HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 3rd June, 2016

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 3rd June, 2016, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Lizzy Adam**
Telephone: **03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mr 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

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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 - 10)

4. Review of winter preparedness and BMA Industrial Action in Kent 2015/16 (Pages 11 - 22) 10:05

5. Darent Valley Hospital: MRSA (Pages 23 - 34) 10:45

6. North and West Kent Neurorehabilitation Service (Pages 35 - 44) 11:15

7. Kent and Medway Sustainability and Transformation Plan (Pages 45 - 70) 11:45

8. East Kent Strategy Board (Pages 71 - 84) 12:30

9. Kent & Canterbury Hospital: Emergency Care Centre (Pages 85 - 90) 13:00

10. East Kent Integrated Urgent Care Service Procurement (Written Briefing) (Pages 91 - 96)

11. Date of next programmed meeting – Friday 15 July 2016 at 10.00

    Proposed items:

    - CQC Inspection Report: East Kent Hospitals University NHS Foundation Trust
    - SECAmb: Update

EXEMPT ITEMS

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

**Timings are approximate*

Peter Sass
Head of Democratic Services
03000 416647

25 May 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, 8 April 2016.

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

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

UNRESTRICTED ITEMS

20. Minutes
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken since 4 March 2016:

(a) Minute Number 9 – NHS Swale CCG: Review of Emergency Ambulance Conveyances. At HOSC on 29 January, a Member enquired if the closure of the A249 (Sheppey) had had an adverse impact on SECAmb. On 15 March SECAmb confirmed that there were no adverse incidents with the closure of the A249 to Sheppey and the Trust utilised the lower road bridge crossing in the event of a A249 closure.

(b) Minute Number 16 – East Kent Strategy Board. A written update about the East Kent Strategy Board detailing the Case for Change was due to be submitted for the April HOSC meeting. The East Kent Strategy Board requested that this update be postponed until the June meeting as the Case for Change had not yet been presented to the Board – it was due to be considered by the Board at their next meeting on 14 April. Rachel Jones, EKSB Programme Director, offered to share the draft document (once considered by the Board) and meet with interested Members in early May before formal presentation to the Committee in June.

(c) An item about the Kent and Medway Sustainability and Transformation Plan was due to be presented to the Committee on 8 April. As the leader of the Kent & Medway Sustainability and Transformation Plan was announced on 30 March 2016 - Glenn Douglas, Chief Executive, Maidstone and Tunbridge Wells NHS Trust – the CCG requested that this item be considered at the June meeting of the Committee when Mr Douglas could be invited to attend and present an update.

(d) The next meeting of the JHOSC was scheduled for Friday 29 April.

(2) Ms Harrison stated that the query about the closure of the A249 (Sheppey) was regarding the sinkhole and not the closure of the road bridge. Mr Davies undertook to clarifying if there had been an adverse impact on SECAmb due to the sinkhole.

(3) The Scrutiny Research Officer requested that paragraph (1) in Minute Number 18 be amended to Ms Dwyer from Mr Dwyer.

(4) RESOLVED that, subject to the amendment in paragraph (3) above, the Minutes of the meeting held on 4 March 2016 are correctly recorded and that they be signed by the Chairman.

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

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

22. SECAmb: Forensic Review of Red 3 Pilot and Review of Ambulance Quality Indicators
(Item 4)

Geraint Davies (Acting Chief Executive & Director of Commissioning, SECAmb), Terry Parkin (Non-Executive Director, SECAmb), Patricia Davies (Accountable Officer, NHS Swale CCG), Dr Fiona Armstrong (Chair, NHS Swale CCG) and Helen Medlock (Director of 999 & 111, NHS Swale CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Parkin began by giving the apologies of Sir Peter Dixon, the new Chair of the Trust appointed by Monitor. He stated that the Trust welcomed the opportunity to present the report and be subject to additional scrutiny from the Committee. He noted that the events detailed in the reported took place over a year ago and there were now systems in place to prevent it from happening again.

(2) Members of the Committee then proceed to ask a series of questions and make a number of comments. A Member enquired about governance. Mr Davies explained that at the time of the pilot there was high demand with a growth in activity, handover delays and responding to the Ebola virus at Gatwick Airport. There was also an influx of activity transferring from 111 to 999 particularly at the weekends. He stated that the pilot was introduced to meet clinical need following discussions with the Trust's commissioners but acknowledged that it had been implemented with poor governance, risk assessment and assurance. Ms Medlock noted that the NHS England review of the pilot stated that early assessment was good practice; there were now formal national standards which included a clinical assessment when calls were transferred from 111 to 999.

(3) A number of comments were made about the public and their expectations for immediate access to healthcare. Ms Davies acknowledged that there was an expectation of immediate access particularly at A&E where patients could be

seen and treated within four hours but stated that this was not sustainable. She highlighted work being carried out in NHS Swale CCG and NHS Dartford, Gravesham and Swanley CCG to understand patient behaviour and work being carried out by the borough councils to signpost the public to appropriate services. Dr Armstrong noted that GPs in Swale were looking to improve access to general practice by working with other professionals such as paramedic practitioners to reduce pressure on SECAmb and out-of-hours services. Ms Medlock stated the importance of paramedics assessing patients' needs and determining if they could be met in a non-hospital environment. Mr Davies reported that the Trust's growth in activity had increased from 5-6% last winter to 11-12% this winter; the Trust had witnessed changes to behaviour in accessing the system. He stated that he welcomed the development of a system based approach through the Sustainability and Transformation Plans.

(4) A number of questions were asked about commissioner oversight. Ms Davies explained that since the pilot the contract management arrangements had changed so that there was a coordinating commissioner for each contract area: Patricia Davies, Accountable Officer, NHS Swale CCG for Kent and Medway; Julia Ross, Chief Executive, NHS North West Surrey CCG for Surrey; and Geraldine Hoban, Accountable Officer, NHS Horsham and Mid Sussex CCG for Sussex which had led to more coordinated, robust and sustainable scrutiny of the Trust's performance. She stated that those processes had to be balanced against the Trust's needs to be responsive and innovative. Ms Medlock noted that the sharing of commissioning responsibilities between contract areas had enabled a greater depth of scrutiny and quality assurance. She explained that proposed Trust projects and pilots were now presented to the commissioners bi-monthly for scrutiny and approval. The proposals were required to be documented and the decision formally recorded and signed off. She noted that the commissioner's quality leads were working with the Trust to undertake quality reviews. Mr Parkin noted that whilst the Board was responsible for scrutinising the Trust, he was grateful for the robust approach taken by commissioners. He stated that there had been a failure of process and procedure by the Trust with the implementation of the project and it had now put systems and structures to prevent it from happening again.

(5) In response to a specific question about the Trust's responsibilities to its commissioners and regulators, Mr Davies explained that this was one of the key learnings undertaken by the Trust's Board and Executive Team. He stated that he had made a commitment to the commissioners that the Trust would treat them as their primary audience and there had been significant improvement in engagement between them particularly around proposed projects and pilots. He noted that the introduction of the national ambulance response programme would facilitate dispatch on disposition and enable ambulance trusts to retriage calls. He stated that this would only be introduced by the Trust after the appropriate governance process and sign-off.

(6) RESOLVED that the report be noted and SECAmb and Swale CCG be requested to share the findings of the Patient Impact Review and the principles of the ambulance response programme at the Committee's July meeting.

23. Better Care Fund

(Item 5)

Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG) was in attendance for this item.

(1) The Chairman welcomed to Ms Carpenter to the Committee. Ms Carpenter began by explaining that she was presenting this item on behalf of the four Kent CCG Accountable Officers. She stated that the Better Care Fund (BCF) was a national mechanism introduced in 2015/16 to pool health and social care budgets together. She confirmed that the BCF was not new money, it was funding already allocated across the health and wider care system. She reported that the BCF would be a foundation for integration in many areas but in Kent the plans for integration were more ambitious than the prescriptive national policy guidance and the BCF had only cemented what was already being done. She noted that Kent was appointed an integration pioneer by the Department of Health in 2013 which had enabled health and social care services to work together and build positive relationships in advance on the BCF.

(2) A Member asked about seven day services and workforce. Ms Carpenter stated that there were local discussions were taking place to look at what services needed to be seven days a week to enable appropriate access. She noted that workforce in Kent was a critical issue and the Kent Health and Wellbeing Board had established a Task & Finish group to explore this issue and would be reporting their findings to the Board's next meeting in May.

(3) A Member enquired about the design of integrated service. Ms Carpenter reported that in Kent the ambition was to design integrated patient focused services beyond the legal mechanism of the BCF. She stated that NHS South Kent Coast CCG was looking to bring together the entire health and social care budget to create an integrated care organisation; a compact agreement on the integration of health and social care had been developed and adopted by all partner organisations. She highlighted a benefit of integration, the BCF and Prime Minister Challenge Fund funding had reduced A&E admissions in NHS South Kent Coast CCG.

(4) In response to a specific question about the public health datasets, Ms Carpenter explained that the dataset was a technical device to pull together public health, social care and health data and had been commended nationally. She stated that GPs were able to use the data at a local level to see how their patients accessed health and social care services and put in place a more individual care plan to better support them and provide value for money.

(5) RESOLVED that:

(a) the report on the Better Care Fund be noted;

(b) the Kent Accountable Officers be requested to present an update on integration including the development of an integrated care organisation in NHS South Kent Coast CCG to the Committee in September.

(c) Mr Scott-Clark be requested to provide a briefing to the Committee on public health datasets and how they help to support health and social care commissioning.

24. King's College Hospital NHS Foundation Trust: Outpatient Services at Sevenoaks Hospital
(Item 6)

Gail Arnold (Chief Operating Officer, NHS West Kent CCG), Professor Julia Wendon (Executive Medical Director, King's College Hospital NHS Foundation Trust) and Sue Field (Head of Capacity Planning and Service Development, King's College Hospital NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. A Member enquired about the future of services at Sevenoaks Hospital and the provision of a walk-in centre.

(2) Ms Arnold explained that in October 2013 King's College Hospital NHS Foundation Trust acquired a number of sites and services, including outpatient services at Sevenoaks Hospital, following the dissolution of South London Healthcare NHS Trust. She reported that a review of services at Sevenoaks Hospital was undertaken by the Trust and found that their clinics on the site were underutilised; following the review the Trust decided to withdraw services from the Sevenoaks site and continue to provide them at Orpington Hospital and Princess Royal University Hospital. She stated that Maidstone and Tunbridge Wells NHS Trust also ran outpatient clinics at Sevenoaks Hospitals and had agreed to take over all of the outpatient clinics from King's College Hospital NHS Foundation Trust with the exception of dermatology. Ms Arnold noted that dermatology was currently provided by Medway NHS Foundation Trust at Borough Green; procurement for this service was being undertaken. She highlighted that patients could choose to transfer to Maidstone and Tunbridge Wells NHS Trust for their outpatient services at Sevenoaks Hospital or continue to attend clinics provided by King's College Hospital NHS Foundation Trust at Orpington Hospital and Princess Royal University Hospital.

(3) Ms Arnold explained that NHS West Kent CCG had appointed a project manager to review primary and community care in Sevenoaks. She noted that the CCG was having initial discussions with GPs about the creation of a hub at Sevenoaks Hospital to utilise the good facilities available at the accessible site; attract medical staff which had previously been a problem in Sevenoaks; and expand general practice as a number of Sevenoaks surgeries had no space to expand.

(4) The Chairman invited the local Member for Sevenoaks Central for Margaret Crabtree to speak. Mrs Crabtree enquired about the progress of discussions with Maidstone and Tunbridge Wells NHS Trust and requested a breakdown of postcodes for patients who used King's College Hospital NHS Foundation Trust clinics at Sevenoaks Hospital. Ms Arnold confirmed that Maidstone and Tunbridge Wells NHS Trust had agreed to take over all general outpatients clinics from King's College Hospital NHS Foundation Trust with the exception

of dermatology. Ms Field undertook to provide postcode data on patients who used King's College Hospital NHS Foundation Trust clinics at Sevenoaks Hospital. She confirmed that 80% of patients who used the Trust's clinics at Sevenoaks Hospital were from NHS West Kent CCG.

(5) RESOLVED 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 in September.

25. Kent and Medway NHS and Social Care Partnership Trust (Written Briefing)
(Item 7)

(1) The Committee received a report from Kent and Medway NHS and Social Care Partnership Trust which provided an update on the Trust's CQC Quality Improvement Plan, quality assurance visits in North Kent and out-of-county placements.

(2) The Scrutiny Research Officer advised the Committee that a new Chief Executive had been appointed and would be starting in June. She suggested that the Agenda recommendation be changed from June to September in order to invite the new Chief Executive and ask her to reflect on her first three months with the Trust.

(3) Members requested that the Trust be asked to provide information about out-of-county placements and their work with the community and voluntary sector as part of their update in September.

(4) RESOLVED that that the Kent and Medway NHS and Social Care Partnership Trust report be noted and Helen Greatorex, Chief Executive designate, be invited to present a general update to the Committee in September including infomation about out-of-county placements and the Trust's work with the community and voluntary sector.

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

(1) The Committee received a report from the Kent CCGs and Kent County Council which provided information about the Five Year Forward View for Mental Health published in February 2016 and its implications for Kent.

(2) RESOLVED that the written briefing on the Five Year Forward View for Mental Health and the implications for Kent be noted and the Kent CCGs be requested to provide an update at the appropriate time.

Item 4: Review of winter preparedness in Kent 2015/16

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 June 2016

Subject: Review of winter preparedness and BMA Industrial Action in Kent 2015/16

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

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

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1. Introduction

(a) On 27 November 2015 the Committee considered the actions being taken across the health and social care system in Kent to prepare for winter 2015/16. The Committee agreed the following recommendation:

- *RESOLVED that the report be noted and NHS England be requested to provide an update about the performance of the winter plans to the Committee at its April meeting*

(b) On 10 March 2016 the Chairman agreed to a request from NHS England to postpone the item until the June meeting to enable the review to cover the whole of winter including the Easter period.

