HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 25th November, 2016

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 25th November, 2016, at 10.00 am	Ask for:	**Lizzy Adam**
Council Chamber, Sessions House, County Hall, Maidstone	Telephone:	**03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (8):	Mr M J Angell (Chairman), Mr N J D Chard (Vice-Chairman), Mrs A D Allen, MBE, Mr A H T Bowles, Mr D L Brazier, Mr G Lymer, Ms D Marsh and Mr C R Pearman
UKIP (2):	Mr H Birkby and Mr A D Crowther
Labour (2):	Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor N Heslop, Councillor J Howes, Councillor M Lyons, and Councillor C Woodward

Webcasting Notice

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UNRESTRICTED ITEMS

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

Item Timings*

1. Substitutes

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

3. Minutes (Pages 7 - 16)

4. Membership

(1) Following the Council's approval of the revised proportionality statement on 20 October 2016, it was agreed that the Conservative group would gain a seat on the Health Overview and Scrutiny Committee at the expense of the Labour group.

(2) Members of the Health Overview and Scrutiny Committee are asked to note that:

(a) Mr Brazier (Conservative) has replaced Mrs Brivio (Labour) as a member of the Committee.

5. Dates of 2017 Meetings

(1) The Committee is asked to note the following dates for meetings in 2017:

Friday 27 January
Friday 3 March
Friday 2 June
Friday 14 July
Friday 1 September
Friday 6 October
Friday 24 November

6.	NHS preparations for winter in Kent 2016/17 (Pages 17 - 22)	10:05
7.	Local Care in West Kent (Pages 23 - 30)	10:30
8.	Gluten Free Services in West Kent (Pages 31 - 36)	11:00
9.	Kent and Medway Sustainability and Transformation Plan (Verbal Update)	11:30
10.	KMPT - Transformation of Mental Health Services (Pages 37 - 60)	12:15
11.	Mental Health Rehabilitation Services in East Kent (Pages 61 - 68)	12:45
12.	East Kent Integrated Urgent Care Service (Written Briefing) (Pages 69 - 74)	

13. Date of next programmed meeting – Friday 27 January 2017 at 10:00

Proposed items:

- North Kent: Urgent Care Review
- North Kent: Adult Community Services
- Emotional Wellbeing Strategy for Children, Young People and Young Adult

- Maidstone & Tunbridge Wells NHS Trust: Financial Special Measures
- CCG Annual Rating: Update on Improvement Plan
- NHS West Kent CCG: Diabetes Services
- Darent Valley: MRSA

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*

John Lynch
Head of Democratic Services
03000 410466

17 November 2016

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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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, 7 October 2016.

PRESENT: Mr M J Angell (Chairman), Mr A H T Bowles, Mrs P Brivio, Mr N J D Chard (Vice-Chairman), Dr M R Eddy, Ms A Harrison, Mr G Lymer, Mrs P A V Stockell (Substitute) (Substitute for Mrs A D Allen, MBE), Mr A Terry (Substitute) (Substitute for Mr H Birkby) and Mr D L Brazier (Substitute) (Substitute for Ms D Marsh)

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: Ms L Adam (Scrutiny Research Officer) and Ms A Duggal (Deputy Director of Public Health)

UNRESTRICTED ITEMS

54. 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. Mr Chard apologised to the Committee for not withdrawing from the meeting on 2 September during the Healthwatch Kent item, after having declared an interest at the beginning of the meeting.

55. Minutes

(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken since 2 September:

(a) Minute Number 19 - Emotional Wellbeing Strategy for Children, Young People and Young Adults. At HOSC on 4 March the Committee requested that NHS West Kent CCG be invited to attend a meeting of the Committee in six months to provide an update. In September NHS West Kent CCG requested that an update be provided once the contract had been awarded which the Chairman agreed to. An update paper was circulated to Members on 5 September.

(b) Minute Number 25 - Kent and Medway NHS and Social Care Partnership Trust. At HOSC on 8 April during the Kent and Medway NHS and Social Care Partnership Trust (KMPT) item, a Member requested information about the Trust's work with the community and voluntary sector as part of their next update to the Committee. Upon clarification, the Member confirmed that information related to the new

Live Well Kent contract being delivered by the Shaw Trust and Porchlight.

A written briefing regarding the Live Well Kent contract - a new community mental health and wellbeing service commissioned jointly by Kent County Council (KCC) and the seven CCGs in for Kent was circulated to Members on 26 September. A Member requested that the written briefing was resent to Members and the Scrutiny Research Officer undertook to do this.

(c) Minute Number 51 - SECAmb: Update. Mr Angell reminded the Committee that at HOSC on 2 September, the Committee requested that South East Coast Ambulance NHS Foundation Trust (SECAmb) share the findings of the Patient Impact Review and CQC Inspection Report upon publication.

Mr Angell noted that the CQC Inspection Report for SECAmb was published on 29 September (on the same day as Agenda publication); the Trust received an overall rating of Inadequate by the CQC and NHS Improvement subsequently placed the Trust into Quality Special Measures.

Mr Angell stated that he had attended the Quality Summit with the Chairmen of the six HOSCs in the South East. He reported that concerns were raised about the number of formal committees the Trust may need to attend following the publication of the CQC report which could impact on the delivery of improvements by the Trust.

Mr Angell explained that, in order to minimise this, there was a proposal for the Chairs of the six HOSC to form a working group to monitor the Trust's improvement plan and to report back to their individual committees. A Member enquired if Members would have access to minutes and papers of the working group, the Scrutiny Research Officer explained that the Terms of Reference were being drafted and it was her understanding that Members would have access to those. Mr Inett asked if Healthwatch could be involved in the working group, the Scrutiny Research Officer undertook to raise this with the South East Health Scrutiny Network.

(d) Minute Number 49 – All Age Eating Disorder Service in Kent and Medway. At HOSC on 2 September a Member enquired about the difference between waiting time standards between children & young people and adults. NHS West Kent CCG notified the Committee on 3 October that the same access standards would now apply to children & young people and adults - treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.

(e) Minute Number 52 – Healthwatch Kent: Annual Report and Strategic Priorities. The Scrutiny Research Officer explained that following the incident at HOSC on 2 September relating to Disclosable Pecuniary Interests, as referred to in the previous Minutes, she needed to remind Members that under the Constitution:

A Member with a Disclosable Pecuniary Interest or Other Significant Interest in a matter to be considered, or being considered at a meeting must:

- disclose the interest; and
- explain the nature of that interest at the commencement of that consideration or when the interest becomes apparent (subject to paragraph 5 of this Procedure Rule); and unless they have been granted a dispensation:
- not participate in any discussion of, or vote taken on, the matter at the meeting; and
- withdraw from the meeting room whenever it becomes apparent that the business is being considered; and
- not seek improperly to influence a decision about that business.

A Member with an Other Significant Interest, may attend a meeting but only for the purpose of making representations, answering questions or giving evidence relating to the business, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise. The Member will withdraw from the meeting room immediately after making representations, answering questions or giving evidence.

The Scrutiny Research Officer informed Members that a copy of the Members Interest section of the Constitution had been placed on each desk. She stated that if any Member felt that they were unable to ask a question during the Healthwatch item, they were to inform her in writing after the meeting and she would approach Healthwatch Kent for a written response which would be circulated to the Committee. She noted that if there were any further queries, Healthwatch Kent would be invited back to attend the Committee.

(2) The Chairman explained that there was an error in Minute Number 46 under paragraph 5; “Kent and Medway Sustainability and Transformation Plan” needed to be replaced with “East Kent Strategy Board”.

(3) RESOLVED that:

(a) the Minutes of the meeting held on 2 September are correctly recorded, subject to the amendment in paragraph 2 above and that they be signed by the Chairman;

(b) a working group is established, made up of the Chairmen from the six Health Scrutiny Committees in the South East, to monitor the SECAmb’s improvement plan and to report back to their individual committees.

56. Kent and Medway NHS and Social Care Partnership Trust: Update
(Item 4)

Helen Greatorex (Chief Executive, Kent and Medway NHS and Social Care Partnership) and Vincent Badu (Director of Transformation (Integrated Older People's Services), Kent and Medway NHS and Social Care Partnership) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Greatorex began by explaining that she and Mr Badu were in new post; Ms Greatorex had been working for the Trust for four months and Mr Badu had joined the Trust two weeks ago. She stated that she had been really impressed with the Trust and the opportunities for improvements.

(2) Ms Greatorex reported that she had three immediate priorities. The first was the reduction in private bed use. She explained that on her first day at the Trust there were 76 patients in private beds, in locations as far away as Manchester and Hull, which was costing the Trust over £1 million a month. She stated that she had set a target of no more of 15 private beds being used by 1 November and the Trust was currently using 21 private beds. She noted that there had been positive feedback from families of patients who had been repatriated.

(3) Ms Greatorex stated her second priority was to improve Section 136 detention and roll out Street Triage across Kent and Medway, a programme where mental health professionals worked with police officers to divert and support people at risk of Section 136 detention. She noted that she had already had constructive dialogue with the Police & Crime Commissioner and the Assistant Chief Constable. She noted that her third priority was to carry out a thorough review of Older People's Services to ensure high quality, evidence based, person centre care was being provided.

(4) Mr Badu stated that he had been appointed the Director of Transformation at the Trust and had previously been a Director at the Sussex Partnership NHS Foundation Trust focusing on Section 136 detention and Older People's Services. He noted the importance of good quality care being provided to older people whilst in a crisis and supporting those who can be treated at home. He reported that he had spent the last two weeks travelling across Kent and Medway to see the delivery of services and engaging with partners and stakeholders.

(5) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about the Trust's collaboration with other organisations in relation to Section 136 detentions. Ms Greatorex explained that only 20% of people who were detained, under Section 136, required inpatient admission; 80% of people had another issue such as alcohol or drug use. She stated that the Trust had a strong partnership with the Police; she highlighted that from April 2017 people detained under Section 136 could no longer be taken into Police Custody. She noted that the Trust needed to work more closely with local authorities to offer support to people who were intoxicated. Mr Badu added that mental health practitioners could help reduce demand by triaging and signposting intoxicated people to alternative services. He noted that intoxicated people were challenging to assess; it was not appropriate for a person who required

acute care to be held in custody or admitted to a mental health unit. He stated the need to develop a better pathway for intoxicated people.

(6) A number of comments were made about Crisis Resolution Home Treatment (CRHT), A&E Mental Health Liaison services and emergency readmissions. Ms Greatorex noted that the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness led by Professor Louis Appleby had only been published the day before and the Trust had not been able to analyse the data yet. Ms Greatorex stated that CRHT was used to support patients in a community setting and the Trust was looking to review and strengthen the CRHT team. She clarified that six local authority areas of the county did not have 24/7 liaison psychiatry cover within their emergency departments and there was only one 24 hour A&E Mental Health Liaison service in Kent which was based at Maidstone Hospital. She stated that the Trust was working with Commissioners to improve Mental Health Liaison services which could reduce pressure on A&E and private bed spend. Ms Greatorex explained that the Trust believed that the majority of service users who were admitted in an emergency following an inpatient stay were those patients with a personality disorder. She stated that there was not currently a proper care pathway for patients with personality disorders and it was priority of the Trust to redesign the pathway. She noted that it was not helpful for people with personality disorders to be admitted to hospital and if admission was recommended that it should be no longer than 72 hours. Mr Badu explained that the services users who experienced delayed transfers of care tended to be older people who required additional health or social care interventions; the Trust was working closely with Adult Social Services and residential facilities.

