HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 27th January, 2017

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 27th January, 2017, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

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

Tea/Coffee will be available from 9:45 am

Membership

Conservative (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

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UNRESTRICTED ITEMS

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

Item Timings*

1. Substitutes

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

3. Minutes (Pages 5 - 18)

4. East Kent Hospitals University NHS Foundation Trust: Update (Pages 19 - 22) 10:05
   a) CQC Inspection Report (Pages 23 - 24)
   b) Chemotherapy Services in East Kent (Pages 25 - 26)
   c) East Kent Cervical Screening Programme (Pages 27 - 30)

5. North Kent CCGs: Urgent & Emergency Care Programme Update (Pages 31 - 38) 10:45

6. North Kent CCGs: Adult Community Services (Pages 39 - 44) 11:15

7. Kent and Medway NHS and Social Care Partnership Trust: Mental Health Update (Pages 45 - 54) 11:45

8. Maidstone & Tunbridge Wells NHS Trust: Financial Special Measures (Written Update) (Pages 55 - 62)

9. CCGs Annual Rating: Update (Written Update) (Pages 63 - 74)

10. Darent Valley Hospital: MRSA (Written Update) (Pages 75 - 84)

11. Date of next programmed meeting – Friday 3 March at 10:00

    Proposed items:

    - Kent & Medway Sustainability & Transformation Plan
    - North Kent CCGs: Urgent & Emergency Care Programme
    - Patient Transport Service
    - Emotional and Wellbeing Services for Children and Young People
    - West Kent CCG: Gluten Free Services

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

19 January 2017

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 25 November 2016.

PRESENT: Mr M J Angell (Chairman), Mrs A D Allen, MBE, Mr H Birkby, Mr D L Brazier, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr G Lymer, Mr C R Pearman, Cllr J Howes, Cllr M Lyons and Mr B J Sweetland (Substitute) (Substitute for Ms D Marsh)

ALSO PRESENT: Mr S Inett

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

UNRESTRICTED ITEMS

1. Minutes
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken since 7 October:

(a) Minute Number 46 - East Kent Strategy Board. On 2 September, the Committee considered an update about the work of the East Kent Strategy Board and requested that an update be presented to the Committee in November. On 24 November 2016 the Committee was notified that the East Kent strategy work had become the STP content for east Kent and that the Board would now operate as an East Kent Delivery Board to refine recommendations for how services could best be organised in east Kent in the future.

(b) Minute Number 52 - Healthwatch Kent: Annual Report and Strategic Priorities. As part of the update regarding follow-up actions taken since the previous meeting on 7 October, Members were asked to submit any questions for Healthwatch which had not been covered during the Healthwatch item on 2 September. The responses to those questions were circulated to the Committee on 22 November.

(c) Minute Number 57 - Medway NHS Foundation Trust: Update. On 7 October the Committee requested that 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. A series of slides showing the Trust's improvements was circulated to the Committee on 22 November. Medway NHS Foundation Trust had also invited the Committee to come for a tour of the hospital to see first-hand some of the recent improvements including work to improve emergency department.

(2) RESOLVED that the Minutes of the meeting held on 7 October are correctly recorded and that they be signed by the Chairman.

2. Membership
(Item 4)

(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 note that:

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

3. Dates of 2017 Meetings
(Item 5)

(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

4. NHS preparations for winter in Kent 2016/17
(Item 6)

Pennie Ford (Director of Assurance and Delivery, NHS England South (South East)), Hazel Gleed (Head of Emergency Preparedness, Resilience and Response, NHS England South (South East)), Matthew Capper (Director of Performance and Delivery, NHS Ashford and Canterbury & Coastal CCGs), Corrine Stewart (Assistant Director of Commissioning, NHS Dartford, Gravesham and Swanley CCG), Jacqui West (Health Interface Manager, Kent County Council) and Adam Wickings (Joint Chief Operating Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Ford began by explaining that the previously established Systems Resilience Groups had been replaced with Local Accident and Emergency Delivery Boards (LAEDB) which had a more focused remit on the delivery of urgent and emergency care. She stated that the winter pressures facing Accident and Emergency departments were really challenging and there had not been a reduction in pressure throughout the course of the year. She noted that there was a national A&E Improvement Plan which had made recommendations to be implemented locally including improving flow and discharge processes. She reported that improved discharge was particularly important for older people who began to lose function if they stayed in hospital longer than required. Mr Scott-Clark commented that, in addition to muscle wastage, the longer

patients stayed in hospital, it was more likely that they would get a hospital acquired infection.

(2) Ms Ford explained that in preparation for winter, each system had been refreshing their escalation plans and changing terminology following a national review of definitions. She reported that all systems had tested their plans including their response to snow and flooding; an increase in pressure was expected over the bank holiday period and into early January. She highlighted the national flu immunisation programme and the importance of Councils in encouraging people to take up the flu vaccination. The peak of the current winter's flu season was not known; it had been late last winter and at Christmas during the previous winter. Ms Ford invited each health economy to give an overview of their preparations for winter.

(3) Mr Capper stated that in East Kent, a whole system meeting was held at the beginning of October to review and refresh response plans, escalation triggers and terminology to ensure they dovetailed together. He noted that the cold weather and flu plan was due to refreshed within the next two weeks. In the run-up to the Christmas holidays, a super discharge week was planned where all agencies would be working together in an enhanced way to create additional capacity in the system; a follow up activity was planned for January. He reported that the implementation of GP triage model at the Kent & Canterbury Hospital, Canterbury last year had reduced the number of admissions; the CCGs with the providers were looking to replicate model as quickly and safely as possible at the William Harvey Hospital, Ashford and the Queen Elizabeth The Queen Mother Hospital, Margate. He explained that the daily escalation levels were circulated including the information about beds, workforce and A&E performance from the Single Health Resilience Early Warning Database (SHREWD).

(4) Mr Capper noted that the Out of Hours and 111 services had changed to a new provider which would provide greater efficiencies; the 111 service had recently gone live and would be responsible for providing 80% of the call cover by Christmas as part of the handover with South East Coast Ambulance NHS Foundation Trust (SECAmb). He stated that a community geriatrician resource had been developed to increase flow through acute and community hospitals as part of the Integrated Discharge Team provided by the Kent Community NHS Foundation Trust. He reported that the Discharge to Assess pilot, which carried out health and social care assessments, had been expanded alongside the Home First programme.

(5) Ms Stewart reported that North Kent had been preparing since spring to align their plans, learn from previous years and implement improvements. She stated that the North Kent CCGs had implemented SHREWD and had developed a monthly operational resilience group as part of LAEDB. She explained that in Dartford, Gravesham & Swanley, the key priority was to stream patients at the front door of Darent Valley Hospital, Dartford and assess within 15 minutes to understand their needs and direct them to alternative setting if appropriate such as the Minor Injuries Unit or the Ambulatory Ward for patients with COPD and Asthma. She reported that in Swale, the CCG was working with Medway Maritime Hospital to redirect patient from A&E to the primary care unit which had led to a 22 – 33% reduction in A&E attendance and improve discharge, with the implementation

of the Safer Care pilot which included an estimated discharge date, to reduce ambulance handover delays.

(6) Ms Stewart stated that a discharge lounge at Darent Valley Hospital had been created to enable patients fit for discharge to be moved out of beds and create capacity for new patients. The CCGs were also implementing Discharge to Assess initiatives to support frail patients return home such as the Hilton Nursing Project which provided assessments and recovery support in the patient's home; the project was currently helping to support 10 discharges a week. In Dartford, Gravesham & Swanley, a Care Navigators Pilot had been implemented with health, social care and voluntary services' support. Projects for frequent A&E attendees and palliative & end of life patients were also planned.

(7) Mr Wickings noted that West Kent had implemented SHREWD and were in daily discussions with Maidstone and Tunbridge Wells NHS Trust; he reported that there was good working relationship between the CCG and the Trust. He stated that using winter resilience money from the beginning of the year, a number of measures had been implemented including integrated COPD services, Home First service and additional support in nursing homes. He noted that GPs were working in both A&E departments with the service working better in one than the other. He stated that the CCG had assurance that preparations were going well but acknowledged that there may be difficulties in the winter period.

(8) Ms West explained that Kent County Council were partners of the LAEDBs and used SHREWD as part of its system resilience planning which included non-validated data as it was only validated once a week. She noted that the Hilton Nursing Project had also been implemented at Tunbridge Wells Hospital using CCG funding. She reported that KCC occupational therapists were providing assessments which provided additional equipment to patients post-discharge and helped to reduce their overall care package and improve patient flow. She stated that the central purchasing team were working with families able to identify homes with vacancies. She noted that Integrated Discharge Teams had been implemented on all hospital sites whose teams included KCC staff and the voluntary sector. She also stated that KCC supported Home First service and provided Enablement at Home services.

(9) The Chairman enquired about the communications plan. Ms Ford explained that there were a number of national campaigns such as the Stay Well This Winter campaign by NHS England and Public Health which encouraged members of the public to look after themselves during the winter. She reported that there were local communication campaigns which included details about alternative care provision including the use of pharmacists and using 111 as an alternative to A&E. Mr Capper noted that the communications team in East Kent were providing face-to-face information in shopping centres about alternative care provisions. He highlighted the Health Help Now app which provided users with information about their nearest health services in Kent and campaign information. He noted that as part of the national vanguard in Canterbury & Coastal CCG, a waiting list app was being developed. Ms Ford acknowledged that there were different ways to communicate with older and younger people; apps and social media were aimed at younger and working

age groups. Members gave suggestions of engaging with older people through established groups such as the Elders' Forum in Dartford; the Women's Institute and National Women's Register in Sevenoaks; and town & parish councils across Kent. Ms Ford resolved to take Members' comments about improving communication back to the LAEDBs.

(10) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about winter pressure levels remaining in the summer, engagement with the care home sector and assessments at home. Ms Ford explained that the late winter pressures last year remained into the summer which had resulted in services already being stretched going into this winter; the cause of this was unknown. She stated that the recommendations in the national A&E Improvement Plan could make a difference once implemented. Ms West stated that engagement with the care home sector; the Central Purchasing Team was speaking daily with the private sector and a Care Home Forum run by KCC and the CCGs had developed strong links with the care home sector. Ms West explained that as part of Discharge to Assess model in East Kent, patients whose needs could be safely met at home, were considered as part of Pathway 1 and were assessed within two hours of arrival at home. She noted that the Discharge to Assess team functioned within set working hours and patients were not discharged outside of these times; a similar system was due to be implemented in North and West Kent.

(11) In response to a specific question about patient and GP involvement in discharge, Ms Stewart explained that Dartford, Gravesham and Swanley CCG had recently held a four day event to look at improving discharge with health, social care and voluntary sector partners. One of the key outcomes of the event was to improve communication in and outside of hospital; a 30 day review event was planned for December. She noted that Dartford & Gravesham NHS Trust provided each patient with a booklet about the type of care they would be receiving and the estimated date of discharge. She acknowledged the importance of GPs as part of a patient's care particularly in A&E where doctors were able to see GP records and prescriptions for the patients and the provision of a telephone service which enabled GPs to speak to a senior nurse to explain the specific circumstances of a patient and receive advice about whether to refer them to the ambulatory care unit.

(12) Mr Inett stated that Healthwatch Kent had carried out Enter & View visits to all A&Es in February 2016. Patients were generally very satisfied with the service; lots of the attendees had turned up A&E as they had been unable to get a GP appointment and did not like using 111 service. He noted that Healthwatch had recently carried out a piece of work about discharge; staff were working very hard to improve discharge processes but there was a tension as there was a lack of placements in East & West Kent and difficulty in recruiting carers in North Kent to support discharge. A Member requested a wider discussion about delayed discharge of care to establish what KCC and partners could do to improve to reduce delays.