(c) NHS England – South (South East) has asked for the attached reports to be presented to the Committee:

Winter Preparedness	pages 13 -16
BMA Industrial Action	pages 17 -22

2. Recommendation

RECOMMENED that the report be noted and NHS England be requested to provide an overview of the 2016/17 winter plans to the Committee at its October meeting.

Background Documents

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (27/11/2015)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=36182

Contact Details

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Briefing on the NHS response to winter in Kent 2015/16

To: **Kent HOSC**

From: **Pennie Ford, Director of Assurance and Delivery, NHS England South (South East)**

Author: **Matthew Drinkwater, Head of EPRR,**

Date: **23 May 2016**

1.0 Purpose

This report provides a briefing to the Kent Health Overview and Scrutiny Committee (HOSC), which describes the actions that were taken across the health and social care system to manage winter pressures.

2.0 Background

Historically, the effects of winter have been shown to place additional pressures on health and social care services across Kent. This is caused by a number of issues including an increase in respiratory illness, increased slips and falls and the impact of seasonal influenza.

The key vehicle for winter Response activities are the Systems Resilience Groups (SRGs) that were established in 2014. Kent has four SRGs covering the North, East, West and Medway and Swale. Kent County Council is a core member of each of these groups and is represented on them by an Executive Director.

A report on the winter preparedness activities was provided to the Kent HOSC in May 2015.

3.0 Winter Pressures

Whilst the health and social care system in Kent experienced the predicted winter pressures – and all of the Kent SRGs moved to Red escalation at some point over the winter reporting period - none of the systems moved into whole system Black escalation. This meant that NHS England was not required to support the activities of the SRGs who were able to manage the system pressures using their own local

Surge and Capacity Management Plans. A review of the escalation reporting suggests that pressures were greatest in the months of February and March.

As with winter 2013-14 there has been no quick recovery from winter pressures in Kent. This is reflected across the South East and England.

4.0 Junior doctor Industrial Action

The preparedness and response for the Junior Doctors Industrial Action involved additional planning and response activities, which are covered in an accompanying report.

5.0 System Resilience Groups Response

Each of the Kent SRGs and the health and social care organisations of which they comprise implemented their Surge Management and Capacity Plans to manage the additional winter activity.

The SRGs, led by the Clinical Commissioning Groups, ran daily teleconferences with SRG member organisations to keep oversight of system pressures. These calls ensured that each organisation were implementing the pre-agreed actions in their plans. These actions ensured that each organisation supported one another to ensure good patient flow across the different parts of the health and social care systems.

6.0 NHS England's Winter Resilience Room

NHS England South (South East) operated a winter resilience room in Tonbridge Kent from 17 December 2015 to 31 March 2016. This room operated between 09:00 – 17:00hrs and was supported by NHS England's on call staff during out-of-hours and weekend/bank holiday periods.

The Winter Resilience Room monitored pressures being experienced across the South East including Kent and allowed NHS England to act to support SRGs as required, when they moved to Red or Black escalation.

The Room provided enhanced information flows between regional and local level and acted as a focal point for winter briefings, escalation discussions and communications through the winter.

It enabled NHS England to collate and analyse up to date information from SRGs. This was used to prepare daily reports which were sent to the South Region's Winter Resilience Room in Reading. This in turn was sent onto the National Winter Resilience Room in London, where the information was used to provided briefings to the Secretary of State for Health.

Situation reports were also sent to SRGs to help them understand the pressures being experienced by neighbouring SRGs.

7.0 Winter Communications

Kent's SRGs implemented their winter communications plans that supported the nationally led 'Stay Well This Winter' campaign, which was a joint initiative between NHS England and Public Health England. http://www.nhs.uk/staywell/ .

8.0 South East Winter debrief

NHS England South (South East) held a winter debrief on 3 May 2016. Each of the SRGs provided a summary presentation of what went well, what has been learned and what they would like to see improved when the plans are refreshed.

Some key themes that emerged from the debrief were:
What went well?

- Early planning and testing of plans via exercise was valuable.
- The communications campaigns worked well.
- Member of SRGs worked well together to support each other.
- The "SAFER bundle" being applied in hospitals works and should be continued. (This is a systematic approach to discharge best practice)

What has been learned?

- A lack of availability of domiciliary care staff impacting on capacity for care packages at home.

- The nationally confirmed GP indemnity arrangements for out of hours activity worked, but needs to be repeated next year.
- Winter spikes in activity will always happen, but not necessarily at the same point each year and need to be prepared for flexibly.

What can we improve?

- A need to continue the work to unify the escalation criteria and actions taken when they are reached across all organisations.
- To see if we can streamline the national reporting requirements
- Continued work across systems to minimise delayed transfers of care and to streamline both complex and more simple discharges.

9.0 Summary

- In common with the South East and England as a whole the health and social care system in Kent experienced winter pressures: an increased number of patients with higher acuity.
- The Kent SRGs, of which KCC is an integral part, implemented their Surge Management and Capacity Plans which had been tested via exercise ahead of winter.
- These plans worked to manage system pressures locally as evidenced by the fact that no SRGs in Kent moved to Black escalation.
- There were periods over winter where Kent SRGs moved to Red escalation, but the use of their pre-agreed arrangements meant that they were able flex capacity to manage the pressures and de-escalate the system to Amber quickly.
- NHS England monitored pressures across Kent via a South East Winter Resilience Room, but was not required to intervene to support the SRGs in Kent.
- A debrief of winter has been conducted. This has identified good practice, which has been shared and items to be learned that will be included in the update of plans. It identified some key areas where future work is required.
- As with winter 2013-14 there has been no quick recovery from winter pressures in Kent. This is reflected across the South East and England.

Briefing on the actions of NHS England South (South East) and the NHS in South East England in response to the British Medical Association's industrial action over the winter of 2015/16

To: **Kent HOSC**

From: **Pennie Ford, Director of Assurance and Delivery, NHS England South (South East)**

Author: **Hazel Gleed, Head of EPRR, NHS England South (South East)**

Date: **23 May 2016**

Purpose of this Paper

1. The purpose of this paper is to:
   - Summarise the background to the industrial action by the British Medical Association (BMA)
   - Summarise the actions which were taken by NHS England to secure pre-action assurance from the NHS in the South East of England
   - Set out how NHS England South (South East) and NHS providers and commissioners in the South East supported and monitored the impact of industrial action on the NHS in the South East during the planned direct industrial action
2. This is a relatively fast moving issue and some detail may have change post circulation of this paper.

Introduction

3. There are 53,000 Junior doctors employed in England. Juniors' are defined as doctors and dentists in approved postgraduate medical and dental training programmes in the UK. This includes:
   - those in GP training
   - approved less than full time training programmes
   - academic doctors in training
   - public health doctors in training where they have an NHS employment contract.
4. In 2012 the Government asked the British Medical Association (BMA) to look into negotiating a new contract for junior doctors. After 2 years of negotiations, the BMA withdrew from the table because they did not feel that the contract on offer provided sufficient safeguards for junior doctors and their patients.
5. The Government asked the Doctors' and Dentists' Remuneration Board (DDRB) an independent body to undertake a review and provide recommendations for a new contract. After the recommendations were released the Government asked the BMA to re-enter negotiations with the recommendations of the DDRB review as the basis of the talks. The BMA did not agree to that and the Government stated they would impose a new contract from August 2016. On 26th November 2015 it was confirmed that both parties would utilise the services of ACAS

(Advisory, Conciliation and Arbitration Service) to try to reach a resolution to the dispute.

6. The BMA balloted eligible members from 5th November – 18th November 2015. On a turnout of 76% the BMA voted, 99% voted for action short of a strike and 98% voted to take part in strike action.
7. Industrial action was planned for three dates in December 2015, on 1st, 8th and 16th, but was suspended the night before it was due to take place so that negotiations could commence between Junior Doctors representatives and the Government.
8. On 4th January 2016, the BMA announced 3 further strike dates; 12th – 13th January, 26th – 28th January and a full withdrawal of labour on February 10th 2016.
9. Following 24 hours of direct industrial action with emergency cover provided from 12th – 13th January 2016, the BMA suspended the direct industrial action which had been planned for 48 hours from 26th – 28th January 2016. The BMA took further direct industrial action, again providing emergency cover only from 0800hrs on Wednesday 10th February to 0800hrs on Thursday 11th February 2016.
10. On 23rd February 2016, the BMA informed the NHS in England and the Government that it intended to launch a judicial review to seek to overturn the decision to impose the new contract. The BMA also announced three further strike dates; a further 48 hours from 8am on Wednesday 9 March to 8am on Friday 11 March, a second 48 hours from 0800hrs on Wednesday 6 April to 0800hrs on Friday 08 April 2016 and a third 48 hours from 0800hrs on Tuesday 26th April to Thursday 28th April 2016.
11. On 23rd March 2016 the BMA announced that it was escalating its proposed industrial action and a full walkout, including emergency cover, would take place between 0800hrs and 1700hrs on Tuesday 26th April and 0800hrs and 1700rs on Wednesday 27th April 2016. NHS England described the proposed action as “a very significant change from previous periods of action”.
12. Talks between the Government and the BMA resumed on Monday 9th May 2016, and were extended on Friday 13th May 2016 until Wednesday 18th May 2016. On 18th May it was confirmed that the Government negotiators and the British Medical Association leadership have reached an agreement and the offer will now be put to a referendum of BMA members.

Actions taken by NHS England to secure pre-action assurance from the NHS in South East England

13. In response to the planned industrial action NHS England liaised with the NHS in England requesting pre-action assurance templates ahead of each round of planned industrial action from acute, community and mental healthcare providers. This was in line with our duties under the Health and Social Care Act 2012 which states that NHS England and clinical commissioning groups must take appropriate steps for securing that the NHS is properly prepared for dealing with a relevant emergency.

14. Pre-action assurance focused on ensuring that healthcare providers could continue to deliver emergency patient care safely and sought to establish the staffing baseline that are eligible to take industrial action.

15. Ambulance service providers were not asked for a return for the initial periods of action. However, South East Coast Ambulance Service NHS Foundation Trust (SECAMB) also put in place specific plans for the period of direct industrial action. SECAMB also wrote to Acute Trust Chief Operating Officers / Directors of Operations and Chief Officers Clinical Commissioning Groups to ensure they are aware of SECAMB's plans and asked commissioners to work with primary care to ensure that any Health Care Professional (HCP) referrals made during the periods of direct industrial action are visited and reviewed rather than assessed over the phone.

16. For the most recent round of planned industrial action which included a full withdrawal of labour, including emergency care, NHS England wrote to the NHS in England requesting pre-action assurance templates from acute, community and mental healthcare providers, which focused on, but were not limited to:
    - Emergency Departments
    - Acute medicine (including Percutaneous coronary intervention (PCI) for ST-segment elevation myocardial infarction (STEMI) and acute stroke)
    - Acute paediatrics and neonatology
    - Intensive care
    - Maternity Services
    - Emergency surgery, all specialties (adult and paediatrics)
    - Trauma
    - Mental health – crisis intervention teams
    - Resuscitation teams

17. This was further supplemented by a whole local healthcare system review of the plans in place through the System Resilience Groups (SRG), focusing on the continued and safe level of urgent and emergency healthcare provision for patients. This covered all parts of the healthcare system which work to deliver patient care including ambulance services, primary care, social care, 111, acute, mental health and community care providers, CCGs and NHS England as well as working with social care partners and planning for the time before and time after the period of industrial action.

18. Ambulance service providers were also asked for a return and South East Coast Ambulance Service NHS Foundation Trust (SECAMB) revised its planning assumptions in light of the escalation of the action to include a full withdrawal of emergency cover.

19. Primary care services were not asked for a return. The NHS England Head of Primary Care Commissioning stated at the outset of this period of industrial action that there are a number of features that mean primary care is less impacted to the effects of strike action by trainee doctors than other healthcare providers. Whilst noting that there could be implications on primary care arising through reduced capacity in secondary care services:

    - GP registrars (GPR) are employed by the practice (though funded through HEE) and they are required to be supernumerary which means that although

they contribute to service delivery, they are not critical to service delivery in the same way as junior doctors in hospital settings.

- GP registrars cannot be left to work unaccompanied. Therefore in the event of a GPR taking direct industrial action, there will be clinical cover in place through the senior GPs covering the GPR.
- Primary care can prove adaptable, with adaptions to how surgeries run, therefore if a GPR was taking strike action, other clinical staff can adapt the structure of the surgery, for example to give more surgery slots to 'same day' appointments rather than 'pre-booked' appointments, so the surgery has capacity to absorb additional requests for appointments. In addition the numbers in each practice are very low (one or two) and therefore the surgery can adapt to manage as they would do to cover annual leave for example, or when the GPR is in their induction phase.

20. Specific assurances were sought ahead of each period of planned industrial action that in the event of a Major Incident being declared, there were processes in place to ensure that Junior Doctors return to work to support the emergency response. Processes have been put in place to support this, agreed nationally between the BMA and NHS England
21. National and local communications have been key in informing local populations about the industrial action on each occasion and helping them to access the healthcare that they need during the periods of industrial action.
22. NHS England South (South East) has been in regular contact with our regional colleagues to keep abreast of the latest developments and planning of the national team who are working closely with the Department of Health to support the Cabinet Office Briefing Room (COBR) meetings which have been taking place in preparedness for this direct industrial action.
23. NHS England South (South East) has also worked with all Clinical Commissioning Groups and NHS ambulance, acute, community and mental health providers across the South East to help ensure that collectively the NHS is as prepared as it can possibly be and to identify any particular areas of concern or greater risk.

How NHS England South (South East) and NHS providers and commissioners in the South East supported and monitored the impact of industrial action on the NHS in the South East

Command and Control

24. For each period of industrial action NHS England South (South East**)** set-up and ran one Incident Control Centre (ICC) to cover the South East. The ICC was open during the hours of industrial action during the day and reverted to usual on-call arrangements out of hours.
25. South East Coast Ambulance Service NHS Foundation Trust also put in place some additional command and control arrangements, co-located with their Emergency Control Centre (EOC) for each period of direct industrial action.