(7) A Member enquired about the grant bid for the peer-supported open dialogue (POD) model, the work streams in Appendix A and the definition of cluster eight service users. Ms Greatorex announced that the Trust had been awarded the grant; the POD approach was a non-medicalised model developed in Finland in the 1970s which focused on what the service users and their families wanted. Ms Greatorex apologised for work streams 4, 8 and 11 being missing from Appendix A. She stated that Cluster 8 service users were people with personality disorders; they were defined as part of the national clustering of diagnostics.

(8) The Chairman invited Mr Inett and Ms Duggal to comment. Mr Inett enquired about the challenges of working with eight CCGs and how the Trust works with partners to support people with mental health problems who are well known in the community. Ms Greatorex explained that the CCGs recognised the difficulty of working with eight different commissioners in Kent and Medway. She stated that the Sustainability and Transformation Plan (STP) process had been very helpful for her as a new Chief Executive to meet with all of the Accountable Officers and Chief Executives. Ms Greatorex noted that people with personality disorders were often known to the police, emergency departments and voluntary organisations. She reported that people with personality disorder were currently receiving a poor service from all partners as services were not aligned; however she stated that it was easy to resolve, with a small investment, the pathway could be transformed. Ms Duggal congratulated the Trust on the progress made so far and looked forwarded to working with them as part of the STP process.

(9) Members enquired about the reduction in beds following the 2013 adult inpatient bed review, the recruitment of Community Psychiatric Nurses (CPN) the treatment for overseas patients and the upcoming CQC inspection in January. Ms Greatorex explained that the Trust now had 174 beds following the 2013 review which met demand; she highlighted that 30% of patients had a primary diagnosis of a personality disorder and they should not be admitted for any longer than 72 hours. She noted the importance of reinforcing the CHRT, as part of the clinically led improvements, to support patients with a personality disorder to be treated in a community setting. Ms Greatorex reported that there was a national shortage of Community Psychiatric Nurses; the Trust was using Golden Hellos and Retention Recognition schemes to recruit and retain CPNs. Ms Greatorex stated that a translator or worker was identified to meet the needs of overseas patients as part of the care planning process. Ms Greatorex explained that the CQC would be re-inspecting the Trust on 16 January 2017. She noted that she had recently reread the 2015 report and the Trust had undertaken an enormous amount of work following the inspection particularly around staffing. She highlighted the innovative Multi-Disciplinary Team which had been implemented on the wards since the inspection.

(10) RESOLVED that the report be noted and KMPT be requested to provide an update to the Committee in January.

57. Medway NHS Foundation Trust: Update
(Item 5)

Diana Hamilton-Fairley (Medical Director, Medway NHS Foundation Trust) and Shena Winning (Chairman, Medway NHS Foundation Trust) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Winning began by explaining that the Trust last visited the Committee in March 2016 following the CQC inspection in August 2015. She stated that the Trust was currently preparing for a further inspection taking place in November 2016. She introduced Dr Hamilton-Fairley who was the interim Medical Director, as part of the Trust's buddying agreement with Guy's and St Thomas' NHS Foundation Trust (GSTT).

(2) Dr Hamilton-Fairley stated a further CQC inspection would take place on 29 & 30 November 2016. The CQC had undertaken a fieldwork visit in March 2016 and the CQC had reported that the hospital was safer for patients and the leadership & staff engagement at the Trust had improved. She highlighted a number of improvements which had been made in the last six months:

- 65% of ambulance patients were seen within 15 minutes of arrival; the A&E was now the highest performing Trust in the region;
- The refurbishment of the new 24 bed majors unit had begun and was expected to be completed by December 2017;
- The Trust was regularly performing above 80% for patient being seen and treated within four hours; the Trust had moved from 127th to 86th in the performance tables;
- Patients requiring a KMPT acute inpatient bed were being admitted within 24 hours.

(3) Dr Hamilton-Fairley noted that the Trust had introduced a new Medical Model in March 2016. Following the introduction of the model 60% of patients were now discharged within 48 hours and overall length of stay had reduced. She reported that the Friends and Family test had risen above 80% for the first time in 18 months and the number of consultants seen by the patients was reducing. She stated as part of the new ambulatory care unit, GPs were able to directly refer patients to the unit and bypass the Emergency Department.

(4) Dr Hamilton-Fairley noted that staffing and finance were two areas of challenge. The Trust had been unable to recruit English trained staff and 75 Skype interviews had been scheduled with foreign staffing. She stated that nursing vacancies in the Emergency Department had reduced from 60% to 25%. She reported that the Trust had forecast a deficit of £40 million for 2016/17 and was aiming to make saving of £12.8 million through procurement and estate efficiencies.

(5) Dr Hamilton-Fairley highlighted that two CT scanners and a MRI scanner located in the car park would be installed by the end of the year to reduce waiting times. She noted that the hospital would become smoke free from 17 October with onsite support for staff and patients by Medway Council's Stop Smoking Service. She reported that the Trust was working closely with partners, including KMPT and Maidstone & Tunbridge Wells NHS Trust, as part of the Sustainability and Transformation Plan for Kent and Medway. She stated that she was confident that the Trust would come out of quality special measures following the CQC inspection in November.

(6) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about the impact of 4% efficiency savings on the Trust's recovery plan. Dr Hamilton-Fairley explained that the recovery plan was under review and the savings targets were on track. She stated that in addition to procurement efficiencies, the Trust was changing the way it delivered services which included the closure of some acute beds. The Trust currently had 50-60 patients who were fit for discharge but were not able to do due to external factors; once those beds become free the Trust would be able to close them and redistribute staff to areas of staffing shortages which would create efficiencies. To help support discharge and improve flow, the Trust had implemented a Hospital at Home service which put in place support for patients within two hours of discharge; 35 patients a week used the service.

(7) Local Members shared the views of their constituents: a Member stated that their constituents had begun to notice improvements whilst another Member stated their constituents still had major concerns. A Member asked for reassurance that the Trust was improving. Dr Hamilton-Fairley stated that when the CQC visited the Trust in March 2016 they found it to be safer for patients and was providing better care. She noted that the number of deaths in the hospital had decreased from 118.3 to 100.9 which were within the average mortality band for a District General Hospital; the Trust had not been within the average band for the last three years. She stated that the Trust had data to demonstrate significant improvement; the Trust had received feedback from a variety of stakeholders about the improvements made following the last full CQC inspection in August 2015. She noted that there were areas of good and outstanding practice in the maternity, paediatric and neonatal wards.

(8) A number of comments were made about staffing. Dr Hamilton-Fairley explained that the Trust was losing as many staff as it gained; however the Trust currently had 30-40 more staff than it had lost this year. She stated that the most challenging wards to recruit to were the general and elderly care wards. The Trust was looking to develop nursing support roles as part of career progression. She noted that the Trust carried out regular exit interviews and organised a full induction programme for overseas staffing including English language lessons, social events and staff accommodation for the first three months. She reported that the Trust was trying a number of different methods to recruit and retain staff including an educational package for nurses which was being developed for medical staffing too.

(9) In response to specific questions about collaboration with other hospitals and ambulance handover delays, Dr Hamilton-Fairley explained that the Trust worked as part of a complex matrix with partners and the Trust delivered some services on behalf of another provider to enable patients to receive high quality services closer to home. She stated that the Trust received 110 – 120 ambulances a day and 65% of ambulance patients were seen within 15 minutes of arrival making the Trust the best in Kent.

(10) RESOLVED that:

(a) the report be noted

(b) Medway NHS Foundation Trust be requested to provide an update to the Committee following the publication of the CQC inspection report;

(c) Medway NHS Foundation Trust be requested to provide the Committee with a series of graphs to demonstrate progress since the original CQC inspection in 2014.

58. Kent Health & Wellbeing Board Annual Report
(Item 6)

Roger Gough (Cabinet Member for Education and Health Reform, Kent County Council) and Karen Cook (Policy and Relationships Adviser (Health), Kent County Council) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Gough began by highlighting the three strands of 2015/16 Annual Report. The first was the statutory responsibilities of the board including the production of the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS). In 2015/16 both core documents were reviewed. An event was held in September 2015 to revise the JSNA to enable it to provide better support to Commissioners when making commissioning decisions; a more forward looking JSNA Plus was being developed. A mid-term review of the current JWHS was also held; work was underway to see how the new strategy could align with the Sustainability and Transformation Plan.

(2) Mr Gough stated that the second strand of the Annual Report was the major topics considered by the Board including the Kent & Medway Mental Health Crisis Care Concordat to reduce number of detentions under Section 136 of the Mental Health Act 1983; Learning Disability – Joint Health and Social

Care Self-Assessment Framework and update on Transforming Care (Winterbourne); Emotional Wellbeing Strategy for Children, Young People and Adults which had articulated a new family focused model of care. The Board also reviewed the five outcomes set out in the Joint Health and Wellbeing Strategy: best start in life; prevention; people with long term conditions; people with mental health issues and people with dementia.

(3) Mr Gough noted that the third strand of the Annual Report was the development of the Kent and Medway STP. The Board had been involved early on in the process and had had discussions in open and closed session. He reported that one of the strengths of the Kent and Medway STP was strong clinical engagement. There were a number of areas which fed into the Board through the STP such as workforce and estates. He explained that the STP also raised questions regarding the role of the Board going forward particularly how the Board fits into the governance process and the purpose of the Joint Health and Wellbeing Strategy if the Kent & Medway STP was strong.

(4) Members enquired about HOSC's role with the STP and the impact of the STP on surrounding areas. Mr Gough explained that a further submission by the Kent & Medway STP was due on 21 October. He noted that an earlier version of the STP was submitted in the summer and reviewed by Simon Stevens (Chief Executive, NHS England) and Jim Mackey (Chief Executive, NHS Improvement) and there had been a positive discussion. He stated that there was a considerable amount of work to do in Kent and Medway particularly in creating a financially sustainable system to reflect the Five Year Forward View without new legislation and within a short time frame. He expected the CCGs to take further information about the STP to their Governing Bodies after the submission on 21 October. He reported that the Kent & Medway STP recognised the big dependencies towards London and the A21 corridor. He stated that it was important for the STP to be brought to the HOSC and the Health and Wellbeing Board. Mr Inett noted that Healthwatch Kent was working with the STP Engagement Lead for Kent and Medway; he highlighted that underneath the Kent & Medway wide STP, local plans were being developed such as the strategy for East Kent.

(5) A number of comments were made about the future of local Health and Wellbeing Boards and the inclusion of growth areas in the STP. Mr Gough stated that there was uncertainty about local Health and Wellbeing Boards going forward. He noted that as part of the STP, areas of growth such as Ebbsfleet which had gained Healthy New Towns status had been separated out as part of the Plan. He noted that health was an important part of growth infrastructure and investment.

(6) RESOLVED that the Kent Health and Wellbeing Annual Report 2015/16 be noted.

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Item 6: NHS preparations for winter in Kent 2016/17

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2016

Subject: NHS preparations for winter in Kent 2016/17

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 3 June 2016 the Committee considered a review of the NHS response to winter 2015/16 in Kent and the actions they took in response to the BMA's industrial action. The Committee agreed the following recommendation:

- *RESOLVED that the report be noted and NHS England be requested to:*

  (a) provide an overview of the 2016/17 winter plans to the Committee at its October meeting;

  (b) provide a written briefing on the SAFER bundle to the Committee.

(b) A written briefing about the SAFER bundle was circulated to Members on 9 June. On 19 September 2016 the Chairman agreed to a request from NHS England to postpone the item until the November meeting.