(13) A number of questions were asked about muscle wastage, pressure on services from border areas such as Bexley and the involvement of KMPT. Ms Stewart stated that Dartford & Gravesham NHS Trust had implemented the

use physiotherapists on wards to help mobilise people and ensure that they remained physically fit; a finding of the recent discharge event organised by Dartford, Gravesham and Swanley CCG was that muscle deterioration began when patients entered assessment wards. Ms Stewart reported that pressure from border areas was a significant issues; a third of the activity from Dartford & Gravesham NHS Trust came from Bexley and the surrounding areas. The CCG was working with colleagues and representatives from Bexley to align the work being carried out. She noted that the London Ambulance Service (LAS) would convey patients to Darent Valley Hospital when services in London are under pressure; the CCG had ambulance liaison meetings with SECAmb and LAS to improve communication and talk through issues. Ms Ford reported that KMPT was a crucial member of each LAEDB. A Member requested further details about SHREWD and Ms Ford undertook to provide this.

(14) RESOLVED that the report be noted and NHS England be requested to provide an update about the performance of the winter plans to the Committee at its June meeting.

5. Local Care in West Kent
(Item 7)

Gail Arnold (Chief Operating Officer, NHS West Kent CCG) was in attendance for this item.

(1) The Chairman welcomed Ms Arnold to the Committee. Ms Arnold began by explaining that the paper provided an initial overview of West Kent CCG's plans to design and implement local care, in line with the CCG's strategic vision, Mapping the Future, and the Sustainability and Transformation Plan. She stated that the CCG had begun to work with key partners and stakeholders on the proposals. She reported that the delivery of care would be undertaken in two phases. The first phase was the development of a service specification for core cluster level team which would support GP federations to provide services. She reported the likely establishment of eight clusters: Sevenoaks, Tunbridge Wells, Tonbridge, Weald and four clusters covering the Maidstone district which would act as building blocks in developing the local care and training. She noted the importance of having a critical mass of services for an effective hub of care. She reported that the specification would comprise of four work streams including the provision of mental health and social care. She explained that the service would begin to take effect in 2017/18 in an informal way; in 2018/19 it was expected that the CCG would move towards the multi-speciality community provider model (MCP). The new model of care was expected to be fully established and embedded by March 2019; the CCG was in discussions with providers about how the new model would be delivered and governed.

(2) Ms Arnold highlighted that the emergence of two GP federations in preparation for local care; the two federations had jointly set up a provider arm and were joint shareholders. It was anticipated that services would be provided by hubs of care with services collocated on the same site. The location of hubs was still to be determined, as part of discussions with local providers, but would need to serve a population of 100,000 to be cost effective and sustainable. It was

expected that hubs would provide access to diagnostics and extended opening hours with the potential to include a GP surgery to enhance medical cover on site. Ms Arnold stated that the she was engaging with 61 GP practices over the next 8 – 10 weeks; she noted that national pressures on general practice had begun to impact on the delivery of services in West Kent with a high percentage of surgeries being unable to fill GP vacancies. She acknowledged that GP surgeries were all independent businesses and all had their own plans and aspirations for the next five – 10 years.

(3) Ms Arnold noted that there had been advance discussions in Edenbridge and Sevenoaks. In Edenbridge, the CCG was looking to combine the current GP surgery, whose building has reached the end of its life, with services at Edenbridge Hospital. The strategic outline case was in the final stages of development and needed to be signed off by NHS England before formal consultation with local people and the Committee. In Sevenoaks discussions were taking place to explore the possibility of collate a GP surgery at the hospital. A stakeholder event was held to look at the wider opportunities and to identify the key work streams which will be needed to take this work forward.

(4) The Chairman enquired about the involvement of borough & district councils and the local Health & Wellbeing Boards with the proposal. Ms Arnold stated that districts had been involved in all discussions so far; the Chairs of the Patient Participant Groups and League of Friends had also been involved. Local members had been notified in Edenbridge and would be informed in due course in Sevenoaks.

(5) A number of comments were made about the availability of workforce, demographic growth in West Kent and the provision of services in Edenbridge & Sevenoaks. Ms Arnold explained that it was hoped that the reorganisation of local care would help to fill staff vacancies. She acknowledged that population growth was a problem but noted the CCG was working collaboratively with Maidstone Borough Council's planning department who provided advanced warnings on planning developments and sought the CCG's input. She confirmed that that the plans for Edenbridge and Sevenoaks were distinct from each other; the development of a hub would be for a wider population for 100,000 and part of a wider local care proposals for West Kent.

(6) Mr Inett highlighted that Healthwatch Kent was keen to be involved with the public engagement work and stated that Ian Ayres and Bob Bowes had given their agreement for Healthwatch Kent to be involved.

(7) RESOLVED 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.

6. Gluten Free Services in West Kent
(Item 8)

Gail Arnold (Chief Operating Officer, NHS West Kent CCG) and Priscilla Kankam (Lead Pharmacist, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Kankam began by explaining that NHS West Kent CCG was looking to stop the routine

prescribing of gluten free items as part of its review into cost effective prescribing. She noted that the CCG spent £130,000 on gluten free products for 300 patients a year in West Kent with coeliac disease. Patients with other conditions which required specialist diets such as diabetes and renal failure were not prescribed food items. She reported that when gluten free items on prescription were introduced, the availability of these items was low; now there were readily available in supermarkets and a loaf of gluten free bread cost £1.60 in Asda, Tesco & Waitrose. The cost to the NHS for a loaf of gluten free bread would be £4 - £10 which included the cost of the product, dispensing fee and delivery charge. She noted that there was a small group of patients who could only have a low protein food and those patients would be allowed to be prescribed low protein products as part of the proposals. She stated that the CCG had consulted its GPs and Governing Body and a public consultation would begin on 29 November to inform the public about the issue.

(2) Members enquired about the availability of gluten free prescriptions nationally and if there was an advisory committee which provided guidance about the prescription of gluten free items. Ms Arnold stated that it was technically down to each individual GP to prescribe. Ms Kankam advised that there were lots of other gluten free products available which did not require a prescription such as potato and rice. Ms Arnold reported that there was an advisory committee which looked at the clinical conditions for gluten intolerance but did not have a role in providing guidance or criteria about prescriptions. Mr Inett commented that this change would most impact those who received free prescriptions, due to being on benefits or a low income; a loaf of gluten free bread which cost £1.40, in comparison to a normal loaf which cost 40p, would be unaffordable.

(3) There was a discussion by Members about whether this constituted a substantial variation of service. The Scrutiny Research Officer advised the Committee that there was not a definition or criteria for substantial variation of service set out in the regulations and if the Committee did determine the proposal to be substantial, a period of formal consultation between the Committee and the CCG would start. If the CCG went ahead with the proposals but the Committee did not think that the proposals were in the best interests of the local people, the Committee could make a referral to the Secretary of State for Health. The Scrutiny Research Officer noted that there were separate duties on the NHS to consult with the Committee and the public and if the Committee did determine the proposals to be substantial, the decision to consult with the public was with the CCG and not for the HOSC to determine.

(4) RESOLVED 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.

7. Kent and Medway Sustainability and Transformation Plan (Verbal Update) *(Item 9)*

Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG) and Michael Ridgwell (Programme Director, Kent & Medway Sustainability and Transformation Plan) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Mr Ridgwell began by acknowledging that the draft Kent and Medway Sustainability & Transformation Plan (STP) was published on 23 November which had not given Members long to consider the documents and it was proposed that the item return to the Committee for full consideration in January.

(2) A Member requested that Mr Ridgwell provide an overview of the key service changes set out in the document. Mr Ridgwell explained that the STP was a work in progress and there were no definitive proposals; the STP required a cross organisation approach to resolve the quality, inequality and financial challenges facing the NHS. The emerging four themes from the STP was care transformation by improving prevention, local care, hospital transformation and mental health; productivity through efficiencies in shared services, procurement and prescription; creating enablers for transformation by investing in workforce, digital infrastructure and estates; and system leadership. He reported that the extended Case for Change was due to be published in the New Year along with public and stakeholder engagement.

(3) Ms Carpenter explained that the work carried out previously by the East Kent Strategy Board was part of the STP. There would be a process to set out which areas of work would be achieved on a Kent & Medway wide level and which would be specific to geographic area. She noted that workforce was an area which needed to be considered on a Kent & Medway wide level; as part of the STP it was hoped that that in partnership with the local universities that a medical school could be developed. She stated that in East Kent high level modelling for local care was being developed and she anticipated that there would be a specific consultation in 2017 for East Kent with updates brought back to the Committee.

(4) The Committee then proceeded to ask a number of questions and make a number of comments. A Member enquired about the differences between the published draft STP submission and a summary presentation which had been circulated to the Committee. The Scrutiny Research Officer clarified that the summary presentation had been presented to the South East Regional HOSC Network on 18 November. Mr Ridgwell explained that the STP was a live document and the published draft STP submission was the document submitted to NHS England on 21 October; the summary document was a shortened version of the published draft STP submission which had been condensed for the purpose of the presentation resulting in minor differences between the two papers. Ms Carpenter reported that the STP Programme Board had made the decision to publish the draft STP submission as there was nothing in the document which could prevent it from being published.

(5) In relation to a specific question about the reduction of 300 beds in East Kent, Ms Carpenter explained that as part of developing models of local care, a review of acute services with the hospital trust had identified the potential reduction of 300 beds as part of the model which needed to be discussed and debated with stakeholders including the public and the Committee. Mr

Ridgwell stated that the figure of 300 beds had been included in order to be transparent; a range of different methodologies were used which had all identified that approximately 300 beds were being used by patients who no longer required acute care. A bed audit was being carried out to identify bed capacity across the whole of Kent and Medway.

(6) A number of comments were made about the inclusion of the 'as is' model in the published draft STP submission and the STP being a work in progress. Ms Carpenter explained that the STP would look and evaluate a range of options including some that are more viable than the others. She stated that the 'as if' model was not likely to come as viable option due to the challenges which will be set out in the Case for Change. Mr Ridgwell explained that there would be ongoing dialogue with the Committee as the STP progressed. He noted that the STP acknowledged those there were significant challenges including demographic growth and these would be detailed further as part of the published Case for Change.

(7) Members requested a briefing for all KCC Members, Borough and District Councils.

(8) RESOLVED that the Committee note the publication of the draft Kent and Medway Sustainability and Transformation Plan and request that an update to the Committee be presented in January to enable full consideration of the draft Plan.

8. Mental Health Rehabilitation Services in East Kent
(Item 11)

Ivan McConnell (Executive Director of Commercial Development and Transformation, KMPT) and Hazel Carpenter (Accountable Officer, NHS South Kent Coast CCG and NHS Thanet CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Carpenter began by explaining that the proposed closure of Davidson Ward was a positive change which she felt had not been conveyed in the submitted paper. She stated that the Davidson ward was one of two wards located in the St Martin's building which was an old asylum building and the suitability of the building in providing appropriate care had been questioned by the CQC; it was not best practice for patients to be treated in its current setting. The ward was a ten bedded rehabilitation ward but only had five occupants and did not provide acute care. She noted that KMPT had increased the number of community rehabilitation beds through the provision of nine beds in supported housing. She reported that there was an opportunity to invest the £10 million in community rehabilitation services, which was currently spent in out of area placements for patients in East Kent, by repatriating them to the county; eight patients from Thanet have already been identified to return locally.