26. All provider organisations (acute, community and mental health) and clinical commissioning groups had some level of command and control arrangements in place for each period of direct industrial action.

Reporting

27. During each period of industrial action a number of returns were collected from acute, community and mental health providers. These were done via the NHS England national reporting system, Unify2.
28. Additional reporting was also conducting on occasions by NHS Improvement with specified trusts as and when it was felt necessary.

Impact

29. The hard work and planning ahead of each period of planned industrial action has enabled healthcare providers and commissioners across the South East to maintain patient safety throughout. Consultants and senior clinical decision-makers have supported services in the absence of Junior Doctors on each occasion and worked to maintain patient services in a planned way.
30. Many thousands of patients nationally have had their operations and/or outpatient appointments postponed. Each trust is managing the impact of these postponements to the best of their ability and re-booking these appointments at the earliest opportunity.

Next steps

31. The BMA still have a mandate to take industrial action. They are required to provide a minimum of 7 days' notice to take further industrial action.
32. We are also aware that the GMB is currently consulting with staff to gauge the appetite to balloting ambulance staff for industrial action and that Unison are proposing to ballot their ambulance staff members, too. NHS England South (South East) is maintaining watching brief on these.

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Item 5: Darent Valley Hospital: MRSA

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 June 2016

Subject: Darent Valley Hospital: MRSA

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

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

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1. Introduction

(a) Following a discussion at the conclusion of HOSC on 8 April 2016, the information for this item has been requested from Dartford and Gravesham NHS Trust and NHS Dartford, Gravesham and Swanley CCG.

(b) The following reports are attached for Members' information:

2. Recommendation

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

Background Documents

None

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Executive Summary

In 2015/16 there were 14 MRSA bacteraemias at Dartford & Gravesham NHS Trust, 9 of which happened between 20 December 2015 and 25 February 2016. An external team of Infection Control Nurses visited the Trust and wrote a critical report with a number of recommendations.

Key Actions

The trust has changed its infection prevention and control team and has worked with outside agencies (TDA/NHSI and PHE) on infection prevention processes.

The Trust is part of the TDA/NHSI 90 day improvement workshop.

On 13 May 2016, NHS E, NHS I, the CQC, Public Health England, CCG and Healthwatch visited the Trust and found that the trust had appropriate plans and governance in place to turn the MRSA issues around. They were assured that the data confirmed that the incidence of infection was responding to the range of measures in place .

The trust has not had another MRSA bacteraemia since 25th February 2016.

Other reportable infections, such as Clostridium difficile, MSSA and E Coli all were within the limit / regional incidence.

New Infection Prevention & Control Team

The previous infection control team all left during March 2016. A new interim IPC team, three experienced infection control nurses, have all started and made an immediate impact. New permanent staff have been appointed, the lead taking up her role on 31 May 2016. The interim IPC nurses' experience from other places offers an excellent 'fresh eyes' approach and several issues have been highlighted.

The areas of focused attention are around

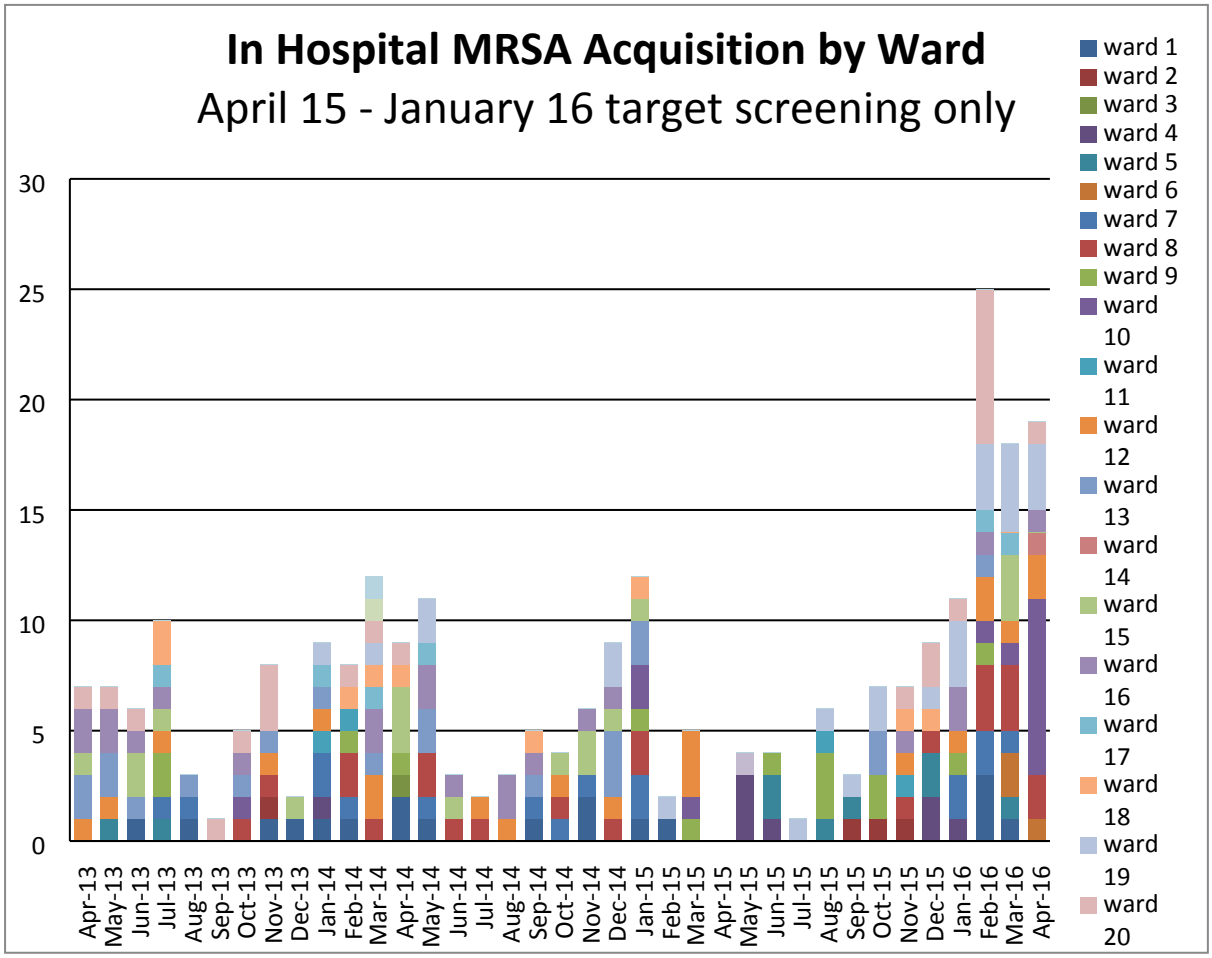
- MRSA screening and MRSA acquisition (acquisition is when MRSA colonises the skin in a previously MRSA negative person without causing infection). Since universal screening has started again on 25 January 2016, the Trust has had a higher number of MRSA acquisitions than before, however this number is gradually decreasing.
- Aseptic non-touch technique (ANTT) to improve any invasive devices insertion and care
- Cleaning – work is being done with our contractors Carillion to enhance the process
- Mattresses – to improve the checking management process for mattresses.

Task force

The Task force meets 2 weekly and after agreeing the ANTT policy, is now working through the action plan developed after the TDA visit in March. It is a very detailed action plan, developed with the support of TDA's infection control lead. It is a live document and is regularly presented to the Trust's Infection Control Committee and the Trust's Quality and Safety Committee.

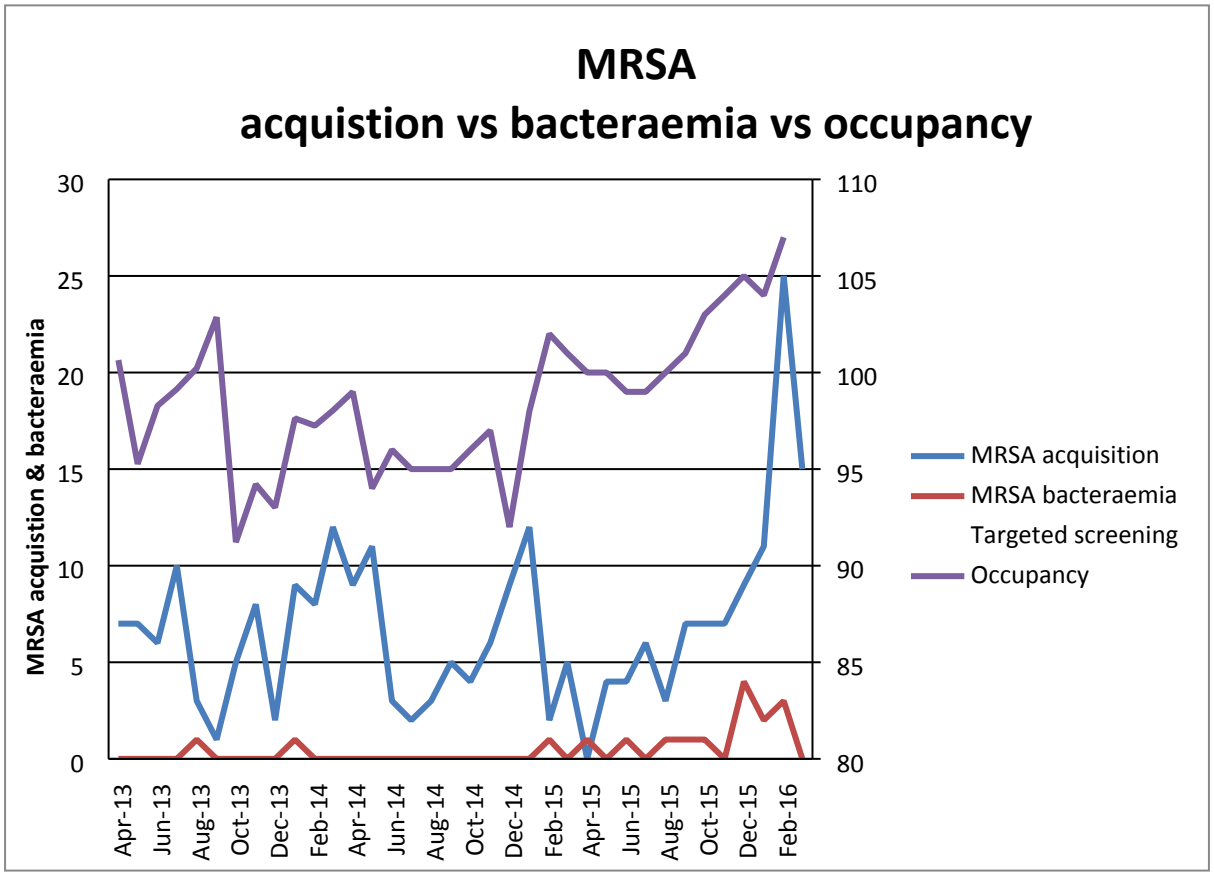
MRSA Acquisition

MRSA acquisition was chosen as the improvement target for the TDA 90 day improvement workshop. Acquisitions were reviewed over the last 3 years and each new acquisition is now investigated. PHE helps by providing an epidemiological toolkit to understand these acquisitions better.



Infection rates - occupancy

It is well known that occupancy rates and infection rates are linked and that infection rates rise with an occupancy over 85%. The Trust has had occupancy rates well in excess of 85% for the last 3 years. Since April 2013 the trust was below 95% occupancy in only 5 months and almost consistently above a 100% since April 2015, with a peak of 107% in February 2016.



Targeted screening was introduced following PHE advice; in Janaury 2016 the Trust reverted back to universal screening/

Infection Control Committee

While the MRSA issues are being actively addressed, the ICC will be held monthly instead of quarterly. A Non Executive Director is in attendance to give further assurance to the Board that the issues are addressed properly and in a timely manner.

As always, the ICC is open to commissioners and PHE representation.

Other workstreams

There are weekly IPC team meetings attended by the Medical Director, the IPC nurses, the antimicrobial pharmacists and the microbiologists.

There are daily MRSA huddles at 8.30 every morning to coordinate the work from day to day and hold all the various work streams together.

CCG Recovery Action Plan

In February the Trust agreed a recovery action plan with the CCG and this was completed and submitted. The CCG Performance and Quality Committee on 3 May 2016 agreed that the Action Plan had been completed satisfactorily.

90 day TDA improvement work

The TDA/NHSI set up a 90 day improvement process for several trusts who had breached their infection limits, mainly C difficile. The Trust attended the first TDA improvement workshop in Manchester and the Trust's presentation on improving antimicrobial stewardship was well received. The improvement task for the Trust is to reduce MRSA acquisition.

The second meeting in London probed the improvement plans submitted, a further meeting will be held on 8 July.

CQC visit

The CQC announced a visit and came to DVH on 15 April 2016. It was not an 'inspection', but they visited wards. The verbal feedback was positive, saying that they clearly saw that we were tackling the issues. They desisted from an enforcement notice as they were satisfied that appropriate actions were being taken.

Quality Surveillance Group 13 May 2016

NHS E, NHS I, the CQC, PHE, CCG and Healthwatch visited the Trust and found that the trust had appropriate plans and governance in place to address the MRSA issues.

It was agreed that the TDA/NHSI infection control lead would take the lead in feedback for all regulators to avoid double or triple reporting of the same items.

Further assistance

Beyond the assistance already received, the Trust has requested help in reducing occupancy levels. In particular, we have asked for help in reducing the number of patients delayed in hospital and we have requested financial flexibility to redevelop some of our floor plans to increase clinical capacity.

In summary

During 9 weeks December 2015 to February 2016 there were 9 MRSA bacteraemias; the trust has taken this very seriously and has put multiple processes in place to improve the handling of infection prevention and control at the trust.

A meeting with all regulators on 13 May recognised this work and decided that the trust has the process and governance in place to deal with the issue in an appropriate way.

