uploads/2016/02/annex4-bcf-planning-requirements-1617.pdf

Contact Details

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By:	Kent and Medway Clinical Commissioning Group Accountable Officers
To:	Health Overview and Scrutiny Committee – 8 April 2016
Subject:	**Better Care Fund 2016/17**
Classification:	Unrestricted

Summary: This paper presents an update on the Better Care Fund 2016/17 in relation to the Policy and Planning Requirements; Financial Allocations; Assurance and Approval process.

FOR INFORMATION

1. Introduction

1.1 The purpose of this report is to update the Committee members on the way in which the Better Care Fund will be implemented in the financial year 2016/17. This is based on the national policy framework and financial allocations which have recently been issued.

1.2 The published information confirms that the Department of Health (DH) and the Department for Communities and Local Government (DCLG) worked in partnership with the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and NHS England (NHSE) to develop the guidance. Even so, in line with the legal framework NHS England has reserved power to make final decisions.

2. Key Policy and Planning Requirements

2.1 As with the previous guidance, the latest document reiterates that BCF funding covers the minimum level of pooled fund and therefore it is open to local areas to decide if they wish to put in more than the specified minimum level.

2.2 The guidance makes it clear that the Health and Wellbeing Board as well as the constituent Councils and CCGs should sign off the plan. There are seven national conditions which local area plan must address. These relate to:

(1) a condition to maintain (protect) the provision of social care;
(2) a condition of making progress towards seven-day services;
(3) a condition of better data sharing between health and social care using the NHS number;
(4) a condition that there should be a joint approach to assessment and care planning;
(5) a condition that the impact of the changes on NHS providers are factored into plans;
(6) a condition that some of the money is invested in NHS commissioned out-of-hospital services and;
(7) a condition that local action plans should tackle delayed transfer of care.

2.3 There is confirmation that the Pay for Performance element of the BCF allocation relating to the target to reduce non-elective admissions has gone. It has been replaced with a requirement that the NHS is required to invest in out-of-hospital services. It appears that this is seeking to address the fact that with more and more people being supported in the community it comes with additional cost for which the NHS should have some ongoing responsibility. Recently two of the four Acute Trusts are attempting to implement charging KCC fines for delayed transfer of care which is unhelpful in terms of diverting resources away from the expenditure which actually address the problems.

2.4 It is worth stating that the Care Act contains a discretionary provision that acute trusts can choose to exercise in terms of whether to charge the local authority a penalty fine for delayed discharge days. The long held agreement in Kent is that the fines system should not be used; instead we would reinvest resources in services.

2.5 The Social Care Capital Grant (SCCG) has transferred to the Disabled Facilities Grant (DFG) however the funding process remains largely unchanged with funding routed through KCC to District and Borough Councils. The guidance confirms that "In order to maximise value for money of central funding the Department of Health has concentrated its social care capital grant funding into the Disabled Facilities Grant, as research suggests it can support people to remain independent in their own homes – reducing or delaying the need for care and support, and improving the quality of life of residents." KCC is working with the District and Borough Councils to develop integrated working. It is very important that KCC reaches agreement with the District and Borough Councils otherwise there is likely to be a negative impact for all organisations.

2.6 There is an opportunity here to fully exploit technologies to support people in their own homes. The recent contract for the integrated community equipment services which KCC is the administering body means that Kent should be in a better position to do more in this area.

2.7 The guidance recognises that local authorities have increased responsibility for prevention and carers support. The guidance further reminds CCGs that they have ongoing responsibility for reasonable investment in carer-specific support.

2.8 Also the BCF plan needs to be seen in context of the Sustainability and Transformation Plans (STP). They are related and inter-dependent and NHSE expects the impact of the BCF to be separately identified.

2.9 The decision that additional BCF funding will be made available to local authorities was confirmed in the Spending Review and Autumn Statement 2015. The Government's blue book states that "From 2017-18, the government will make funding available to local authorities, worth £1.5bn by 2019-20, to be included in the Better Care Fund". This could be interpreted as an expectation that local authority BCF and health authority BCF funds are to be pooled which implies there may be strings attached to the local authority element despite DCLG assurances to the contrary.

3. Overview of the Better Care Fund Allocations

3.1 In 2015/16 the national allocation for the Kent Better Care Fund was £101m. For 2016/17 this has been increased to £105m. The Social Care Capital Grant has ceased and the Disabled Facilities Grant has been increased from £7.2m to £14m. The detailed allocations are as follows:

Contributions from Partners to Better Care Fund	£m Contribution	Summary of what is included
Social Care Contribution (via CCG's)	£32.380m	Includes £28.742m Protection of Social Care and £3.545m for Care Act Implementation.
CCG Contribution	£59.792m	Includes Carer's Break Funding £3.443m; Out of Hospital Commissioned Services (ring fenced) £26.192m.
District/Borough Councils Contribution	£13.128m	Disabled Facilities Grant.
Total BCF Funding in the S75 Agreement 2016/17	**£105.300m**	

4. Assurance and Approvals Process

4.1 It is expected that local Better Care Fund plans will be agreed in line with the guidance. The key elements of the assurance and approval process and the timescales are being revised due to a delay issuing the detailed planning guidance. The indicative final submission date is 25 April and the final plan is not likely to be ready for sign off until after the March Health and Wellbeing Board and so would need to be signed off before the next meeting in May.

First BCF submission (following CCG Operating Plan submission on 8 Feb), agreed by CCGs and local authorities, to consist of: BCF planning return only All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net .	2 March 2016
Assurance of CCG Operating Plans and BCF plans	March 2016

Second submission following assurance and feedback, to consist of: Revised BCF planning return High level narrative plan All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	21 March 2016
Assurance status of draft plans confirmed	By 8 April
Final BCF plans submitted, having been signed off by Health and Wellbeing Boards	25 April 2016
All Section 75 agreements to be signed and in place	30 June 2016

5. Recommendations

5.1 It is recommended that:

The Health Overview and Scrutiny Committee notes progress on the Better Care Fund.

6. Additional Documents

6.1 Kent High Level Narrative – 2016/17 BCF

Contact Details:

Hazel Carpenter

Simon Perks

Patricia Davies

Ian Ayres

Contents:

1. The Kent Vision for Integrated Care
2. The Case for Change
3. Integration Plans 16/17
4. The National Conditions
5. The Joint Approach Going Forward
6. Additional Documents

Owner: The Kent Health and Wellbeing Board

Date: 21 March 2016

Version No: 4 (Draft)

1. The Kent Vision for Integrated Care

Kent's Better Care Fund for 2015/2016 was about implementing the building blocks for establishing an integrated system that will "*transform services within the community so they support independent living, empower people and place a greater emphasis on the role played by the citizen and their communities in managing care*" (Kent JSNA). Delivery within the plan has resulted in establishing programmes of activity across the health and social care footprints in North, East and West Kent that will increase the pace and scale of integration and development of the New Models of Care as outlined in the NHS England Five Year Forward View and associated guidance.

The Kent plan for 2016/17 will build on these early developments to support the implementation of Sustainability and Transformation plans (STPs) and ensure a fully integrated system by 2020. This will be achieved through sustaining the current system – with targeted improvements to support urgent care, delayed transfers of care, reablement and commissioning of out of hospital provision and the maintenance of social care services. But with an eye to the future and the development of local integrated health and social care models which incorporate a broad range of person centred and outcome focussed interventions, encompassing prevention, early intervention, primary and community health services, social care, home care, residential and nursing care and in reach to acute health care.

1.2 The Kent Context

The county council is largely responsible for adult and children social care services; it currently works in partnership with 7 Clinical Commissioning Groups and 12 District Authorities that commission related health care and housing services respectively. The provider landscape is also extensive, with 4 acute trusts spread over 7 hospital sites, 2 community health providers across the county, 1 mental health and social care partnership trust, 1 ambulance trust and many third sector and voluntary organisations including 4 hospices.

Kent has a population of 1.5 million. Overall, the population of Kent is predicted to grow by 8.4% over the next seven years, representing an extra 123,000 people. Including significant growth in North Kent due to the development in Ebbsfleet. The biggest increases are to be expected in the older age groups; 65 to 84 and over 85. The 65 to 84 growth is anticipated to be 21.4%, an extra 49,000 people, but the largest increase will be in the over 85 age band, at 27.1%. This represents an additional 10,000 people.

1.3 What will change?

As in 15/16 the Better Care Fund will contribute to improving the following outcomes identified within the Health and Wellbeing Strategy:

- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
- People with mental ill health issues are supported to live well.

- People with dementia are assessed and treated earlier.

It is recognised that we need to go further and faster in order to deliver the whole system change required, developing greater alliances and exploring appropriate footprints in planning and integration. At the Kent Health and Wellbeing Board on 27 January 2016 (*https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6179&Ver=4*) all Clinical Commissioning Groups and Social Care identified how they will meet the ongoing challenges with the development of STPs and the development of areas such as the MCP, ICO and Mapping the Future. A commitment was given to use the BCF to ensure implementation across Kent and see significant change to:

- Improve people's experience and promote their health and wellbeing
- End the current crisis driven model of care
- Create a value driven and outcome focussed culture that nurtures creativity and innovation in meeting people's needs
- Support people to access good quality advice and information that enable them to self-care/manage
- Create the right conditions which enable people to find solutions that support their wellbeing outside of traditional medical or service driven models of care and support
- Encourage community development and increase volunteering, befriending and good neighbour schemes
- Support carers in their vital role through the provision of advice and individually tailored support
- Provide flexible and proactive models of care and support that can increase and decrease according to need
- Free professionals up from the rules and bureaucracy; to do the *right thing* and provide person centred holistic support that promotes wellbeing
- Provide responsive models of long term care that can flex up or down according to people needs
- Bring services together to ensure better communication and better use of resources and create a better experience for people

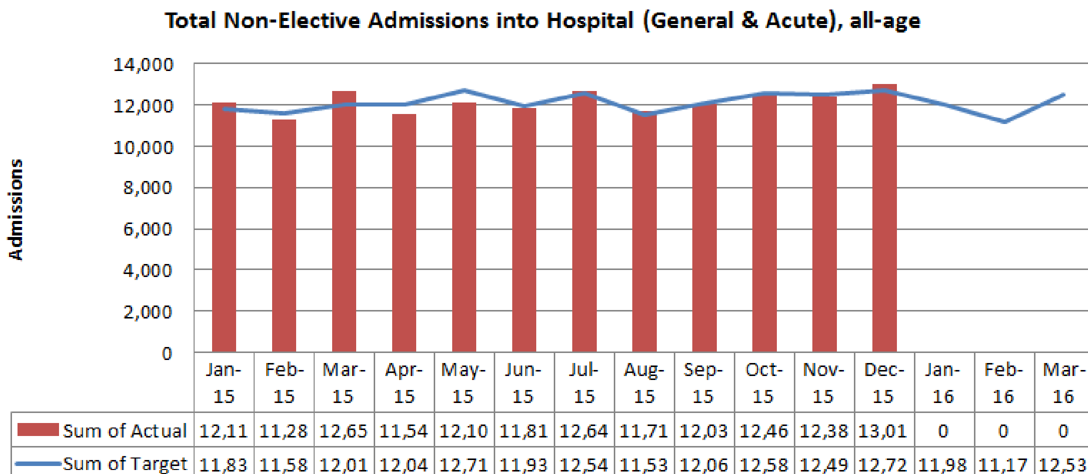
For those users of services this will make it clearer around:

- *"What care will you receive?"* – clear service models and pathway specifications
- *"Who will provide your care?"* – provider/organisational models, the new shape of integrated, local out of hospital providers (ICOs/MCPs/Vanguards), acute physical provision and acute mental health provision
- *"Who will commission your local services?"* – commissioning models with local Health and Wellbeing Boards, aligning primary and specialist commissioning to seek devolution within the new models of care.