(2) Mr McConnell explained that Davidson Ward was not fit for purpose and had been heavily criticised by the CQC. It was not a suitable facility for patients to undertake rehabilitation as it did not have access facilities and the Trust was unable to recruit staff to the ward. He highlighted that the guidelines stated that community rehabilitation should take place in the local community with

intensive support. He noted that there were two types of rehabilitation: services provided in the community and intensive services for post-acute discharge which were provided in three units in East Kent which were highly acclaimed.

(3) A Member enquired about engagement with partners about supported housing and out of area placements. Mr McConnell stated that nine beds in supported housing had been created which would help to mitigate the closure of the 10 bedded Davidson Ward. He noted the importance of working with partners including borough and district councils with regards to social housing and undertook to work more collaboratively with them. Mr McConnell explained that seven patients from Thanet who received intensive rehabilitation out-of-area cost £951,208 a year in locations as far away as Manchester and Newcastle; if all out-of-area patients in East Kent were repatriated and they could be treated nearer to home and £10 million would be saved which would be used to invest in local rehabilitation services.

(4) A number of comments were made about staffing. Mr McConnell explained that rehabilitation services did not always need to be undertaken by social workers and mental health professionals; a whole range of alternative staffing could be used such as peer support workers to provide support in the community. He reported the need to look at alternative models of staffing and highlighted the work of some housing providers in London who were training apprentices to become support workers. Mr McConnell stated that traditional models of care over medicalised staffing; the Trust had introduced a therapeutic staffing model which had nursing cover supported by occupational therapists; art, drama and music therapists; and psychologists to assist with the patient's recovery. He noted that the Trust had successfully been able to recruit assistant psychologists, as there were a large number of people with psychology degrees in Kent & Medway, to support rehabilitation services.

(5) A Member requested if it would be possible for the Committee to visit some of the units. Mr McConnell stated that he would be happy to facilitate a visit, but requested that there was a maximum of three people for a visit to an inpatient ward as it was disruptive to the ward; he noted that he would welcome the Members' feedback. Mr Inett noted that Healthwatch Kent had undertaken a Enter & View visit and they found that it had been a positive experience for patients; the reports were available on Healthwatch Kent's website.

(6) Mr Inett enquired about engagement with service users and careers. Mr McConnell reported that all existing service users and those who provided rehabilitation support had been engaged in dialogue with the CCG and Trust.

(7) RESOLVED 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.

9. KMPT - Transformation of Mental Health Services

(Item 10)

Ivan McConnell (Executive Director of Commercial Development and Transformation, KMPT) was in attendance for this item.

(1) Mr McConnell began by explaining that the paper was an update and appraisal to the paper presented in October and it was proposed that the Trust would return to the Committee in January with more detailed feedback. He noted that the new Chief Executive, Helen Greatorex, had set the Trust a target of reducing out-of-area beds to fifteen by October and zero by December; he reported that, as of 25 November, there were only five people in psychiatric intensive care out-of-area beds. He stated that there were no young or older people in out of area beds and this was a position that the Trust needed to sustain. He noted that the Trust currently had a bed occupancy rate of 97% which higher than the recommended rate of 85% set by the CQC and Royal College. He noted that bed occupancy was an issue that the Trust needed to work with its commissioners; the repatriation of patients from out-of-area beds had created significant quality improvements and financial savings.

(2) Mr McConnell reported that that the Trust had been working with the Police & Crime Commissioner on Section 136 detention and there were now two funded street triage pilots in Medway and Thanet. He noted that the Trust was involved with an internationally acclaimed research project to support early intervention in psychosis and had received £2 million of funding to support this; the Trust was the only Trust in the country to be involved in this project. He explained that the Trust's Board had received feedback that the therapeutic staffing model was helping patients to get out of hospital and support recover quickly. He noted that he was leading a review of community mental health teams to reduce their high caseload to 35 cases; the Trust needed to work with partners to prevent the Trust being responsible for all aspects of mental health as it was only a designated secondary care provider.

(3) Mr McConnell noted that improvement of perinatal mental health was a priority; there was currently only one consultant and three specialist nurses covering the county. The Trust had recently been successfully in being awarded £2 million of NHS England funding to support perinatal mental health including post-partum and post-natal depression. He reported that perinatal services were an attractive area of work for staff and the Trust was able to recruit staff to these posts.

(4) Members made comments about services for young people and Section 136 detention. Mr McConnell stated that whilst services for children and young people were provided for Sussex Partnership NHS Foundation Trust, the Trust provide intervention psychosis services for young people aged 14 and over and it was important that those young people were captured early to avoid deterioration later.

(5) In response to a specific question about Section 136 detention, he noted that Section 136 detentions were challenging for both the Police and Trust. He reported that Kent & Medway had the highest levels of detention in the country but one of the lowest conversation rates of detention to admission. He stated that the Trust needed to support and train the police officers to recognise

mental distress; an example of this support was allowing police officers to shadow staff on an inpatient ward and a crisis team and take the learning back to their police teams. He noted that there was a single point of access where police officers were able to call a dedicated telephone number to speak to a nurse for advice and guidance which would be supported by the implementation of the street triage pilots. He highlighted that Kent Police had one of the only mental health custody liaison services which had been rated as outstanding. He noted that if the Police & Crime Bill became an Act, A&E would no longer be a designated place of safety which would put additional pressure on the Trust. He reported that Kent had a good relationship with the Police & Crime Commissioner who was committed to making a difference.

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

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

(1) The Committee considered an update about the implementation of the new East Kent integrated urgent care service contract provided by Nestor Primecare Limited.

(2) A Member raised concerns about the mobilisation of the 111 service and requested that the CCGs be invited to present an update in March. Mr Inett stated that service users had reported significant problems accessing out of hours GP appointments.

(3) RESOLVED that the report be noted and the East Kent CCGs be requested to provide an update, including performance data about the GP out-of-hours service and the mobilisation of 111 service, to the Committee in March.

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Item 4: East Kent Hospitals University NHS Foundation Trust: Update

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 27 January 2017

Subject: East Kent Hospitals University NHS Foundation Trust: Update

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

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

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1. Item 4a - CQC Inspection Report

(a) East Kent Hospitals University NHS Foundation Trust was originally inspected by the CQC in March 2014 and the inspection report was published in August 2014. The Committee considered the Trust's initial response to the inspection findings on 5 September 2014; the Trust's Improvement Plan on 10 October 2014 and an update on progress since the inspection on 5 June 2015.

(b) The CQC re-inspected the Trust in July 2015 and the inspection report was published in November 2015.The Committee considered the Trust's response to the inspection on 29 January 2016.

(c) The third inspection of the Trust by the CQC took place in September 2016 and the inspection report was published in December 2016. The inspection reports can be viewed here:

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

2. Item 4b - Chemotherapy Services in East Kent

(a) On 4 September 2015, 9 October 2015 and 2 September 2016 the Committee considered reports from the Trust which provided an update about the Celia Blakey Centre at the William Harvey Hospital, Ashford.

(b) The Committee agreed the following recommendation on 2 September 2016:

- *RESOLVED that the report on the Chemotherapy Services in East Kent & East Kent Cervical Screening Programme be noted and the Trust be invited to submit an update to the Committee in January 2017.*

3. Item 4c - East Kent Cervical Screening Programme

(a) On 2 September the Committee considered the actions taken by the Trust following the Public Health England Screening Quality Assurance Review of the East Kent Cervical Screening Programme.

(b) The Committee agreed the following recommendation on 2 September 2016:

- *RESOLVED that the report on the Chemotherapy Services in East Kent & East Kent Cervical Screening Programme be noted and the Trust be invited to submit an update to the Committee in January 2017.*

4. Recommendation

RECOMMENDED that the reports on the CQC Inspection, Chemotherapy Services in East Kent and East Kent Cervical Screening Programme be noted and the Trust be requested to provide an update to the Committee in six months.

Background Documents

Kent County Council (2014) '*Health Overview and Scrutiny Committee (05/09/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5399&Ver=4

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

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

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

Kent County Council (2015) '*Health Overview and Scrutiny Committee (09/10/2015)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=35545

Kent County Council (2016) '*Health Overview and Scrutiny Committee (29/01/2016)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=36904

Kent County Council (2016) '*Health Overview and Scrutiny Committee (02/09/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6261&Ver=4

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East Kent Hospitals University NHS Foundation Trust

HOSC Briefing (January 2017)

Care Quality Commission Report

Introduction

East Kent Hospitals University NHS Foundation Trust (EKHUFT) was re inspected by the Care Quality Commission in September 2016. The CQC's report was published in December and showed widespread improvements to the quality of care patients receive.

The Trust was placed in special measures by Monitor (now NHS Improvement) in 2014 when the CQC rated the Trust 'inadequate'. A year later the Trust was upgraded to 'requires improvement' as a result of "big steps forward" witnessed by the CQC. The Trust remained in special measures to allow more time to fully embed the improvements.

This third inspection for the Trust looked in detail at emergency care, medical services, maternity and gynaecology and end of life care at Kent & Canterbury, William Harvey and Queen Elizabeth the Queen Mother hospitals. It also focussed on how "well led" the Trust was.

The Trust now has no "red" inadequate scores and Sir Mike Richards, England's Chief Inspector of Hospitals, has recommended that the Trust be taken out of special measures as a result of "further significant improvements" for local patients.

NHS Improvement (NHSI) will make the final decision about whether the Trust will come out of special measures. The regulator's decision is expected at the end of February.

The CQC held a Quality Summit on 12 January. This was attended by the Chair of HOSC, NHSI, East Kent Hospitals Trust and local partners. The CQC presented its findings, the Trust gave an update on further improvements it had made since the re inspection in September and NHSI led a discussion about the next steps, which focussed on partnership working.

CQC Report Findings

Key findings include:

- **Safer emergency services at all hospitals**, with the Urgent Care Centre at The Kent and Canterbury Hospital (K&C) upgraded to 'good' overall; safer services at Queen Elizabeth The Queen Mother Hospital's (QEQM) A&E department; and safer, more effective and better-led services at William Harvey Hospital's (WHH) A&E department;
- **Improved medical care at all hospitals**, with services at QEQM upgraded to 'good' overall, more effective at WHH and more responsive at K&C;

We care

- **All hospitals rated 'good' for 'caring'**, with a continued "culture of compassionate care", staff who put patients first, and patients and carers confident in how involved they are in their or their relatives' care;
- **Outstanding practice was found in the Trust's Improvement and Innovation Hubs**, highlighted as "an established forum to give staff the opportunity to learn about and contribute to the Trust's improvement journey";
- **Improved leadership**, with a fully established Executive Team and Trust Board, described as a "highly engaged team with a clear and common view on Trust strategy, risk and operational priorities", who have provided "greater clarity" about the direction of the Trust, with staff "appreciative of the increased visibility and accessibility" of the Executive Team;
- **Improved staffing**, recognising that "significant investment has been made by the Trust to increasing staffing establishment", with "key appointments made in emergency care, end of life care and maternity" addressing previous gaps;
- **Better culture within the Trust**, which had "improved significantly since 2014" and continues on "a trajectory of improvement with a continued reduction in bullying and harassment";
- **Improved end of life care**, with better training and resources to support staff caring for patients at the end of their life and their relatives;
- **Improved maternity services,** with more staff, better equipment and new leadership.

The CQC reports also highlighted further areas for improvement, such as recruiting and retaining more staff, enabling more patients to access treatment sooner, improving the flow of patients through our hospitals, fully embedding early signs of improvement in maternity and end of life care, and making financial savings.