Annette Schreiner, May 2016
Dartford and Gravesham NHS Trust the TDA/NHSI infection control

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NHS
Dartford Gravesham and Swanley
Clinical Commissioning Group

Response from NHS Dartford, Gravesham & Swanley (DGS) CCG to the

MRSA incidence at Dartford & Gravesham NHS Trust

20th May 2016

The aim of this report is to provide the Kent Health Overview and Scrutiny Committee (HOSC) with information relating to the incidence of Meticillin Resistant Staphylococcus aureus bacteraemias (MRSA (b)) and MRSA colonisations at Darent Valley Hospital (DVH) which is part of Dartford & Gravesham NHS Trust (DGT) and the response from DGS CCG.

This report is to give the Kent HOSC assurance of actions being taken to reduce the incidence and improve the patient safety and performance.

Incidence of MRSA bacteraemia (MRSA(b))

The Trust has reported 14 MRSA (b) cases between 1 April 2015 and 31 March 2016. The rate of MRSA (b) is 7.57/100,000 occupied bed days and meant that the Trust has the highest rate and number of MRSA (b) cases for all Trusts in England who submit data to the Public Health England (PHE) surveillance system.

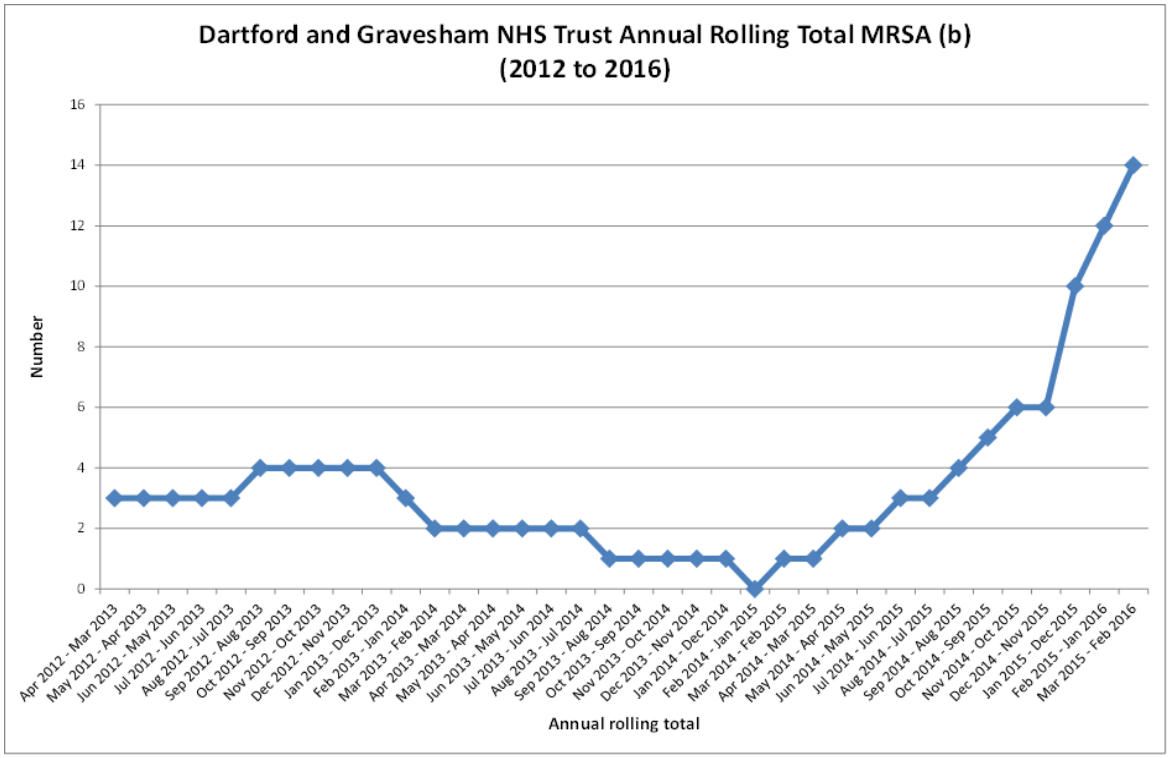

Fig.1

It can be seen in figure 1 above that the Trust has had the worst year of performance since April 2012 (*source: TDA draft report following visit 8th March, presented at DGT Trust Board 31st March 2016*).

History of Infection Prevention Concerns with the Trust – March 2015

Concern was raised with the Trust in March 2015 regarding their infection prevention processes and systems following outbreaks of C. difficile on Spruce ward the previous year and a peak of cases in the December of 2014. This prompted the CCG to undertake a table top external review of infection prevention systems and processes in May 2015. A summary of the Key recommendations from this visit and update on progress are as follows:

- The amount of time from microbiologists that was available for infection control was not in accordance with the recommendations of the Royal College of Pathologists. ***NEW ADDITIONAL CONSULTANT MICROBIOLOGIST RECRUITED – AWAIT START DATE***
- Be clear who is responsible for blood culture technique training and ensure this is included as part of junior doctor induction. ***CARRIED FORWARD TO CURRENT PLAN***
- Antibiotic defined daily dose (DDD) data to be reported at ward/department level as a this will then help the Trust to focus on the key areas for improvement. ***COMPLETED***
- Develop and implement an Antimicrobial prescribing policy as this document is how the Trust outlines how they will measure compliance and it identifies everyone's key role in compliance with the policy. ***COMPLETED***
- The agenda for the Infection Prevention and Control Committee (IPCC) needs to include feedback of hand hygiene and saving lives audits. This could be included as part of the reporting template from the directorates.
  CARRIED FORWARD TO CURRENT PLAN
- The RCA process does not include a timeline of events leading up to the incident. This can greatly help with the understanding of an incident and the investigation processes. ***CARRIED FORWARD TO CURRENT PLAN***
- Themes and trends identified from the RCA process to be included in the monthly Director of Infection Prevention and Control report in order to give some context and narrative to the data graphs that are reported. ***CARRIED FORWARD TO CURRENT PLAN***
- Hand hygiene audit results do not break down the stages of the 5 moments of hand hygiene in order to then enable the Trust to have focused actions on the worst elements which are pulling the aggregated scores down. In doing this, it will help to focus on the key elements to target and give the evidence as to why they are being targeted. ***CARRIED FORWARD TO CURRENT PLAN***
- All Infection Prevention and Control policies need to be up to date and current in order to be compliant with the Code of practice on the prevention and control of infections and related guidance 2015. ***CARRIED FORWARD TO CURRENT PLAN***
- There is no National recommendation to have a Non-Executive Director on the Trust IPCC but this may be something you wish to consider ***COMPLETED***

It can be noted that a number of the recommended actions are carried forward to the current improvement plan. Throughout 2015 the Trust struggled with a consistent infection prevention team due to periods of sick leave and accrued annual leave. Progress with the action plan was monitored through the North Kent CCGs Healthcare Associated Infection Assurance (HCAI) panel and attendance from the Trust at these meetings was variable throughout 2015.

CCG Contract Performance Notice – January 2016

In January, the CCG issued the Trust a Contract Performance Notice indicating that we would be putting them under a Remedial Action Plan (RAP) using contractual levers with regards to their MRSA performance. This was considered in November but not implemented as the Trust at this time had gone two months without reporting any new cases and it was felt the improvement plan may be starting to reap improvements. The Trust then experienced 4 cases in December, hence the implementation of the RAP.

At this time, the Trust indicated that the current matron for infection prevention was to be retiring in March 2016. This was further compounded by the remaining 2 members of the infection prevention nursing team leaving the Trust within the same week in March (1 left after a period of prolonged sick leave; the other left for family reasons).

It was agreed at the Quality Assurance meeting with the Trust 3rd May that they had completed the actions required in the RAP and it was agreed that the RAP could be closed.

There is currently an interim infection prevention team in place comprising a senior nurse on secondment from Eastbourne NHS trust, an interim infection prevention specialist nurse employed on private contract and an infection prevention nurse seconded from DGS CCG quality & safety team for a 3-6 month period. The substantive lead nurse commences 31st May and will recruit to a new team once in post.

Re-instating of All Admission MRSA Screening

In January 2013, the DoH published a report 'The National One Week Prevalence Audit of MRSA Screening' and part of the aims of this study was to assess the cost effectiveness of the all admission screening protocols that had been implemented in Trusts, as opposed to targeted screening of high risk patients. The Trust changed the MRSA screening policy to screen high risk patients on admission but to reduce the all admission screening.

As a result of the rise in incidence in MRSA (b) cases, the Trust reinstated all admission screening from 25th January 2016.

This has meant there have been a large number of MRSA colonised patients identified due to the length of time with the absence of screening. There have also been clusters of MRSA identified on a number of wards and the Trust are holding fortnightly meetings to manage these clusters.

All have been reported as Serious Incidents (SIs) and are being investigated accordingly and will be presented to the North Kent CCGs SI closure group to gain assurance of the implementation of any learning identified as a result.

Trust Development Authority (TDA) Visit – March 2016

The rise in cases of MRSA(b) prompted a visit from the NHS Improvement (NHSI) (formerly the Trust Development Authority (TDA) and an external team visited 8th March.

The aim of the visit was to test the Trust's assurance and to support the Trust to make improvements regarding patient safety and arrest the current upward trend in MRSA (b) cases.

An improvement plan has been developed, incorporating the findings and recommendations from the NHSI visit. NHSI are the co-ordinating organisation for monitoring progress against the improvement plan with regular updates shared with both the CCG and the CQC.

Support offered to the Trust from the CCG to date:

A band 7 infection prevention specialist nurse working within the Quality & safety team I the CCG has been seconded to the Trust on a 0.5 whole time equivalent for 3-6 months to help stabilise the infection prevention team and bring consistency and continuity.

DGS CCG Governing Body Lay Member for public and patient engagement and the Governing Body Independent Nurse both visited the Trust in February to learn and offer support and guidance and plans are being made for them to revisit imminently.

There are weekly update calls in place between the Trust, NHSI and the CCG which also offer support and guidance.

Next Steps and ongoing actions:

Monthly verbal updates on progress against the improvement plan to the North Kent HCAI Assurance panel meetings

The CCG will also gain verbal progress against the plan at the bi-monthly quality assurance meetings held with the Trust.

A re-visit has been arranged for the end of June and the CCG will be represented on this. This will be jointly with NHSI and the CQC.

The infection prevention specialist nurse seconded from DGS CCG will remain in post until the substantive team has been recruited and for a period of hand-over.

Weekly telephone updates and progress reports between the CCG, NHSI and the Trust will continue to have an update of the situation and key actions implemented.

Item 6: North and West Kent Neurorehabilitation Service

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 June 2016

Subject: North and West Kent Neurorehabilitation Service

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

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

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1. Introduction

(a) On 27 November 2015 the Committee considered the new service model for specialised neuro rehabilitation services in North and West Kent. The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the Committee does not deem the new service model for specialised neuro rehabilitation in North Kent, West Kent CCG and Medway CCG to be a substantial variation of service.

  (b) NHS Dartford, Gravesham and Swanley CCG and NHS West Kent CCG be invited to submit a progress report on implementation and a flowchart detailing the patient pathway to the Committee at its March meeting.

  (c) NHS Dartford, Gravesham and Swanley CCG and NHS West Kent CCG be requested to consult the Committee about their longer term plans for the neurorehabilitation provision and work with Healthwatch Kent as part of their engagement plan.

(b) On 2 February the Chairman agreed to a request from NHS West Kent CCG to postpone the item until the June meeting.

2. Recommendation

RECOMMENDED that the report be noted and NHS Dartford, Gravesham and Swanley CCG and NHS West Kent CCG be requested to present an update at the appropriate time.

Background Documents

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (27/11/2015)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=36183

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NHS
West Kent
Clinical Commissioning Group

West and North Kent Neuro rehab service update

Health Overview and Scrutiny Committee

June 2016

Patient focused,
providing quality,
improving outcomes

Update to West and North Kent Neuro Rehab service

Summary

This report is to provide the Kent Health Overview and Scrutiny Committee (HOSC) with a progress update of the West Kent and North Kent neuro rehabilitation service as of 24 December 2015.

Recommendations

The committee is asked to:

Note the report and comment

Background

- Patients in West Kent, Dartford, Gravesham and Swanley (DGS) and Medway who require a neurological intervention in a rehabilitative environment have been principally served by the West Kent Neuro Rehab Unit (WKNRU) at the Knole Centre in Sevenoaks, which was managed by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

- WKNRU was an eight bedded unit and in 2014-2015, 29 patients from across West Kent, DGS and Medway accessed the service.

- KMPT issued formal notice on their contract on 2 April 2015 stating that they would no longer be providing the service from 31 March 2016. KMPT advised that it was not sustainable for them to continue to provide the service due to issues involving service quality, safety and cost.

- KMPT brought to the CCG's attention concerns about safe staffing over Christmas. As the CCG's plans were well advanced, it was agreed with KMPT that the unit would close on 24 December 2015.

- This meant that KMPT would not accept any new referrals where a patient was not guaranteed discharge home before 24 December 2015, as this would be deemed clinically unsafe.

- Since the announcement, the CCGs worked alongside KMPT to develop a new, community based care model.

- The new model was implemented in December 2015.

The new model

It is the view of the commissioners that the best solution for these patients, who have very specialist needs, is a focus on recovery for independent living in the community with the potential for many patients to receive treatment closer to home, depending on need.

The new model of care has been implemented based on bespoke neuro-rehabilitation treatments with local, private and NHS providers in either the community or acute settings as appropriate. The CCGs are purchasing these packages of care from community providers on a cost per case basis that will be invoiced as non-contract activity (NCA).

This new model is a more tailor made approach which takes into account the specific needs of individual patients, which will have a more positive impact on families and carers. It also offers the potential of enabling increased access to specialists in neurological conditions when appropriate, and offering safe and high quality provision for people across the spectrum of severity.

Commissioners have approached community providers to ensure that there is capacity and appropriate availability, as well as gaining assurance advice from NHS quality colleagues to ensure that these services within Kent are sufficient in terms of service delivery, safety and quality.