2. The Case for Change

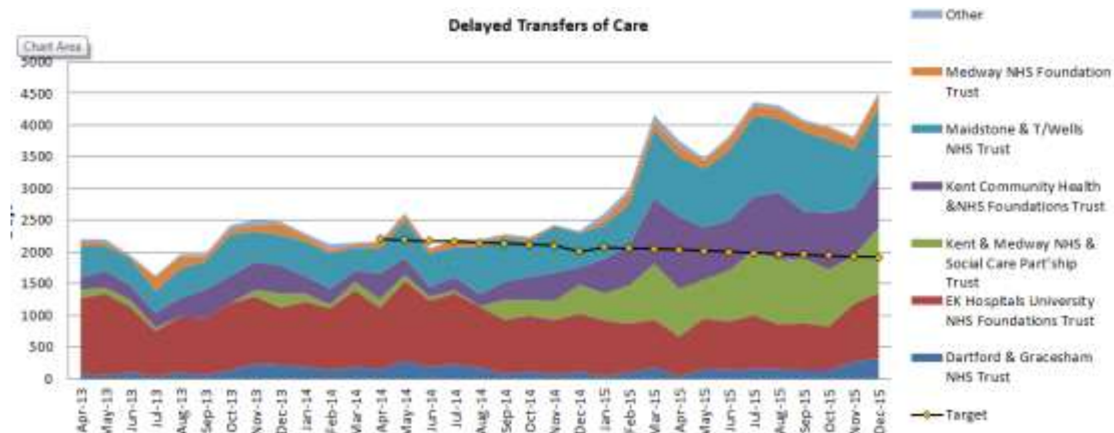
Kent has continued to use information provided through a Public Health led longitudinal study using risk stratified (based on a local version of the King's Fund tool) Kent whole population person level linked datasets to demonstrated variation in service utilisation (and costs) over time, across different services and different risk stratified groups. The Kent LTC Year of Care Programme comes to an end in March 2016. The programme has successfully built a linked data set comprising data from 12 health and social care organisations and 128 GP practices. The programme has also used risk stratification to identify a cohort of patients most likely to benefit from integrated care services. This approach is now being used to support the development of capitated budgets for intermediate care organisations being developed in East Kent. Kent's approach to the use of risk stratification is described in a case study on the NHSE website which can be found by following this link:
http://www.nhsiq.nhs.uk/media/2747711/risk_scores_case_study.pdf

As part of the BCF plan for 15/16 a 1% reduction in non-elective admissions was targeted. The graph below evidences that this has been achieved and continues to help control demand.



	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sum of Actual	12,11	11,28	12,65	11,54	12,10	11,81	12,64	11,71	12,03	12,46	12,38	13,01	0	0	0
Sum of Target	11,83	11,58	12,01	12,04	12,71	11,93	12,54	11,53	12,06	12,58	12,49	12,72	11,98	11,17	12,53

In line with national trend DTOC figures have risen, but priority work continues to achieve the 2.5% national target with a 3.5% stretch.



Delivery of the Better Care Fund during 15/16 has identified what has worked well and where continued improvements are required in 16/17. Examples of what has worked well are:

- Governance structures – allows for open debate, planning and monitoring of delivery
- Alignment of commissioning and integration of commissioning
- Joined up provision – IPCTs, IDTs, and real inclusion of the voluntary sector

Some examples of the results from this include in North Kent a 1% reduction in ambulance conveyance, low DTOC – Nov 1.74% and better patient experience.

In Thanet the establishment of a detailed integrated working programme plan overseen by an 'Integrated Executive Programme Board' – co-chaired by KCC and the CCG. Integration is being driven at a local level with the development of strong town based (Margate, Ramsgate, Broadstairs and Quex) integrated health and social care teams. These have been built to enable GP practices to increasingly work together to join health and social care within a single infrastructure. This local service model will be supported through a multi-disciplinary 'hub' based at the local acute hospital, to be developed in 2016/17.

3. Integration Plans 16/17

The planning template identifies the detailed areas of spend for the Kent 16/17 BCF. Each health economy via the existing BCF Section 75 agreement has governance and programme and project management arrangements in place to deliver the required new models of care. For example an Integrated Executive Programme Board exists in Thanet and South Kent Coast with a multi-agency approach.

In broad terms the plans and how each of these areas will contribute to the required national conditions is outlined below.

2016/17 Schemes	National conditions supported by the scheme
• Integrated working through local models that deliver 7 day access:	• Delivery of 7-day services • Data sharing between health and social care
• Develop models that support integrated working	• Joint approach to assessment and care planning • Invest in NHS commissioned out of hospital services
• Self-Management	• Invest in NHS commissioned out of hospital services • Delayed Transfers of Care
• Maintenance of Social Care	• Maintain provision of social care services
• Disabled Facilities Grant	• Invest in NHS commissioned out of hospital services

2016/17 Schemes	National conditions supported by the scheme
	• Delayed Transfers of Care
• Implementation of the Care Act	• Maintain provision of social care services
• Carers support	• Invest in NHS commissioned out of hospital services • Delayed Transfers of Care
• Delayed Transfers of Care – action plan	• Invest in NHS commissioned out of hospital services • Joint approach to assessment and care planning • Delayed Transfers of Care

Risk sharing agreements and contingency plans for delivery of the Better Care Fund are outlined in the Section 75 agreement. Some key risks identified in the delivery plan are:

There is a risk that:	**Mitigating Actions**
Increased pressure on Acute care could result in additional long term placements or long term social care input. Lack of rapid response for health and social could result in additional admissions to hospital and long term care.	BCF plans and Kent's Pioneer Programme designed to develop service models to mitigate risk. KCC Adult Social Care Transformation is also targeting this risk.
Shifting of resources may destabilise existing providers, particularly in the acute sector.	The development of our plans will be conducted within the framework of our Kent Pioneer Programme. This facilitates whole system discussions and further work on co-design of, and transition to future service models.
The implementation of the Care Act will result in an increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	Ensure the use of the Care Act money is in line with allocation.
Primary care not at the centre of care-coordination and unable to accept complex cases.	Engagement with clinical leads and primary care providers essential as part of implementation of the BCF and Pioneer programme.
Absence of effective demand management, investment in voluntary sector and equipment will result in additional NHS and social care admissions.	Monitor/tracking systems in place to assist in determining effectiveness – further development of performance based dashboard.
Workforce and Training – The right workforce with the right skills	Workforce and training is a key objective of Kent's Integration

may not be available as required to deliver the integrated models of care. The types of training to deliver new models of care may not be in place. Additional risk is presented by age demographics of GPs and future resources impacted by retirement.	Pioneer Programme. A programme of work is structured to explore the requirements of future workforce and implement changes to meet these requirements.

4. The National Conditions

The table below identifies how the plan will meet the national conditions:

Maintenance of Social Care Services Significant work to transform social care services has taken place during 15/16, alongside the implementation of the Care Act. £28.7m will be used from Kent's Better Care Fund to maintain social care and continue to support the significant numbers of people with complex needs, who live in their own homes, want to stay and be supported in their own homes and those who require carer support services which enable carers within Kent to continue in their caring role. Kent Adult Social Care has developed a clear vision to support integration by 2020 with the model described through three groups of approaches; Promoting Wellbeing, Promoting Independence and Supporting Independence. This is a means of describing differing types of interventions that support people accessing 'the right care at the right time' in order to be as independent and well as possible at all times.
7 day services For 16/17 £2.1m directly linked to delivering 7 day services – this includes building on successful pilots for GP extended hours in the Vanguard and implementation of a 7 day community equipment service across Kent. In Thanet steps were taken towards a proactive model of 24/7 community based care with adult social care shifting working hours to be 8am to 8pm, seven days per week as standard. Further work is now taking place within the Adult Social Care Transformation Programme to identify the steps required to achieve extended working hours in all areas of delivery.
Data sharing Areas have been developing their Local Digital roadmaps which include exploring how to improve data sharing across systems. The footprint covers North Kent including implementation of hospital access to GP records via Vision 360, initially for A&E department at D&G and then for other providers; East Kent (working on developing the Medical Interoperability Gateway) and West Kent who are piloting a Care Plan Management System in conjunction with KCC and other partners. This seeks to bring health and social care information together by taking a direct feed from partners' systems. Crucially, the information collected can then be used to create one holistic care plan; this is contained within CPMS and can be updated and used by everyone.

Work on the Kent Integrated Data Set has also resulted in 128 out of 195 (66%) GP practices signed up to share their data. Following presentations to GP patch meetings 20 (out of 61) practices in West Kent have now signed up. 8 out of 14 practices in Ashford have now agreed to share their data.

Arrangements are in hand to continue the linked dataset once the Year of Care Programme ceases at the end of March. A Memorandum of Understanding has been drafted to underpin the partnership and funding arrangements for the Kent Integrated Dataset. Funding is also being sought from NHSE for programme management support to CCG's to develop capitated budgets. Jonathan Bates, CFO at Thanet and South Kent Coast CCG's will chair the new Kent Integrated Care Payments Group involving commissioners and providers which will lead the work on developing capitated budgets. The PSSRU will present their analysis of the linked dataset at the March meeting and will make recommendations for using the data to build capitated budgets.

A methodology has been agreed with HSCIC to collect and allocate costs to GP prescribing data.

Joint assessments and care planning

One of the key social care priorities for 2016/17 is the integration of health and social care, and this includes planning for joined up approach to assessments and care planning. CCG areas are in varying stages of plan development, but all are in progress.

Local Action Plan for DTOC

DTOC plans are in development and are a key social care priority for 2016/17. Plans are in development within the CCG areas. For example in Swale - reducing DTOCs is an area of focus next year for Swale CCG. The Medway and Swale System Resilience Group are working with the Emergency Care Improvement Programme to identify good practice in reducing DTOCs.

There are a number of initiatives that are in progress to address DTOC which see an integrated approach across health and social care. Swale CCG is piloting a 'Home to Assess' model, where patients considered appropriate are discharged and assessed within 4 hours of discharge within their own home. Health and social care teams within the IDT at MFT work to the 'home is best' principle, discharging patients home with support as opposed to a step down community bed, where appropriate. This has resulted in a significant reduction in the demand for community beds in Swale.

East Kent CGG's, KCHFT, EKHUFT and KCC are currently piloting a 'Discharge to Assess' scheme which has already been successfully introduced in other parts of the country such as Sheffield, Manchester, Worchester, and Oxford.

Discharge to assess provides an opportunity for patients who are medically optimised to be transferred in a timely way from the busy acute hospital

environment to their own home with support and further assessment or to an appropriate community setting for ongoing assessment and rehabilitation. Objectives: 1. Maximise people's capacity for independent living, increase the number of people able to remain living at home and reduce the number of people permanently admitted to long term care. 2. Support timely hospital discharge so that patients only stay until their acute medical episode is finished and then move to a more appropriate location for assessment of their future care needs. 3. Provide an environment which helps people meet their rehabilitation and reablement potential and to become as functionally independent as possible. Integrated discharge teams have also been set up in all of the hospitals. In DVH and EKHUFT they have also introduced the care navigator role as part of the integrated discharge teams linking the support the voluntary sector can access to facilitate timely discharges from the acute hospitals. Surge Resilience Groups and Executive Systems Boards have emerged in each Health and Social care economy to drive the whole system changes required to support the acute sector.
Investment in NHS commissioned out of hospital services £26.2m is identified for out of hospital services, full details of this can be found in CCG Operational Plans (links in additional document section). In Thanet this money will be invested into: • GP step up beds • The provision of equipment to support individuals in the community • Development of integrated health and social care teams including integrated nursing teams and the development of ICT to support sharing of patient records • Rehabilitation beds at Westbrook House. • Support for carers

5. The Joint Approach Going Forward

Since the development of the plans for 15/16 significant work has taken place through the joint governance forums across Kent to engage the entire system, to help understand the impact on providers as integration develops, for example the East Kent Whole System Clinical Strategy. Further work is taking place alongside Districts within the devolution agenda and to explore how to make best use of the Disabled Facilities Grants. KCC social care and district councils are working together to explore ways of encouraging closer working arrangements to facilitate the pathway for a service user requiring a DFG. A paper was taken to the Districts chief executive group to request

project development and support for 2016/17 to work up a model for a new way of working which is most suitable and appropriate for Kent.

KCC are working closely with District Councils to share responsibility for areas of activity currently covered by social care capital grant which has been removed from social care and added to DFG funds this year, as existing commitment needs to be covered, and all work contributes to increasing the independence of people living with disabilities, facilitating them to remain living in their own homes, and decreasing their dependence on statutory services in the future.

Across all CCG areas detailed work has been carried out within the Making it Real agenda and Think Local Act Personal to further embed the use of I Statements and ensure meaningful involvement from patients, users and carers. Full details of this work is contained within the Integrated Care Pioneer Progress Reports.