As well as the overall Trust rating the CQC gives an individual rating to each of the Trust's three hospitals inspected this year.

- **William Harvey Hospital, Ashford** - rated 'requires improvement' overall, 'good' ratings for critical care and outpatient and diagnostic imaging.
- **Queen Elizabeth The Queen Mother (QEQM) Hospital, Margate** - rated 'requires improvement' overall, with medical care, critical care, services for children and young people, and outpatient and diagnostic imaging all 'good'.
- **Kent and Canterbury Hospital (K&C), Canterbury** – rated 'requires improvement' overall, with the urgent care, critical care, services for children and young people, and outpatient and diagnostic imaging all 'good'.
- The ratings for the Trust's two hospitals in Dover, **Buckland Hospital**, and Folkestone, **Royal Victoria Hospital**, were rated 'good' in 2015 and not re-inspected in September.

The Trust is committed to continuing its improvement journey and building on the progress it has made with a dedicated team, improvement plan and close working relationship with its partners and regulators.

The full report can be found here.

East Kent Hospitals University NHS Foundation Trust

HOSC Briefing (January 2017)

Chemotherapy Services in East Kent

Introduction

In September and October 2015, East Kent Hospitals University NHS Foundation Trust provided HOSC with an update about the Celia Blakey chemotherapy unit at the William Harvey Hospital in Ashford. The Trust reported to the HOSC that the chemotherapy unit was expected to reopen in July 2016.

On 2 September 2016 the Trust provided HOSC with a further briefing which stated that the unit was expected to reopen by the end of 2016.

This short report outlines the work that the Trust has been doing to improve staffing levels for the chemotherapy service over the past twelve months and provides HOSC with assurance that the service will return to the William Harvey Hospital by the end of March / beginning of April 2017.

Staffing Pressures

In June 2015, the Celia Blakey Centre at the William Harvey Hospital, Ashford reported an emerging staffing risk of a reduction in 50% of its permanent workforce. This was as a result of a mixture of staff leaving the service, maternity leave and long-term sickness. Consequently, the Trust was presented with a patient safety issue and required the service to consider how it would safely continue to deliver care to patients.

As described in the previous HOSC briefing, a number of options were considered and discussed with the Divisional Leadership Team and Executives.

Over the last year the Trust has been recruiting and training nurses and the Chemotherapy Service has had a targeted recruitment and retention campaign. This involved a benchmarking exercise with other Chemotherapy Services as it was recognised that EKHUFT Chemotherapy trained staff were leaving to join other Trusts once they had achieved their chemotherapy competencies. As a result of this we now have a fully staffed team, with a minimal number of vacancies across the Chemotherapy Services

Timescales for Returning to WHH

Following the previous briefing, work is progressing with the refurbishment of the Arundel Unit. There was a delay in this work due to the original construction company going into administration and the work commenced November 2016. A completion date has been given for the end of February/ March 2017. The aim is move patients in a gradual, planned process to ensure a smooth transition to the new updated premises.

East Kent Hospitals University NHS Foundation Trust

Cervical Screening Quality Assurance Visit 2016
Health Overview and Scrutiny Committee Briefing Paper

1 Introduction

1.1 This briefing paper is to inform the Health Overview and Scrutiny Committee (HOSC) about progress on the recommendations made by the South East Coast Cervical Screening Quality Assurance Programme visit in April 2016. The review team identified several areas of good practice in cytology and colposcopy that were worth sharing nationally.

a) The cytology laboratory has continued to place greatest emphasis on the maintenance of screening quality, despite severe difficulties with workload and staffing

b) The four colposcopy clinics have begun to work towards an integrated Trust wide service, including centralised first appointments and common protocols

Upon inspection, overall, the review team found a safe service. They did however identify a number of non-conformities considered high priority. This included one immediate concern related to business continuity, which related to an area of service that relied on a single member of admin staff. Necessary measures were put in place to partially mitigate the immediate risks within the programme and a further response was submitted to the QA programme office, which was sent and received within 7 days.

All the high priority issues have now been addressed. The cytology service expects achievement of the 14 day TAT for results of screening by May 2017. It has a formalised its relationship with Maidstone and Tunbridge Wells NHS Trust (MTW) for provision of HPV testing and the colposcopy service has built in resilience to its administrative function. The Division has also ensured effective leadership of the service is in place, mitigated against estate issues on the Kent & Canterbury Hospital (K&C) site and ensured protocols and best practices are being adhered to in a standardised way.

2 Background

2.1 The East Kent cervical screening programme serves approximately 362,500 women and is provided by EKHUFT. The cervical cytology component is provided at the William Harvey hospital (WHH) site along with the cervical histology service. The cytology laboratory had a UKAS accreditation visit in 2013. The programme incorporated HPV testing (Triage and Test of Cure) into the cervical screening service in 2012 and this is provided by MTW. The programme offers further assessment and treatment at four colposcopy clinics at WHH, Buckland Hospital Dover (BHD), KCH and Queen Elizabeth the Queen Mother Hospital Margate (QEQM).

In April 2016 a Quality Assurance review was undertaken at East Kent Hospitals University NHS Foundation Trust East Kent. QA visits are undertaken by Public Health England Assurance Service and the aim of the visit is to maintain standards and promote continuous improvement in cervical screening.

3 Recommendations from QA Programme visit and mitigation

A number of recommendations were made related to the immediate and high Level issues and are summarised in the table below:

Level	Theme	Description of recommendation	Mitigation
Immediate	Colposcopy	Business continuity requires that more resilience is introduced to the Colposcopy coordinator role.	A deputy co-ordinator post has been established and filled and maternity cover for the current admin support has also been provided.
High	Colposcopy	Fully implement national test of cure protocol, including discharge after treatment. Written protocols and practice should be updated.	The clinical Colposcopy Lead has ensured that Trust protocols and practices have been revised to ensure compliance with national guidelines.
High	Colposcopy	K&C accommodation should be reviewed and reconfigured to improve facilities and provide a recovery facility in accordance with NHSCSP 20.	A full review of facilities at Canterbury has been undertaken with the estates department. An option to move the service from Canterbury to Buckland Hospital in Dover is currently being explored. Mitigating actions have been identified and put into place whilst this review is completed.
High	Governance & Leadership	There should be a Trust wide lead Colposcopist to enhance a single approach to Colposcopy across the Trust. The Trust lead will require a job description showing lines of accountability and sufficient allocated time within their job plan.	A Trust wide Colposcopy Lead has been appointed with clear lines of responsibility and the job plan has been signed off by the Divisional Medical Director and role being undertaken
High	Cytology	Implement changes in laboratory processes and working practices to facilitate achievement of two week (14 days) turnaround of Cytology results.	Changes implemented to improve working practices to facilitate achievement of 14 day target. Backlog significantly reduced with overtime and locum use during the summer 2016 to meet KPI. However this remained challenging when locum left and difficulties in recruitment. We now have agreement to outsource to Taunton Laboratory to bring position back in line with KPI. Backlog continually reviewed and monitored closely. 98% of cytology results communicated within 14 days will not be achieved until May 2017.
High	Governance & Leadership	Formalise the East Kent Hospitals NHS Trust agreement with Maidstone & Tunbridge Wells NHS Trust for provision of HPV testing for triage and test of cure.	Contract agreement with MTW and EKHUFT in place
High	Histology	All Histopathologists should use either a standard proforma or minimum dataset list for the reporting of cervical treatment specimens to ensure that all national required elements are included and an associated SOP detailing this should be devised.	Histopathology has introduced a standard pro-forma for reporting of cervical biopsies and LLETZ and the necessary associated SOP detailing this.

4 Key points of note

4.1 EKHUFT advises the HOSC that the cytology service at now has optimal staffing and measures are in place to reduce the backlog of cervical screening slides and meet the agreed KPI. The department also adopted a policy whereby if the 8 day KPI is breached, overtime is immediately triggered to maintain service delivery. Colposcopy has put in place mitigation to transfer patients that have fainted to Outpatients for recovery which is geographically next door to Colposcopy. This has been worked up with both staff and outpatients. It should be noted that there have been no patient safety issues.

5 Conclusion

5.1 EKHUFT advises the HOSC that the cytology service expects to meet and maintain the necessary national KPI by May 2017 to facilitate achievement of 14 days turnaround of Gynae Cytology results and improve the patient experience. Between now and 2019 the cytology department at EKHUFT will face further challenges in maintaining service delivery due to the impending conversion from conventional screening methodology to HPV testing. Therefore, EKHUFT will continue to work in collaboration with MTW as part of the present configuration and future pathology transformation. The colposcopy service has built in resilience to its administrative function; ensured effective leadership of the service is in place; mitigated against estate issues at K&C and ensured protocols and best practices are being adhered to in a standardised way.

Item 5: North Kent CCGs: Urgent & Emergency Care Programme Update

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 27 January 2017

Subject: North Kent CCGs: Urgent & Emergency Care Programme Update

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

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

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1. Introduction

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

- *RESOLVED that:*

  (a) The Committee do not deem this change to be substantial.

  (b) The guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and that they be invited to attend a meeting of the Committee in six months.

(b) On 29 January 2016 the Committee considered an update on the review which was delayed following a national and local pause on the programme. The Committee's deliberations resulted in the following recommendation:

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

(c) In October 2016 NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG requested to bring an update to the Committee in January 2017 following the re-establishment of the urgent and emergency care programme, with a different scope, to that of the one originally presented to the Committee in October 2014.

(d) NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG held a stakeholder event on 23 November 2016 which was attended by Mr Angell and Ms Harrison.

(e) The CCGs propose to present the case for change and proposed clinical models to the Committee in March 2017 for the Committee to determine if it considers the proposals to be a substantial variation.

2. Recommendation

RECOMMENDED that the report be noted and NHS Swale CCG and NHS Dartford, Gravesham and Swanley CCG be requested to present the case for change and proposed clinical models to the Committee in March

Background Documents

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

Kent County Council (2016) '*Health Overview and Scrutiny Committee (26/01/2016)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6256&Ver=4

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Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG)

Swale Clinical Commissioning Group (Swale CCG)

Urgent & Emergency Care Programme Update

Report prepared for:	Kent County Council [KCC] Health Overview and Scrutiny Committee [HOSC] 27 January 2017
Reporting Officer:	Patricia Davies, Accountable Officer, DGS and Swale CCGs
Report Compiled By:	Gerrie Adler, Programme Director for Urgent & Emergency Care, DGS and Swale CCGs

1. Introduction

1.1 This report has been prepared by DGS and Swale CCGs to provide the Committee with an update on the urgent and emergency care programme which underwent a national pause between July and October 2015, and with an amended focus and scope than the initial work (in line with the Commissioning Standards – Integrated Urgent Care (September 2015)), has been restarted again in both CCGs since May 2016.

1.2 The CCGs have conducted initial engagement activities with GPs and wider stakeholders including patients, and voluntary organisations. Efforts at collaborative working across organisational boundaries have also been started as there is a realisation that successful achievement of the goals for urgent and emergency care lies in working together.

1.3 The CCGs propose to present the case for change and proposed clinical models to the Committee in March 2017 to determine if the Committee considers the proposals to be a substantial variation and if a period of formal consultation with the Committee is required.

1.4 The CCGs intend to embark upon a public consultation after the period of purdah ends in May 2017 as the changes to the urgent and local care models are considered to be significant enough to require this.