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

2. Recommendation

RECOMMENDED 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 June meeting.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (03/06/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=38121

Contact Details

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NHS Preparations for winter in Kent 2016/17

1.0 Purpose

This report provides a briefing to the Kent Health Overview and Scrutiny Committee, which describes the actions that are being taken by across the Health and Social Care system to prepare for winter.

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 Preparedness and Response activities over winter 2016/17 are the Local Accident and Emergency Delivery Boards (LAEDB), which in August 2016 replaced the previously established System Resilience Groups.
Kent has four LAEDBs 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.

NHS England South (South East) Assurance and Delivery Team has a nominated relationship manager for each CCG and a nominated senior manager who attends each LAEDB. These colleagues work together to ensure that the CCG through the LAEDB is working effectively with their local health and social care providers to manage the delivery of urgent care patient pathways across that health economy.

3.0 A&E Performance: Current Position and Recovery Planning

Currently none of the 4 acute healthcare providers in Kent are meeting the four hour A&E waiting standard, and there are a high level of delayed transfers of care in several Trusts, in particular at the Maidstone and Tunbridge Wells NHS Trust and Medway NHS Foundation Trust.

LAEDBs and individual provider trusts have A&E recovery plans to address these issues, and to implement the five key themes of the national A&E Improvement Plan which are:

1. Emergency Department streaming at the front door

2. Increase in NHS 111 calls transferred to a clinical advisor
3. Implementation of the national Ambulance Response Programme
4. Improved flow
5. Improved discharge processes

Most of the specific initiatives involved are not new; they are based on known good practice that can help improve performance, patient safety and reduce waste, but implementation is at different stages across the country. These include ensuring that acute providers are appropriately linked in with primary care, mental health, community and intermediate care services, social care and independent care sector providers, that there is appropriate access to out of hospital services so that populations are not reliant on A&E, that appropriate discharge arrangements are in place for all patients and there is senior leadership and oversight in place across organisations. This includes an expectation that social care and independent care sector providers are also fully engaged in work to prevent delayed transfers of care (DTOC).

Delayed Transfers of Care can be a result of difficulties placing patients, who are considered by the hospital to be medically fit for discharge (that is patients who no longer require an Acute Hospital bed), back into their homes with appropriate support or into NHS Community or KCC Social Care beds.

4.0 Local Accident and Emergency Delivery Boards' Winter Preparedness and escalation and surge management

NHS England South (South East) set a clear expectation that all Local Accident and Emergency Delivery Boards will have put in place robust winter plans including capacity and surge management plans ahead of winter. There is a national assurance process and arrangements are expected to include collaborative planning with social services and mental health services, comprehensive flu strategy, action plans for adverse weather and processes to manage infection disease outbreaks and mechanisms to flex capacity in the event of surge.

Nationally NHS England has published an Operational Pressures Escalation Levels (OPEL) Framework to ensure consistency in approach, terminology and nomenclature across the country. KCC will notice a move away from the use of the escalation terminology of Green, Amber, Red and Black and the implementation of

Operational Pressure Escalation Level (OPEL) 1-4. Local Capacity and Surge Management plans will reflect the national framework and set out how systems escalate pressures and support each other to continue to deliver urgent and emergency care during times of increased demand.

NHS England South (South East) has ensured that each LAEDB has conducted, or planned, a Surge Capacity exercise ahead of winter 2016-17. All LAEDB are expected to update their winter plans including capacity and surge management plans to take account of the review and lessons identified by exercise. All healthcare providers and CCGs in Kent are also now utilising a software system to enable them to share real-time data on a local health economy basis to assist them in managing more proactively capacity and surge issues.

5.0 Winter Communications, including Seasonal Flu vaccination.

All LAEDBs have in place plans winter communications plans that support the nationally led 'Stay Well This Winter' campaign, which is a joint initiative between NHS England and Public Health England. http://www.nhs.uk/staywell/

The Met Office have also commenced their Cold Alert Level service as well as their Storm naming service, successfully trialed in winter of 2015-16 to raise awareness with the public of severe winter weather and the potential for its effects.

Outbreaks of flu can occur in health and social care setting, and, because flu is so contagious, staff, patents and residents are at risk of infection. As a result front-line healthcare workers are offered a flu vaccination. LAEDB are required as part of their winter planning to have put in place measures to maximise and monitor update by eligible Health and Social care staff.

6.0 Winter Reporting

NHS Improvement commenced daily winter reporting on all NHS providers of acute healthcare in England on 1st November 2016. NHS England has implemented a system similar to last year's process whereby local health economy system pressures are escalated to NHS England when LAEDB's Surge and Capacity Management Plans are triggered at a level when the local health and social care

system is experiencing major pressures compromising patient flow and these continue to increase.

In addition there will be additional focus on winter reporting during the two Bank Holiday periods as well as scrutiny of primary care and 111 plans in the run-up to these critical periods.

9.0 Summary

- The key vehicle for winter Preparedness and Response activities over winter 2016/17 are the Local Accident and Emergency Delivery Boards (LAEDB) of which KCC is an integral part, which in August 2016 replaced the previously established System Resilience Groups.
- Kent's acute healthcare providers are not currently meeting the A&E four hour waiting standard, and there are high level of delayed transfers of care in several Trusts.
- The Local Accident and Emergency Delivery Boards (LAEDB) have taken and are continuing to take steps to improve A&E performance. All LAEDBs have now provided an action plan that describes how they will continue to implement the 5 national priorities, and progress will be monitored
- Individual Health and Social Care organisations and LAEDBs have winter plans including surge and capacity plans in place and the Local Accident and Emergency Delivery Boards (LAEDB) have taken and are continuing to take steps to prepare the health and social care system to manage winter pressures.
- Lessons identified from winter 2015/16 have been incorporated into these plans and systems have exercised these plans.
- A strong national communications campaign is being supported and delivered locally. The NHS recognises and welcomes KCC's ongoing support to successfully deliver these important messages to the population of Kent
- KCCs support in encouraging the update of seasonal flu vaccination is welcomed.
- A robust system of winter reporting has been implemented from 1st November 2016 to identify and respond any challenges as they arise.
- The high rates of Delayed Transfers of Care at some NHS Hospital sites are highlighted as an area where further work is required in coordination with KCC.

Item 7: Local Care in West Kent

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2016

Subject: Local Care in West Kent

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

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

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1. Introduction

(a) On 8 April 2016 the Committee considered briefings from King's College Hospital NHS Foundation Trust and West Kent CCG regarding changes to outpatient services provided at Sevenoaks Hospital. The Committee agreed the following recommendation:

- *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.

(b) On 19 September 2016 the Chairman agreed to a request from NHS West Kent CCG to postpone the item until the November meeting.

(c) NHS West Kent CCG has asked for the attached report about local care in West Kent including updates about Edenbridge Hospital and Sevenoaks Hospital to be presented to the Committee.

2. Recommendation

RECOMMENDED that the report on Local Care in West Kent be noted and NHS West Kent CCG be requested to update the Committee at the appropriate time.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (08/04/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6258&Ver=4

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West Kent
Clinical Commissioning Group

Local Care in west Kent

November 2016

Patient focused,
providing quality,
improving outcomes

Summary

This paper provides a briefing for the Kent Health Overview and Scrutiny Committee (HOSC) on the progress made by NHS West Kent Clinical Commissioning Group (CCG) to design and implement Local Care.

This is where GPs, nurses, therapists, social care workers, mental health staff and urgent care staff will work together across towns and rural areas so that people can get the care they need at home and in their community wherever possible, reducing the need to go to hospital.

The aim is for people to be supported by a single team, with GP leadership, which treats their physical and mental health needs, seven days a week. By working together more effectively, this team will free up GPs, nurses, therapists and others to spend more time on frail older patients, people with complex needs including mental health needs, and patients at the end of their lives.

Recommendation

Members of the HOSC are asked to note the contents of this report.

Background

In line with its strategic vision, Mapping the Future and with national guidance, NHS West Kent CCG has been designing its response to Local Care. In west Kent this includes providing services on a hub and cluster model, which will enable groups of GP practices to be linked geographically. They will then be able work together and share resources to deliver viable and sustainable services for appropriately sized groups of population, in buildings suitable to support this new way of working.

Overview

The delivery of Local Care in west Kent will be undertaken in two phases. Phase one is the development of the service specification for a core cluster level team focussing on prevention and planned care covering four main areas: frailty, end-of-life, dementia and mental health. Phase two will be the development of an additional service specification including pharmacy, paramedics and therapy services.

This overall specification has been developed through the establishment of **West Kent's Cluster Commissioning Project Group** which has started to define a service specification focusing on what is best for the patient and for primary care and what is needed to evolve into the new model of delivery. GPs from federations in west Kent and frontline staff from community and mental health services, who are the key parties involved in the commission

and delivery of primary care, have already given support to this model and are involved in its development. The project group is comprised of four work streams:

1. Community Nursing Services
2. Complex Care Nurses and Health and Social Care Coordinators
3. Mental Health Services
4. Social Care

A new model of primary care will begin to take effect for services commissioned in 2017/18 through alterations to existing contracts. It is expected that during year two, NHS West Kent CCG will move towards the multi-speciality community provider (MCP) model, as set out in the NHS Five year Forward View.

An outline service specification developed by the project group was presented and discussed at a specially convened **meeting on 19 July, 2016 for frontline Primary care and community staff** where further feedback was taken to incorporate into the draft specification

Public engagement is being undertaken to ensure the service specification requirements meet the needs of patients and carers.

Federations have been working on defining the 'clusters' within their respective federation areas.

Public health is undertaking population stratification at each cluster level, which will assign the densities of specific personnel as per the needs of the cluster population.

Our current providers have been key in contributing to the work which defines the way Local Care will work in the future and the CCG is now in the process of discussing with them how the system can move the way it is structured, its governance and accountability and the practical ways in which services are delivered to align with this new way of working over the next 18 months. It is the CCG's and local providers' intention that the new model of care is fully established and embedded in west Kent by March 2019.

GP federations

West Kent GPs have formed into Federations in preparation for the move to Local Care. In turn west Kent practices will be grouped into clusters of local delivery. There will be eight clusters of delivery (Sevenoaks, Tunbridge Wells, Tonbridge, Weald and four clusters covering the Maidstone district). These will range in the size of population they cover from 45,000 patients to 80,000 patients approximately, depending upon demographic make-up of the population in each cluster and the geographical distances involved. GP Federations are active partners now in the move to establish the new Local Care landscape in west Kent and they include setting up a provider arm of their business which will evolve over the next

18 months to be in a position to bid for the full range of services alongside other providers in future tenders.

Creating local hubs of care

The model for Local Care includes the development of hubs of care within west Kent. It is anticipated that, depending upon the exact services which are delivered from each hub, these will need to be serving a population of around 100,000 people. This is to ensure that a critical mass of services, with interdependency, can be co-located and that services can be delivered on a cost effective and sustainable basis. The CCG is currently in discussion with local providers, including west Kent GP Federations, to determine the most suitable place for hubs to be sited and the clinical service construction of each of these. This will include determining the range of models which will apply and the degree to which these are enhanced by having a GP surgery within the hub. This work is ongoing.

However, due to other issues which have formed the catalyst for discussion, two specific locations in west Kent are continuing ahead of the remainder – in Edenbridge and Sevenoaks.

In Edenbridge, local people have been engaged to help shape future services in Edenbridge which are likely to combine the current GP surgery (which can no longer be delivered within the constraints of a building which is at the end of its life) and many of the services provided from Edenbridge Hospital. The strategic outline case is in the final stage of development and this needs to be signed off by NHS England. We will then formally move to a consultation phase on this work which will include the Health Overview and Scrutiny Committee and local people.