A key concern raised has been on future capacity and workforce requirements. Therefore a Kent wide task and finish group has been set up to sit under the Kent Health and Wellbeing board. This will explore how to develop a more integrated support workforce, look at recruitment and retention and how we support the over 50 workforce. Kent will be hosting workforce events across each locality to promote careers in the Health and Social care sector and a draft Integrated workforce strategy is in development.

The Kent Health and Wellbeing Board continue to play a key strategic role in ensuring alignment across the variety of initiatives and monitoring of delivery. The Board has considered and endorsed the proposed planning footprint to support the delivery on the proposed STP.

6. Additional Documents

JSNA: http://www.kpho.org.uk/joint-strategic-needs-assessment
JHWBS: https://www.kent.gov.uk/__data/assets/pdf_file/0014/12407/Joint-Health-and-Wellbeing-Strategy.pdf
SKC CCG: http://www.southkentcoastccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Thanet CCG: www.thanetccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Canterbury CCG: http://www.canterburycoastalccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Ashford CCG: http://www.ashfordccg.nhs.uk/about-us/our-plans-reports-and-strategies/
West Kent CCG: http://www.westkentccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Dartford CCG: http://www.dartfordgraveshamswanleyccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Swale CCG: http://www.swaleccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Kent Integration Pioneer: http://www.kent.gov.uk/social-care-and-health/health/health-and-public-health-policies/kent-integration-pioneer

Item 6: King's College Hospital NHS Foundation Trust: Outpatient Services at Sevenoaks Hospital

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 8 April 2016

Subject: King's College Hospital NHS Foundation Trust: Outpatient Services at Sevenoaks Hospital

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by King's College Hospital NHS Foundation Trust and NHS West Kent CCG.

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

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1. Introduction

(a) Following a briefing provided by King's College Hospital NHS Foundation Trust about changes to outpatient services provided by the Trust at Sevenoaks Hospital, the Chairman has requested the Trust and NHS West Kent CCG to attend on 8 April 2016 to provide further information to the Committee.

(b) King's College Hospital NHS Foundation Trust and NHS West Kent CCG have asked for the attached reports to be presented to the Committee:

King's College Hospital NHS Foundation Trust pages 47 – 50
NHS West Kent CCG pages 51 – 52

2. Recommendation

RECOMMENDED that the report on outpatient services at Sevenoaks Hospital be noted and NHS West Kent CCG be requested to present a paper on the future development of Sevenoaks Hospital at the appropriate time.

Background Documents

None

Contact Details

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King's College Hospital NHS
NHS Foundation Trust

Briefing: Future of services provided at Sevenoaks Hospital

Briefing for: Kent Health Overview and Scrutiny Committee

Date March 2016

Subject Withdrawal of outpatient services from Sevenoaks Hospital and transfer to sites in Bromley

Contents

1. Introduction
2. Review of clinic utilisation and conclusions
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1. Introduction

In October 2013, King's College Hospital NHS Foundation Trust acquired a number of sites and services following the dissolution of South London Healthcare NHS Trust. This included a number of outpatient services at Sevenoaks Hospital as follows:

- Orthopaedics
- Ear Nose & Throat (ENT)
- Ophthalmology
- Dermatology
- Pain
- Gastrointestinal
- General Surgery
- Urology
- Cardiology

A contract has been in place with the site owners, Kent Community Health NHS Trust, through which King's leases space to deliver these services. The majority of patients (80%) that use these services are from West Kent. Dartford, Gravesham and Swanley patients are the third largest cohort (6%). If looking at all outpatient activity by site within the West Kent CCG area, this equates to 16% of patients using Sevenoaks Hospital.

Other sites and services that King's acquired in October 2013 include:

- Princess Royal University Hospital (PRUH)
- Orpington Hospital
- Some services at the Beckenham Beacon and Queen Mary's Hospital, Sidcup

Post-acquisition King's set about making wide-scale changes to improve the quality of care for local patients. This included a major nurse recruitment drive and the complete refurbishment of Orpington Hospital. In more recent times however, whilst progress continued there was a significant change in the financial position of the Trust and we faced a very serious ongoing deficit. As a result, the Trust set an ambitious savings target of £86m for this year and is well on the way to achieving this. Whilst we are in a much better place than previously, challenge still lies ahead, with further work to be done over the next few years to achieve financial sustainability

2. Review of clinic utilisation and conclusions

As part of our ongoing Cost Improvement Programme, a detailed review of all patient activity within outpatient services across the Trust was undertaken. This included services at Sevenoaks Hospital and was considered alongside contractual costs.

Findings of the Sevenoaks Hospital review showed that clinic utilisation was lower than at other Trust sites, with a third (33%) of available appointment slots not being used. In addition, the review identified the repatriation potential for the services currently undertaken, into capacity available on other sites.

The viability of delivering services from any site is dependent on the level of patient activity and it is vital that capacity is used to its full potential. Where this is not the case with regard to external sites we have to look at where we can provide services from our own sites. The number of patients using Sevenoaks Hospital clinics is very low in comparison to other sites therefore the Trust has had to consider alternative options for providing these services.

Following this review and discussions with Kent Community Health NHS Foundation Trust and our local commissioners we have taken the decision to withdraw our services from Sevenoaks Hospital and will continue to provide them at our nearby sites, Orpington Hospital and the PRUH.

We have a responsibility to ensure we are a financially stable organisation; therefore we have to balance service provision with the need to achieve financial sustainability. This does mean we have to make some difficult choices about the services we provide.

Achieving financial stability is in the interests of the population we serve as it ensures the continuity of essential services for our patients.

All of our savings initiatives go through rigorous review processes to assess risk and ensure the clinical care and treatment we provide to our patients is not impacted.

3. Future plans for delivering the services

We will be taking a phased approach to the withdrawal over the next few months to ensure a smooth transfer process and that patients continue to receive the care that they need.

The timeframe for our withdrawal is as follows:

End of March 2016	Cardiology, Gastroenterology, General Surgery, Pain Management and Urology
End of July 2016	ENT, Ophthalmology, Orthopaedics
End of September 2016	Dermatology

Services for these patients will continue immediately and patients can book follow up appointments at the PRUH or Orpington Hospital. Where clinic provision is available we will be offering patients the choice of either hospital location and will be contacting all patients with existing bookings to inform them of the new options. New patients will be invited to attend one of the hospitals as appropriate. Both sites are within a reasonable travel time from Sevenoaks on public transport and by car.

We are working with colleagues at Kent Community Health NHS Foundation Trust to ensure robust communication to patients on these moves.

We remain committed to providing high quality care to the people of West Kent, Dartford, Gravesham and Swanley and look forward to continuing the delivery of this care from our Bromley hospital sites.

Briefing from NHS West Clinical Commissioning Group (CCG) following the decision by Kings College Hospital to withdraw outpatient clinics from Sevenoaks Hospital.

The decision by King's College Hospital NHS Foundation Trust (KCH) to withdraw non-specialised outpatient clinics does not mean the end of Sevenoaks Hospital.

The CCG has recently commissioned proposals for the future development and use of the hospital and will bring these to the HOSC once the work is scoped.

The services that KCH has given notice on are for general outpatient clinics. They are accessed by west Kent residents when referred directly to clinics at Sevenoaks Hospital by their local GP.

There are currently three providers offering this type of clinic at Sevenoaks Hospital; Maidstone and Tunbridge Wells NHS Trust (MTW), Queen Victoria Hospital (East Grinstead) and KCH.

Discussions are in progress for MTW to take over the general outpatient clinics that KCH have said they will no longer provide at Sevenoaks Hospital, apart from dermatology. The CCG will look to alternative providers to continue this service.

Therefore, patients will still have access to outpatient clinics in the same general services at Sevenoaks Hospital including:

- Cardiology
- Care of the elderly
- Chest and thoracic
- Dermatology
- Diabetes
- Ear, nose and throat (ENT)
- Fracture
- Gastroenterology
- General surgery
- Gynaecology
- Maxillo-facial surgery
- Ophthalmology
- Orthopaedics
- Paediatrics

- Pain
- Plastics
- Rheumatology
- Trauma and orthopaedics
- Upper / lower gastro-intestinal surgery
- Urology
- Vascular.

Patients who wish to continue to attend clinics provided by KCH will have the option of going to Orpington for their on-going care.

Item 7: Kent and Medway NHS and Social Care Partnership Trust: Update (Written Briefing)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 8 April 2016

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

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

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

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1. Introduction

(a) On 4 March 2016 the Committee considered an update about the Kent and Medway NHS and Social Care Partnership Trust (KMPT). The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the report be noted;

  (b) KMPT be requested to submit a written briefing about CQC style inspections carried out by the CCGs; the timescale for the six key areas of improvement and which area of the Quality Improvement Plan they sit under; and the number of out-of-county placements for the Committee's meeting on 8 April;

  (c) KMPT be requested to present an update to the Committee in June;

  (d) Ms Carpenter be requested to liaise with colleagues and arrange for a written briefing on the Five Year Forward View for Mental Health and the implications for Kent to be submitted to the Committee for its meeting on 8 April.

(b) Kent and Medway NHS and Social Care Partnership Trust has asked for the attached reports to be presented to the Committee:

KMPT Letter – 14 March 2016 pages 55 - 56
KMPT Letter – 30 March 2016 pages 57 - 58
Quality Assurance Visit Report - Littlestone Lodge pages 59 - 60
Quality Assurance Visit Report - Jasmine Ward pages 61 - 62
Quality Assurance Visit Report - Newhaven Lodge pages 63 - 64

Item 7: Kent and Medway NHS and Social Care Partnership Trust: Update (Written Briefing)

Quality Assurance Visit Report - Frank Lloyd Unit	pages 65 – 68
CQC Quality Improvement Plan – Assurance Report	pages 69 - 72

2. Recommendation

RECOMMENDED that the report be noted and KMPT be requested to present an update to the Committee on 3 June.

Background Documents

Kent County Council (2016) *'Agenda, Health Overview and Scrutiny Committee (04/03/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6257&Ver=4

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14 March 2016

Councillor Robert Brookbank
Chairman
Health Overview and Scrutiny Committee
Kent County Council
Members Suite
Sessions House
County Hall
Maidstone ME14 1XQ

Dear Councillor Brookbank

Re: Health Overview and Scrutiny Committee [HOSC]
Kent and Medway NHS and Social Care Partnership Trust [KMPT] Update
Follow up actions to meeting held on 4 March 2016

Thank you for the opportunity to present an update on KMPT's activity to the HOSC at its meeting held on 4 March 2016.

As agreed by the Committee and as a follow up action specifically in support of the discussion in response to the queries raised by Councillor Harrison and Councillor Eddy in respect of KMPT's Care Quality Commission [CQC] Quality Improvement Plan [QIP] and out of area bed usage respectively, I am delighted to share with you the following information:

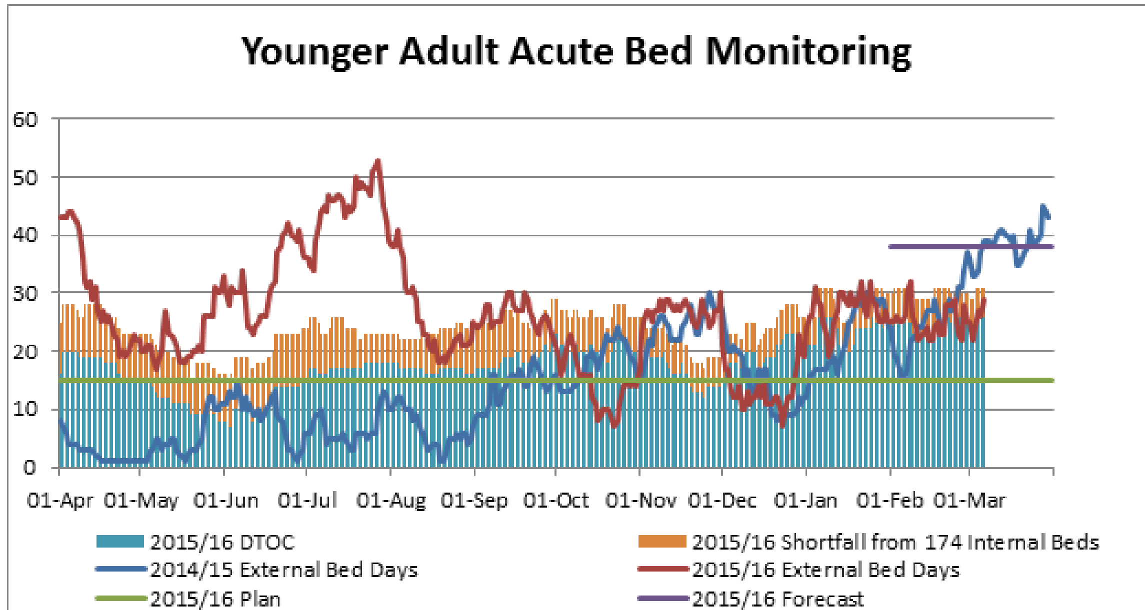
1. A copy of the **CQC Inspection Summary Report**, enclosed with this letter

2. A copy of KMPT's **CQC QIP (Version 5 updated 29 January 2016)** and KMPT's **CQC QIP Assurance Report January 2016**, both enclosed with this letter.