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

2. Where have we been?

2.1 In November 2013, the Keogh Review - End of Phase One Report outlined the case for change and proposals for improving urgent and emergency care services in England. The report highlighted five areas for the future of urgent and emergency care;

2.1.1 Provide better support for people to self-care

2.1.2 Help people with urgent care needs to get the right advice in the right place, first time

2.1.3 Provide responsive urgent care services outside of hospital so people no longer choose to queue in the Accident & Emergency (A&E)

2.1.4 Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise the chances of survival and a good recovery

2.1.5 Connect all urgent and emergency care service together so the overall system becomes more than just a sum of its parts

2.2 The findings of this report were further supported by the publication of the NHS Five Year Forward View in October 2014, which stated that urgent and emergency care services will be redesigned to improve integration between emergency departments, GP out-of-hours services, urgent care centres, NHS 111 services and ambulance services.

2.3 Between February and May 2015, both DGS and Swale CCGs, in partnership with Medway Clinical Commissioning Group (Medway CCG), pursued a programme of activity across North Kent which began to look at urgent care. In both DGS and Swale CCGs, patient and clinician reference groups were held and a preferred solution was identified which was based around a hub and spoke model. Swale CCG made further progress and held both a GP Engagement Event, and a Market Engagement Event.

2.4 In June 2015, DGS CCG took a local decision to pause the programme due to the recognition of the emerging impact of the Ebbsfleet development on the local health economy; an impact which required further analysis before the programme could be moved any further forward.

2.5 In July 2015, a national programme pause was applied. CCGs received a letter from Dame Barbara Hakin which focused on the need to ensure a functionally integrated 24/7 urgent care access, treatment and clinical advice service incorporating NHS 111 and out of hours. With NHS 111 previously out of scope of the urgent care redesign, programmes were paused pending publication of further guidance.

2.6 In September 2015, guidance was published within the Commissioning Standards Integrated Urgent Care, which focused urgent care redesign on the planned reconfiguration of urgent and emergency care services to enable 'commissioners to deliver a functionally integrated 24/7 urgent care service that is the 'front door' of the NHS and which provides the public with access to both treatment and clinical advice'.

2.7 In October 2015, the national programme pause was lifted, and in May 2016, the DGS CCG local programme pause was lifted.

3. Where are we now?

3.1 Since June 2016, the urgent and emergency care programme has been re-established albeit with a different scope than that which was originally used before the national pause in July 2015.

3.2 The scope of the programme now falls in line with the Commissioning Standards - Integrated Urgent Care (September 2015) focusing on the following:

3.2.1 The commissioning of NHS111 as the telephony single point of access for urgent care providing a call handling, initial triage and signposting service.

3.2.2 The provision of an Integrated Clinical Advice Service (ICAS) to support NHS111 with telephony clinical triage, multi-disciplinary team advice, guidance and referral, ensuring no decision is made in isolation.

3.2.3 The GP out-of-hours service (including base sites and home visits).

3.2.4 System interoperability to enable greater integration.

3.3 Other face-to-face aspects of urgent and emergency care services, and the points at which urgent and emergency care overlaps with the requirements and proposals laid out for the General Practice Forward View, and the Sustainability & Transformation Plans [STP], are also being reviewed i.e.:

3.3.1 Extended primary care access by March 2019 (General Practice Forward View) and provision of urgent same day bookable appointments within primary care.

3.3.2 Primary care managed urgent care service to support the acute trust to avoid unnecessary ED attendance and/or hospital admission, deliver the 4 hour ED standard and meet ambulance handover times.

3.3.3 Workforce and workload issues.

3.3.4 Increased use of technology and improved interface between general practice and hospitals.

3.3.5 Preventative support services and the ways in which self-care can be encouraged from NHS111 and ICAS without the need for a face-to-face consultation, where clinically appropriate.

3.3.6 Increase efficiency and implement demand reduction measures whilst addressing predicted growth.

3.4 To provide economies of scale, and to ensure resilience for the NHS111 and ICAS services, DGS, Swale and Medway CCGs have agreed to pursue procurement of a single NHS111 service across North Kent, that is functionally integrated with three local urgent care models (one for each CCG area). Discussions are underway to determine if the geographical scope for the telephony based NHS111 service can be extended further across Kent, Surrey and Sussex. The outcome of these discussions is not yet known.

3.5 DGS CCG has carried out a GP Engagement Event in November 2016, and both DGS and Swale CCGs hosted a whole systems engagement event on 23rd November 2016, which saw over 80 attendees from across health and social care in North Kent. The event brought together patient representatives, voluntary sector organisations, hospital clinicians, GPs, out-of-hours providers, community staff and commissioners to collaborate and discuss possible future models of care in DGS and Swale CCG areas. Presentations and workshop sessions allowed the delegates to work together to tackle issues and focus on improving patient access,

promoting appropriate health services and breaking down organisational barriers to improve patient experience. This was a positive first event, and strong commitments were made to keep the momentum going throughout the review process which is anticipated to continue throughout next year.

3.6 Opportunities to collaborate with partner organisations are also currently being explored. In DGS CCG, a co-design group has been established to explore how the acute trust can be supported to ensure that, where clinically appropriate, patients who present at the acute trust can be triaged, treated and discharged in primary care without having to access secondary care. There is a general realisation that successful achievement of the goals for urgent and emergency care lies in organisations working together. From the co-design group work other benefits of collaboration have been identified e.g. opportunities to improve recruitment and retention across organisations and these will be further explored.

4. Next Steps

4.1 By the end of 2016 to:

4.1.1 Determine the geographical scope of the procurement activities for NHS111

4.1.2 Determine the geographical scope for the provision of the ICAS

4.1.3 Agree 'go live' dates across participating CCGs and with the current providers of services

4.1.4 Ensure contracts are in place to secure seamless service provision for all relevant services so that patients are not disadvantaged in any way

4.2 By March 2017 to:

4.2.1 Further engage with the public to assist in the formation of the case for change, and in the co-design of a proposed model

4.2.2 Present the case for change and proposed model to the HOSC on 3rd March 2017 to determine if the Committee considers the proposals to be a substantial variation and if a period of formal consultation with the Committee is required.

4.3 By the end of May 2017 to:

4.3.1 The CCGs intend to will embark upon a public consultation after the period of purdah ends as the changes to the urgent and local care models are considered to be significant enough to require this.

5. Conclusion and Recommendation

5.1 The Committee is requested to note the content of this update report on the Urgent and Emergency Care Programmes for DGS and Swale CCGs and to advise on how the Committee wishes to be engaged in the future.

Item 6: North Kent CCGs: Adult Community Services

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 27 January 2017

Subject: North Kent CCGs: Adult Community Services

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

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

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1. Introduction

(a) The Committee considered proposals for adult community services in North Kent on 11 April 2014, 10 October 2014, 6 March 2015 and 5 June 2015. At the end of the discussion on 5 June, the Committee agreed the following recommendation:

- *RESOLVED that:*

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

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

(b) On 29 January 2016 the Committee was informed that the North Kent CCGs, following a procurement process, had awarded the contract for adult community services to Virgin Care Services Limited (Virgin Care). The Committee agreed the following recommendation:

- *RESOLVED that the report be noted and NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG be requested to provide the Committee with an update about:*

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

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

(c) On 20 October 2016 the Chairman agreed to a request from NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG to postpone the item until the January meeting.

2. Recommendation

RECOMMENDED that the report be noted and NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG be requested to provide an update about the performance of the provider in September and the development of any new service model at the appropriate time

Background Documents

Kent County Council (2014) *'Health Overview and Scrutiny Committee (11/04/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27880

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

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

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

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

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

HOSC Briefing – January 2017

Introduction

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

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

3. As previously discussed with the HOSC in March and June 2015 and again in January 2016, the procurement was undertaken on 'an-is' basis. This meant that patients would continue to receive the same range of adult community services as was previously available. The new contract is for seven years with the potential to extend a further three years. From the outset, the CCGs specified that the successful organisation would need to be responsive to any future changes in local health requirements over the period of the contract. However, any change in future service provision would need to follow formal due process as appropriate, including consulting the Committee about a potential substantial variation of service.

4. The new contract was due to be mobilised on 1st April 2016 but following a legal challenge by Kent Community Health NHS Foundation Trust (KCHFT), contract award was suspended pending conclusion of the legal process.

5. The CCG's applied to the High Court to have the suspension lifted on the grounds of needing to install the new provider in good time to support effective planning for winter and on-going concerns over service provision.

6. Following a successful challenge by the CCG's, the Court gave the CCG's leave to proceed with the contract award in June and mobilisation re-commenced.

7. The transfer of services to Virgin eventually took place on 26th September 2016.

8. The new contract has now been mobilised and Virgin Care are now providing the range of services previously provided by KCHFT and Medway Community Health.

9. Most of the staff employed by the previous providers who provided the applicable adult community services, transferred to Virgin on the go live date, carrying with them their continuous services and the same terms and conditions of employment.

Background

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

    - Long-standing health inequalities across the population

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

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

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

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

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

Current position

14. The new contract went live on 26th September 2016 with Virgin Care taking responsibility for the provision of the Adult Community Services.

15. Issues immediately prior to ‘go-live’ presented some concern over the mobilisation period, namely:

    a. Incomplete transfer of all staff records
    b. Incomplete transfer of some patient records
    c. Staff shortages, particularly in the Community Hospitals and with some specialist nursing services in Swale
    d. Operation of the Care Coordination Centre

16. Virgin Care worked extraordinarily hard in the first weeks to support staff and ensure the safe delivery of services. There were a small number of individual incidents concerning patient care which were dealt with quickly and reported accordingly.

17. A list of residual issues has been managed carefully, whilst every effort is being made to ensure that services are provided and patients are cared for appropriately. These are mainly associated with continuing difficulties with recruitment and some transfer anomalies.

18. It’s fair to say that whilst the vast majority of services are running effectively, there have been some teething problems and some GP’s have been dissatisfied with some elements of the service, primarily the handling of referrals and in a small number of cases the responsiveness of services. This is being carefully monitored and Virgin Care is being held to account via the monthly Contract & Performance meetings.

19. Equally Virgin Care are actively seeking service delivery improvement and efficiency opportunties both internally and across the economy, using their experience elsewhere, objective enquiry and preliminary observations.

20. Virgin Care are becoming more integrated into the local health & care economy now and are part of the Executive Programme Board and the Sustainability & Transformation Planning.

Conclusion

21. The HOSC are asked to note the progress with mobilisation of the new contract for Adult Community Services.

NHS Dartford, Gravesham and Swanley
and NHS Swale CCGs

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Item 7: Kent and Medway NHS and Social Care Partnership Trust: Mental Health Update

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 27 January 2017

Subject: Kent and Medway NHS and Social Care Partnership Trust: Mental Health Update

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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 update 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) On 25 November 2016 KMPT provided an additional update about transformation of mental health services. The Committee agreed the following recommendation:

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

2. Recommendation

RECOMMENDED that the report 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

Kent County Council (2016) *'Health Overview and Scrutiny Committee (27/11/2016)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6263&Ver=4

Item 7: Kent and Medway NHS and Social Care Partnership Trust: Mental Health Update

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

Mental Health Update

Report prepared for:

Kent County Council [KCC]
Health Overview and Scrutiny Committee [HOSC]
27 January 2017

Version:	4.0 Final	**Reporting Officer:**	Vincent Badu Director of Transformation (Integrated Older Peoples Services), KMPT
Date:	16 January 2017	**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 mental health services in Kent.

1.2 This report aims to update Members on current activities and priorities and new initiatives and opportunities.

1.3 This report will be presented under the following set of headings:

i. Current activities and priorities.

ii. New initiatives and opportunities.