In Sevenoaks discussions have started with local GPs and other providers of services on the Sevenoaks hospital site (including Darent House) to explore whether it will be possible and sensible to locate a hub at the hospital and whether there is an appetite within the local GP group to co-locate a GP surgery on the site. Recently the first meeting was held, in conjunction with providers, Sevenoaks District Council, GP practice representatives and their PPG Chairs to look at the wider opportunities and to identify the key workstreams which will need to be established to take this work forward. This includes the involvement of NHS Propco, the owners of the hospital site, to assist in considering options going forward and particularly the suitability and sustainability of the current stock of buildings and services.

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Item 8: Gluten Free Services in West Kent

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2016

Subject: Gluten Free Services in West Kent

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

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

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1. Introduction

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

2. Potential Substantial Variation of Service

(a) It is for the Committee to determine if the withdrawal of gluten free prescriptions constitutes a substantial variation of service.

(b) Where the HOSC deems the withdrawal of gluten free prescriptions as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the CCG.

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

3. Recommendation

If the withdrawal of gluten free prescriptions is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the withdrawal of gluten free prescriptions by NHS West Kent CCG to be a substantial variation of service.

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

3. Recommendation

If the withdrawal of gluten free prescriptions is *substantial*:

RECOMMENDED that:

(a) the Committee deems the withdrawal of gluten free prescriptions by NHS West Kent CCG to be a substantial variation of service.

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

Background Documents

None

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NHS
West Kent
Clinical Commissioning Group

Gluten-free services in west Kent

November 2016

Patient focused,
providing quality,
improving outcomes

Summary

This paper provides a briefing for the Kent Health Overview and Scrutiny Committee on the proposal by NHS West Kent CCG to stop routine prescriptions for gluten-free products for people with coeliac disease.

The CCG is about to start a consultation on this process to find out whether people who fund and use West Kent NHS services agree with this proposal and if there are any groups who would be particularly impacted by the change.

Recommendation

Members of the HOSC are asked to note the contents of this report.

Background

All of the NHS, social care and public health in Kent and Medway are working together to develop ideas for a shared plan for the future. This will be a Sustainability and Transformation Plan (STP) that will set out how we think services need to change over the next five years to achieve the right care for people for decades to come and to cope with demand that is rising every year.

Every health and social care organisation is also reviewing each aspect of its work to see where improvements can be made, how waste can be reduced and productivity improved to make sure we provide the best value services with the workforce and money available.

As part of this, West Kent CCG has been reviewing the all the services, aids and medicines it provides to identify potential savings which would not have a detrimental effect on the health of those affected.

We are consulting on gluten free as we recognise this will be a change of service for those people currently receiving these products by prescription.

Current situation:

In England, the current annual spend on gluten-free (GF) products is £24.7 million (based on ePACT data April to June 2014), which is significant. Given the current challenges facing the NHS, prescribers need to ensure a fair use of resources for all their patients. There are several conditions which require specialist diets as part of the treatment (for example, lactose intolerance or nut allergies). However, coeliac disease is the only one to receive specialist diet foods on prescription.

Coeliac disease is a common digestive condition where a person has an adverse reaction to gluten. Patients who are diagnosed as having coeliac disease should follow a strict gluten-free diet.

Patients who meet Advisory Committee on Borderline Substances (ACBS) indications are prescribed gluten-free foods on free prescription which include:

- Gluten-sensitive enteropathies including steatorrhoea due to gluten sensitivity where the immune system reacts to gluten damaging the surface of the small bowel (intestines), disrupting the body’s ability to absorb nutrients from food
- Coeliac Disease, proven by biopsy
- Dermatitis herpetiformis (a skin condition linked to coeliac disease).

Historically, availability of gluten-free foods was low. Therefore, obtaining these products from community pharmacies via prescriptions improved access to them. However, with increased awareness of coeliac disease and gluten sensitivity, this has led to better labelling and information.

A general trend towards eating less gluten also means there is more demand for gluten-free foods and more availability of gluten-free products.

A wide and expanding range of gluten-free foods is available from supermarkets and online. This means the requirement to prescribe items for a person maintaining a gluten-free diet has been reduced and now does not represent value for money.

The current spend on gluten-free prescribing in west Kent is £130,000.

The proposal
NHS West Kent CCG faces substantial budgetary challenges. In reviewing our prescribing budget to ensure we are spending it in the most effective and equitable way, we feel the money spent on gluten-free prescriptions can be spent on other services without having a significant impact on the health of those affected.

The CCG therefore proposes to stop the routine prescribing of gluten-free items.

Exceptions to the proposal
There are a group of patients who have "an in born error of metabolism" called Phenylketouria (PKU) – who can only have low protein food. Even some of the foods (vegetables, fish, meat, eggs) that are available to a person on a gluten-free diet, cannot be eaten by a patient with PKU. Therefore patients diagnosed with PKU will be allowed "healthy" low protein products on prescription.

The consultation
The consultation will start in mid November and will run to mid-January.

It will include:

- A consultation document and questionnaire
- A public event to discuss any prevalent issues
- Targeting interested groups such as parents in children's centres, schools, local coeliac society, disability forums
- Working with partners such as Healthwatch Kent to share the information
- Patient Participation Group chairs and the West Kent Health Network to promote consultation across the area
- Stands and attendance at public events and places with high footfall to promote the consultation
- Banners and dedicated pages on the CCG website
- Social media activity via the CCG's Facebook and Twitter pages
- Press releases to local media.

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Item 10: KMPT: Transformation of Mental Health Services

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2016

Subject: KMPT: Transformation of Mental Health Services

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

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

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1. Introduction

(a) On 7 October 2016 the Committee considered a report from KMPT which included an updates on the Chief Executive's first 100 days at the Trust; private bed use and reduction plan; work with the community and voluntary sector; and the piloting of the Health Foundation Innovating for Improvement Programme. The Committee agreed the following recommendation:

- *RESOLVED that the report be noted and KMPT be requested to provide an update to the Committee in January.*

(b) KMPT have offered to provide an update about transformation of mental health services to the November meeting of the Committee.

2. Recommendation

RECOMMENDED that the report on the Transformation of Mental Health Services be noted and KMPT be requested to update the Committee at the appropriate time.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (07/10/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=42067

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Kent and Medway NHS and Social Care Partnership Trust

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

Transformation of Mental Health Services

Report prepared for:

Kent County Council [KCC]
Health Overview and Scrutiny Committee [HOSC]
25 November 2016

Version:	2.0	**Reporting Officer:**	Ivan McConnell Executive Director Transformation and Commercial Developments, KMPT
Date:	10 November 2016	**Report Compiled By:**	Sarah Day Programme Management Office [PMO] Programme Manager, KMPT

respect ◆ open ◆ accountable ◆ working together ◆ innovative ◆ excellence

1. Introduction

1.1 This report has been prepared at the invitation[1] of Kent County Council [KCC]'s Health Overview and Scrutiny Committee [HOSC] to provide an update about the transformation of mental health services in Kent.

1.2 This report will provide an update on five areas:

i. Context, national and local drivers.

ii. Kent and Medway Sustainability and Transformation Plan [STP] – Mental Health Overview.

iii. National mental health priorities.

iv. Transformation of mental health services 2016 and beyond.

v. The future of dementia specialist mental health care.

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

2. Context, national and local drivers

2.1 The Trust is the only county-wide provider of health services in Kent, working to a set of county-wide policies applied at a local level.

2.2 Building on this unique position, it is the Trust's vision to create an environment where mental health is everyone's business, where every health and social care contact counts, where everyone works together to encourage and support children, their parents, young people and adults of all ages with a mental health problem or at risk of developing one to live in their own community, to experience care closer to or at home and to stay out of hospital and lead a meaningful life.

2.3 To achieve this the Trust is committed to working with its partners, commissioners and other care providers to ensure:

2.3.1 All service users irrespective of age, and their carers, are treated with respect and dignity in the least restrictive, most appropriate setting of care to meet their needs.

2.3.2 All services operate across organisational boundaries to deliver care in a more effective manner through collaboratively and partnership working with community and voluntary bodies and more integrated working with primary and community health services thereby promoting wellbeing and enabling individuals with a mental health problem to live in their own community with access to care closer to home.

2.3.3 All developments and services support service users in their journey to recovery by allowing individuals to own and drive their care and treatment through an agreed integrated care planning approach that will promote the use of self-help and deliver collaborative and integrated physical and mental health services in which the

[1]KCC (24 October 2016) Lizzy Adams (Scrutiny Research Officer Strategic and Corporate Services (Governance and Law), KCC) email to Helen Greatorex (Chief Executive, KMPT).

reliance on an inpatient admission as the default response to urgent and emergency care is the exception and not the rule.

2.4 . These commitments are set within the parameters of national and local policy, namely:

2.4.1 Government plans and national policy[2] to put mental health at the centre of health reform by recognising the individual service user as a whole-person, and thereby seeking to close the gap between mental and physical health services – that is delivering mental health investment standards.

2.4.2 Local system-wide plans for 2016/17 and beyond – that is the Kent and Medway Sustainability and Transformation Plan [STP], which sets out the overarching vision and framework for the delivery of improved mental health services by 2020/21.

2.5 The projects that underpin the overarching Kent and Medway STP have been developed with a particular focus on improving clinical effectiveness. For mental health, three core areas of focus have been identified, namely promoting wellbeing and reducing poor mental health, delivering integrated physical and mental health services, and delivering improved care for individuals and their carers at times of crisis.

2.6 These work streams provide a platform for the implementation of new and innovative ways of working in partnership with partners, commissioners and other providers and are set in the STP context that the delivery of future services county-wide must include a financially sustainable health and social care system, integrated models of care, and improved prevention and reduced reliance on secondary and tertiary models of care.

3. Kent and Medway Sustainability and Transformation Plan [STP] – Mental Health Overview

3.1 The STP sets out:

3.1.1 An agreed vision for mental health services.

3.1.2 A framework for the delivery of improved out of hospital services focussing on the promotion of well being and reducing poor mental health and delivering more integrated physical and mental health services.

3.1.3 A framework for improved acute services which meet the needs of service users and carers when they are in a crisis.

3.2 Kent and Medway has a solid platform from which it can develop and deliver improved mental health services within primary, community and secondary care. Examples include:

[2] (2014) HM Government *Mental Health Care Crisis Concordat: Improving outcomes for people experiencing mental health crisis* which sets out how public services should work together to respond to people who are in mental health crisis; (2014) NHS England [NHSE] *NHS Five Year Forward View* which sets out a new shared vision for the future of the NHS based around the new models of care; (2014) Department of Health [DH] *Examining new options and opportunities for providers of NHS care: the Dalton review* which sets out new options and opportunities to help the organisations in the NHS to do more for patients; (2015) DH *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (Carter)* which sets out how large savings can be made in the NHS; (2016) NHSE *The Five Year Forward View for Mental Health* which sets out three main areas for improvement to better support people with mental health problems, namely improved access to high quality services; integration of physical and mental health care services; and promoting good mental health and stopping people from having mental health problems.

3.2.1 Live Well – a partnership between community, voluntary, arts and leisure, technology, housing and social care to promote emotional wellbeing and improved mental health.

3.2.2 Peer-Supported Open Dialogue [POD] – an international research project focused on providing holistic family intervention for people experiencing their first episode of psychosis.

3.2.3 Encompass Multi-Speciality Community Provider [MCP] Vanguard – an opportunity for community, primary and secondary care services to deliver more integrated physical and mental health services within a locality base.