   - ✓ The QIP captures all the actions required and associated with the compliance notices, must do and should do actions raised by the CQC and the status against each as at 29 January 2016.
   - ✓ The Assurance Report summarises the position set out in the QIP as at 31 January 2016.
   - ✓ Progress against the QIP is monitored monthly by a Monitoring Group jointly chaired by the Trust Development Authority [TDA] and NHS England [NHSE]. Kent County Council [KCC] is represented on this group by Penny Southern (Director of Disabled Children, Adult Learning Disability and Mental Health).

3. With regards to the **out of area bed day usage**, the graph overleaf provides a visual view of the bed capacity, external pressures and delayed transfers of care [DToC] per bed day. In so doing, it helps KMPT identify why it has to use external beds, and to track this usage against annual plan and monthly forecast. The graph illustrates the bed days lost to DToC and the shortfall from 174 beds commissioned in 2015/16. It also provides a comparison of the reported bed day usage to the same day the previous year. A variance that highlights the financial consequences of the increase in out of area bed usage.

Monitoring out of area bed usage is part of the robust process KMPT has established, in partnership with its commissioners, to prioritise the movement of patients back to area as soon as possible, thereby seeking to promote a better experience for services users and their carers.



I do hope this provides the Committee with the additional information it requires. Do please let me know if Members have any additional questions and, if so, if the Committee would prefer these questions be responded to immediately or included as part of KMPT's next formal presentation to the HOSC scheduled for June 2016.

With best wishes

Yours sincerely

MALCOLM MCFREDERICK
Executive Director Operations

Enclosures: As listed

Chairman – Andrew Ling
Chief Executive – Angela McNab

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Kent and Medway NHS
NHS and Social Care Partnership Trust

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30 March 2016

Councillor Robert Brookbank
Chairman
Health Overview and Scrutiny Committee
Kent County Council
Members Suite
Sessions House
County Hall
Maidstone ME14 1XQ

Dear Councillor Brookbank

Re: Health Overview and Scrutiny Committee [HOSC]
Kent and Medway NHS and Social Care Partnership Trust [KMPT] Update
Follow up actions to meeting held on 4 March 2016

I understand that you have requested clarification on information provided in my letter of 14 March 2016.

Please see this further clarification below:

1. **Summary of the CQC style inspections carried out by the CCGs:**

   Currently, inspections have been carried out by North Kent CCGs on the following:

   - Littlestone Lodge (25.11.2015)
   - Jasmine Ward (20.01.2016)
   - Newhaven Lodge (25.01.2016)
   - Frank Lloyd Unit (03.02.2016)

   The conclusions of each report is attached.

2. **The timescale for the six key areas of improvement and which area of the Quality Improvement Plan they sit under:**

   The CQC QIP Assurance Report summarises this. I believe a copy was sent to the HOSC with the letter of 14 March 2016 but I enclose a further copy here.

3. **The number of out-of-county placements in the last 12 months.**

   The number of individual placements in the 12 months March 15 – Feb 16 is as follows:

	Count of Patient
Acute	611
OPMH	28
PICU	129
Grand Total	**768**

I trust that this provides the Committee with the additional clarification that it requires. Do however let me know if Members have any additional queries or questions.

Yours sincerely

MALCOLM MCFREDERICK
Executive Director of Operations

Enclosures: As indicated above.

NHS
Dartford Gravesham and Swanley
Clinical Commissioning Group

Kent and Medway NHS and Social Care Partnership Trust (KMPT)

Revisit to Littlestone Lodge, Dartford 25th November 2015

CCG Assurance

The visiting team felt assured by the considerable progress that has been made since the visit in May.

Significant improvements were noted and the appointment of substantive staff members appears to have had a desired effect in staff claiming ownership and commitment to their roles and responsibilities.

Conclusions

The service feels safer and the ward manager appears to be a positive catalyst for change to improve the quality of service provided. The staff appear to be embracing the changes and are supporting the improvements in quality of service provided. They are working more cohesively as a team, across services, within the unit.

The recruitment of a RGN (Registered General Nurse) to the unit is expected to further support improvements in the quality of care provided including early recognition of physical and changing health needs.

Safeguarding appears to be embedded in all practices within the unit. The appointment of the ward manager, who has a safeguarding background, has been invaluable to ensuring the safeguarding agenda is being met.

The improvement in this unit is evident in the satisfaction feedback received from service users family/carers. They gave glowing recommendations of all aspects of care being received and also the level of involvement they could input into their family members care and decision making.

The service has further areas to improve but there are now in a position to understand what these areas are and how they can make the necessary changes. This has been possible by the hard work and commitment of all staff and includes a level of executive oversight that has been maintained on the unit.

Staff morale is greatly improved and all staff recognise the improvements but are striving to improve further, where possible. Staff ideas are being encouraged and where possible implemented.

Overall there were no areas that the visiting team felt posed a risk to patient safety and there was clear direction of travel for the areas that were to improve further.

Dartford Gravesham and Swanley Clinical Commissioning Group

Kent and Medway NHS and Social Care Partnership Trust (KMPT)

North Kent Quality & Safety Team CQC 3rd Line of Assurance visit to Jasmine Ward, Dartford 20th January 2016

CCG Assurance

There were some clear evidence of good practice with system processes and procedure changes seen during the visit. In particular safeguarding systems, Emergency Equipment, Incidents and Risks all demonstrated good levels of understanding and systems in place.

However, there were also some significant areas that the visiting team did not obtain relative assurance that mitigated the risk to patient safety, the points of which have been included within this report and relate to areas of:

- Observation procedures and monitoring
- Pharmacy and Medication systems and compliance
- Infection, Prevention and Control systems

In addition the visiting team noted some areas where further improvement is required but were assured that this was being addressed:

Workforce – the levels of vacancy, in particular relating to Occupational Therapy posts
MSA – a review of MSA compliance in line with national guidance and agreement of the processes for reporting breaches
Physical Health – further development to ensure staff are confident in identifying and acting upon signs of physical health deterioration

At the present time the visiting team are unable to provide full assurance that patient safety is not being compromised.

It is requested that clarification of the immediate actions taken to address the 3 key areas listed above is provided and a revisit to reassess these areas will be undertaken within 4 weeks' time.

The visiting team would like to thank all staff for their engagement and co-operation during the visit.

Kent and Medway NHS and Social Care Partnership Trust (KMPT)

North Kent Quality & Safety Team CQC 3rd Line of Assurance visit to Newhaven Lodge 25th January 2016

CCG Assurance

The visiting team did not feel there were any issues identified that impacted on patient safety. There were many aspects where, in light of the reduced workforce, that staff went over and above the requirements of their role.

Staff worked well as a team to ensure they maintained the day to day running of the service and in the absence of an OT post had continued to provide an extensive level of activity and recovery programmes. There were some systems and processes discussed that could be tightened to enhance safety and quality areas further, these minor areas have been identified within the report.

The visiting team would like to thank all staff for their engagement and co-operation during the visit.

Kent and Medway NHS and Social Care Partnership Trust (KMPT)

North Kent Quality & Safety Team CQC 3rd Line of Assurance visit to Frank Lloyd Unit 3rd February 2016

CCG ASSURANCE

Whilst there were two wards located within Frank Lloyd it was evident they had different areas of good practice and areas for improvement. There did not appear to be consistency in sharing of good practice between the two wards.

The visiting team felt there was more stability on Woodstock than Hearts Delight however, the number of vacancies on both wards currently has an impact. Commitment by staff on both wards was evident and whilst extra shifts were being filled by substantive staff, the trust needs to consider the impact on staff in regards to the number of shifts and extra work they are taking on.

Staff were proud of the service and care they provided with many citing they ‘loved their job’. Interactions between staff, patients and family were noted as positive with care, compassion and patience clearly demonstrated during interactions. However, the trust need to recognise that staff morale is currently low amongst both wards and need to ensure they invest in the staff currently in post.

The ‘daily sparkle’ newspaper is a really good initiative, which is in place on Woodstock ward. It is unclear if this has been replicated on Hearts Delight but recommended this is considered.

Both wards were clean, bright and had clearly made efforts to make the wards homely. The implementation of a hairdressing salon and ‘pub’ were real assets to the wards.

Infection Prevention and Control measures were well maintained and monitored, with appropriate actions taken following a D&V outbreak on Hearts Delight ensuring it was contained.

Incidents and Risk management systems appear clearly embedded with all staff demonstrating a good understanding of the importance of reporting and learning from incidents.

There appears to be a significant difference in the safeguarding provision between both of the wards. The safeguarding agenda seems to be better addressed and practices embedded on Woodstock ward than on Hearts Delight.

Good safeguarding practice was evident in the systems and processes established on the ward by the ward manager which could be replicated on Hearts Delight ward. Knowledge, learning and good practice could be shared across the unit by the development of a peer support system locally (initially facilitated by one of the safeguarding team) in addition to the Link Nurse Forum that is already established across the trust. This would also provide much needed support for the ward manager on Woodstock as well as developing junior staff.

It is evident from the relative feedback that further support from the trust’s safeguarding team is needed on Hearts Delight ward to improve all staffs knowledge and understanding of safety concerns, MCA and Deprivation of Liberty Safeguards (DoLS) and in particular the emotional needs of relatives and friends of patients with

Dementia and Dementia Care Mapping. This is especially important when a patient with dementia is first admitted to the unit as their carer may experience a range of conflicting emotions, including relief, sadness and guilt. In order that care of the patient is holistic, and patient centred the family need to know that they are able to continue to play an active part in their relatives care.

Whilst there were no areas raised for immediate escalation and it was felt there were no immediate risks to patient safety there were many areas of inconsistency noted and recorded within this report that require addressing. The visiting team identified and reported a number of recommendations which include:

Hearts Delight

- To re-familiarise staff with the National Guidance on MSA and ensure zoning and MSA compliance is considered and implemented following appropriate risk assessments for residents.
- To reinforce the importance of accurate spelling within patient records and care plans
- Adjustments required to the CD register documenting processes so that errors are clearly documented, initialled against and dated.
- A clearer and concise way needs to be adapted to document running totals within the CD register
- Reinforce the requirement that drug trolleys must be attached to the wall when not in use
- To ensure repeat prescriptions are locked away
- To review temperature monitoring systems are reviewed in the clinical room to take action when temperatures reach over 25'C
- Review expiry date checking systems and destroy any out of date medications
- Review the repeat prescription ordering system to ensure that only medications required are ordered
- To clearly define continuity of waste in bins and ensure sharps are disposed in the appropriate manner.
- To reinforce with all staff that there should be no communal use of medications
- To ensure physical health systems are fully embedded. Monitoring and systems to ensure signs of deterioration are acted upon need to implemented
- To obtain further support from the trust's safeguarding team
- to improve all staffs knowledge and understanding of safety concerns, MCA and Deprivation of Liberty Safeguards (DoLS) and in particular the emotional needs of relatives and friends of patients with Dementia and Dementia Care Mapping

Woodstock

- Inconsistencies documented in relation to inclusion of patient views and cognitive impairment limiting views included in care plans and patient notes
- Invest in a lock for the fridge cupboard
- Consider displaying the resus box in a more visible area
- Archive of old CD request books
- To review CD recording procedures and ensure all staff are made aware of the requirement to accurately calculate totals in the CD register

- Ensure the most up to date policies are displayed and ensure all staff are sited on the correct versions
- To review MAR chart recording systems and implement a system for accurate and clear recordings
- To ensure all physical health risk assessments are fully completed and to review systems for reassessment requirements, when risk is identified. An easy glance document may support staff in correlating risk scores/outcomes and timeframe required for reassessment.
- To ensure appropriate actions are taken when fluid intake is low and documented clearly within the patient record, shared at handover etc.
- To engage discussions with the GP to ensure VTE Risk Assessments are reassessed, when appropriate
- To ensure DNACPR forms are fully completed and include details of discussions with family members.
- To agree a consistent format for completing food charts, and ensure all staff are aware and completing the forms in line with policy.
- To ensure all staff groups are provided with appropriate support, especially those working within isolated roles
- To ensure all staff are fully aware and understand the Duty of Candour and how it applies to them

Both Wards

- To support recruitment to posts by ensuring the recruitment process is not significantly delayed in arranging start dates for appointed staff
- To keep staff informed of recruitment and appointment to posts
- To ensure staffs efforts and areas of good work are recognised and acknowledged.
- To establish systems to learn from areas of good practice and not just when things go wrong
- Consistency of recording within care plans – this varied between and across the wards and there were some good areas of practice that could be shared to obtain a consistent approach throughout
- To ensure keys are separated, it is recommended they are held by different staff members, identified at the beginning of each shift to reduce the risk of access. If this is not possible they should at least be separated onto separate key rings.
- Consideration of developing a peer support system locally to share knowledge, learning and good practice
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It is requested that updates on progress will be provided and monitored at the bi-monthly quality meetings

The visiting team would like to thank all staff for their engagement, commitment and co-operation during the visit.