1.4 The Committee is asked to note the content of the report and provide comment.

2. Current activities and priorities

2.1 The Trust continues to experience a high demand for its services. The table below provides a summary of contacts within the Kent teams for quarter 1 (1 April 2016 to 30 June 2016), quarter 2 (1 July 2016 to 30 September 2016), quarter 3 (1 October 2016 to 31 December 2016) and quarter 4 to date (1 January 2017 to 5 January 2017).

Type of Contact	Quarter 1	Quarter 2	Quarter 3	Quarter 4 (to date)
Crisis Resolution Home Treatment [CRHT] episodes	727	755	611	5
Community Mental Health Team [CMHT] contacts following assessment	30,937	28,142	25,965	1,046
Liaison Psychiatry referral / attendance	2,046	2,149	1,943	75

2.2 Kent is also a high area for Section 136[2] activity. In the period 1 January 2016 to 31 December 2016 Trust records[3] indicate 943 people were detained and taken to a place of safety (mental health section 136 suite, Police custody or accident and emergency department [A&E]), for further assessment under Section 136 powers in Kent. Of these people when a full clinical assessment was carried out by a local authority approved mental health practitioner [AMHP] and section 12 approved doctor the outcomes showed that 8.17% required admission to an acute mental health bed for treatment and agreed to be admitted informally, 12.94% were admitted under a section of the Mental Health Act [MHA] to an acute mental health bed and approximately 78.90% were not admitted and could be supported through another form of primary care, crisis resolution home treatment [CRHT] or discharged with other types of social care and health support. In addition to those individuals detained by the police under Section 136, the Kent Police also receive a significant number of additional mental health related calls made by the public. As an example in the Thanet area alone for the period 1 April 2015 to 31 March 2016, of the overall number of 1,005 people detained by the police across Kent and Medway, 230 of these people were detained in public places within the Thanet area with 20-30% then requiring informal or formal admission to acute health services as an outcome following a full mental health assessment. During this same period for the Thanet area the Kent Police also recorded 440 mental health related calls being received specifically from the Thanet area.

2.3 In the same way the ambulance service is often the first response to those experiencing mental health crises who believe that the only way to receive help is to dial 999 to receive an emergency

[1] KCC (14 December 2016) Lizzy Adams (Scrutiny Research Officer Strategic and Corporate Services (Governance and Law), KCC) email to Helen Greatorex (Chief Executive, KMPT).

[2] A section 136 is a power under the 1983 Mental Health Act [MHA] (amended 2007) that 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).

[3] The information provided relates to the Trust's recorded Section 136 assessments. It differs from the data held by Kent Police and the Kent Approved Mental Health Professional [AMHP] Service. Work is underway to validate the information and ensure future reporting is accurate and agreed by all organisations.

response for their distress. This means that many people are being unnecessarily conveyed to an Emergency Department [ED] for a mental health assessment in the absence of a physical health condition. This not only places a burden on already stretched services but provides a poor patient experience.

2.4 Furthermore the Trust experiences significant pressures on its inpatient beds. Pressures that are impacted by a number of factors including:

2.4.1 The ability of CRHT teams to home treat patients and support them in a community setting thereby reducing admission.

2.4.2 The ability of CRHT teams to home treat when they undertake non-home treatment roles including section 136 assessment.

2.4.3 Effective management of discharge from the point of admission.

2.4.4 Effective management of delayed transfers of care [DToCs][4].

2.4.5 Enhanced levels of therapeutic intervention during an inpatient stay to speed the process of recovery and discharge.

2.4.6 High numbers of service users presenting at an ED when in a crisis following a KMPT intervention.

2.4.7 High numbers of patients with a personality disorder being admitted for long lengths of stay [LoS][5].

2.4.8 High numbers of emergency readmissions following an inpatient stay.

2.4.9 The speedy repatriation of those patients placed within private beds to improve outcomes and experience as well as reduce cost.

2.5 To improve patient flow, the Trust's Patient Flow Programme, continues to meet weekly to monitor the use of acute mental health and psychiatric intensive care unit [PICU] beds and monitor progress against agreed work streams. These work streams reflect the whole system approach needed to deliver and sustain change.

2.6 Members will recall the Patient Flow Programme was established in August 2016 to focus on reducing the use of private beds in line with an agreed trajectory that identified a maximum usage of private beds to 15 by the end of October 2016 and to 0 by the end of December 2016. Having successfully delivered against trajectory at the end of October 2016 and with good progress maintained to deliver at the end of December 2016[6], the focus has now shifted to sustaining this position in the longer term. To support this a number of new work streams have been identified. These include:

2.6.1 *Emotionally Unstable Personality Disorder [EUPD]*: this work stream seeks to ensure a pathway is developed to provide an alternative to admission for those service users with an EUPD. It is set within the wider strategic work to restructure the whole personality disorder care pathway. A Personality Disorder Care Pathway Strategy is currently being developed.

2.6.2 *Liaison Psychiatry Services*: this work stream seeks to ensure the Trust is ready to deliver the recommendations of the National Institute for Health and Clinical Excellence

[4]DToCs are those service users who no longer require acute inpatient care and are deemed fit for discharge from a Trust bed. These service users require other health or social interventions and continue to have a significant impact on the use of external beds.

[5]National Institute for Health and Clinical Excellence [NICE] guidance indicates hospital admission is not helpful for individuals presenting with an acute personality disorder, and that where hospital admission is recommended to manage risk this is brief. The Trust interprets 'brief' as normally kept to a maximum of 72 hours.

[6]Appendix C provides an illustrative representation of achievement against trajectory.

[NICE] and NHS England [NHSE] guidance[7] that recommends that liaison mental health teams should be available to respond to mental health crises within one hour.

2.6.3 *Section 136 (reduction in detention from 72 hours to 24 hours)*: this work stream seeks to ensure the Trust is ready to meet the change in maximum length of detention under Section 136 from 72 hours to 24 hours which is scheduled to go live in April 2017.

2.7 Recognising improving the integrated acute pathway and creating an environment in which an improved crisis response can be delivered is only one element of a whole system approach to promoting well being and reducing poor mental health, the Trust is undertaking a targeted programme of support and recovery within the Community Mental Health Teams [CMHTs] as part of its Community Recovery Programme. Engagement events have taken place across all Kent localities and the Assistant Medical Director has spent three days in each locality to observe practice and operating processes. Following these visits each CMHT will have a local level status report and improvement plan, with tailored recommendations. As a supporting framework, a Trust Wide Target Operating Model [TOM] for Community Services will be issued. The TOM will define pathways and mandate a set of standard processes that include:

2.7.1 Eligibility and discharge criteria (including shared care arrangements).

2.7.2 Waiting list management.

2.7.3 Caseload review clinics.

2.7.4 Clinical governance arrangements.

2.8 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, supporting re-enablement, mental health and recovery models.

2.9 In addition there are currently a number of challenges facing providers in relation to the provision of specialist services for people with a diagnosis of dementia. To address these challenges the Trust continues to actively engage with KCC and its partners and 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.

3. New initiatives and opportunities

3.1 The Trust continues to welcome the opportunity to develop new initiatives and opportunities to deliver its vision[8]. To achieve this, the Trust is involved in a number of projects in partnership with Local Authorities, Kent Police, other NHS organisations, community and voluntary sector providers. These include:

3.1.1 *Kent Police:* The Trust is working with Kent Police to develop a joint strategy to improve the joint response to people with crisis. The strategy is county-wide. The aim of the strategy is to provide the right care and support for people in crisis by:

[7](November 2016) NICE and NHSE *Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent an Emergency Liaison Mental Health Services for Adults and Older Adults - Guidance*

[8]KMPT's vision is to create an environment within Kent and Medway 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.

- ✓ Reducing the number of people who reach mental health crisis in circumstances that require police intervention.
- ✓ Reducing the number of people who are detained under Section 136.
- ✓ Minimising the use of police custody as a place of safety except in exceptional circumstances where a person is violent, or has committed a crime or cannot be safely accommodated elsewhere in line with legislation and best practice.
- ✓ Reducing the time people spend in a police custody waiting for an assessment under the MHA where one is deemed as being required.
- ✓ Reducing the time and resources utilised by police officers, health and social care staff spent with detained persons who require assessment.
- ✓ Improving the pathways and services available for people suffering from mental health crisis before, during and after a crisis occurs.

To achieve this the Trust will work closely with Local Authorities, Kent Police, and other NHS organisations in Kent and Medway to develop effective and economically sustainable services for those in mental health crisis. The Trust will continue to work with the Crisis Care Concordat Group[9] to improve the service provided to those in mental health crisis. This means the Trust will:

- ✓ Develop Mental Health Street Triage teams in local areas with high activity at times of peak demand which will see a mental health professional working with Kent Police to provide advice on alternative suitable care people in crisis.

3.1.2 *Thanet Community Street Triage:* Subject to funding from commissioners, the Trust proposed street triage trial pilot, will commence in February 2017 in Thanet for a period of 12 months. This will see a mental health practitioner and a police officer in a dedicated (unmarked) vehicle responding to Section 136 call outs, providing an initial assessment and, with rapid access to information systems, being able to offer alternatives to detention under Section 136 where appropriate. The team will work closely with the Police's Force Control Room and the Trust's county-wide Single Point of Access [SPoA] team and the local Kent CRHT teams in order to facilitate a range of appropriate options for supporting those individuals in crisis. The service will operate during identified peak hours of Thanet Section 136 detention activity, that is Friday to Sunday evenings between the hours of 18.00 hours to 00.00 hours each week. The service will be for all age groups. For young people who present under the age of 18 there will be close liaison with the Child and Adolescent Mental Health Services [CAMHS] provided by Sussex Partnership NHS Foundation Trust [SPFT] for support, advice and possible assessment.

3.1.3 *Mental Health Triage Nurse:* In November 2016 the Trust launched a new development that sees a Trust mental health triage nurse based in the South East Coast Ambulance Service NHS Foundation Trust [SeCAmb] local control centre. The service provides additional clinical advice to call handlers with 999 calls where there may be a mental health concern. One of the key focusses of the new development is to improve the effectiveness of the response and patient experience. The triage team is funded to operate three nights a week with peak activity times identified as Sunday, Saturday and Monday respectively between 16.00 – 01.00 hours. The team has access to clinical systems and can see calls coming in and where police or ambulance services are responding. Data for the period 28 November 2016 to 23 December 2016 has demonstrated that the service is able to support non deployment of an ambulance on six occasions, A&E avoidance for 13 individuals (frequent callers) and section 136 avoidance on four occasions.

3.1.4 *Liaison Psychiatry Services:* Local Clinical Commissioning Groups [CCGs] are leading on the development of a bid for new transformation funding for urgent and emergency

[9]Taking account of existing challenges, the county-wide Crisis Care Concordat Group seeks to engage all partners in ensuring the pace of deliverable change is increased and that this is supported by detailed planning. Current priorities include the changes required as a result of the Policing and Crime Bill (2016) and reducing the unsustainable demand on emergency services across the system. This includes the development of a number of initiatives to support improvements to pathways with an emphasis on early intervention and initially targeting those areas with high local activity.

liaison mental health services in acute hospitals. The closing date for bid submissions is 18 January 2017. This is linked with the NICE and NHS England [NHSE] guidance[10] that recommends that liaison mental health teams should be available to respond to mental health crises within one hour as part of the transformation of urgent and emergence care pathways nationally.