3.2.4 Therapeutic staffing model – which has delivered significant change in how acute mental health wards are staffed and the number of therapeutic interventions that are available to all inpatients on a daily basis thereby reducing length of stay and promoting a recovery focussed approach.

4. National mental health priorities

4.1 NHS England [NHSE][3] has set out its expectations on how two year contracts and the STP plans should reflect the imperatives for mental health. The key priorities set out are themed under the following headings:

4.1.1 Commissioning additional psychological services to increase the numbers of people accessing treatment for anxiety and depression.

4.1.2 Commissioning additional children's and young people's mental health services to meet new national waiting time standards.

4.1.3 Increasing access to evidence based specialist perinatal mental health services.

4.1.4 Implementing suicide reduction plans.

4.1.5 Ensuring that people experiencing a first episode of psychosis receive national Institute of Clinical Excellence [NICE] concordant care within two weeks of referral.

4.1.6 Commissioning community eating disorder teams.

4.1.7 Commissioning effective 24/7 crisis care.

4.1.8 Delivering a Core 24 liaison psychiatry service.

4.1.9 Improving the integration of physical and mental health services providing access to NICE physical health care checks and interventions.

4.1.10 Increased liaison and diversion services within the criminal justice system.

4.1.11 Diagnostic and evidence based standards for dementia.

4.2 The Kent and Medway health and social care system has worked proactively to develop the mental health elements of the STP. The elements of the plan align to these national

[3](21 October 2016) NHSE letter from Claire Murdoch (National Mental Health Director) to all mental health trust Chief Executives

priorities. Further work is required to develop the implementation plan in detail and in partnership with all agencies. This is being facilitated through the STP process.

4.3 NHSE[4] has published its first ever mental health dashboard. This will evolve over time but had a primary focus on publication on mental health spend. The table below provides a summary of the analysis for Kent and Medway. The analysis highlights that all CCGs, with the exception of Dartford and Gravesham achieved the mental health parity of esteem standard for 2015-16.

Summary NHS Mental Health Dashboard: Finance Metrics Only	England	NHS England South	Ashford	Canterbury and Coastal	Dartford and Gravesham	Medway	South Kent Coast	Swale	Thanet	West Kent
Mental Health Spend 2015/16 - Planned Spend as Proportion of CCG allocation	12.50%	11.80%	10.00%	13.10%	10.00%	8.40%	11.70%	10.50%	11.90%	10.10%
Mental Health Spend 2016/17 - Planned Spend as Proportion of CCG allocation	13.10%	12.20%	10.80%	13.80%	10.10%	8.40%	12.10%	10.70%	12.50%	10.20%
Mental Health 2015/16 Outturn £k	9,148,314	2,075,799	143,74	34,274	30,958	28,869	32,349	14,535	24,575	54,077
Mental Health 2015/16 Planned Spend £k	9,490,781	2,153,823	15,673	36,388	31,505	30,328	33,922	15,237	26,324	56,714
Parity of Esteem Achieved 2016/17 - Planned Spend	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes

4.4 KMPT and other providers will be working actively with all Commissioners during the 2017 - 2019 contracting round to ensure that the Mental Health Investment Standard is delivered within each of their contracts and that service developments align to the NHS England National Priorities.

5. Transformation of Mental Health Services

5.1 Mental health services are experiencing increased levels of demand. Voluntary, community and statutory agencies must improve their levels of collaboration and deliver more integrated services. The Kent and Medway STP will act as a catalyst for change in responding to this challenge. The STP will enable a focus on prevention, promotion of self care, early intervention and the delivery of integrated physical and mental health care plans for those people who have complex needs. The Trust will focus on how it makes use of community assets to improve service access and how it will support and develop its peer support workforce to deliver enhanced levels of service provision based upon their lived experience.

5.2 Analysis of performance data across Kent and Medway highlights that not only acute mental health services but partner agencies – social care, acute hospitals, police, ambulance and NHS111 – experience considerable demand from people when they experience a mental health crisis. The STP has a focus on ensuring that the Trust delivers a more integrated and improved service to people presenting in a crisis. This includes developing its liaison psychiatry model to deliver a Core 24 offering, improving the range of service available to people who have a personality disorder, improving inpatient flow, enhancing partnerships with Kent police to reduce section 136[5] detentions and ensuring that people who experience a substance misuse problem receive timely support and care.

5.3 Appendix A provides a summary presentation of the projects and work streams that together form the Transformation of Mental Health Services programme.

[4](October 2016) NHSE *Mental Health Five Year Forward View Dashboard v1.0*
[5](1983) HM Government Mental Health Act [MHA] - Section 136 of the MHA allows a constable to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital (often a special section 136 suite).

5.4 To promote wellbeing and reduce poor mental health there is a need to change the way community services are provided. Implementing a community recovery change programme within the Trust cannot be done in isolation and must include developing and implementing new ways of working that will deliver integrated physical and mental health services across multiple organisations. Whilst these changes will not necessarily require new services to be commissioned, they will require resources and expertise to be moved and arrangements to be put in place for the pooling of resources which may see a delegation of certain functions to the other partner(s) to enable an improvement in the way those functions are exercised. Acknowledging the complexity and risk involved in the programme, the Trust firmly believes by magnifying its expertise in this way, there will be greater opportunity to promote mental health education and awareness in primary and community services thereby ensuring a greater focus on community emotional well being, mental health and recovery models.

5.5 To deliver improved care for individuals and their carers at times of crisis, there is a need to further improve the integrated acute pathway and create an environment in which an improved crisis response can be delivered. This must be all age and will be achieved through a focus on patient flow which includes working with the Police to reduce the number of section 136 presentations, implementing alternatives to admission in partnership with other agencies and with a particular focus on supporting those people presenting under Cluster 8 (with a diagnosis of personality disorder), providing a Single Point of Access [SPoA] telephone triage service across all providers, and implementing a Core 24 Liaison Psychiatry model.

6. Future of dementia specialist mental health care

6.1 There are currently a number of challenges facing providers in relation to the provision of specialist services for people with a diagnosis of dementia. In addition to demographic pressures and market factors, dementia care is too expensive and too fragmented to be person centred or efficient, with too much care provided in hospital and / or care homes. The Trust, like KCC, acknowledges whilst there are some strong services across the county, there is a lack of a clear integration strategy across the health and social care spectrum.

6.2 To address these challenges the Trust is actively engaging with KCC and its efficiency partner, Newton Europe, to make rapid, sustainable and quantifiable improvements that are cost effective and improve outcomes for people with dementia and their carers while meeting targets. The Trust welcomed the opportunity to participate in the recent Dementia Summit hosted by KCC which took place on 27 October 2016.

6.3 In addition the Trust has launched its own internal Older Peoples Services transformation programme. This programme seeks to work alongside partner organisations, to support older people with dementia, and other mental health problems, and their carers to live well in their own homes and communities with integrated support, meeting their physical, mental health and social care needs. Appendix B provides a summary of the projects and work streams that together form the Older Peoples Services Transformation programme.

7. Conclusion and Recommendation

7.1 The KCC HOSC is requested to note the content of this report.

APPENDIX A : TRANSFORMATION OF MENTAL HEALTH SERVICES

KMPT is committed to improving access to service users and carers and through its recent innovations has demonstrated its commitment to working in new and innovative ways

1 Open Dialogue Pilot	• £2m internationally funded research project to implement the Peer-Supported Open Dialogue [POD] approach • Provides holistic family intervention in first episode of psychosis and reduces admission
2 Single Point of Access [SPoA]	• Dedicated clinically led mental health screening, assessment and signposting SPoA service 24/7 • Available to professionals, service users and carers (commenced April 2016)
3 Improved Patient Flow	• Reduced use of private beds in year (from 76 in June 2016 to 13 at the end of October 2016 with a trajectory to 0 by the end of December 2016)
4 Therapeutic Staffing / Peer Support	• Implementation of Therapeutic Staffing model on acute wards which provides a therapeutic day and reduces length of stay and use of temporary staff • Implementation of peer support worker programme which facilitates improved discharge
5 Liaison Psychiatry	• Implementation of National Patient Safety Agency [NPSA] award winning Specific, Measurable, Achievable, Realistic and Timed [SMART] tool for Acute hospital emergency departments [EDs] to triage mental health patients presenting risks and leading to improved throughput in ED

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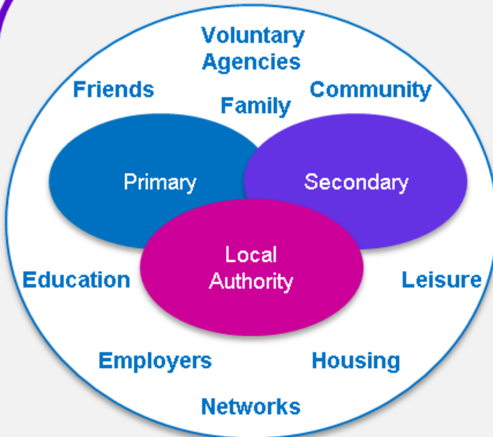
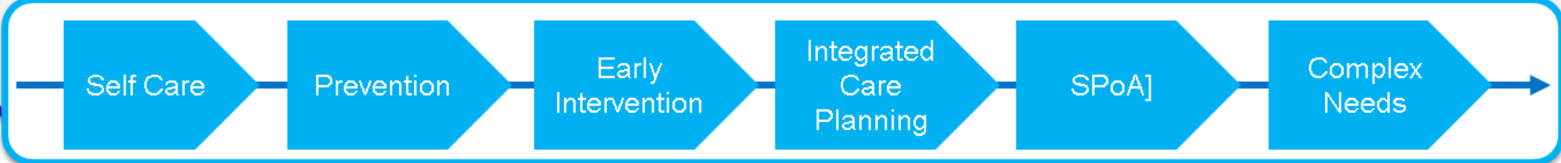
We must work as a system to sustain long term change in the provision of community mental health services

We must promote prevention, well being and deliver integrated physical / mental health services



- Promote self management and prevention
- Improved access to mental health services in primary care
- Integrated pathways of care with physical health teams particularly for those people who suffer frommultiple co-morbid long term conditions

- Use of community assets to deliver improved access to mental health and well being support
- Promote mental health education and awareness in primary and community services
- Continue to develop our peer support workforce



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Promoting well being and reducing poor mental health	Delivering integrated physical and mental health services	
Initiative	**Actions**	**Outcomes**
1 Open Dialogue Pilot	• We will increase the numbers of staff and peers trained in the POD approach to intervene early during a first episode of psychosis • We will conduct ongoing reviews of impact to support our nationally accredited open dialogue research programme	• Reduce anti psychotic medication prescribing • Reduce ED presentations • Reduce service dependency
2 Community Hubs (multispecialty community provider (MCP)	• We will ensure mental health professionals are an integral part of the new community / primary care models being implemented • We will develop integrated care plans for those individuals with a co-morbid long term condition and mental health condition • We will promote the implementation of a joint physical / mental health recovery college	• Integrated care plan for physical / mental health • Seamless care delivery • Reduced appointments
3 SPoA	• We will ensure that the SPoA provides an all age service and links to NHS 111, South East Coast Ambulance Service NHS Foundation Trust [SECAmb], Acute providers, and primary care • We will enhance the levels of signposting offered by the single point of access	• Improved access to services and sign posting across all providers • Reduced waiting times • Reduce attendance at ED
4 Meeting the needs of people with complex needs	• We will review all patients with complex needs in out of area specialist placements and seek to repatriate those we can to intensive support within Kent • We will refine the processes for placing patients in out of area placements	• Increased service access • Improved partnership working