Kent and Medway NHS
NHS and Social Care Partnership Trust

CQC Quality Improvement Plan

Assurance Report January 2016

This report is produced to provide staff, patients, stakeholders, the CQC and the board with an assurance against the Quality Improvement Plan developed and agreed in response the CQC inspection report that was published in July 2015. This is a monthly report (commenced September 2015 onwards), following which the main Quality Improvement Plan will be updated

The report will be submitted to the Trust Executive Management Team (EMT), Quality Committee, the Trust Board, TDA and the CQC and will be shared with local commissioning groups. A summary will be published on the Trust intranet and Trust website.

The first section presents the progress on the Warning notices and Compliance actions, the 'Must do actions'. The second section provides information about the progress on the 'Should do' actions to date.

Levels of Assurance

Ongoing compliance is a key priority for the Trust. First, second and third level assurances are in place and facilitating the continuous improvement cycle by highlighting concerns and inconsistencies so these can be focussed on and corrected. As previously reported, the assurance system highlighted areas where further action was required to attain full compliance specifically MHA/DoLs/Safeguarding and Care Planning. Additional actions and auditing are now being undertaken and deadlines revised before full compliance can be confirmed. The revised deadlines relate to staffing levels but also to MHA/DoLs/Safeguarding and Care Planning levels of assurance are still not being satisfied.

Overview of progress to date

There are now a total of 15 Must do actions outstanding. Three actions relate to capital, two are system wide and 10 are internal actions. Of the 10 internal actions outstanding 6 relate to Older Adult Services.

Action Outstanding by Service Line

	Total Must do	Outstanding		
		Internal	Capital	System wide
Acute	8	2	1	1
CRSL	8	2		1
Forensic	6		2	
Older People	12	6		
	34	10	3	2

Warning action – Littlestone

The Warning notices relating to Littlestone were responded to immediately with actions undertaken to address the issues and ensure governance is now place to prevent the risk of re-occurrence. The CQC inspection team returned to inspect compliance on 21 May 2015. The inspection team noted that improvements had been made and were satisfied that appropriate steps have been taken to allow the warning notices to be withdrawn.
A second CCG review visit took place on the 25th November 2015. Their report concluded that the "visiting team identified the significant progression that has been made in a number of areas. The improvement in this unit is evident in the satisfaction feedback received from service users family/carers. They gave glowing recommendations of all aspects of care being received and also the level of involvement they could input into their family members care and decision making. Overall there were no areas that the visiting team felt posed a risk to patient safety."

Warning Notice – Frank Lloyd Unit

CQC inspectors visited the Frank Lloyd Unit during January and expressed concern over some elements of care on the Unit. They have since issued a Warning Notice which the Trust is responding to urgently.

Must do actions – Acute Service Line

The refurbishment within the 136 Suite in the East of the county has been completed and the facility is now in use.

The Service Line is focussing on ensuring consistency of standards in all wards and reviewing actions in place in light of audited outcomes specifically MHA and Care planning. For example

- The Lead Nurse will complete a detailed case notes audit by end of February
- There will be a formal feedback of audits against mental health act compliance on the wards, these are achieved by way of external scrutiny visits supported by mental health act administrators
- Locality matrons will be asked to included randomised audits of patients rights within the now established 3 tiered assurance framework
- Further training on behavioural care planning to be rolled out by March
- Further director led drive on SafeT training by March to increase compliance figures
- By the end of February the 136 policy will have had a full review against the new code of practice and serious incident learning, and will be out for consultation to all stakeholder agencies
- Audits occurring to look at the use of caged vehicle and the decision making process that will have a trends analysis and action plan by March

Must do actions - CRSL

In 8 out of 9 teams the case loads are below 40. The remaining team, South Kent and Canterbury, is working to plans to achieve this target by the end of March. PODs have been implemented across CRSL which are utilising case load clinics and RAG rating. CMHTS Case loads are a standard item on the agenda for CRSL patient safety meeting.

Work with partners to address capacity has resulted in agreement that KCC Primary care health and well being service will become operational on 01/04/2016 and West Kent CCG are implementing a GAP analysis process on care pathways.

Full assurance has been obtained that all teams have lone working protocols adapted specifically for each individual area.

Lead Nurse and Quality Lead carrying out specific care plan reviews and RiO sample checks to confirm recording of consent in care plans during February. A Consent to Share Information form has been produced and will be ratified by the Information Governance team prior to roll out across the Service Line (SL) by end of Feb to meet the March deadline.

BI reporting in place for capacity to consent. OA Lead Nurse is using this to work with individual wards to target improvements. FSSL leading on additional work around capacity to consent to treatment to ensure consistent best practice across all Service Lines.

Further Rehabilitation specific training in relation to safeguarding and clinical risks assessments are being undertaken by Trust corporate leads. Lead Nurse to conduct a review in RiO taking a sample from across the community teams and rehab to get an accurate picture of where the teams are now.

Must do actions – Older Adult Service Line

As with the Acute Service Line, the Older Adult Service Line is focusing efforts on remaining areas of inconsistency, using the results and outcomes from audits and assurance systems to highlight areas of inconsistency and requirements for further work. Care planning and MHA/DoLs/Safeguarding consistent good practice remain a focus of work across the Service Line and the Trust. As does risk management and the processes and systems in place to ensure risks are recognized and actively managed.

Risk Management - Training programme to ensure that staff who had access to the Risk Module on Datix were confident in following the risk management process, including the application of the Control Calibration Tool.

The Training package was targeted at reinforcing the responsibilities of a ‘Risk Manager’ under Datix and provided guidance in applying the Control Calibration Tool when assessing risks. Additionally Risk trainers have been undertaking a 1:1 visit with the attendees in their work environment to ensure that they fully understand the process and provide assurance that these processes are being embedded.

The directorate are introducing a system to ensure that all team Risk Assessors are providing confirmation of the monthly review of the team Risk Register at the monthly team meeting and the identification and display of the team top 3 risks.

An in-depth review of risks across the SL with 1-1 refresher meetings arranged for those indicating any concerns. All services to have a copy of their top 3 risks displayed.

Safeguarding Alerts related to ‘Falls’ has been discussed at DTM with further guidance to all teams on the raising of alerts.

All teams to ensure that the Top Ten Policies are available in paper form in a file on the ward.

Incident Reporting and description of 'level of incidents 'to be displayed in the staff office on all wards.

DoLs Breach Report and Capacity and Consent audit findings to be reported to the Directorate Team Meeting on a monthly basis for review, identification of 'hot spots' and agreement of associated actions including Care Plan and Risk Assessment audits, training and support.

All services have a risk detailed on the local on Datix for monthly review.

Trust Safeguarding Lead to re-visit Frank Lloyd and ensure all OA wards have been visited and that staff are confident in identifying abuse.

All Service managers and Ward Managers are required to attend the new training available now.

There is recognition that there are specific workforce challenges in DGS, Shepway and Thanet. Efforts are being made to recruit additional staff in the OA community teams and CAPA is being rolled out across all teams.

Lead Nurse and Quality Lead carrying out specific care plan reviews and RiO sample checks to confirm recording of consent in care plans during February.

A minimum standard bridging statement to be produced to support the Care Planning Guide.

Team Leaders to sign confirming that all staff have read and understand the Care Plan Guide and supporting 'bridging statements'.

A 2 hour workshop is to take place for services in the East and Medway/West respectively to provide a PCCP (to include capacity/consent) refresher session for Ward Managers/DWM's and Snr Practitioners.

A Consent to Share Information form has been produced and will be ratified by the Information Governance team prior to roll out across the Service Line (SL) by end of Feb to meet the March deadline.

BI reporting in place for capacity to consent. OA Lead Nurse is using this to work with individual wards to target improvements. FSSL leading on additional work around capacity to consent to treatment to ensure consistent best practice across all Service Lines

Patients do have a Crisis Card that has details of who to contact in an emergency. Out of hours crisis support is a recognised gap in service provision and is a risk on Datix. SL Director continues raising this issue with Commissioners.

Safeguarding DoLs breach reports to be requested on a monthly basis from the Trust team for reviewing. The report to be reviewed on a monthly basis with Snr Managers.

A Best Interest Assessor to be identified and invited to attend either a workshop or meeting in February 16 to provide insight.

Trust Safeguarding Lead confirmed that ward managers are submitting data to Safeguarding Team in the form of a DoLs breach report. The Safeguarding team will have reviewed all OA wards by the end of the February.

Must do actions – Forensic and Specialist Services

The Service Line must do actions are now largely complete.

The Service Line continues to work closely with the Capital and Estates team on progressing Business Cases for capital works.

The Service line is assisting other Service Lines and leading on a Trust wide basis initiatives such as capacity to consent where their systems and practices were recognized to be good and effective.

Changes to planned actions and completion dates

The actions relating to staffing are being reviewed for completion dates in view of particular areas of recruitment difficulties. It is likely the deadlines for these actions both Must and Should do's will be revised to July 2016. The completion dates for System wide actions will have to be clarified when contractual agreements are reached. If Commissioners agree to increase capacity in March, the impact of the increased capacity will not be effective until September 2016.

The actions which failed to meet deadlines in December, Canterbury 136 suite and full assurance of Lone working protocols were completed in January.

Continued auditing and assurance checks are indicating that MHA/DoLs/Safeguarding, Care planning including clinical risk assessments deadlines of March 2016 may not be achievable. Senior Nurses and Compliance team members are conducting ward visits during February and will confirm the viability of the March deadlines.

Dashboard as at 29/01/16

Quality Improvement Plan

Dashboard

Must do	**34**
Should do	**49**

Progress as at	29 01 16	Complete	On track	At Risk
Must do	34	19	13	2
Should do	49	20	25	4

Completion dates	Date	Complete	On track	At Risk
Must do				
Mar-16	30	19	9	2
3 months or more	4	0	4	0
	34			

Completion dates	Date	Complete	On track	At Risk
Should do				
Mar-16	40	20	16	4
3 months or more	9	0	9	
	49			

Action category		Total	Complete	Ongoing
Internal Actions	Must do	26	16	10
	Should do	36	17	19
Capital Requirements	Must do	6	3	3
	Should do	9	3	6
System wide	Must do	2		2
	Should do	4		4
		0		

Action by Service Line

	Must do	Should do
Acute	8	11
CRSL	8	5
Forensic	6	24
Older People	12	9
	34	49

Domain

	Must do	Should do
Safe	26	24
Effective	4	13
Caring	0	0
Responsive	2	11
Well Led	2	1
	0	0

Theme

	Must do	Should do
Patient Centred Care and Treatment	6	11
Risk/safety/privacy and dignity/PSTS	7	22
Safeguarding	2	0
Medicines Management	4	4
Estates/136/seclusion	8	9
MCA/MHA	5	3
Caseload	1	0
Supervision	1	0

Regulation	No. of Actions	
	Must	Should
Compliance action Regulation 9 - Patient Centered Care and treatment	4	9
Compliance Action Regulation 10 - Risk/Safety	7	22
Compliance Action Regulation 11 - MCA/Safeguarding	3	0
Compliance action Regulation 15 - Risk/safety/privacy and dignity/PSTS	4	3
Compliance Action Regulation 13 - Medicines Management	4	4
Compliance Action Regualtion 17 - Estates/136/seclusion	5	8
Compliance Action Regulation 18 - MCA/MHA	5	3
Compliance action Regulation 22 - Patient safety Caseloads	1	
Compliance Action Regulation 23 - Supervision	1	
	0	0

Status of plan

Rating below relate to the progress of the enforcement/compliance action as a whole based on the date of **overall completion**. The table also provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

Blue		Fully Assured – Three levels of assurance obtained confirming compliance
Green		Assured / in progress – First level assurance obtained, second level of assurance in place, third level confirmation of compliance being obtained
Amber		More assurance required – First level assurance in place, second level in progress, third level assurance still required
Red		Not assured – Second and third level assurance not yet in place or non compliance reported

Assurance levels

First level assurance is ward manager, second level assurance from Modern Matron or Service Managers, third level assurance is Corporate Team or Trust level specialists such as infection control or resuscitation leads or where applicable third level assurance will be independent of the Trust.