3.1.5 *Dartford, Gravesham and Swanley [DGS] Section 136 Drugs and Alcohol Liaison Team:* A bid has been submitted to Health Education England (Kent, Surrey and Sussex) and DGS CCG to support the development of a section 136 drugs and alcohol liaison team at Darren Valley Hospital. The team would be part of the A&E liaison services and carry out specialist triage assessment of people brought in under section 136, provide support and onward referral to appropriate services and deliver practice development training to police, acute and ambulance staff. Subject to approval of funding the service could be operational by March / April 2017.

3.1.6 *Mother and Infant Mental Health Services [MIMHS]:* The Trust has been successful in securing more than £2m funding over the next three years. The funding will enable the Trust to recruit more specialist staff which will help the service to reach an additional 598 women per year county-wide. Care will become more integrated, comprehensive and seamless while, importantly, meeting NICE and Royal College of Psychiatrists [RCPsych) standards. The existing team provides a good foundation for development with a strong history of partnership working and training provision across the perinatal pathway. Thanks to the team, the Trust is highly visible within the regional and county-wide clinical networks where an integrated pathway is being developed. In addition Kent and Medway is one of four areas in England to test the Competency Framework for Perinatal Mental Health.

3.1.7 *Peer-supported Open Dialogue [POD][11]:* The Trust continues to implement Open Dialogue at pace. Two POD teams are being developed in Canterbury and Medway - localities chosen as a result of the particular circumstances and unique challenges each offers. Work is ongoing to reconfigure existing trained practitioners from the Acute and Community Recovery service lines to form standalone POD teams in each of the chosen localities. It is hoped that the first team will start to take formal referrals in January 2017. The service has also secured further funding from Health Education England (£54K) to train another six practitioners in POD and support two clinicians to attend the Train the Trainers course in Helsinki. This training will ultimately contribute to the sustainability of the model and offer opportunities for Kent and Medway to be seen as a beacon of best practice for this approach. In addition and in recognition of this pioneering work the Trust won the 2016 National Social Worker of the Year award for Creative and Innovative Practice and was one of five shortlisted projects in the 2016 NHS England Positive Practice in Mental Health - Crisis Care award category.

3.2 The Trust continues to proactively work with a number of key stakeholders including Healthwatch Kent, the Armed Forces Network Kent and Medway, Carers First, Live It Well, Herne Bay Umbrella, . Details of the Trust's work with each of these groups was provided to Members in the October 2016 Mental Health Update report and is therefore not repeated here.

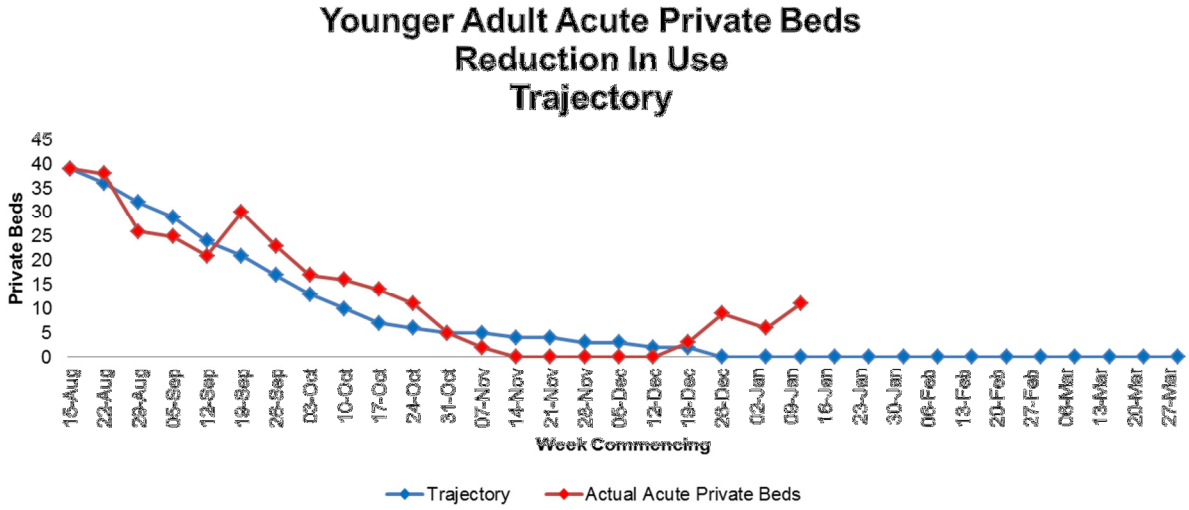
4. Conclusion and Recommendation

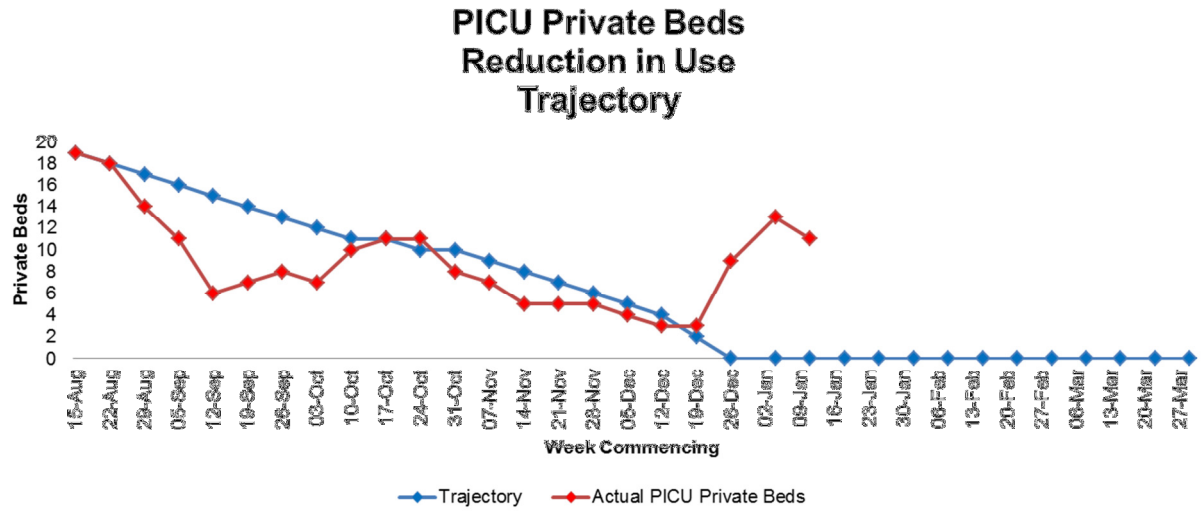
4.1 The KCC HOSC is requested to note the content of this report.

[10](November 2016) NICE and NHSE *Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent an Emergency Liaison Mental Health Services for Adults and Older Adults - Guidance*

[11]The Trust is one of four Trusts in England piloting and introducing the POD model. Developed in Finland the strong psychosocial POD model (open dialogue) focuses on following what the service users and their family want and has been shown to improve return to work / study rates for those with a first episode of psychosis by 78% and reduce relapse for that group by 19%.

APPENDIX A : PATIENT FLOW PROGRAMME ACHIEVEMENT AGAINST TRAJECTORY (as at 11 January 2017)





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Item 8: Maidstone & Tunbridge Wells NHS Trust: Financial Special Measures (Written Update)

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 27 January 2017

Subject: Maidstone & Tunbridge Wells NHS Trust: Financial Special Measures (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Maidstone & Tunbridge Wells NHS Trust.

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

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

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1. Introduction

(a) On 2 September 2016 the Committee considered a report by Maidstone & Tunbridge Wells NHS Trust who had been placed in Financial Special Measures by NHS Improvement as part of the first cohort of providers in July 2016. On 2 September, the Committee agreed the following recommendation:

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

2. Recommendation

RECOMMENDED that the report on the Maidstone & Tunbridge Wells NHS Trust: Financial Special Measures be noted and an update be presented to the Committee in six months.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (02/09/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=41835

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Maidstone and Tunbridge Wells NHS
NHS Trust

KCC HOSC
Financial Special Measures
UPDATE

27th January 2017

Financial Special Measures

- Financial Special Measures (FSM) was introduced in July by NHS England and NHS Improvement to help strengthen financial and operational performance. They are part of the “reset” of NHS finances designed to ensure the financial sustainability of the NHS.

- 5 NHS provider Trusts were identified to be part of the first cohort, with 8 CCGs also identified. We are one of the provider Trusts. A further 3 Trusts have also now been identified as being in Financial Special Measures.

- A Financial Improvement Director, Simon Worthington from Bolton NHS Foundation Trust, has been appointed by NHS Improvement and continues to work with us. He is supported by staff from NHS Improvement.

- The Trust has had two progress meeting with NHS Improvement, with a third scheduled to take place at the end of January. At the current time, the Trust remains in Financial Special Measures.

Progress with Financial Special Measures

- The Trust has signed up to the delivery of its control total in 2016/17, although this remains high risk. Prior to entering FSM, the Trust had not accepted its control total.

- The control total requires the Trust to have a deficit of £4.7m, before the application of Sustainability and Transformation Funding (STF). The Trust's original plan for the year was a deficit of £22.9m. The Trust is currently forecasting a deficit of £15.3m, before application of STF.

- This demonstrates the significant progress that has been made in improving the financial position since the start of the FSM process. There does remain, however, more work to do to achieve the control total and this is a key focus for the organisation.

- The Trust has also signed up to the delivery of its control totals in 2017/18 and 2018/19.

Areas of Focussed Action

- All actions that we undertake are Quality Impact Assessed to ensure that any expected impacts on quality are understood and robustly mitigated. This is a live process and is reviewed throughout the financial year.
- **Pay** – A particular focus on temporary staff reduction through continued recruitment and retention efforts, but also the most effective use of staffing. The Trust has reduced nursing agency by 33%, a £3.6m full year benefit.
- **Non-Pay** – Three approaches – ensure the most effective procurement, ensure that stock holding and stock management processes are optimised and challenge the necessity of all items of expenditure through rigorous control processes.
- **Balance sheet flexibility** – The Trust has reviewed all relevant accounting guidance, guidance from NHS Improvement and best practice from other organisations to ensure that it only takes appropriate assets and liabilities to the balance sheet.

Sustainability and Transformation Funding (STF)

- As MTW has now agreed its control total, it can access the STF funding. However as the Trust accepted its control total in Quarter 2, it cannot access Quarter 1's element of the STF.

- This means that of the funding identified for MTW - £12.5m - only £9.4m is available for the trust to earn.

- The funding is split 70% for the achievement of financial targets, and 30% for the achievement of its improvement trajectories to the delivery of constitutional targets. At the current time, the Trust has delivered its financial targets for Quarter 2 and Quarter 3, and some of its constitutional target performance.

- Currently MTW has earned £4.9m from the STF, which is incorporated in to its bottom line reported position.

Next Steps

- The Trust has a progress meeting with NHS Improvement at the end of January. The Trust is currently working on its position ahead of this meeting and will be doing all it can to reduce the forecast deficit further.

- The Trust has signed up to its control total for the financial years 17/18 and 18/19 and is implementing the actions to deliver this financial performance.

- The Trust has explored a range of benchmarks from various sources and all suggest that there remains a significant opportunity for the Trust to be more efficient.

- The Trust's ongoing approach to improving its financial position is to continue to identify opportunities to utilise its resources in the most effective way. The Trust has made significant progress to date, and expects to make more over the remainder of this financial year and into future years.

Item 9: CCGs Annual Rating: Update (Written Update)

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 27 January 2017

Subject: CCGs Annual Rating: Update (Written Update)

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

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

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

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1. Introduction

(a) On 2 September the Committee considered the performance of the CCGs in Kent following the publication of the annual ratings by NHS England in July 2016. The Committee agreed the following recommendation:

- *RESOLVED that the report be noted and the Kent CCGs be requested to provide an update to the Committee annually.*

(b) The Chairman, in consultation with the group representatives, has asked for a six month update to be provided to the Committee in January on the key actions from the CCGs' improvement plans.