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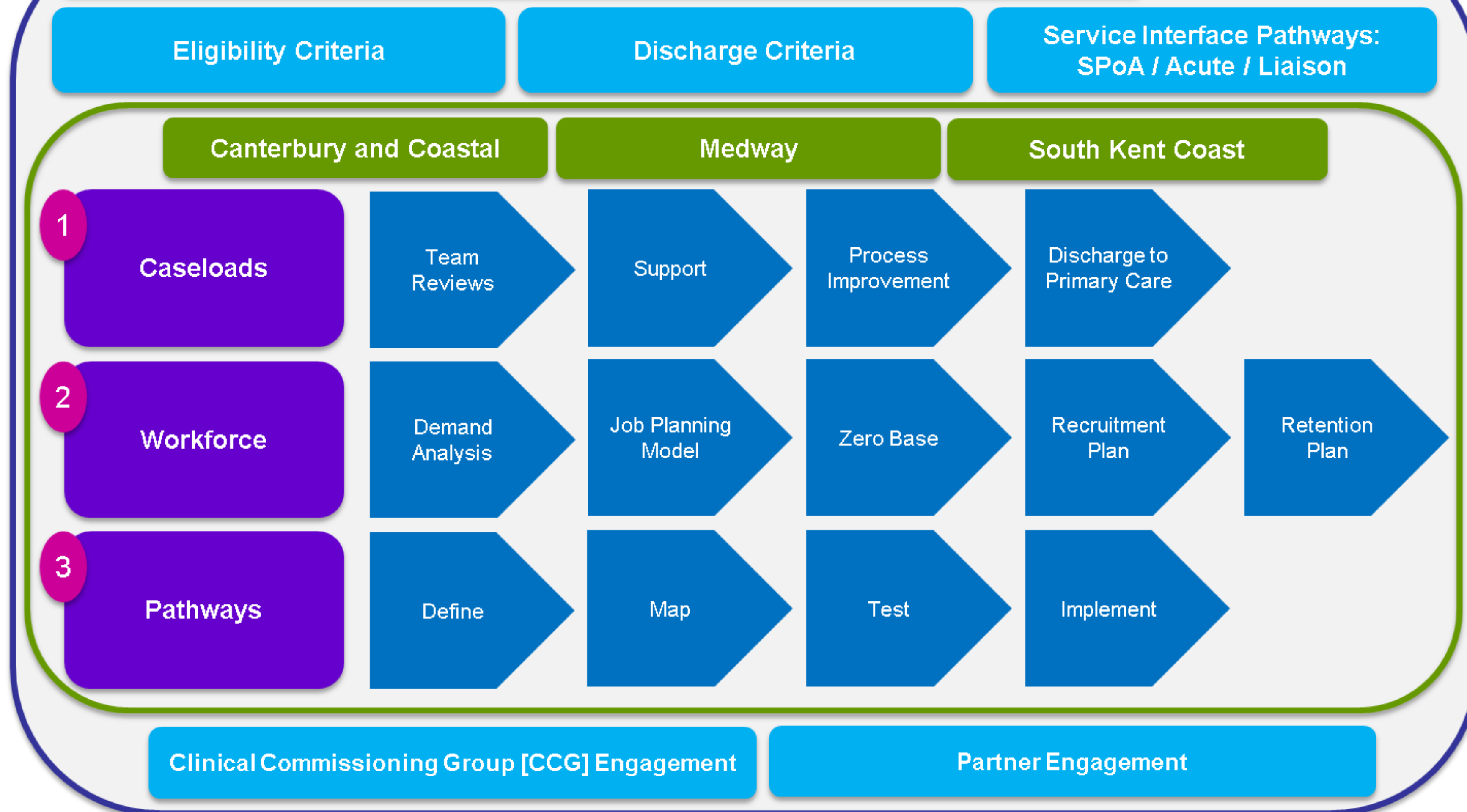

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If we are to deliver a further improved acute care model we must address a number of challenges

- NHS 111
- Police
- Acute ED
- Primary Care
- Self Referral

- Create an environment in which we deliver an improved crisis response
- Work with partner agencies to reduce the number of section 136 detentions
- Implement integrated crisis plans for those people who frequently present across all services

- Implement Core 24 Liaison Psychiatry model
- Implement alternatives to admission for people who have a personality disorder
- Implement integrated pathways of care for those people who frequently present with either substance misuse issues or a dual diagnosis

KMPT will deliver an integrated acute pathway for all ages

- All age pathway
- National Institute of Clinical Excellence [NICE] complaint personality disorder pathway
- Increased use of technology
- Integrated crisis plans for frequent presenters
- Integration with Social Services, Police and physical health
- Old age crisis support
- Core 24 Liaison Psychiatry model
- Links to substance misuse pathways
- Implementation of Medically Unexplained Symptoms [MUS] service

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Delivering improved care for people and their carers when in a crisis

Initiative	Actions	Outcomes
1 Patient Flow	• We will reduce reliance on private beds to 0 by December 2016 • We will implement alternative models of care to prevent admission in partnership with other agencies • We will actively manage delayed transfers of care [DToCs] and issues with partner agencies seeking to implement alternatives e.g. supported housing	• Saving on private bed use • Improved patient experience • Reduced DToCs • Reduced length of stay [LoS]
2 Liaison Psychiatry	• We will implement a Core 24 Liaison Psychiatry model in all Acute EDs by 2018 • We will implement a model of care in partnership with Acute providers to deliver a MUS outpatient service	• Improved ED flow and waiting time performance • Reduced costs of repeat diagnostics
3 Personality Disorder Pathway	• We will implement a NICE compliant personality disorder pathway ensuring effective prevention, community based treatment and acute crisis response - the pathway will also support a NICE compliant inpatient programme • We will implement alternative models of care to support individuals with a personality disorder	• Reduced ED presentations • Reduced inpatient admissions • Reduced LoS • Reduced number of section 136 presentations
4 SPoA	• We will ensure that the SPoA provides an all age service and links to NHS 111, SECAmb, Acute providers, and primary care • We will provide tele triage across all providers to ensure a rapid assessment of anyone presenting in a crisis	• Improved crisis response • Allocation of appropriate resources • Reduced waiting times in EDs • Reduced number of section 136 presentations

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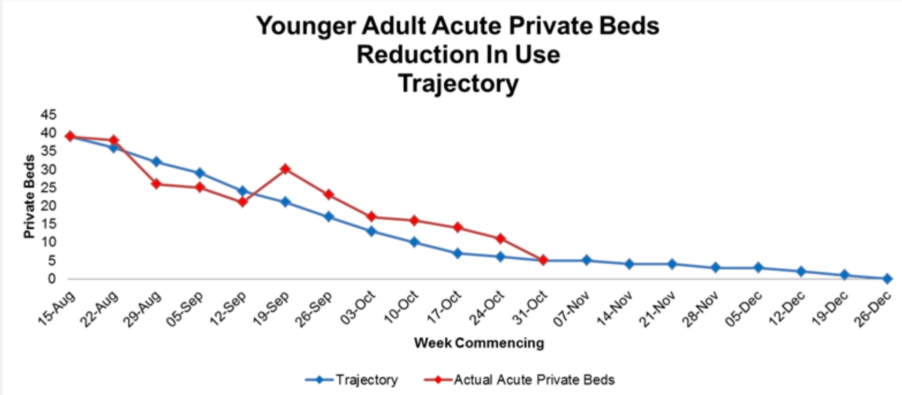
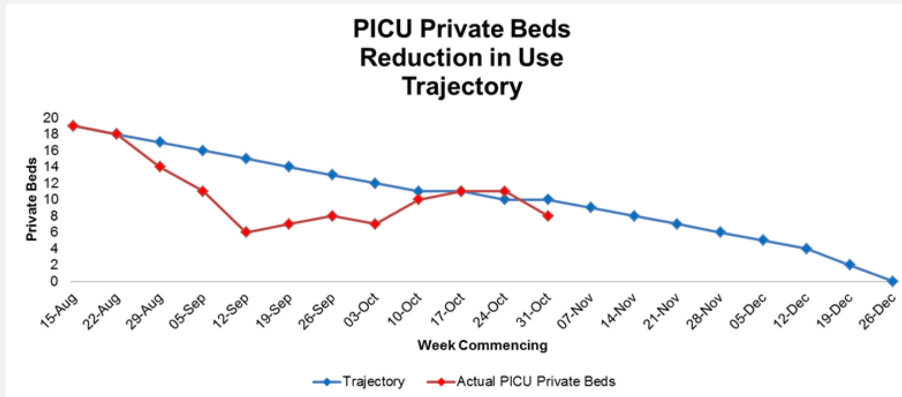
Improved patient flow will deliver benefits to services users, their carers and the health economy

KMPT is committed to reducing private bed use to 15 by the end of October 2016 and 0 by the end of December 2016

- Gatekeeping
- Patient flow calls
- Improved discharge planning
- Improved care / crisis planning
- Improved clinical site management
- Senior clinical review





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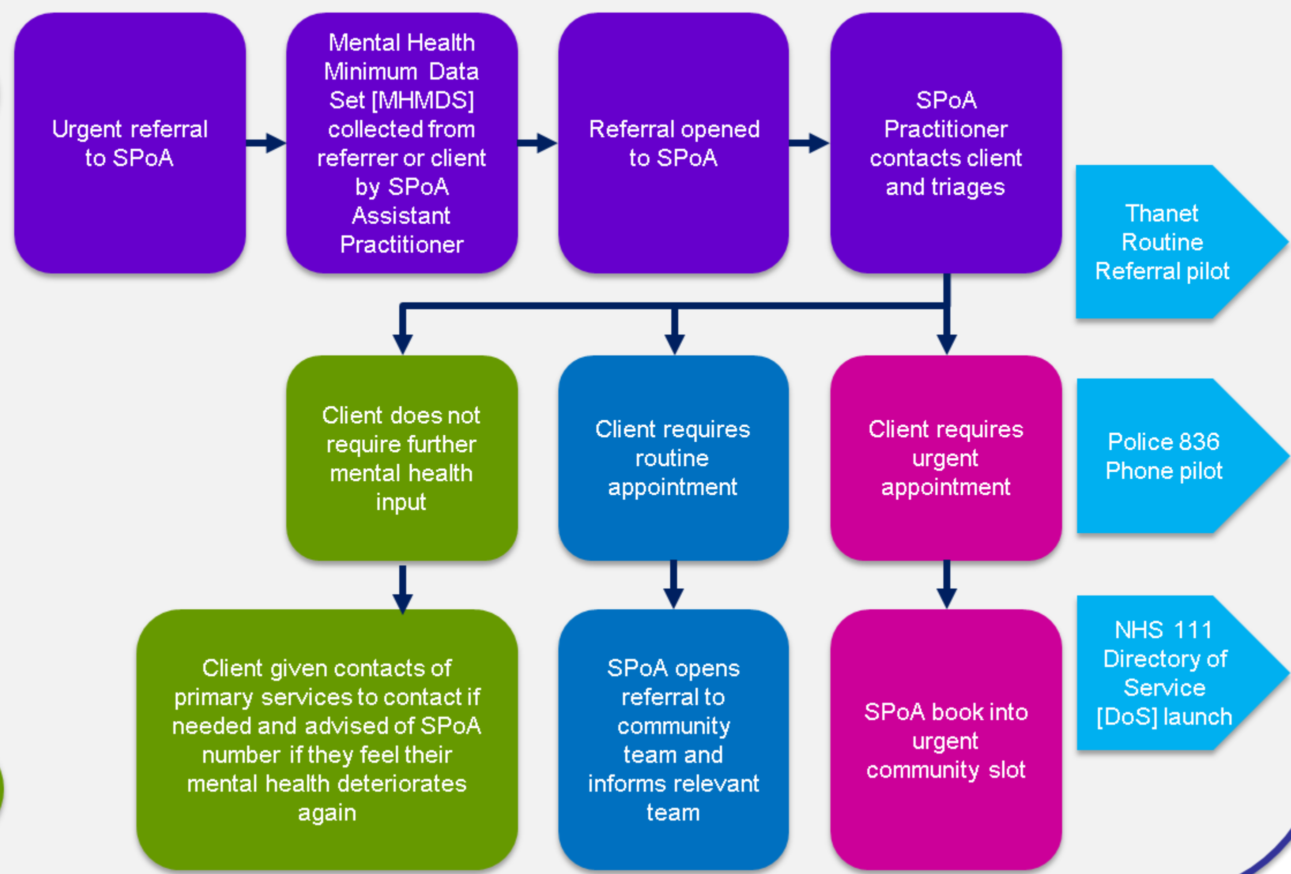

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KMPT's SPoA provides an important response to people who present in a crisis

'I wanted to thank Ian for his patience and for listening to me. I feel much better now.'