Must do Actions due for completion January 2016 or earlier	Issue	Progress rating	Issues / Comments
Warning Notices RGP1-2006656243 RPG1-2006671545	Littlestone Continuing Care Unit	Blue	Action completed and ward has been revisited by CQC. Warning notices have been withdrawn. CCG independent assurance visit took place on 25 November 2015. The Report has been received with positive confirmation.
MI1 - Acute	Emergency Equipment	Blue	Equipment reviewed, replaced, updated where required – action progress reverted to Amber as less than 100% compliance on 3rd tier assurance checks
MI9 – Community LD (CRSL)	Lone Working Practice	Blue	Final 3rd tier assurance now received that all local protocols in place
MI10 – Rehab (CRSL)	Risk Management and Learning	Blue	Significant progress with incident reporting with Datix training introduced, flowcharts updated and weekly monitoring at Business Unit Meetings. Learning shared through CRSL briefings, team and business meetings. Rehab-specific learning is being communicated immediately via e-mail. Risk Management Team assurance received.

MI11 – Forensic	Safekeeping of Medicines on Penshurst ward		Action complete and fully assured
MI12 – Forensic	Infection Control – Clozaril Clinic		Trust Infection Control lead has visited clinic
MI16 – Older Adult Wards	Physical Health, Mobility and Pain Management		Littlestone independent report received
MI8 – Older Adult Wards	Risk Management and Learning		Littlestone independent report received
MC63 – Acute	136 Suites		Canterbury work now complete
MC65 - Rehab	Mixed sex arrangements		Zoning plans in place
MI7 - Rehab	Self medication management		Service Line Actions complete, assurance system in place –specific Ethelbert Road assurance received from Pharmacy Team
MI13 – LD Wards	Raising safeguarding alerts		KCC third tier assurance visit on 10/12/15, positive report
MI17 – Older Adult Wards	Littlestone – risk management pain and physical heath		Littlestone independent report received
MI19 – Older Adult Wards	Risk Management Processes		Service Line Actions complete, Risk Management Team sample check (Cranmer Ward) positive, all wards were not checked by end of January
MI21 – Community Older Adults	Supervision at Swale		Service Line Actions complete, assurance system in place, final assurance check results by 8/01/16
MI3 - Acute	Medicines Management		Assurance given that there are no further specific concerns in the highlighted areas(Cherrywood) being raised by the pharmacy teams monitoring these sites
MI5- Acute	Risk Management		Service Line Actions complete, Risk Management Team Action plan complete
MI15 – Older Adult	Medicines Management		Pharmacy Team assurance required for all Older Adult Wards
MI25 - Rehab	Risk Management		Risk Management Team assurance received
MC68 – Older Adult Wards	Privacy and Dignity – Hearts Delight		Deputy Director of Nursing assurance

Must do's due for completion in January 2016	1 Action due for completion and full assurance		Completion dates for Staffing actions being reviewed
Must do's due for completion by March	10 Actions due for completion and full assurance		System wide actions to be agreed as part of Contract round for 2016/17 Care Planning and MHA/MCA full assurance
Must do's with target completion dates beyond March 2016	3 Actions due for completion		Capital work on Seclusion rooms – dates for capital works now scheduled Seclusion rooms at Allington and Penshurst are scheduled for completion by July and September 2016 respectively but this is still dependant on capital funding availablity

Should do actions

The following provides an update on 'should do' actions that are due by end of January.

REF	Service or Directorate	Issue Identified	Action/s	Date to be completed	Progress Summary	RAG rated completion forecast Red = Deadline likely to be missed Amber = Potential delay Green = Completion forecast on time
SI41	Forensic	The availability of emergency and resuscitation equipment in the HDU at the Allington Centre.	Review the availability of emergency and resuscitation equipment in the HDU at the Allington Centre.	31/10/15	Lead Resuscitation officer has reviewed and made recommendations. A second set of equipment is being purchased for HDU in line with recommendation. Equipment has been re-ordered but not yet delivered.	**Completion date extended** **Equipment received awaiting ward confirmation all are in date**
SI49	Forensic	Pay phones on TGU and Allington	Review the payphone facilities across all wards to ensure all patients have access to make private phone calls and that a consistent approach is agreed across the service line in regards to equality of provision and cost.	31/10/15	Payphone usage is monitored to ensure privacy. Service Line checking: a. all wards have a phone hood or screen b. Posters are by the ward pay phone area to state that private calls to solicitors/IMHA etc. can be made in a separate area where required. c. phone charges are clearly stated	**Action extended to include provision of hoods on phones.**
SI52	LD Wards	The trust should review the provision and access for patients for their finances.	This relates to the times the patients bank is open. Finance Director to review access to the patients' bank in ERC.	31/10/15	Money handling policy has been reviewed and updated Service Manager is reviewing patient monies procedure from the TIAA report, including access to the limited opening hours of the patient. Corporate action point: discussions with the patient bank and the finance director	**Action extended to include all Internal Audit recommendations on money handling** **SL actions complete now Trust Action**
SI28	Acute	The provider should ensure that all patients have a risk assessment which is reviewed	New training has been developed and has been published across the acute service line for all staff to do	30/11/15	Ongoing work to improve training compliance across all areas, which is being picked up through both the training team, and by contact at Director	**Action included in Care Planning assurance actions**

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REF	Service or Directorate	Issue Identified	Action/s	Date to be completed	Progress Summary	RAG rated completion forecast Red = Deadline likely to be missed Amber = Potential delay Green = Completion forecast on time
		regularly and updated in response to changes.	in groups as part of team meetings		level, to raise concerns where there are specific issues. Forensic Service Line secondment in place to support education, training and actions	
SI47	LD Wards	The trust should review their systems for recording and monitoring of outcome measures to evidence whether people improved following treatment and care	Medical Lead/Psychology HOS to review the outcome monitoring systems in order to highlight improvements	30/11/15	Staff member is reviewing all current assessment/outcome tools currently used in order to highlight those that are being used well as outcome measures and those that have the potential to be used as outcome measures. All clinicians have been asked to contribute. Meeting booked for 07.12.15 to decide next steps – draft report now available	
SI48	LD Wards	The trust should review and appropriately implement the use of advanced plans of care	Quality Assistant and Psychology lead to audit advance decisions re RIO/quality in line with CQC comments	30/11/15	Local Business Meeting group agreed to establish that all patients have a WRAP, (Wellness Recovery Action Plan) which is a very full advance decision, formatted for people with a learning disability. The WRAP needs to clearly state that the WRAP is also the advance decision. 1 outstanding from 3 wards	
SI 50	Forensic	At the Allington Centre, review how patients access their money as the current arrangements are restrictive	Service Manager to review patient monies procedure from the TIAA report, including access to the limited opening hours of the patient bank and the fact that the cashpoint also has limited operating hours.	30/11/15	Service manager has completed the report and forwarded to Executive for decision. Recommendation is that the cashpoint machine is accessible 24/7 and that the opening hours are extended to 5 days a week. Plan to standardise the role of the PMO to bring it into line with Maidstone, under the legal team	**Action combined with TIAA audit actions – SL actions complete now Trust Action**

REF	Service or Directorate	Issue Identified	Action/s	Date to be completed	Progress Summary	RAG rated completion forecast Red = Deadline likely to be missed Amber = Potential delay Green = Completion forecast on time
SI55	Forensic	Develop a service model for the intensive care unit (ICU) on Penshurst Ward as well as associated protocols which should include the use of the time out practice in the seclusion room on the ward	The CNM is visiting a service providing similar services, including a seclusion room. Following this visit the ward philosophy and model document will be drafted	30/11/15	Development of philosophy and model is continuing – draft ready for approval - being discussed at SL Clinical Governance meeting on 07.01.16	
SI32	Acute	The provider should ensure there are robust processes in place for assessing and managing environmental risks, and that these are followed.	Risk register for the service line is reviewed monthly, and has been tied into the CQC quality improvement plan. Local Risk registers reviewed by Service Managers Lessons learned bulletin providing monthly update	31/01/16	Discussions are underway to better assure that the Trust is robust in management of risks being led by the health and safety team	
SI35	Acute	The provider should ensure there are adequate numbers of appropriately qualified and experienced staff.	There is a total review of staffing underway, the therapeutic staffing plans are moving forward to recruitment, staff have been in a consultation period leading up to this, which will improve the availability of therapeutic activity and the safety of the wards. Recruitment focus is also within the CRHTs to allow the teams to function more within the realm of home	31/01/16	There are continued efforts to recruit to the newly formulated therapeutic staffing model, however in the light of national staffing shortages and difficulties in recruitment there are remaining vacancies within this model. Efforts are continuing	**Staffing deadline review**

REF	Service or Directorate	Issue Identified	Action/s	Date to be completed	Progress Summary	RAG rated completion forecast Red = Deadline likely to be missed Amber = Potential delay Green = Completion forecast on time
			treatment thus improving the quality of service offered by them			
SI61	Older Adult Community	Ensure that teams are adequately staffed to manage any foreseeable risks to continued service provision such as adverse weather or staff holiday and sickness.	Each service with staffing capacity issues has a workforce action plan in place that is regularly reviewed. Anticipated low staffing levels are discussed and options considered/ agreed at weekly team meetings. Performance is regularly 'tracked' via reports. CAPA has been introduced and is being rolled out across the Service Line. The performance team will monitor time to treat, waiting times and the assessment process and report on any breaches.	31/01/16	Quality and Governance compliance reports include workforce issues and associated locality action plans. Workforce dashboard reviewed in the Workforce and Patient Experience Directorate Management Team meetings every month Staffing risks alerted through Datix risk management system SL on target to achieve compliance implementing CAPA across the Service Line	**Staffing deadline review**
SI62	Older Adult Wards	The trust should ensure that it continues to actively recruit to vacant posts.	Implement Therapeutic Staffing Implement Recruitment and Retention action plan	31/01/16	Recruitment is underway for Therapeutic staffing - Therapeutic staffing Interviews arranged commencing 3.12.15 and will continue for 2 weeks Vacancy dashboard showing an overall vacancy rate of 14%	**Staffing deadline review**

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Item 8: Five Year Forward View for Mental Health and the implications for Kent (Written Briefing)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 8 April 2016

Subject: Five Year Forward View for Mental Health and the implications for Kent (Written Briefing)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Kent CCGs and Kent County Council.

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

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

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1. Introduction

(a) On 4 March 2016 the Committee considered an update about Kent and Medway NHS and Social Care Partnership Trust. As part of the discussion the Five Year Forward View for Mental Health, published in February 2016, was highlighted to the Committee. The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the report be noted;

  (b) KMPT be requested to submit a written briefing about CQC style inspections carried out by the CCGs; the timescale for the six key areas of improvement and which area of the Quality Improvement Plan they sit under; and the number of out-of-county placements for the Committee's meeting on 8 April;

  (c) KMPT be requested to present an update to the Committee in June;

  (d) Ms Carpenter be requested to liaise with colleagues and arrange for a written briefing on Five Year Forward View for Mental Health and the implications for Kent to be submitted to the Committee for its meeting on 8 April.