Benefits to patients

- A focus on recovery through independent or supported living in the community
- Individuals can receive care closer to home and be nearer to their carers and families, depending on need.
- Patients are at the heart of the process through integrated partnerships that work across community, private and NHS providers and have a coordinated and planned approach to managing referrals more effectively.
- Clinically informed decisions are agreed based on patient need, safety, high quality, accessible and appropriateness of care.
- Patients have increased access to specialists of neurological conditions when appropriate, and offering safe and high quality provision for people across the spectrum

of severity.

- There is an increased focus on physical and mental health supporting NHS England's Parity of Esteem agenda

- This model will improve health outcomes and reduce health inequalities.

Current delivery arrangements

Referral process

West Kent CCG is now commissioning South East Commissioning Support Unit (SECSU) to deliver their Neuro Rehab Assessment and Placement Process. North Kent is using their in house team to provide a similar process.

This includes:

- A single point of referral for all patients that would previously have been referred to the Knole Centre.

- Complete assessment for all patients. Based on the assessment, recommendations will be made about the patient's suitability for inpatient neuro rehab, or a rationale will be provided if the patient is unsuitable.

- Appropriate providers of inpatient rehabilitation will be recommended. This is to be provided by a multi-professional team that has undergone recognised specialist training in rehabilitation.

- Recommendations will be made about the length of stay based on assessment, with achievable rehabilitation goals and measureable outcomes.

- SECSU will liaise with West Kent CCG for ratification of decision making.

- Placement reviews with the patient, family and clinical team will take place at appropriate intervals.

- Data will be collated to produce activity report(s).

Neuro rehab activity report – December 2015 – May 2016

Key: EDD: Estimated Discharge Date

Patient	Placement	Date neuro rehab commenced	Discharge status	Overall length of stay	CCG
1.	Raphael Medical Centre	24/12/15	19/3/16	12 weeks and 2 days	WK
2.	Raphael Medical Centre	07/01/16	11/03/16	8 weeks and 4 days	WK
3.	Strode Park	18/01/16	EDD 27/05/16	Approx. 18 weeks	WK
4.	Raphael Medical Centre	27/01/16	EDD 20/04/16	Approx. 12 weeks and 6 days	WK
5.	Raphael Medical Centre	Patient self-discharged on same day as placement	05/04/16	-	WK
6.	Raphael Medical Centre	16/12/15	EDD July 16		DGS
7.	Kirwin Court	15/2/16	30/3/16	6 weeks 3 days	DGS
8.	Strode Park	23/5/16			DGS

For those patients with more complex needs there continues to be the option of referral to the Level 1 providers funded by NHS England. Local Level 3 providers will continue to provide a service to those who require a smaller multi-disciplinary team or a shorter period of rehabilitation.

If current trends continue then it is expected that DGS and West Kent CCG's will each place approximately 12 patients. The approximate cost of this service, based on estimated placements and length of stay will mean that the CCG's will fall in line with their estimated costs for the service.

North Kent are currently in the process of setting up their first neuro-rehab personal health budget for a 60 year old woman who is at home supported by a care package following an acute admission for treatment for a Subarachnoid Haemorrhage with subsequent complications.

Next steps

- SECSU to continue to monitor placements and feedback to West Kent CCG
- West Kent and North Kent CCGs to continue to monitor activity
- Consider a future engagement exercise with guidance from Healthwatch

Update on longer term plans

- To continue with a bespoke NCA service

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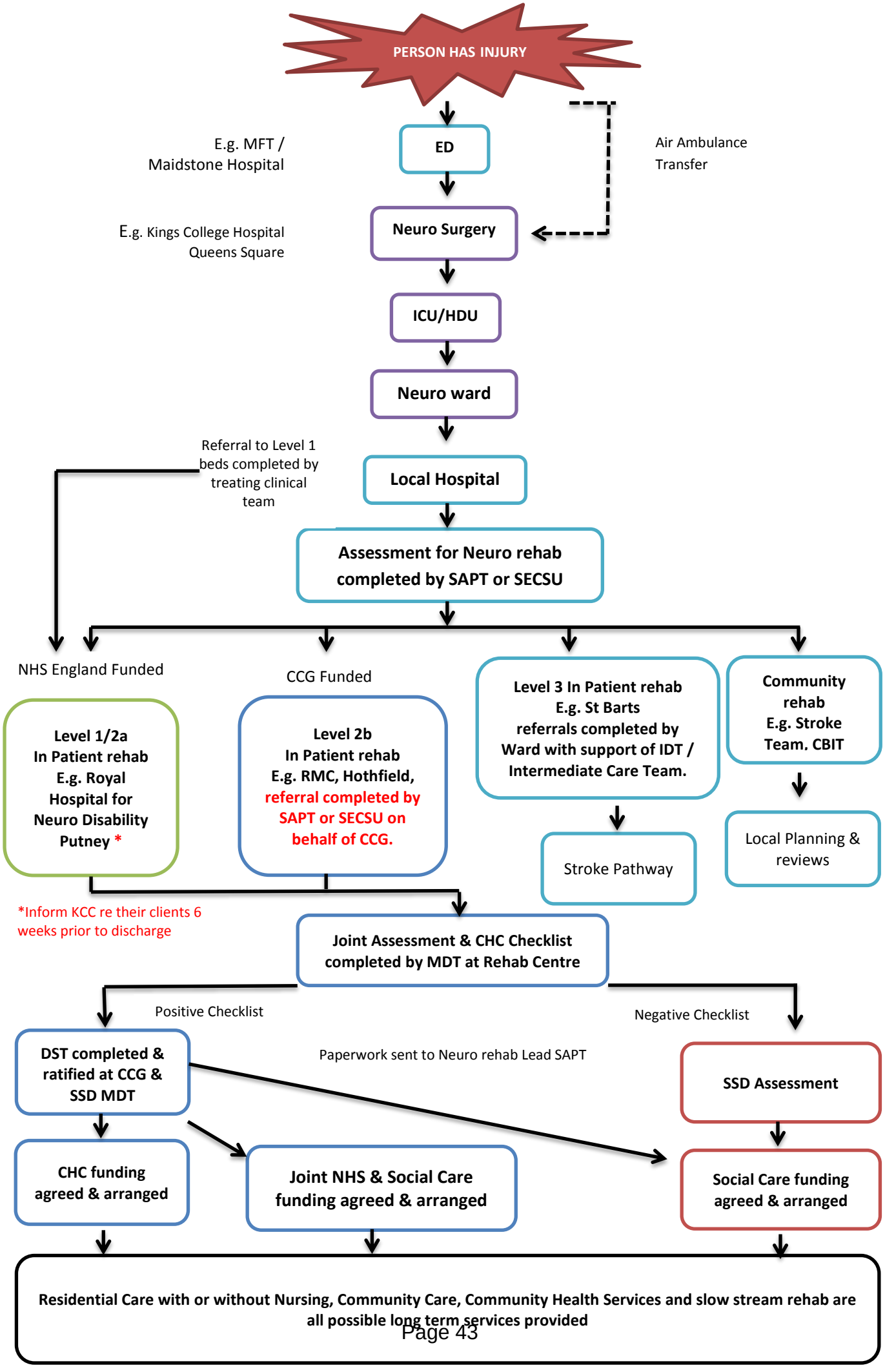
COMPLEX NEURO REHAB PATHWAY



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Item 7: Kent and Medway Sustainability and Transformation Plan

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 June 2016

Subject: Kent and Medway Sustainability and Transformation Plan

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided about the Kent and Medway Sustainability and Transformation Plan.

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

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1. Introduction

(a) NHS England, NHS Improvement (the new body which brings together Monitor and the NHS Trust Development Authority), the Care Quality Commission, Public Health England, Health Education England and NICE – the bodies which developed the Five Year Forward View in October 2014 - have come together to publish 'Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21', setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances (NHS England 2015b).

(b) NHS England has established a Sustainability and Transformation Fund of £2.14bn for 2016/17 to support this process. Of this, £1.8bn will be deployed on sustainability to stabilise NHS operational performance, and £340m for transformation to continue the Vanguard programme and invest in other key Five Year Forward View areas. The Sustainability and Transformation Fund will grow from £2.1bn in 2016/17 to £2.9bn in 2017/18, rising to £3.4bn in 2020/21, with an increasing share of the growing fund being deployed on transformation including the Five Year Forward View's New Care Models, and mental health parity of esteem (NHS England 2015a).

(c) As part of the planning process, all NHS organisations are asked to produce two separate but interconnected plans:

1. A local health and care system Sustainability and Transformation Plan (STP) which will cover the period October 2016 to March 2021; local leaders will be required to set out clear plans to pursue the 'triple aim' set out in the NHS Five Year Forward View –improved health and wellbeing, transformed quality of care delivery, and sustainable finances (NHS England 2015a & 2015c).

2. A plan by organisation for 2016/17 which will need to reflect the emerging Sustainability and Transformation Plan and address nine 'must dos' for every local area in England including:

- returning the system to financial balance;
- introducing a local plan to address the sustainability and quality of general practice;
- reducing waiting times for A&E, cancer and mental health;
- improving quality – particularly for organisations in special measures (NHS England 2015a & 2015c).

(d) To deliver these plans NHS providers, CCGs, local authorities, and other health and care services have come together to form 44 STP footprints. In forming their footprints, local areas have taken the following factors into account:

- Geography (including patient flow, travel links and how people use services);
- Scale (the ability to generate solutions which will deliver sustainable, transformed health and care which is clinically and financially sound);
- Fit with footprints of existing change programmes and relationships;
- The financial sustainability of organisations in an area;
- Leadership capacity and capability to support change (NHS England 2016).

(e) A Kent and Medway STP footprint has been established covering all eight Kent and Medway CCGs over a footprint population of 1.8 million (NHS England 2016).

(f) On 4 March 2016 the Committee considered an item on the East Kent Strategy Board which aligns and links to the Kent and Medway Sustainability and Transformation Plan.

2. Recommendation

RECOMMENDED that the report on the Kent and Medway Sustainability and Transformation Plan be noted and an update be presented to the Committee at the appropriate time.

Background Documents

NHS England (2015a) *'NHS England allocates £560 billion of NHS funding to deliver NHS Five Year Forward View (17/12/2015)*',
https://www.england.nhs.uk/2015/12/nhs-england-allocates-560-billion/

NHS England (2015b) *'NHS Shared Planning Guidance (22/12/2015)'*,
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

NHS England (2015c) *'NHS leaders set out new long-term approach for sustainability and transformation (22/12/2015)'*,
https://www.england.nhs.uk/2015/12/long-term-approach/

NHS England (2016) *'Sustainability and Transformation Plan footprints (15/03/2016)'*, https://www.england.nhs.uk/wp-content/uploads/2016/02/stp-footprints-march-2016.pdf

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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Delivering the Five Year Forward View

- National planning context
- Funding
- The challenge (population demographics including inequalities, quality, performance, finance)
- Governance
- Complexity of Kent and Medway
- Our four main focus areas
- Next steps

National planning context

The national planning guidance, Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 (NHS England, December 2015), outlined the requirement for local health and social care systems to develop:

- a five-year Sustainability and Transformation Plan (STP), place-based and outlining how the Five Year Forward View (FYFV) will be delivered; and
- a one-year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP (to form year-one of the five-year STP).

What we need to cover

The planning guidance indicates that the three interdependent and essential tasks that need to be progressed through the STP are to:

- improved health and wellbeing;
- transformed quality of care delivery; and
- sustainable finances.

…but also establish more robust system leadership.

The 10 big questions we need to answer

How are you going to prevent ill health and moderate demand for healthcare?

How are you engaging patients, communities and NHS staff?

How will you support, invest in and improve general practice?

How will you implement new care models that address local challenges?

How will you achieve and maintain performance against core standards?

How will you achieve our 2020 ambitions on key clinical priorities?

How will you improve quality and safety?

How will you deploy technology to accelerate change?

How will you develop the workforce you need to deliver?

How will you achieve and maintain financial balance?

Funding

- Place-based funding allocations for the period 2016/17 to 2020/21 were published by NHS England in January, comprising CCG allocations, primary care medical allocations and specialised services allocations.
- Separate additional funding has been identified and initially held at a national level for the sustainability and transformation fund, and other elements of transformation such as primary care.
- Kent and Medway 2016/17 STP place-based allocation is £2,897m in 2016/17.
- Allocation rises to £3,287m in 2020/21, without sustainability and transformation funds.
- Allocation rises by £122m to £3,409m in 2020/21 with indicative sustainability and transformation funds.
- Allocations for 2020/21 are indicative, not firm, and the additional funding will actually be distributed based on progress and the strength of STPs or using other targeted approaches.

The challenge

- We are facing a demographic and demand time bomb, with growth in the over 65s population four times that of under 65s. This means by 2020 the over 65s will make up nearly 20% of our total population.
- Significant housing development (e.g. Thames Gateway and Ashford).
- Within Kent and Medway we continue to have unacceptable levels of health inequalities and deprivation for an affluent part of the South East. In one of the most deprived areas of the county, Thanet, a woman who lives in the best ward for life expectancy can expect to live 21.88 years longer than a woman who live in the worst ward for life expectancy.
- We are struggling to recruit to key health and social care roles (for example, 10% of nursing posts are vacant).
- Modelling indicates we need to radically re-shape the health economy to provide far more out of hospital services and preventative support.
- Financially we are no longer managing within the available resources, with a deficit of circa £106m deficit in 2015/16, which rises significantly over the next five years unless we change the way we deliver care.