In a snapshot survey of clients who used the SPoA pathway to refer themselves to mental health services, 83% said they would use the service again

'I would like to thank Emma for taking her time to listen and having someone to talk to who really understand how I am feeling. Emma even made me laugh. Thank you again and keep up the good work.'

Total since launch:

Call Presentations: 19,848

Connected Calls: 16,539 (83%)

Abandoned Calls: 2,857 (14%)

Lost Calls: 413

Average Wait: 1 minute 7 seconds

Average Length: 6 minute 33 seconds

September 2016:

Call Presentations: 3,712

Connected Calls: 3,130 (84%)

Abandoned Calls: 537 (14%)

Lost Calls: 45

Average Wait: 1 minute 23 seconds

Average Length: 6 minute 23 seconds

Total referrals received and opened to SPoA since launch (4 April 2016): 5,508

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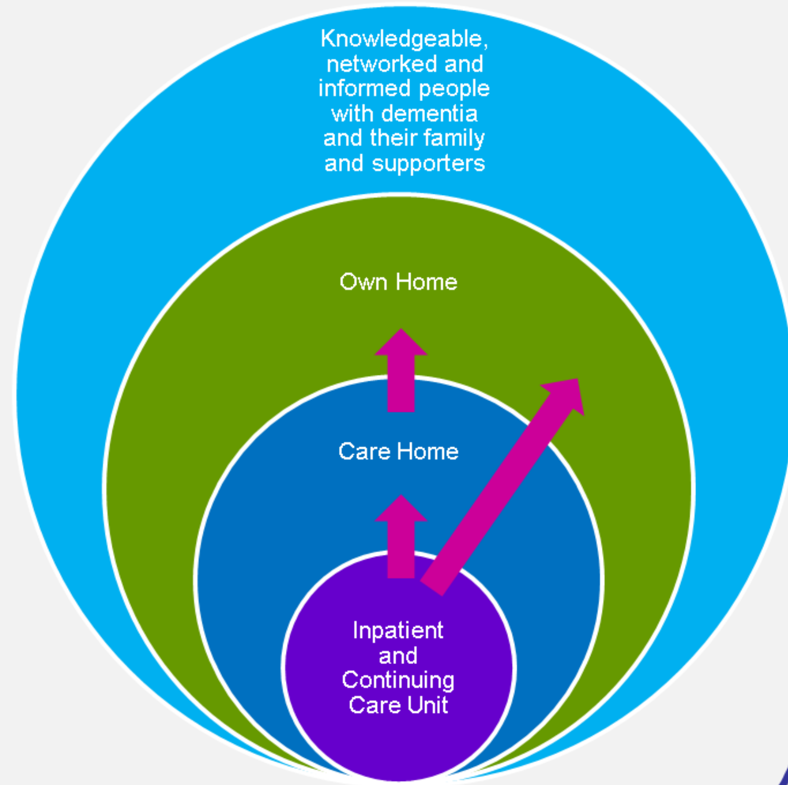
APPENDIX B : TRANSFORMATION OF OLDER PEOPLES SERVICES

KMPT is committed to supporting people with dementia and their carers to live well in their own homes and communities with integrated support, meeting their physical, mental health and social care needs

Principles:
All people with dementia should:
- Be included in decisions about them
- Be included in their communities
- Remain at home through support from cohesive services for them and their carers
- Access care home care that is valued, accessible, of a consistent high standard

Deliverables:
- Acute, Liaison and Continuing Health Care [CHC] models
- Community support and crisis services
- Integrated pathways

Outputs:
- Improved experience, pathways and outcomes
- Sustainable transformation plans



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If we are to deliver improved specialist dementia care we must address a number of challenges

- Demographic pressure and market factors
- Expensive and fragmented services
- Over reliance on care in hospitals and care homes
- Lack of clear integration strategy across health and social care

- Provide wrap around care at home
- Provide good quality of life for all care homes
- Build on partnership working to aid diagnosis and access to support
- Inreach to care homes and manage patient flow

We will deliver improved specialist dementia care

- Contribute to the delivery of an integrated model of care that provides physical health, mental health and social care support outside of hospital
- Provide expert training, advice and support and deliver specialist mental health interventions that prevent crises developing and support re-enablement
- Work with partners to pioneer innovative ways of working and utilise opportunities to participate in research

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Wrap around care at home

Introduce local teams	• Qualified and unqualified staff
Introduce new roles	• Organisational and professionally agnostic
Provide a range of educational and supportive interventions in the person's home	• Supported by a specialist disciplinary team [MDT] provide a range of educational and supportive interventions (family support and education, early intervention model of care, information and education)] • Develop and train the expert carer (family) • Provide family / caregiver respite • Provide crisis care at home • Provide time limited clinical interventions (challenging behaviour and delirium) • Provide evidence based admission in an appropriate environment to enable care home avoidance
Implement a standard model that multiple providers from different sectors can link into	• Implement a standard operating model such as the Buurtzorg Care Model plus combined social , intermediate and mental health care

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Good quality of life for all in care homes

Partnership approach	• With commissioners, regulators and agencies build relationships, invest in development of care home staff, and instil a shared vision for care
Relationship centred care	• Implement good practice based on relationship centred care to ensure staff that listen and facilitate greater voice, choice and control for people with dementia
My Home Life ™ style work	• Implement My Home Life™ (Essex Model) which is part of a wider movement established in 2006 to improve the quality of life of everyone connected with care homes • Ensure leadership starts at the top, that transformational leadership is in place, that staff are helped to engage in their work, and supported with role modelling • Establish community links
Supply = demand	• Align with rational incentives to develop market
Rational charging	• Ensure equitable access and support to find the right place at the right time • Ensure placements in secondary care enhanced specialist beds determined by need not funding stream

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Partnership working to aid diagnosis and access to support

East Kent pilots

- Bridging primary and secondary care and third sector expertise
- Practice based clinics with shared record access (Newton Place Surgery)
- Pilot multiagency open access drop-in clinics in Deal, Herne Bay, and Faversham with secondary care partnering with third sector providers
- Support the expanding role of primary care in managing dementia as a long term condition
- Royal Surgical Aid Society [RSAS] funded Link Worker to bridge diagnostic clinics and third sector support

General Practitioner [GP] Dementia Diagnosis Commissioner Provider project

- Consultant Psychiatrist input into local Thanet care homes
- Consulting with families building relationships
- Consulting with GPs building relationships
- Focus on undiagnosed dementia
- Sensitive feedback and trust building
- Positive reduction in referrals
- Positive improvement in diagnosis /
- High impact with care home confidence

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Inreach care to care homes and managing patient flow

Dedicated care home Community Psychiatric Nurse [CPN]

- Swale and Canterbury project
- Map locality care homes
- Identified dementia cases with regular client review clinics at care homes
- Communication with managers, education, needs assessment and behaviour support, dementia care mapping, admission avoidance
- Reduced admissions and alternatives to admission proven
- Quality assurance support (Creedy House experience) – wider role for this?

CHC review

- Review of clinical model to support detailed and accessible care planning that can be followed by others, safe onward transfer, outreach support for care homes, joined up working with CHC placements team, support for families
- Review of clinical models – discussion with City University of London and My Home Life™
- Scope to network KMPT with care homes using My Home Life™ as a vehicle that might also deliver sustainability in feeder care homes?

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Item 11: Mental Health Rehabilitation Services in East Kent

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2016

Subject: Mental Health Rehabilitation Services in East Kent

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

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

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1. Introduction

(a) Kent & Medway NHS and Social Care Partnership Trust and East Kent CCGs have asked for the attached report to be presented to the Committee.

2. Potential Substantial Variation of Service

(a) It is for the Committee to determine if the redesign of mental health rehabilitation services in East Kent constitutes a substantial variation of service.

(b) Where the HOSC deems the redesign of mental health rehabilitation services in East Kent as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the CCG.

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

3. Recommendation

If the redesign of mental health rehabilitation services in East Kent is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the redesign of mental health rehabilitation services in East Kent to be a substantial variation of service.

(b) East Kent CCGs and KMPT be invited to submit a report to the Committee in six months.

3. Recommendation

If the redesign of mental health rehabilitation services in East Kent is *substantial*:

RECOMMENDED that:

(a) the Committee deems the redesign of mental health rehabilitation services in East Kent to be a substantial variation of service.

(b) East Kent CCGs and KMPT be invited to attend a meeting of the Committee in two months.

Background Documents

None

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Health Overview and Scrutiny Committee

November 2016

Report on the transformation of mental health rehabilitation services for east Kent

This paper is seeking the HOSC's support for the transformation of mental health rehabilitation services in east Kent. Kent & Medway NHS Partnership Trust (KMPT), which runs the rehabilitation services, has consulted service users and our commissioners on these proposed changes. The changes that are outlined below are in line with national best practice, and KMPT is seeking the HOSC's support with the intended direction of travel, which will be better for those who use our services, their loved ones and all our budgets.

KMPT aims to return as many of those patients currently in long term residential placement outside Kent back to the county as soon as possible. The Trust plans to do this by enhancing the rehab community team to enable more intensive support to be provided to patients in their own accommodation. KMPT visited a trust in Sheffield that has developed a similar service and have been highly successful in retuning patients to Sheffield from out-of-area beds. This has led to improve patient and their carer experience.

1. Background

This paper outlines proposals by KMPT to redesign the rehabilitation service for people with severe and enduring mental illness in east Kent. The vision for the redesigned service is that people are supported as close to home as possible, rather than through a variety of out-of-area placements. The redesigned service seeks to work in partnership with housing providers to ensure there is a tiered approach to supporting people into their own tenancy.

Rehabilitation services play a pivotal role within the mental health system as a whole, working in an integrated way with acute psychiatric wards, out-of-area treatments (OATS), forensic psychiatric services, community and third sector services. The primary aim of rehab services is to support service users to be as independent as possible. These services specialise in working with people whose long term and complex needs cannot be met effectively by general mental health services. Use of health and social care resources by this group can be particularly intensive and the process can take a number of years due to the user group's complex needs profile - compounded by co-morbidities like poor physical health, substance misuse or cognitive difficulties.

Around half of the total mental health and social care budget is spent on services for people with longer term mental health problems. Services need to be delivered via 'stepped', whole system integrated care pathways, with each step representing a progression towards independent living. Developing a long-term whole-system integrated pathway for

rehabilitation is essential to achieving good outcomes for people with severe and enduring mental illness in east Kent, as well as ensuring value for money.