2. Recommendation

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

Item 8: Five Year Forward View for Mental Health and the implications for Kent (Written Briefing)

Background Documents

Kent County Council (2016) *'Agenda, Health Overview and Scrutiny Committee (04/03/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6257&Ver=4

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Report for the Kent Health Overview and Scrutiny Committee

Subject: The Five Year Forward View for Mental Health (5YFV) Key recommendations

Date: March 2016

Completed by: Hazel Carpenter, Accountable Officer, NHS South Kent Coast and NHS Thanet CCGs with support from Ian Ayres, Accountable Officer West Kent CCG, Kim Solly, Mental Health Programme Manager for NHS Dartford, Gravesham and Swanley and NHS Swale CCGs, Jessica Mookherjee, Assistant Director for Public Health Kent County Council and Sue Scammell, Commissioning Manager Mental Health Kent County Council.

Introduction

Kent HOSC asked for a written briefing on Five Year Forward View for Mental Health and the implications for Kent to be submitted to the Committee for its meeting on 8 April. This briefing sets out the key 5YFV priorities and targets, the current positon in Kent and the plans in place to improve mental health care.

In February 2016 the mental health taskforce published "Five Year Forward View for Mental Health: An independent report of the Mental Health Taskforce." The taskforce was set up in March 2015 by NHS England. The Taskforce was asked to develop a five year strategy for mental health in England. The full report is available on NHS England's website at https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf. In Kent there has been a 5-year Joint Mental Health Strategy called "Live it Well" www.liveitwell.org.uk/policies/live-it-well-strategy/.

The Kent Strategy has 10 commitments and runs to 2016. It has been agreed by the Kent Health and Wellbeing Board that rather than creating a new overarching mental health strategy for Kent, there will be shared principles that reflect the 5YFV and national policy. These are being developed by all partners currently. It was also agreed that the Health and Wellbeing Board will take an overview of mental health, as stated in the Joint Health and Well Being Strategy for Kent; Outcome 4.

Children's mental health is driven locally by the Children and Young People's Emotional Wellbeing Strategy 2015 and reports to the Children's Health and Wellbeing Board.

Key facts, national and local

Poor mental health affects people of all ages, yet, with effective promotion, prevention and early intervention its impact can be reduced dramatically. There is often a circular relationship between mental health and social issues such as housing, employment, family problems or debt.

- Mental health problems now account for more than twice the number of employment and support allowance and incapacity benefits claims than for musculoskeletal complaints such as bad backs.
- The employment rate of people with severe mental health problems is the lowest of all disability groups at just 7 per cent.
- People with severe mental illness die on average 15 to 20 years earlier than other people- one of the greatest health inequalities.
- People with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care.
- There are groups of people who are at higher risk then the general population for mental health problems, these are; homeless people, substance misusers, people who have been in care, lesbian/gay/bisexual/transgender people, migrants, travellers, offenders and those with a disability.

Mental health needs in Kent

Kent is a large and diverse country of around 1.6 million people and as such mental health needs are not spread evenly across Kent. However national estimates show that 1:4 to 1:6 people have suffered a diagnosable mental health problem at some point in their lives. Kent is similar to the England average picture of mental health need. Mental health problems tend to be more severe and complex in more deprived areas.

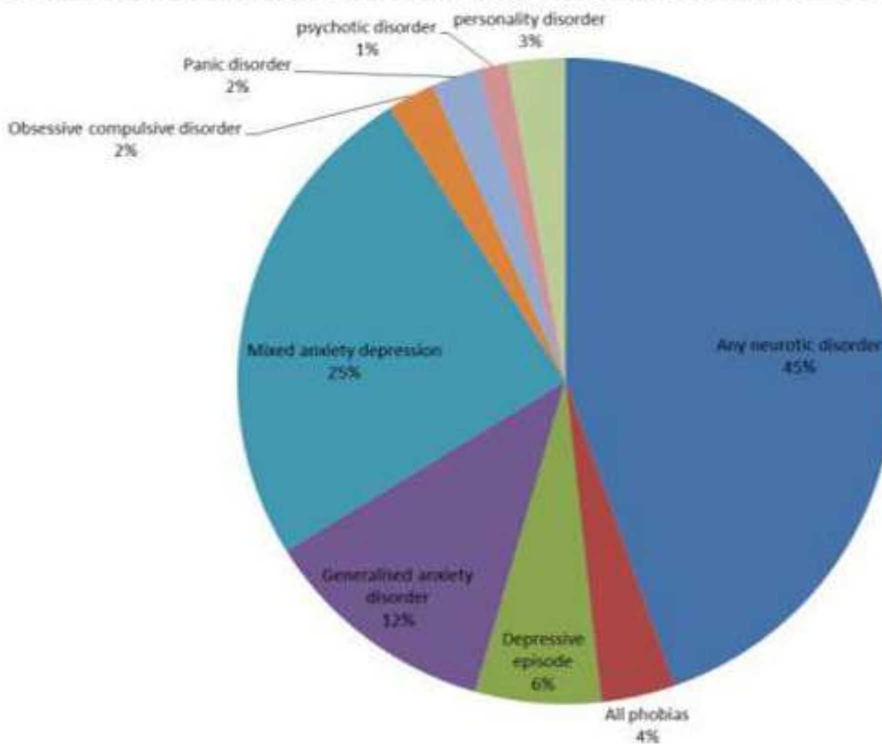
It is difficult to accurately assess the numbers of people with mental health problems because

- There is a high percentage of people who do not seek help due to stigma and other barriers
- There is a high degree of co-morbidity e.g. both depression and anxiety and personality disorder – which means numbers rarely add to 100 per cent
- Clinicians can disagree on diagnosis and treatment.

Adult mental health can be grouped into four categories:

- The general population: with risk factors (issues such as bereavement, divorce, illness, unemployment) around **65 per cent** - **75 per cent** of people in Kent will cope with life's pressures – but may need help at any time.
- Those with common mental health conditions (e.g. depression and anxiety disorders) **25 per cent of population at any time.**
- Those with severe and enduring mental illness (psychosis, bipolar mood disorder, severe personality disorders **5 per cent of population.**
- Those with rare, specialist and/or forensic issues (eating disorders) **1-2 per cent of population**

Figure 1. Estimated percentage of adult mental health disorders in Kent (from National Psychiatric Morbidity Survey 2007 applied to Kent)



Source: KPHO 2014

Most mental illness in Kent, as nationally, is under the category of 'Common Mental Health' such as depression and anxiety. It is labelled 'common' as is it is widespread, but it can be highly debilitating and left untreated can become severe and complex. Severe mental illness is less widespread, often has some genetic basis and the World Health Organisation in 1989 classified it as having a similar debilitating impact as quadriplegia (DALYS).

If people do not get help or seek support for their mental health problem, the consequences can be catastrophic as around 1 per cent of people in Kent kill themselves each year. Of those people who commit suicide, approximately 75 per cent are not known to secondary mental health services. Kent has a higher suicide rate than the national average and the areas in Kent with the highest rates of suicide are currently Swale, South Kent Coast and Dartford, Gravesham and Swanley (Fig 2). Public Health are currently leading a Kent wide suicide awareness campaign called "Release the Pressure" and it's aim is increase people's contact with the 24 hour helpline.

Figure 2 Registrations of death from suicide and undetermined causes, numbers and age-standardised rate (ASR), 2012-14, Kent CCG residents aged 15+, by gender

	Male		Female		Both sexes	
Area	**Numbers**	**ASR / 100,000**	**Numbers**	**ASR / 100,000**	**Numbers**	**ASR / 100,000**
NHS Ashford CCG	26	19.4	7	4.7	33	11.7
NHS Canterbury & Coastal CCG	44	20.0	6	2.4	50	10.8
NHS Dartford, Gravesham & Swanley CCG	70	23.4	10	3.1	80	13.0
NHS South Kent Coast CCG	57	22.8	13	4.8	70	13.7
NHS Swale CCG	30	23.8	7	5.5	37	14.3
NHS Thanet CCG	28	17.4	7	4.2	35	10.5
NHS West Kent	89	16.0	42	7.1	131	11.6
Kent	**344**	**19.5**	**92**	**4.9**	**436**	**12.0**

Source: PCMD, KPHO

The areas of greatest mental health need in Kent are well predicted by deprivation and health inequalities. East Kent has greater mental health needs then West Kent. North Kent, however also has high degrees of mental health need and the estimated numbers are shown in Figure 4. It should be noted however that mental health problems can strike any person regardless of deprivation, the deprivation simply raises the level of stressors and barriers in seeking help. Canterbury has high mental health needs for young people due to high student populations.

Importance of Good Data

The current needs assessments make use of the best available data and information at the time. It is important to continue to improve the data; linkage and quality so that needs assessments continue to improve. One example of use of shared data is seen below in Figure 3. Here the national estimates for depression are compared with GP records to see if people are seeking help and/or being diagnosed at rates that would be expected. The data in Figure 4 shows that in 2011/12 there was a considerable gap between estimated figures and those on a GP database. This is not unique to Kent and is part of the reason why access to psychological therapy has been promoted and funded nationally.

Kent County Council kent.gov.uk

NHS

Figure 3.

Expected Prevelence compared To QOF					
		QOF 2011/12	APMS 2007		
	Depression	Mental Health	1 MH condition (23%)	2+ MH Conditions (7.2)	GAP%
NHS Ashford CCG	12661	793	20598	6448	35
NHS Canterbury and Coastal CCG	15863	1570	36522	11433	52
NHS Dartford, Gravesham and Swanley CCG	14867	1761	41297	12928	60
NHS South Kent Coast	16536	1573	33428	10465	46
NHS Swale	8668	670	17844	5586	48
NHS Thanet	12731	1348	23099	7228	39
NHS West Kent	38182	3135	76935	78171	39

Source KMPHO 2014

Figure 4

Estimated numbers of mental health need in Kent 2014 Source Kent Public Health Observatory	
Children	Adults 18+
20,585 children aged 5-16 have a mental health disorder	154,876 adults over 18 have a common mental health disorder such as anxiety or depression
12,400 children aged 5-16 have a conduct disorder	54,980 adults aged 18-64 have two or more psychiatric disorders
8,000 children aged 5-16 have an emotional disorder	4566 adults over 18 will present with psychosis by 2020.
	3095 adults over 18 will present with personality disorder by 2020.

Children's mental health is categorised differently to adults – this is due to the developmental and behavioural complexities in childhood and adolescence. There are two main categories of child mental health;