Our population

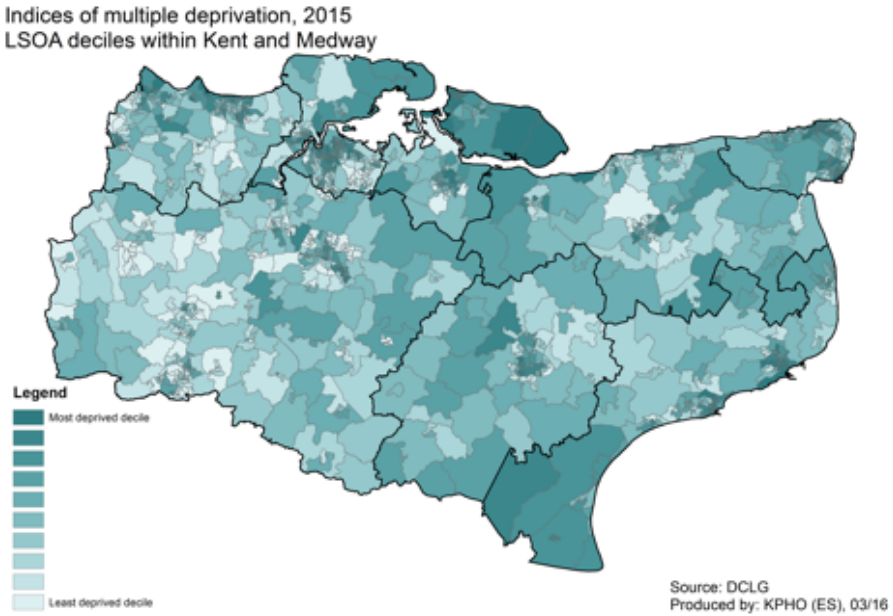
In 2011 the base population for Kent and Medway was calculated as 1,731,400. By 2031 this is projected to increase to 2,024,700, an increase of 293,300 that is equivalent to a 17% rise (circa 42,000 for Medway and 251,000 for Kent). In particular, the percentage of old people, who are living longer with multiple co-morbidities, is changing and by 2021 it is projected there will be a:

25.5% increase in number aged 65 years +

34.1 % increase in the number aged 85 years +

It is important to understand population changes at a local level as the above figures mask significant local variation.

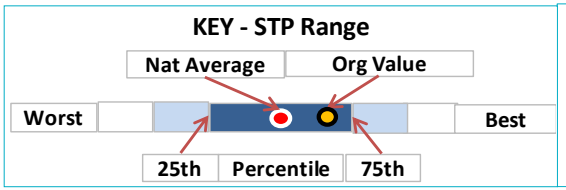
The projected 17% increase in the local population also includes population increases as a result of a planned 158,500 additional dwellings that are expected between 2011 and 2031. These developments will have a skewed impact on different areas. There are significant developments planned in Dartford, Ebbsfleet and Ashford. There are also significant housing developments in Bexley, South-East London, which are not factored into the housing numbers referenced above but whose residents would look to Darent Valley Hospital as their local acute provider.



Financial position (NHS organisations)

	Quarter 3 financial forecast for 2016/17	
Organisation	Forecast financial outturn position for 31/03/16 (£/m)	%
Maidstone and Tunbridge Wells NHS Trust	-23.5	-5.9%
Medway NHS Foundation Trust	-58.1	-23.2%
Dartford and Gravesham NHS Trust	-7.9	-3.5%
East Kent University Hospitals Foundation NHS Trust	-33.9	-6.4%
Kent Community Health NHS Foundation Trust	3.5	1.5%
Kent and Medway NHS and Social Care Partnership Trust	-4.3	-2.3%
South East Coast Ambulance Foundation NHS Trust (across Kent, Surrey and Sussex)	0	0
Trust total	**-124.1**	**-6.8%**
Swale CCG	1.4	1.0%
Medway CCG	3.6	1%
Darford, Gravesham and Swanley CCG	0	0
West Kent CCG	5.6	1.0
Ashford CCG	0	0
Canterbury and Coastal CCG	2.7	1%
South Kent Coast CCG	2.8	1%
Thanet CCG	2.1	1%
CCG Total	**18.2**	**0.8%**
Net System Total:	**-105.9**	

Performance against targets



The spine chart shows the relative performance of the STP – towards the right of the scale indicates "better" performance (which may relate to a lower or higher indicator value depending on the indicator in hand) and towards the left of the scale indicates "worse" performance. Percentiles are based on national data.

Better Care	Reporting Period	STP Value	STP Range
People with urgent GP referral having 1st definitive treatment for cancer within 62 days of referral	Q3 2015/16	76.3%	
One-year survival from all cancers - DATA ONLY AVAILABLE AT CCG LEVEL	2013	No Data	
Cancer patient experience	2014	0.89	
Improving Access to Psychological Therapies recovery rate	Oct-15 to Dec-15	47.5%	
People with a learning disability and/or autism receiving specialist inpatient care per million population	Jan-16	55.00	
Proportion of people with a learning disability on the GP register receiving an annual health check	Jan-16	52.2%	
Neonatal mortality and stillbirths per 1,000 births	2013	5.67	
Women's experience of maternity services	2015	82.1	
Estimated diagnosis rate for people with dementia	Feb-16	62.7%	
Emergency admissions for urgent care sensitive conditions per 100,000 population	Oct-14 to Sep-15	609	
% patients admitted, transferred or discharged from A&E within 4 hours	Feb-16	82.9%	
Ambulance waits - % of cat A red 1 incidents responded to within 8 minutes	Feb-16	65.5%	
Delayed transfers of care attributable to the NHS and Social Care per 100,000 population	Feb-16	14.33	
Emergency bed days per 1,000 population	Q2 2015/16	0.85	
Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population	2014/15	751	
Patient experience of GP services	Jul-15	72.9%	
Primary care workforce - GPs and practice nurses per 1,000 population	2015	0.77	
Patients waiting 18 weeks or less from referral to hospital treatment	Feb-16	91.9%	
People eligible for standard NHS Continuing Healthcare per 50,000 population	Sep-15	48.90	

Population Characteristics

	Period	England	Kent and Medway STP	Ashford	Canterbury And Coastal	Dartford, Gravesham And Swanley	Medway	South Kent Coast	Swale	Thanet	West Kent
Obesity: QOF prevalence (16+)	2014/15	9.0	9.4	9.3	7.8	9.3	12.0	10.9	11.3	9.3	7.6
Percentage of physically inactive adults	2014	27.7	28.3	29.1	30.6	27.0	29.6	27.4	32.4	34.5	25.7
Estimated smoking prevalence (QOF)	2014/15	18.4	18.9	18.2	17.4	18.2	20.5	21.4	22.5	23.5	16.0
Smoking cessation support and treatment offered	2014/15	94.1	93.8	92.3	93.3	94.0	95.7	94.8	95.2	92.8	92.2
Alcohol-specific hospital admission	2013/14	374		212	327	261	243	290	196	412	271
Hypertension: QOF prevalence (all ages)	2014/15	13.8	14.5	14.3	14.0	14.5	14.1	16.3	14.9	16.2	13.6
Depression: QOF prevalence (18+)	2014/15	7.3	7.5	8.6	7.6	5.6	8.3	7.5	7.8	9.0	7.0
Learning disability: QOF prevalence	2014/15	0.4	0.4	0.4	0.4	0.3	0.4	0.7	0.4	0.6	0.3
Premature mortality from coronary heart disease	2014	40.0		33.3	28.5	34.7	53.3	31.2	52.9	54.1	27.0
Premature mortality from stroke	2014	13.5		6.4	12.8	20.7	18.5	14.2	9.2	8.9	12.2
Premature mortality from respiratory disease	2013	28.1		26.5	26.9	23.7	35.4	33.6	40.2	25.4	24.2

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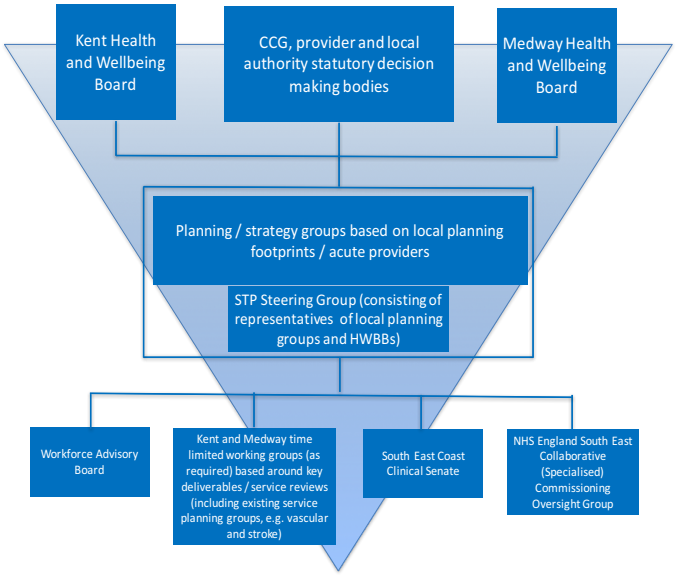
Outcome of CQC inspections (SECamb are not shown as inspected under the old system and now being re-inspected; Medway Community Healthcare have their services inspected individually)

	DGT	EKUHFT	KCHFT	KMPT	MFT	MTW
	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement
Safe						
Effective						
Caring						
Responsive						
Well-led						

	Good
	Requires improvement
	Inadequate

Governance

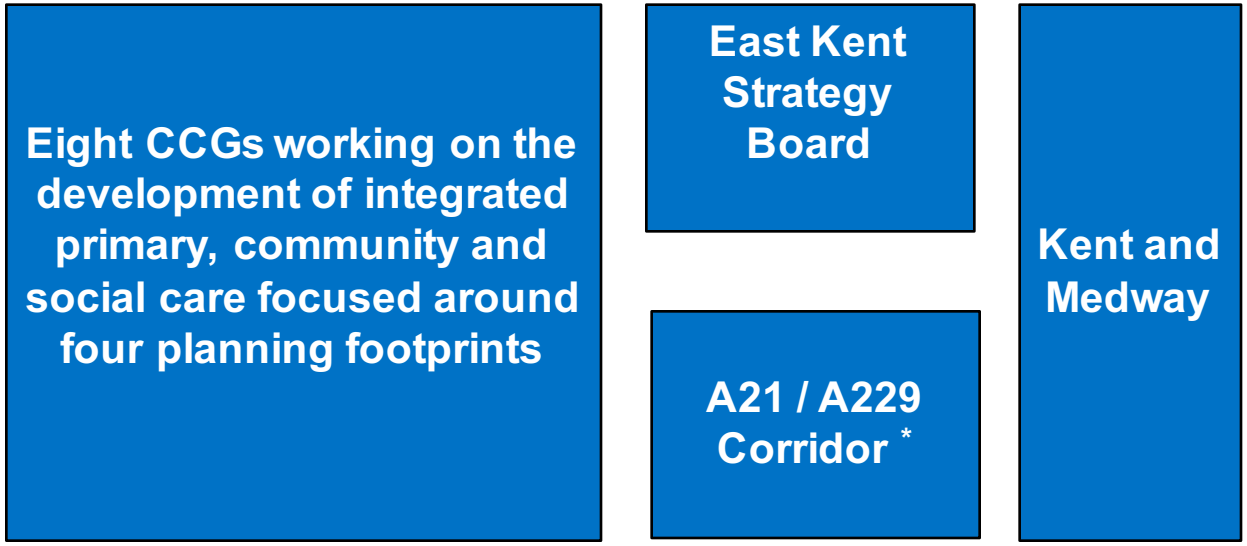
- Have been on a “journey” with organisations and worked at reaching a consensus around the approach and now good buy-in from constituent organisations
- Whilst still a focus on local planning a strong recognition of the K&M footprint, supported by a commitment to work together
- STP Steering Group formed and meeting (draws representation from local planning arrangements, HWBBs and upper tier local authorities – through this all statutory bodies have a seat at the table)



- Work streams initiated and / or existing working groups given new direction
- However, governance will need to be revisited and will need to evolve
- A proposed structure for the submission has been prepared and currently under review to ensure ownership (content being added)

Complexity of Kent and Medway

Like many areas Kent and Medway is complex. Working to a single STP footprint doesn't negate the need to work at different levels.



* Includes part of East Sussex that is outside the STP area and the Dartford and Gravesham NHS Trust vanguard with Guy's and St Thomas' NHS Foundation Trust

Our four main focus areas

1. Self-care and prevention (public health departments have developed the Kent and Medway plan) with identified health and finance benefits
2. Strengthened primary care and integrated out of hospital care (including mental health and social care)
3. Acute hospital strategy (including mental health):
   i. East Kent Strategy Board
   ii. A21 / A229
   iii. Pan Kent and Medway services (e.g. hyper acute stroke and vascular surgery)
4. Cost reduction measures (including "Carter" efficiencies)