2. Strategic Context

The Five Year Forward View for Mental Health and the East Kent Adult Mental Health Strategy (2016 -2021) both clearly identify the need for individuals to be able to access 'high quality services close to home', and the proposed rehabilitation service transformation supports this direction of travel. The strategy also lays out a trajectory for services to increasingly move away from a 'bed based' focus to a more community based intervention, and as such this proposal meets those criteria from a commissioning perspective. The East Kent Mental Health Strategic Improvement Group, on behalf of the four east Kent CCGs and Kent County Council, have considered this transformation proposal and support its objectives and will ensure that mental health commissioners will be involved in the strategic oversight of the process, also ensuring that there is active service user and carer engagement at all stages of the redesign of the service.

2. Proposed Method

The process of the redesign of the rehabilitation service will be undertaken in a number of steps.

1. The closure of the Davidson ward at the St Martin's site in Canterbury. The current patients on Davidson will be supported in the three other inpatient rehabilitation units in east Kent, and staffing will be increased in these units during this transition phase.

2. Clinical evidence supports the view that the patient population currently receiving in-patient care on Davidson would have their therapeutic needs better met in an adaptive stepped care pathway.

3. The development of a rehabilitation community team in east Kent.

4. Working with housing associations to develop a range of supported accommodation to support patients.

5. To return patients from expensive out of area placements to their local communities, and support them to maintain their placements.

The planned closure of the Davidson ward, this financial year, is the first phase of a plan of total redesign across Kent and Medway for rehabilitation services. The philosophy is driven by key documents including the Joint Commissioning Panel for Mental Health Guidance for Commissioners of Rehabilitation Services for People with Complex Mental Health Needs, which sets out a desire for patients with severe and enduring mental illness to be supported in community settings, close to their home, rather than in institutional wards. This supports a whole systems approach including a range of inpatient and community services.

Clinicians and senior managers have undertaken visits in March 2016 to other rehabilitation services nationally which have been identified as providers of excellent care. These have been used as a basis for the proposed redesign and have shown the team the potential to deliver community-based rehabilitation services close to home. This has been strengthened

by the positive outcome of a recent pilot project undertaken by the service in clients' own homes. The pilot community rehabilitation team supported 24 patients in their own flats and supported accommodation. Benefits included:

- Reduced need for inpatient rehabilitation for a number of clients with settled accommodation
- Reduction in inpatient admissions for clients within the pilot
- Significant reduction in Community Mental Health Team and Crisis and Home Treatment involvement for clients within the pilot
- Facilitation of early discharge from inpatient setting (acute and rehab) for clients referred to the pilot
- Improved patient engagement and patient skill development due to treatment being offered in the clients own environment and dealing with 'real' issues
- Positive patient and their carer feedback.

5. Details of proposed change

The proposal is that Davidson ward is closed and the resources are reallocated to establish a fully responsive rehabilitation service within the community Current patients from Davidson will be supported in the three other rehab units in east Kent. Staffing will be increased in the existing units during the transition period; the development of the new community rehab team will enhance and support patients' recovery into the community. The existing community-based services will be further enhanced, ensuring collaborative working with all agencies, including the third sector, to provide an effective, safe and seamless service.

The new rehab community team will include medical, psychological, nursing (both qualified and unqualified) and occupational therapy input. Consideration will also be given to social care support. The introduction of the rehabilitation team in the community will facilitate improved recovery for patients, closer to their homes with the aim to support patients to lead as independent lives as they can, according to need.

The enhanced rehab community team will also function as the patient's care co-ordinator, rather than this role being undertaken by the community mental health team (current function).

KMPT intends to further develop rehabilitation services to deliver a range of interventions appropriate at all stages of rehabilitation, both when stepping up or stepping down is required, and will be realised in the second phase of service redesign in the spring of 2016. This significant transformation will support the repatriation of out-of-area patients back into local services.

6. Working with housing associations

KMPT proposes working with housing associations to increase the range of supported housing to facilitate patients' rehabilitation and their recovery. KMPT is looking to develop a tiered range of supported housing, developed according to need; i.e. nursing lead units for people requiring higher support, and then working with housing associations to establish less intensive residential support. So patients will be able to access a range of supported housing, based on their need, with the aim of supporting them in their own home. KMPT will provide high intensity and supported rehab units, with housing associations providing more of a step down rehab unit, then the Horizons service providing flexible support and ultimately patient's own accommodation, all supported by the rehab community team.

KMPT has visited two other mental health trusts that have utilised housing association help in this way: Camden and Islington Mental Health Trust and Sheffield Mental Health NHS Trust. In both areas this system works well, leaving the mental health trust to focus on what it does well- complexity and risk - rather than estate management.

7. Returning out-of-area patients to Kent

KMPT aims to return as many of those patients currently in long term residential placement outside Kent back to the county as soon as possible .KMPT plans to do this by enhancing the rehab community team to enable more intensive support to be provided to patients in their own accommodation. KMPT visited a trust in Sheffield that has been highly successful in retuning patients to Sheffield from out-of-area beds. This was their experience

- They originally had 60 out of area long term placements, now there are only 7 people with long term placements (these are complex learning disability and forensic psychiatric patients)
- Took the budget from the CCG managed it within the trust
- Challenged private placements (clinically-led)
- Saw the patient in the system, got to know patients
- Housing based approach
- Worked with a housing association who provided flats, whilst the trust team supported patients tenancies and ability to remain in the community
- Originally worked with 25 patients
- Identified flats (patient choice)
- Developed team to support patients
- Eight patients supported by small team of two community psychiatric nurses (CPN's) and nine support workers (originally 24/7, now 8 a.m. to midnight)
- Overarching rehab team, has medical, psychological and occupational therapy input

- Heavily supported by psychology, reflection and formulation, each member of staff has two hours session (as a group) per week, as most patients had a diagnosis of personality disorder or psychosis and co morbid personality disorder
- Senior medical and operational lead to embed change.

KMPT is currently working closely with the CCGs in east Kent to identify and understand the patients in out-of-area beds, and would now like to move to the next stage to identify a cohort of patient to return to the county, supported by the rehab community team.

Further information:

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Item 12: East Kent Integrated Urgent Care Service (Written Briefing)

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 25 November 2016

Subject: East Kent Integrated Urgent Care Service (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.

---

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.

(b) On 3 June 2016 the Committee received a report from the East Kent CCGs which provided an update about the outcome of the East Kent integrated urgent care service procurement combining NHS 111, GP Out-of-Hours and new care navigation service. On 3 June 2016, the Committee agreed the following recommendation:

- *RESOLVED that the report on the East Kent Integrated Urgent Care Service Procurement be noted and the East Kent CCGs be requested to provide an update on the implementation of the new contract.*

(c) Following reports that Primecare, who were appointed to run the services from October 2016, has not been able to mobilise the new contract and SECAmb have been asked to continue providing the 111 service, the East Kent CCGs have been asked to provide an update to the Committee.

2. Recommendation

RECOMMENDED that the report be noted and the East Kent CCGs be requested to provide an update to the Committee in January.

Background Documents

Kent County Council (2014) *'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) *'Health Overview and Scrutiny Committee (06/03/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5838&Ver=4

Kent County Council (2016) *'Health Overview and Scrutiny Committee (03/06/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6259&Ver=4

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Health Overview and Scrutiny Committee Briefing

East Kent Integrated Urgent Care Service

November 2016

This report updates the Kent Health Overview and Scrutiny Committee (HOSC) on the developments of the east Kent integrated urgent care service, for which Nestor Primecare Limited was awarded the contract in April 2016.

Introduction and background

In order to identify local requirements, including addressing ongoing system pressures, a review of the urgent care system across east Kent was undertaken during 2014. This review was undertaken with external support from PwC, which included:

- Development of a service specification – working with local clinical leads
- Review of procurement options – working with providers from across East Kent.

The CCGs aimed to respond to local challenges by collaborating on the design of an integrated urgent care system within east Kent. The alignment of key services, namely the NHS 111 and GP OOH and incorporating the locally developed care navigation service is seen as paramount to success.

The successful provider will deliver for those people with urgent but non-life threatening primary care needs a highly responsive, effective and personalised service. This service should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.

The integrated service will address fragmentation between the formerly separate services and maximise efficiency encouraging use of local pathways to avoid attendance at hospital wherever possible.

Aims and Objectives

The Service specification identified the following key aims for the new service:

1. A patient-centred service that demonstrates the best possible clinical outcomes and improved patient experience.
2. Greater integration between front line services and seamless working
    a. Promote efficient interaction from the patients perspective
    b. The new integrated NHS 111, GP OOH and Care Navigation Service should work seamlessly with the developing Integrated Urgent Care Centres co-located within the Accident and Emergency department that are commissioned by Ashford and Canterbury CCGs

NHS

3. Greater responsiveness of services and reduced duplication. It is proposed that by reconfiguring existing services, the health economy will:
    a. improve health outcomes for patients
    b. reduce the number of patients accessing traditional accident and emergency services by:
        i) utilising services provided by the Integrated Urgent Care Centre (IUCC) (Ashford and Canterbury & Coastal CCGs)
        ii) encouraging patients that are able to travel to the allocated local base at an acute site for urgent care to do so
        iii) increasing the number of Out of Hours treatments undertaken in a patient's home or place of residence (South Kent Coast CCG).
    c. reduce the need for acute admission to Hospital
    d. reduce the length of stay in Hospital when an admission is required

GP Out of Hours

The GP OOH service went live on 28 September 2016. The first weekend was challenging with a number of issues identified. Significant improvement has been seen over recent weeks, particularly on weekday evenings, though weekends continue to be busy across the entire urgent care system

To support the go live period for the OOH service, daily operational calls were held to enable enhanced communication and support to be in place immediate prior to and for two weeks post implementation. This included discussion with provider and commissioner leads to identify and rapidly resolve any issues; supported by an escalation route if senior level involvement were required for resolution.

Key Issues identified

- IT and Telephony
- Staffing
- Directory of Services (DOS)
- 111 Call backs.

NHS 111 services

As part of the ongoing preparation for mobilisation, an operational workshop was undertaken with Primecare leads, led by the CCGs, on 13 October. This workshop identified significant gaps in terms of readiness for go live on 1 November, including staffing, training and operational processes.

The following revised timeline was therefore developed based on the actions identified supported by South East Coast Ambulance Trust (SECAmb) who have agreed to provide continued cover for NHS111 service for east Kent Patients :

22 Nov 16	45 per cent of contract call volume provided by Primecare 55 per cent by SECAmb
6 Dec 16	80 per cent of contract call volume provided by Primecare 20 per cent by SECAmb
10 Jan 17	100 per cent of contract call volume provided by Primecare.

Key risks

Daily reviews of the agreed action plan are in place, supported by assurance reviews by NHS England and National Integrated Urgent Care Clinical Lead.

Current risks identified include:

- Staffing – review of staffing requirements, including training and coaching arrangements to meet NHS Pathways license requirements is in progress
- Operational processes – are currently being reviewed by the SME team and local CCG clinical leads as part of the assurance process
- Estates - the installation of data fibres at the Canterbury Call Centre site has been paused pending completion of a civic suit in relation to works needed on areas of private property locally. In order to mitigate the impact of this work, an alternative site in East Kent has been sourced for an immediate three month period, and is being fitted out to ensure delivery in line with agreed timelines for go live.
- Impact of increased call volumes – analysis of NHS111 activity has been undertaken which has identified a risk of an additional 21,000 calls. A contract variation will be required to reflect this impact and ensure that workforce plans are sufficient to meet demand.

Next steps

The CCGs will continue to work closely with Primecare to ensure improved performance for GP out-of-hours service and the mobilisation of NHS111.

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