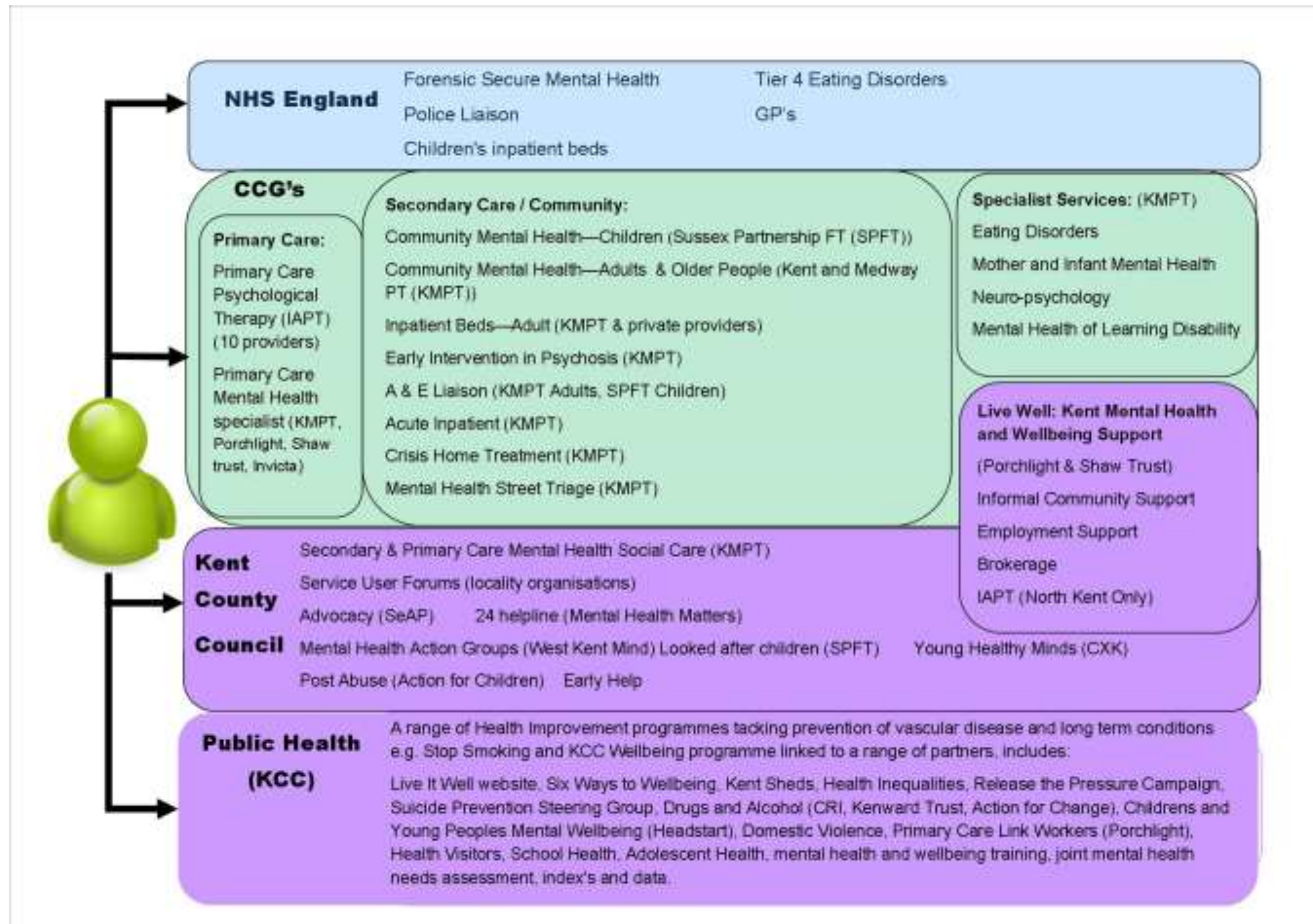
- Emotional disorders
- Conduct and behavioural disorders

Public Health in Kent produce a raft of needs assessments for KCC and CCG commissioners and these are updated every 2-3 years. New issues are examined each year; in 2015 Children's Mental Health Needs Assessment was produced. In 2016 the public health team are focusing on Substance Misuse, Personality Disorder and Maternal Mental Health. The reports will be available in the autumn 2016.

Current needs assessments are available on the Kent Public Health Observatory Website

http://www.kpho.org.uk/joint-strategic-needs-assessment/jsna-disease-groups/jsna-mental-health.

Fig 5



Kent County Council also provides an Approved Mental Health Practitioner Service to undertake its statutory function under the Mental Health Act. A new primary care social care service will also commence on 1 April 2016 which will undertake social care assessments and will enhance services provided in primary care.

By 2020/21 the picture should look very different with the person at the centre of integrated physical and mental health, social and third sector services delivering seamless care and measureable outcomes and an increased choice of providers. Kent is committed to improving the care for those with long term conditions, shifting care into the community and closer to home, making care more personalised and supporting people to live independently for longer. Better coordination between different providers and across the boundaries of care is needed. Lord Darzi's next stage review introduced the concept of integrated care organisations (ICOs); various models of care are now being piloted across England as a way of exploring whether better coordination can improve outcomes and reduce costs.

There are longstanding fault lines in the current provision of care that result from historic divisions between budgets (that is between groups of health providers, health and local authority funders of social care). The NHS Next Stage Review emphasised the concept of integrated care and ICOs as a means to achieve better care for patients. The premise of integrated care is that it will not only help to improve the coordination of care for patients and therefore prevent avoidable ill health, but also that it will result in greater value for money. Kent has already made good progress pooling health and social care budgets to create integrated services such as Live Well and the planned procurement of services for children and young people, there is still much to do.

Kent County Council kent.gov.uk

NHS

Key recommendations from the 5YFV for Mental Health

- **Inequalities must be reduced** to ensure all needs are met, across all ages.
- **Care must be integrated** – spanning people's physical, mental and social needs achieved through partnership working across NHS, public health, voluntary, local authority, housing providers, education and youth justices. Integrated population-based commissioning will combine health and social care spending power to improve mental health outcomes
- **Access to high-quality services close to home:** ensuring that local community services are immediately available so that people experiencing mental health crisis do not need to wait. If people need to use hospital services, they should not have to travel out of their area for the right care.
- **Co-production**: people living with mental illness and carers should be involved in the design and delivery of mental health services
- **Better carer engagement:** health professionals should be trained to better involve carers. Services should also show evidence that they effectively engage with carers as part of their inspections.
- **Action on physical health:** people with mental illness should get enhanced help with their physical health through better screening and lifestyle support. People with physical health conditions should receive better support for their mental health needs.
- **Health and Wellbeing Boards** to have plans in place to promote good mental health prevent problems arising and improve mental health services.
- **The right data** must be collected and used to drive and evaluate progress
- **Prevention and early intervention** must be prioritised with rapid transformation of services for children and young people.

Kent's progress towards key priorities and targets of 5YFV for Mental Health

Kent is ahead of the national position on most of the key priorities with detailed plans to reach the required targets ahead of the 2020/21 dead line.

1. Improved care for people in a crisis			
	NHS England Target	On track	Kent current position and plan
1.1	Access to mental health care 7 days a week, 24 hours a day by 2020/21.	✓ G	Kent CCGS are ahead of the national position with a service already in place for adults. The CQC reports that only 50 per cent of community mental health teams offer a 24/7 service.
1.2	All age mental health liaison service in emergency departments and acute general hospitals by 2020/21	✓ A	Kent CCGS should have services in place by the deadline of 2020 subject to additional NHS funding.
1.3	People experiencing a first episode of psychosis to have access to a NICE-approved package of care within 2 weeks of referral by 2020/21	✓ G	Kent CCGs are believed to be ahead of the national position with Early Intervention Teams in Psychosis teams in place for several years. Although access times targets are being achieved an improvement plan has been developed to ensure NICE guidance treatment, including psychological interventions is provided within 2 weeks.
1.4	Out of area placements for acute care should be reduced and eliminated as quickly as possible	✓ A	Kent CCGs have a plan in place and this is monitored and supported by weekly conference calls. The use of out of area beds and delayed transfers of care have already reduced. In addition people placed out of area have a review date, planned discharge dates and repatriation plans.

2. Integrated mental and physical health			
	Target	On track	Kent current position and plans
2.1	More women to be able to access evidence-based specialist mental health care during the perinatal period by 2020/21	✓ A	Kent has a dedicated specialist provision and plans are in development to improve the whole pathway and join up with general maternity services. A public health needs assessment will be completed in April 2016 and will drive commissioning changes to the current pathway – particularly in the public health commissioning of health visitors and CCG commissioning of midwives, as well as better access to IAPT and social support.
2.2	People living with severe mental health problems should have their physical health needs met.	✓ A	A national physical health care CQUIN is in place to incentivise mental health providers during 2016/17 to improve physical health care checks and follow up in community mental health services for people with a serious mental health condition.
2.3	Increase access to psychological therapies to reach 25 per cent of need by 2020/21.	✓ A	Kent CCGs are amongst the top performers in the country with half of CCGs already achieving a 20 per cent access and 50 per cent recovery rates in some areas. NHS E targeting an increase of 15,500 more people to enter primary care talking therapy treatment in Kent by 2020/21 so that nearly 40,000 adults with anxiety and depression can access care each year, at an additional annual cost of around £4 million.
2.4	People with physical health problems have their mental health needs met	✓ R	Considerable improvement is required. New care models such as Multi-speciality community providers (MCP) GP Vanguards and Integrated care providers (ICP) to improve integration of care will be developed during the next five years. IAPT services already offer primary care talking therapy to people with long term physical conditions

3. Promoting good mental health and preventing poor mental health			
	NHS E targets by 2020/21	on track	Current position
3.1	Future in Mind recommendations to be implemented in full	✓ G	Kent CCGs and KCC have already made good progress through partnership working and have developed a joint strategy and are implementing the Kent Transformation Plan for children, young people and young adults.
3.2	More people living with mental health problems should be supported to find or stay in work	✓ A	KCC with contribution from Kent CCGs have commissioned a new service, Live Well to deliver integrated mental health support services including employment support
3.3	Creating mentally healthy communities through the creation of local Mental Health Prevention Plans	✓ G	Kent Public health have prioritised public mental health, the programme includes community asset mapping and development, projects such as Kent Men's Sheds, funding and supporting library

			wellbeing hubs, supporting programmes such as 'Singing for Health' and putting a major funding contribution towards the domestic violence commissioned programmes. KCC Public health and Social Care are the main commissioners for the Community Mental Well Being programme across Kent called 'Live Well'- this will be delivered by the Shaw Trust and Porchlight – as strategic partners and in collaboration with community groups. In 2016/7 they will develop locality prevention programmes. In addition Public health leads each local delivery of the Alcohol Strategy and commissions Substance Misuse treatment services. In 2016/7 Public health in Kent will work with districts and CCGs to develop local prevention plans that sit alongside local commissioning arrangements. Public health is committed to working alongside each of the local health and wellbeing boards to strengthen community wellbeing by developing local plans alongside the community. This work is at early stages but will progress in 2016/17 and will be underpinned by the Kent Health Inequalities Strategy.
3.4	End the stigma around mental health	✓ A	Kent Public Health and KCC have commissioned a website www.Live it Well.org.uk which is visited by over 10,000 people a month. The Live Well Kent service will lead the Time to Change Campaign to reduce stigma and discrimination alongside the Mental Health Action Groups.
3.5	Better service user and carer engagement (co-production)	✓ G	Kent CCGs have a detailed plan in place to improve service user and carer engagement. KCC has a network of user groups which feed back into commissioning services.
3.6	Improved data linkage across NHS, public health, social care and education with transparency on spending in relation to prevalence access, experience and outcomes	✓ A	Public Health conduct an ongoing series of needs assessments for public mental health, working closely with lead CCG mental health commissioners. There is current work to refresh offender needs assessments, substance misuse, and mental health JSNA. There are current deep dives into personality disorder and maternal mental health. Public Health is working with health care providers to ensure one identifying number is used to enable sharing of data across agencies and track peoples progress through health and social care.

Investment in mental health service provision across Kent by health economy (£millions)						
	Public Health	KCC	DGS and Swale CCGs	West Kent CCG	South Kent Coast, Ashford, Canterbury &Coastal and Thanet CCGs	Total
Wellbeing and suicide prevention	£2.7 m					£2.7 m
Drug and Alcohol substance misuse	£14.9 m					£14.9 m
Children's Mental health community 0-18		£3.4 m	£2.8 m	£3.1 m	£7.3 m	£16.6 m
Primary care psychological therapy (IAPT) 18+			£1.7 m	£2.3 m	£5.1 m	£9.2 m
Adult Acute inpatient beds 18+			£12 m	£14.2 m	£30 m	56.2 m
Adult community mental health		£25m	£12 m	£15.2 m	£30 m	£82.2 m
Total	£17.6 m	£28.4 m	£28.6 m	£35m	£72.4 m	**£182 m**

Note: This does not include the Public Health budget for health visiting and school health or the overall programme for wellbeing which totals £48 million.

Nearly 50 per cent of the adult mental health budget is spent on less than 10 per cent of activity for inpatient beds.

Summary

The traditional divide between primary care, community services and hospitals is a barrier to the personalised and coordinated health services people need. Improved integrated support should include social care, mental health services and GPs and other primary care and third sector services. Within the NHS primary, secondary and tertiary care services should deliver integrated physical and mental health outcomes. Currently needs are addressed in isolation, which is not effective or efficient. CCGs and Local Authorities need to ensure people with multiple needs, such as mental health and substance misuse problems do not fall through service gaps. This may require a redistribution of physical health budgets to contribute to mental health care. Improved integrated services give people information, advice, support and interventions that can be delivered across a whole system from a wide range of providers. However the traditional divide between primary care, community services and hospitals is often a barrier to the personalised and coordinated services people need.

In Kent, CCGs and KCC are committed to putting the person at the centre and consider innovative ways to commission and deliver services across the county.

As part of the planning process to deliver the five year forward view all NHS organisations are asked to produce plans by June 2016 setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances to include a local health and care system 'Sustainability and Transformation Plan' (STP) which will cover the period October 2016 to March 2021.

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