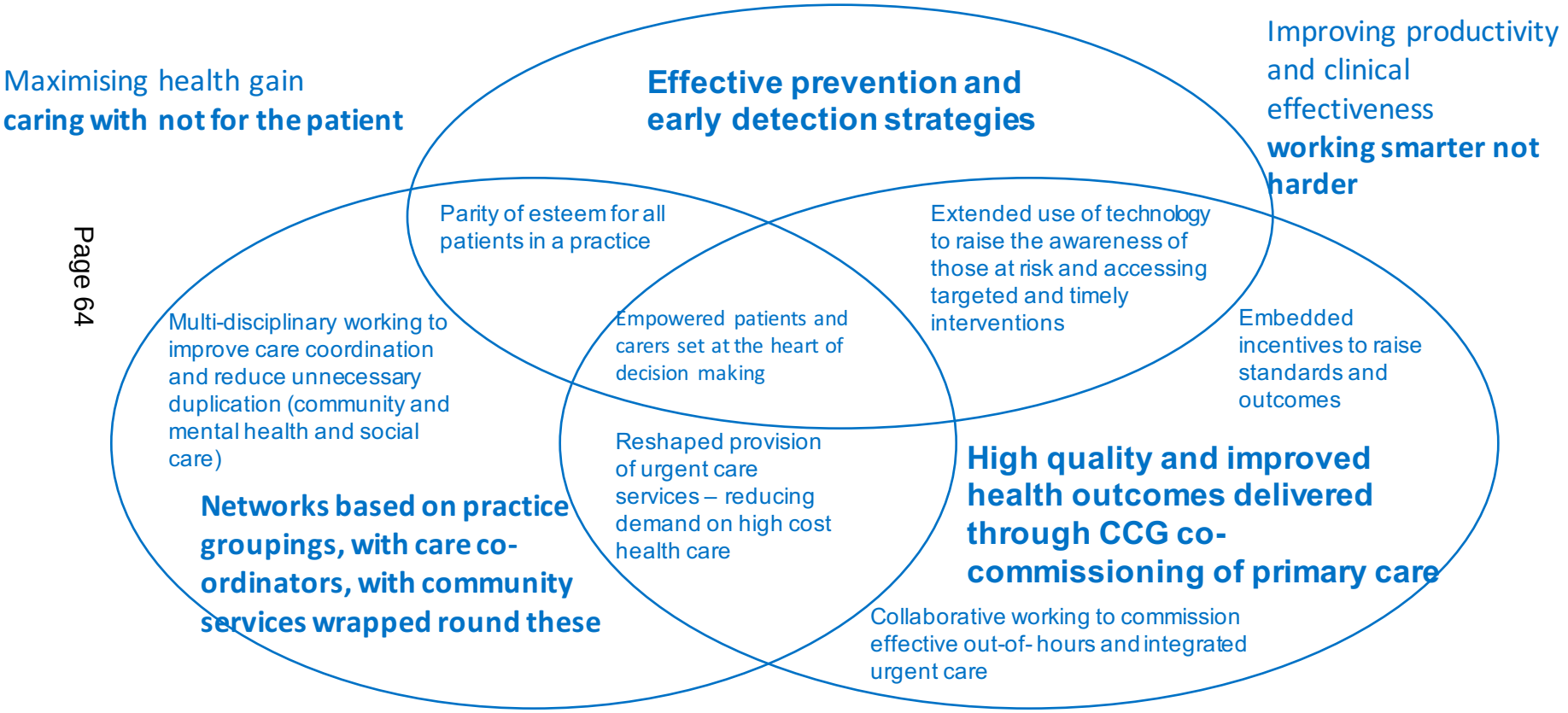
Self-care and prevention

- **Reducing the gap in health and wellbeing outcomes - working across the entire health and care system:** evidence suggests that poorer health behaviours and related outcomes, such as obesity prevalence, smoking prevalence, and higher premature mortality rates correlate strongly with deprived areas.
- **Making Every Contact Count:** use the millions of day to day interactions that organisations and individuals have with people to support them in making positive changes to their physical and mental health and wellbeing.
- **Primary prevention through lifestyle services,** focusing on:
  - **Improving mental health and wellbeing**, addressing:
    - *post-natal depression (PND)*
    - *depression in older people*
    - *conduct disorder mental health (prolonged anti-social behaviour)*
  - **Increasing smoking cessation**
  - **Increasing physical activity**
  - **Addressing overweight and obesity**
  - **Tackling alcohol misuse**

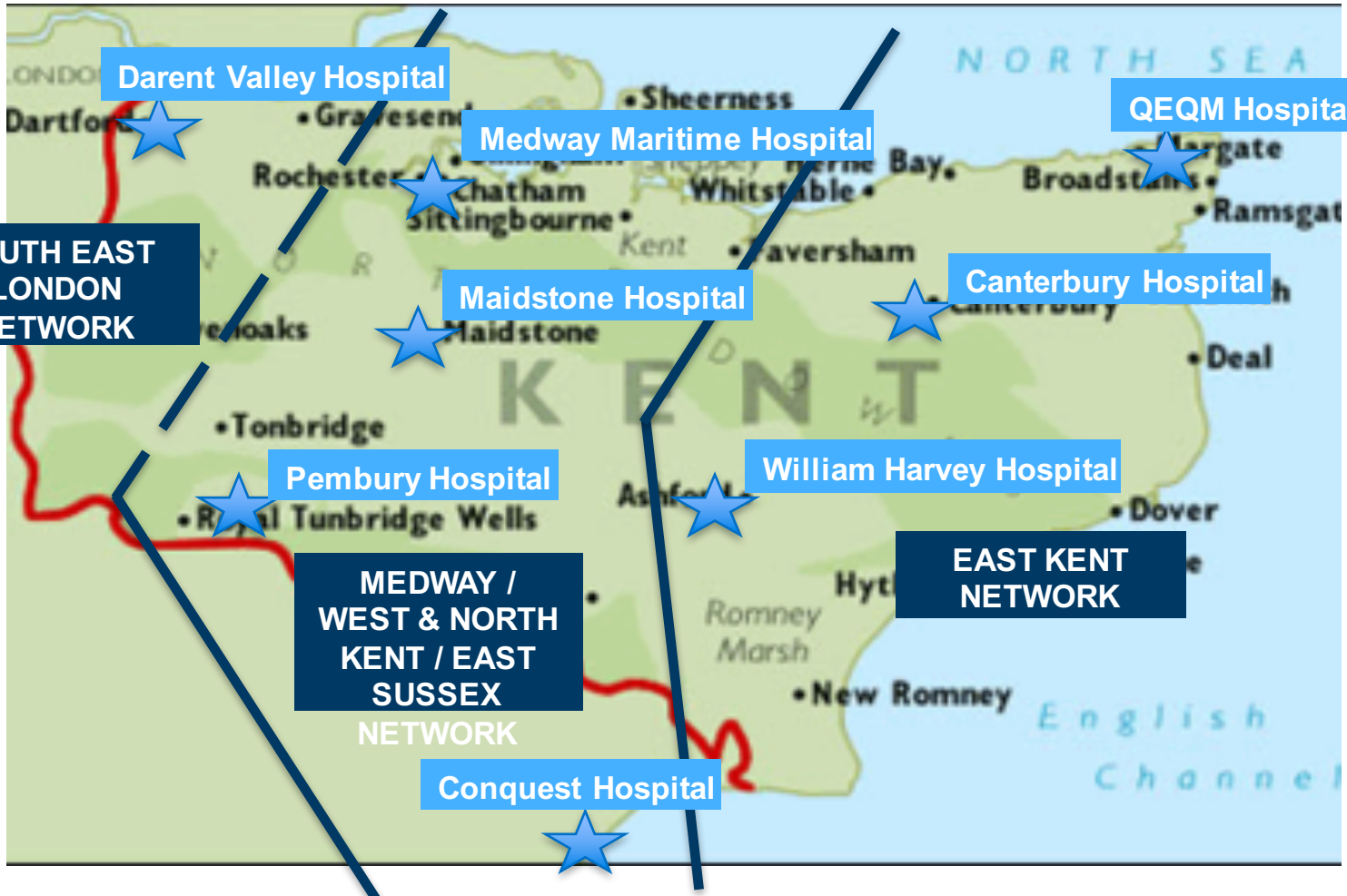
Primary care and integrated out of hospital care (networks of care focused on populations of 30,000 to 60,000 based on GP lists)

- Delivering the general practice Five Year Forward View
- A focus on multi-disciplinary team working, with shared decision making with the patient, focused around the patient's own health goals
- Risk stratification linked to detailed care planning and coordination of the highest risk patients (care coordination)
- Colocation of services, with telemedicine, and immediate access to an extended range of diagnostic services
- On site medicines management support and integration of pharmacist support into primary care and self-care pathways
- Effective triage and streaming, with rapid access for those who are most ill
- Patient held records that are interoperable between primary / community and secondary care
- Multi-disciplinary training
- Joint evaluation of quality outcomes for quality improvement
- Shared clinical protocols with secondary care
- A focus on well-being and prevention

From reactive to proactive



Acute Strategy – emerging relationships



= Current major acute hospital site

Mental Health

Promoting wellbeing and reducing poor mental health:

- Use of Open Dialogue – systemic family intervention psychologically based
- Use of community assets to strengthen response – building communities and social networks and social prescribing
- Taking a preventative strategy where every contact counts
- Building on existing suicide prevention work

Integrated Physical and Mental Health Services:

- Biannual MHH/PH health checks for those with SMI and adherence checks
- Training on stigma for physical health teams
- Management of LTCs on an integrated manner – use of MCP
- Adoption of peer support model of recovery college in physical health

Improve crisis response:

- Integrated single point of access
- Implementation of an alternative place of safety
- Implementation of a Mental Health Decision Unit
- Development of liaison to include medically unexplained symptoms
- Crisis - use of virtual beds

Enabling strategies

- **Digital:**
  - To support direct care, including prevention and self-care
  - To support the sharing of patient information (including more electronic information in hospitals)
  - To support us to develop a better understanding of how the system is operating and the demands being placed upon it (informatics)
- **Workforce:**
  - Recruiting and retaining the required staff
  - Initiatives to address the challenge that the number of posts that local organisations are seeking to fill is greater than the number of people within the employment market)
  - Transforming the roles of our staff to deliver new care models.
- **Estates: optimise utilisation**
- **Leadership:** develop shared system leadership

Cost Reduction

- Activity growth moderated by circa 1% on a sustainable basis
- Provider efficiency of at least 2% on a sustainable basis (Including Lord Carter efficiencies):
  - Pharmacy initiatives
  - Procurement efficiencies
  - Pathology
  - Pay restraint
  - Electronic staff rostering, sickness and absence rates
  - Estate utilisation (clinical vs non-clinical)
  - Back office (administration) efficiencies
- Through expansion of best practice and ending “inexplicable” variation

Next steps

- Modelling to better understand financial and capacity gap
- Work-up four focus areas
- 30th June checkpoint submission (stocktake of work in progress)
- July review meeting with NHS England and NHS Improvement
- Further work over the summer

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Item 8: East Kent Strategy Board

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 June 2016

Subject: East Kent Strategy Board

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

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

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1. Introduction

(a) On 4 March 2016 the Committee considered an update on the work of the East Kent Strategy Board. The Committee agreed the following recommendation:

- *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.

(b) On 31 March 2016 the Chairman agreed to a request from the East Kent Strategy Board to postpone the item until the June meeting as the Case for Change was not being presented to its Board until 14 April.

(c) On 1 June 2016 the HOSC group representatives are scheduled to meet with Rachel Jones (Programme Director, East Kent Strategy Board), Hazel Carpenter (Accountable Officer, NHS Thanet CCG and NHS South Kent Coast CCG) and Dr Sarah Phillips (Chair, East Kent Strategy Board) for an informal briefing.

2. Recommendation

RECOMMENDED that the report be noted and the East Kent Strategy Board be requested to present an update at the appropriate time.

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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East Kent Strategy Board

Developing a Case for Change for East Kent

HOSC Update

May 2016

Developing the Case for Change

The detailed technical case for change is now nearing completion and focuses on:

- Level of expectation and demand from patients and the public around quality and access
- Variations in quality and safety of services unacceptable
- Local and national challenges driving transformation
- Resources need to be utilised more effectively
- Services need to be effective and sustainable

Developing the Case for Change

– We know our system needs to change because:

- Ageing population
- Care needs to be delivered closer to home
- Tackling health inequalities
- Demand is rising
- Prevention rather than cure
- Complex health and care conditions
- National safety and quality standards need to be met
- Financial challenges
- Workforce

Developing the Case for Change

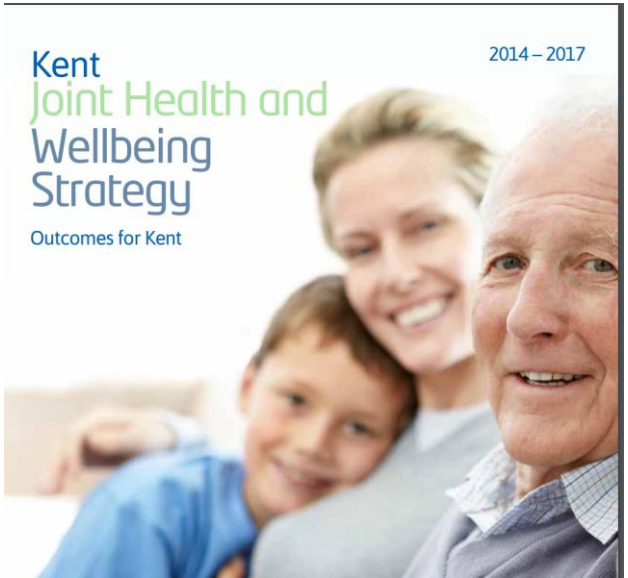
Where are we now?

Issue	Evidence	Impact	What needs to happen?
Workforce	Almost complete	X	Finalise the evidence
Population growth	X	X	Test with the public
Financial challenge	Delivered end May	Delivered end May	Finalise the evidence
Variation in quality/outcomes	X	X	Test with the public
Inequalities across areas/communities	X	X	Test with the public
Infrastructure inc. estates/IT	Work commenced – due end June	X	Finalise the evidence

Developing the Case for Change

What other sources of information are we using?

- Kent County Council Health and Wellbeing board strategy
- Five Year Forward View
- Planning Guidance NHS England 2015
- Reports from Royal Colleges and professional organisations regarding quality and standards such as the RCGP's 'Vision for General Practice in 2022', The King's Fund, 'The Health and Social Care System in 2015 – a view of the future'.



What is already happening across east Kent?

- Hubs in Folkestone and Dover providing GP appointments 8am-8pm seven days a week. Patients are referred by their practice or NHS 111.
- Primary care mental health specialists in a number of GP practices across east Kent, supporting people who are acutely mentally unwell so they are less likely to need care from secondary mental health services (provided by Kent and Medway NHS and Social Care Partnership Trust)
- New multi-speciality community provider model being tested in the Canterbury, Faversham and Whitstable areas, with £1.6million from the NHS England Transformation Fund. It plans extended practice opening hours, paramedic practitioners who will visit patients at home, an integrated nursing service involving both community and practice nurses and an increase in the number of outpatient services through specialist GPs.
- Paramedic practitioners in Folkestone and Dover provide a seven-day service on behalf of GPs, seeing and treating patients who need a home visit from a clinician.

What is already happening across east Kent?

- Thanet CCG are also developing an Integrated Care Organisation
- There are 4 localities covering the population that are integrating and improving local services.
- Thanet are also developing an acute response team of paramedic practitioners, specialist nurses and others to treat people in their own homes
- A new combined NHS, 111 and GP out of hours service for all of east Kent.
- EKHUFT and KCHFT have worked together to review the acuity (how sick) all of the people in our hospital beds are and have identified significant numbers of patients whose needs would be better if alternative services were available. This is also informing what needs to be provided, in the future, out of hospital.

We want to make health and care services…

- **More proactive:** we want to stop people becoming ill in the first place. Health promotion and prevention are key to reducing morbidity, premature mortality, health inequalities and the burden of disease across east Kent. Obesity, smoking, alcohol, drugs and poor diet all need to be effectively tackled irrespective of the quality of medical interventions.

- **More accessible**: to address the variations in service provision, stopping resulting delay in diagnosis and treatment and making sure that people access care in the right place at the right time.

- **More coordinated:** as patients with long term conditions consume more than 75% of the total health and social care spend, care navigation, case management and multidisciplinary approaches are increasingly important. We want to keep people well and out of hospital.

How we will develop our plans

- Evidence-based analysis – looking at where we are now and what we know is best practice, including national quality standards, to help determine where we need to get to in order to deliver consistently safe, high quality, sustainable services into the long-term
- Modelling and understanding our health and wellbeing; care and quality; and finance and efficiency gaps and factoring this into our thinking
- Clinical 'task and finish groups' across pathways of care to describe what good should look like
- Clinically led discussions to design a new model of care for east Kent, working as a whole system across primary, community, mental health and acute care
- Testing our thinking and developing the detail with staff, stakeholders, patients, carers and local communities
- Robust evaluation to develop options for delivering our model of care
- Formal public consultation towards the end of the year on any significant service changes

What can people expect to see?

- A range of options for consultation that have been clinically led.
- These should define the range and quality of services local people should expect to receive. They will encourage innovation and joint working between all organisations involved in delivering health and care and assist in providing greater consistency and tackle inequalities in care provision.
- We want to engage local people/stakeholders in agreeing these changes so that we can reach a consensus on what we mean by a new model of care and what this will mean for local people.

- We will also be commencing the NHS England Assurance Process with a Stage 1 Strategic Sense Check in early June.

Work is well underway to set the strategic context

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

East Kent Strategy Board

KEY

East Kent Strategy Board Meeting

HOSC meeting

National and regional planning priorities

Verbal presentation for HOSC

14th Apr – 1st Draft STP to go to EKSB

12th May – 2nd Draft STP to go to EKSB

9th Jun – Final STP to go to EKSB for sign off

End June submission of final STP

Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16

4th | 8th | 3rd | 15th

29th Jan - Submit proposals for STP footprints and volunteers for mental health and small DGHs trials

22nd Feb First submission of full draft 16/17 Operational Plans

31st Mar - submission - signed contracts

4th Apr - Submission of final 16/17 Operational Plans, aligned with contracts

Clinical Senate approval is required prior to NHS Panel Review

Emerging clinical models and developing service options

Action to be completed

- Developing the criteria for reviewing
- Developing and modelling the options and understanding their impact
- Evaluating the options and securing wide agreement from all key stakeholders

Clinical Senate Assurance

NHS England's Assurance Process by the NHS Panel

Development of outline business case

Public engagement – so public views can be fed into the process

Preparation for consultation

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Item 9: Kent & Canterbury Hospital: Emergency Care Centre

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 June 2016

Subject: Kent & Canterbury Hospital: Emergency Care Centre

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

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 proposals to reclarify the model of care at the Kent & Canterbury Hospital's Emergency Care Centre. The Committee agreed the following recommendation:

- *RESOLVED that:*

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

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

2. Recommendation

RECOMMENDED that the report be noted and East Kent Hospitals NHS University Foundation Trust be requested to present an update at the appropriate time.

Background Documents

Kent County Council (2016) *'Agenda, Health Overview and Scrutiny Committee (29/01/2016)'*,
https://democracy.kent.gov.uk/mgAi.aspx?ID=36905

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

1. Introduction

1.1. The purpose of this report is to update members of the Kent HOSC on the progress made around the change of model to Kent and Canterbury Emergency Care Centre (K&C ECC) which was first discussed at the Kent HOSC in January 2016. The agreed model of care is a Primary Care led Urgent Care Centre supported by a Minor Injuries Unit and Acute Medical Unit.

2. Background

2.1. The changes are required due to mandated actions from Health Education Kent Surrey and Sussex (HEKSS) following a review of the Trust's core medical training at Kent and Canterbury Hospital.

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

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

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

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

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

2.3. HEKSS Recommendations and Implications

- A new emergency model of care which removed trainees from the ECC to be implemented for K&CH by August 2016, ahead of any permanent clinical strategy changes

- Minimise the number of non- medical patients being taken to K&CH

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

2.4. Interim arrangements

Interim arrangements put into place as of 1st December 2015 were to:

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

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

2.6. The proposed way forward agreed by Kent HOSC in January was to work closely with SECAMB to reinforce the ambulance conveyance criteria so non-medical patients (excluding urology and vascular) would not be brought to K&CH and to develop a new model of care for patients that self-presented (non GP referrals) that would be implemented in July 2016

3. Current Position

3.1. EKHUFT has worked with SECAMB to reinforce the criteria for patients conveyed to K&CH. The output of this work is revised clinical criteria which reflect that K&CH has a Minor Injuries Unit and does not have an A&E. The population affected by this are patients that:

- are severely inebriated and do not have, either a minor injury or other medical problem;
- have a primary mental health condition (with no minor injury or other medical problem); and
- have abdominal pain that may require a general surgical assessment.

3.2. The last group of patients are affected because there is no General Surgery at K&CH. HEKSS have been clear that the core medical trainees should not be expected to be the initial doctor assessing patients with non-medical presentations (e.g. paediatric, surgical and other specialty presentations).

3.3. The revised conveyance criteria were implemented on Monday 9th May 2016. As previously identified this is expected to affect approximately 9 patients per week. Safe transfer protocols are in place should these patients be brought by ambulance inadvertently to K&CH to ensure they receive appropriate timely care.

3.4. The Trust has been working in partnership with Primary care and Canterbury and Coastal CCG to design and implement a model of care which ensures all patients that self -present are seen and assessed by a General Practitioner or nurse to ensure they see the appropriate clinical team.

3.5. The key concepts of the model of care include:

- One single front door 24/7;
- All patients who are not referred and accepted to the Acute Medical Unit (AMU) will be streamed to MIU or the GP led Urgent Care Centre (with the exception of agreed conditions);
- The Minor Injuries Unit will operate as now with benefit of close primary care liaison;
- Streaming criteria have been developed and agreed;
- The resuscitation area will remain and be used as per current practice;
- Agreed pathways and protocols have been developed for:
  - Patients requiring A&E services
  - Mental Health patients
  - Urology and Vascular patients
  - Patients requiring general surgical assessment and
  - Patients that may require airway, breathing or circulatory support prior to transfer to another site
- The Acute Medical Unit will accept all acute medical patients and develop new models of care for the frail elderly and emergency ambulatory care to prevent admission to hospital.

3.6. The new model of care and Primary Care led Urgent Care Centre will be introduced on 6th July 2016 ahead of the HEKSS deadline to ensure any initial problems can be addressed.

3.7. There is a significant risk associated with the implementation; that recruitment and availability of General Practitioners to staff the Urgent Care Centre are not available to provide a consistent service 24/7. All recruitment avenues are currently being explored but it has to be acknowledged that there is a known deficiency in this element of the workforce.

4. Communication

4.1. EKHUFT and Canterbury & Coastal CCG have developed a communication plan which includes all stakeholders. The messages to the public have been minimalist as the service provided at K&C will remain unchanged for the vast majority of the general public. The modification is that they will see a Health Care Professional appropriate to their requirements which may be a GP or nurse. The rationale for not communicating this broadly to the public is the concern that additional attendances may occur due to the availability of a 24 hour service.

4.2. The Trust and CCG have worked with Healthwatch Kent and Kent University and will continue to implement the communication plan which includes broad generic messages around access to services and health information close to the date of implementation.

5. Conclusion

5.1. The Trust is doing everything possible to continue to address the issues raised by HEKSS and to provide all of the trainees with a quality experience. However, there is still a very real risk that HEKSS continue to feel that the training experience provided by EKHUFT for medical trainees at K&CH is unsatisfactory and they would then require the General Medical Council (GMC) to review the situation. Should the GMC concur with the HEKSS programme board's views then all medical trainees would be removed from K&CH site. The Trust would then be forced to implement the emergency measures detailed earlier in paragraph 2.3. This would not only affect many of the services provided from K&CH, it would also inevitably have an impact on the provision of emergency services at WHH, Ashford and QEQMH, Margate.

5.2. The Trust has worked with commissioners to develop a more robust approach and implement a new model of care for July 2016. The main risk associated with the implementation of this model is the recruitment and availability of General Practitioners to staff the Urgent Care Centre.

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

Item 10: East Kent Integrated Urgent Care Service Procurement (Written Briefing)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 3 June 2016

Subject: East Kent Integrated Urgent Care Service Procurement (Written Briefing)

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

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 11 April 2014 and 6 March 2015 the Committee considered an update about the pending procurement of East Kent CCG's Out-of-Hours GP and NHS 111 services as part of the urgent care programme. On 6 March 2015, the Committee agreed the following recommendation:

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

2. Recommendation

RECOMMENDED that the report be noted and the East Kent CCGs be requested to provide an update on the implementation of the new contract.

Background Documents

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

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (06/03/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5838&Ver=4

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Meeting:	Health Overview and Scrutiny Committee
Date of Meeting:	3 June 2016
Subject:	East Kent integrated urgent care service procurement
Purpose:	This paper is to update the Health Overview and Scrutiny Committee (HOSC) on the outcome of east Kent's new integrated urgent care service procurement combining NHS111, GP out of hours (OOH) and the new care navigation service. The paper builds on two previous briefings provided for the HOSC on 11 April 2014 and 6 March 2015.

1. Background

In April 2014 the CCGs presented a briefing to the HOSC outlining their plans to modernise the approach to urgent care provision, with a greater focus on integration and local accessibility.

A strategic goal of the four east Kent's CCGs is to develop the integration of urgent care and long-term conditions strategies.

This is intended to improve local services by providing better options for patients to access local care.

The wider objectives of this programme are:

- Modernising and integrating services to wrap around patients' needs within their local community
- Reducing unnecessary attendances to hospital
- Promoting greater independence within the community
- A progressive approach to long-term conditions management within the CCGs
- Structured local initiatives for improving access to primary care and providing more care in patients' homes.

A working group including clinical leads and CCG support staff and lay representatives from all four CCGs was initiated to support the development of key principles.

The public engagement team supported the process and liaised with local patient groups to inform the design of the service model.

The approach included aligning the procurement of the OOH service to coincide with the 111 procurement in 2016 and as intended to integrate key services for primary care response out of hours, This approach has been recognised nationally

as best practice as referrals from 111 to A&E are higher with a fragmented service.

A progress report was presented in March 2016 prior to the start of the procurement process. The report included the proposed service model which was has been designed to deliver highly responsive, effective and personalised services for those people with urgent but non-life threatening needs.

The successful provider would be required to manage fragmentation between the formerly separate services and maximise efficiency encouraging use of local pathways to avoid attendance at hospital wherever possible.

2. Procurement outcome

Following comprehensive and robust procurement process, including a rigorous evaluation by patients and commissioners which looked at safety, quality, service delivery and overall cost-effectiveness, the four clinical commissioning groups for east Kent have agreed to appoint Primecare, to run the 111 and out of hours services from October 2016.

The new service has further been improved by including a care navigation service that can help refer patients with more complex, urgent needs to a variety of responding services to help to keep patients at home whenever appropriate and possible.

The new contract runs for three years, with an option to extend for a further two years.

3. Impact on Existing contracts

Currently there are two contracts: one for emergency out of hours GP appointments at the weekends, evenings and bank holidays, run by IC24, and one for running the NHS 111 phone service, which is provided by South East Coast Ambulance Service. Staff already working for these services will be able to transfer to the new provider where eligible and early meetings between providers have been arranged to ensure smooth service transfer and communication with staff.

4. Mobilisation Governance

Mobilisation Board

The East Kent Integrated Urgent Care Service (EK IUCS) Clinical Governance and Mobilisation Board has been established to oversee the assurance processes for the mobilisation, service commencement, system wide integration and post implementation review of the EK IUCS ensuring clinical quality and patient safety. It will identify any barriers to mobilisation and will co-ordinate a partnership response to overcome any risks or issues needing resolution.

The Board includes commissioner and clinical representation from each CCG, project team and representatives from Primcare and held its first meeting on the 28 April. The board will be accountable to the Governing Bodies of each of the four east Kent CCGs and will send update reports to the Governing Bodies, System Resilience Group (SRG), East Kent Strategy Board and the Kent and Medway Urgent and Emergency Care Network.

5. Sub-working groups

A joint project team with the provider will be established with Mobilisation Board sub-working groups accountable to the EK IUCS Clinical Governance and Mobilisation Board to address specific aspects of work for the project covering the key areas:

- Clinical Governance and Pathways
- Quality
- IM&T, Telephony and Interoperability
- Pharmacy
- Workforce
- Estates
- Business Continuity
- Communications and Engagement
- Finance and Business Intelligence
- Contract.

6. Key Milestones

A detailed project plan was presented and reviewed by the mobilisation board on the 28 April and the first project meeting has already taken place with the new provider.

The service is planned to go live from 28 September 2016.

Key milestones have been identified and include:

- Recruitment (in progress)
- Stakeholder engagement plan (in progress)
- Assurance testing during August 2016
- Service mobilisation review during October 2016

7. Further information

Please contact: Bill Millar – Chief Operating Officer, NHS Ashford and NHS Canterbury and Coastal CCGs Email: billmillar@nhs.net