2. Recommendation

RECOMMENDED that the report be noted and the Kent CCGs be requested to provide an update on their 2016/17 rating and assessment in September.

Background Documents

NHS Improvement (2016) *'Strengthening financial performance & accountability in 2016/17 (21/07/2016)'*
https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf

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Kent Health Overview and Scrutiny Committee Briefing: Annual assessment 2015/16 of Kent CCGs

January 2017

Background

The assurance framework for 2015/16 assessed CCGs against five components set out in the CCG assurance framework.

For each component, CCGs were assessed in four categories: outstanding, good, requires improvement and inadequate.

CCGs were then given an overall headline assessment, based on their ratings in the five components of assurance.

An overall rating of **outstanding** means that at least one of the five components is outstanding and all others are good.

Good means that all components are good or at least four components are rated as good (or good and outstanding) and one component is rated requires improvement, unless requires improvement is in the finance, planning or well led component

Requires improvement applies if four components are rated as good (or good and outstanding) and the finance, planning or well led components are assessed as requires improvement or inadequate. Or, there is more than one requires improvement component rating and no more than one component is assessed as inadequate.

A CCG is **inadequate** overall if more than one component is rated as inadequate and it already has directions (under section 14.z.21 of the NHS Act 2006, as amended) in force.

Kent CCG ratings

Nationally, 10 CCGs were rated 'outstanding', a further 82 'good' and 91 were found to 'require improvement'.

In Kent the headline rating for each of the CCGs were as follows:

CCG	Headline rating
NHS Ashford CCG	Requires improvement
NHS Canterbury and Coastal CCG	Requires improvement
NHS Dartford, Gravesham and Swanley CCG	Requires improvement
NHS South Kent Coast CCG	Requires improvement
NHS Swale CCG	Good
NHS Thanet CCG	Requires improvement
NHS West Kent CCG	Good

A more detailed summary of ratings for Kent and Medway CCGs is included in Appendix 1

CCG improvement plans

All CCGs have improvement plans in place and progress against these plans is summarised below:

CCG	Key actions (September2016)	Progress to January 2017
NHS Ashford CCG NHS Canterbury and Coastal CCG NHS South Kent Coast CCG NHS Thanet CCG	• Address the entrenched poor performance against the A&E standard, the national referral-to-treatment standard and the national cancer standards in the East Kent system	The four east Kent CCGs are working collectively to improve performance across the health economy and have an improvement plan in place. For progress on A&E see Appendix 2. For progress on cancer see Appendix 3. For progress on referral-to-treatment see Appendix 4.
NHS Ashford CCG NHS Canterbury and Coastal CCG NHS South Kent Coast CCG NHS Thanet CCG	• Deliver the new Early Intervention in Psychosis standards	The four east Kent CCGs are working collectively to deliver the new Early Intervention in Psychosis standards. For progress see Appendix 5
NHS Ashford CCG NHS Canterbury and Coastal CCG	• Develop a robust primary care development and transformation strategy that supports wider system strategies such as the Sustainability and Transformation Plan (STP)	A robust strategy is in place for both CCGs that supports wider transformation. Both CCGs are also developing primary care operational plans which are due to be finalised by the end of February 2017.

NHS Ashford CCG	• Stabilise and improve the financial position such that NHS Ashford CCG delivers the required one per cent surplus in 2017/18 that business rules require	The CCG has submitted a financial recovery plan which has been approved by NHS England. However, owing to support for both the acute sector and social care to manage winter pressures, plans to reduce elective waiting times and transformation costs, the CCG is forecasting a financial deficit for 2016/17.
NHS Dartford, Gravesham and Swanley CCG	• Continue to work with our service providers to achieve key performance standards as set by the NHS Constitution • Work with service providers, GP members and our partners to deliver future financial sustainability. • Continue to make changes and improvements to ensure our assurance ratings improve year on year	• At the time of reporting the local acute provider is achieving the majority of NHS Constitution targets. However, A&E remains a significant challenge across all Kent &Medway providers and other risks remain, particularly around ambulance response rates. • The CCG is forecasting a financial deficit for 2016/17. This is largely due to the over-performance of the CCG's providers and underfunding of allocations, both based on significant population growth. • We are working with GP Members and wider clinical partners to develop new local models of care to deliver effective, sustainable services.
NHS Swale CCG	• Continue to work with our service providers to achieve key performance	• At the time of reporting the local acute provider is achieving some NHS

	standards as set by the NHS Constitution.	Constitution targets and trajectories agreed with NHS England. However, A&E, Cancer and elective access remains a challenge. In addition, other risks remain particularly around ambulance response rates.
	• Work with service providers, GP members and our partners to deliver future financial sustainability.	• We are working with service providers, GP members and our partners to deliver future financial sustainability - the CCG is currently forecasting non-achievement of mandatory targets in 2016/17 with a return to full delivery in 2017/18.
	• Continue to work hard in all areas of assessment to improve our rating further	• We are working with GP member practices and wider clinical partners to develop new local models of care to deliver effective, sustainable services.
NHS Thanet CCG	• Develop a robust primary care development and transformation strategy that supports wider system strategies such as the Sustainability and Transformation Plan (STP).	• Our Primary Care Strategy was approved by the CCG Governing Body in December 2016. Resilience and Transformation Plans underpinning this as well as the General Practice Forward View and Sustainability and transformation Plan (STP) are in place and awaiting NHS England sign off.
	• Stabilise and improve the financial position such that NHS Thanet CCG delivers the required one per cent surplus in 2017/18 that business rules	• The CCG has negotiated contracts for 2017-19 that will encourage transformation to be driven through with cost savings as one of the outcomes. In

	require	addition, the operational plan includes projects that are designed to review and improve productivity and ensure better value for money. Regular monitoring on a monthly basis will keep deliverables on track throughout the year.
NHS West Kent CCG	• Work with providers to improve performance on constitutional standards, in particular on A&E waiting times • Deliver the national standard on dementia diagnosis rates	Significant challenge to deliver across all of Kent and Medway and nationally, mainly due to delayed discharges / transfers of care. There is a robust plan in place to address these issues, based on national guidance and best practice, including revised discharge pathways. The national standard requires the CCG to have identified 66.67 per cent of the expected prevalence. Current performance (December 2016) is 60.7 per cent, which equates to approximately another 400 diagnoses to achieve the standard. The CCG has an action plan in place to identify those patients, which includes improving data accuracy and provider incentives to reduce the time between referral and diagnosis.

Appendix 1 Kent CCG ratings in full

CCG	Headline rating	Well led	Delegated functions	Finance	Performance	Planning
NHS Ashford CCG	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
NHS Canterbury and Coastal CCG	Requires improvement	Requires improvement	Good	Good	Requires improvement	Good
NHS Dartford, Gravesham and Swanley CCG	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
NHS South Kent Coast CCG	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Good
NHS Swale CCG	Good	Good	Good	Good	Requires improvement	Good
NHS Thanet CCG	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Good
NHS West Kent CCG	Good	Good	Good	Good	Requires improvement	Good

Appendix 2: Progress on East Kent A&E Improvement Plan

The four CCGs in east Kent are working collectively to improve performance across the health economy.

- A&E Delivery Board established.
- Revised A&E Delivery Board improvement plan developed.
- Held an East Kent Discharge Summit in November with clear outputs reporting progress to the monthly A&E Delivery board.
- Kent and Canterbury Hospital has GP provision within the urgent care pathway for 24 hour period working to agreed streaming criteria and where appropriate patients are seeing GPs. Full evaluation published.
- CCGs are working with local GPs and East Kent Hospitals University Foundation Trust (EKHUFT) towards implementing a GP service in A&E at the William Harvey Hospital.
- GP out of Hours Service is co-located with and supports urgent care departments between 6.30pm and 8am and 24 hours during weekend and bank holidays on all three hospital sites.
- Patients are directed from 111 or through urgent care teams.
- Thanet CCG has implemented a GP led integrated Acute Response Team (ART) at QEQM, supported by community, social care and voluntary sector teams. The team are based within the A&E department 10am to 6pm daily to reduce A&E attendances and admissions. In addition at QEQM partial implementation of streaming and frailty model to the Acute Response Team Monday to Friday 9am-5pm.
- Robust arrangements to recruitment to all posts.
- QEQM- Additional consultant is supporting weekends.
- Twice daily consultant board rounds across all three sites.
- CEO / AO communication re ED daily.
- CEO/ COO/ Med Director/ Chief nurse supporting the sites daily.
- Super Discharge week implemented 12 – 20 December across east Kent within acute and community hospital. A&E delivery board will receive feedback at its meeting in January.

Daily whole system conference calls have been held since 21 December and remain in place throughout January.

Appendix 3: Progress on East Kent Cancer Improvement Plan

EKHUFT is currently non-compliant with the 62 day treatment cancer standard (85 per cent of patients must receive their first definitive treatment within 62 days of referral). Performance against the standard, as at December 2016, was 75 per cent (equating to 41 breaches across east Kent).

The CCGs have an improvement plan in place with EKHUFT and progress against the plan is monitored on a monthly basis as part of a contractual management process and demonstrates a clear joint commitment across all organisations to improve performance and achieve the standard.

The process is clinically led by the EKHUFT Cancer Consultant lead and local CCG GP leads. The reasons for non –compliance against the target are complex and vary across cancer pathways (tumour sites) but include the following:

- Access to diagnostic tests (such as such as Endoscopy and Hysteroscopy) within a timescale that will support delivery of the pathway. This is largely due to demand and capacity for tests early enough in the patient's pathway (also affected by the ability to recruit skilled workforce).
- Clinicians to ensure that patients with complex morbidity are reviewed throughout the pathway, essentially ensuring that the patient does not wait longer than 62 days.
- Patient choice – where patients choose to delay their diagnostic tests or first treatment because of personal reasons such as family commitments, pre-booked holidays etc.

The Improvement plan covers a range of areas where we intend to address the issues causing non-compliance, for example:

- Improved internal EKHUFT processes for the management of diagnostic capacity and prioritisation of cancer patients.
- A Kent and Medway bid for national cancer transformation funds to improve access to diagnostics tests across the county (submitted 18 January 2017).
- Improved tumour site specific action plans which set clear milestones for delivery and improvement.
- Training and education for GPs in relation to early diagnosis and referral pathways (successful event held on 14 January 2017 attended by 160 local GPs).

Patient education – ensuring that patients understand that they are being referred to hospital on a rapid access pathway to eliminate the possibility that they may have cancer ; and therefore the importance of accepting early appointments for consultations, tests and treatments.

Appendix 4: Progress on East Kent Referral to Treatment Standard Improvement Plan

- As with the Cancer standard the EK CCGs work collaboratively to improve performance against the referral to treatment standard (92 per cent of patients should receive their first definitive treatment for planned care within 18 weeks of referral from primary care).
- Currently the standard is not being achieved across EK with performance in December at 82.5 per cent.
- The CCGs and EKHUFT have an improvement plan in place and performance is monitored in a number of contractual performance meetings on a weekly and monthly basis. The CCGs have recruited some short term specialist support from NHS Elect to work with the Trust to deliver an improvement of the position, a stepped reduction in the outstanding backlog of patients (patients waiting over 18 weeks) and develop a sustainable RTT plan for the future.
- Compliance against the standard varies across specialities. Some of the lowest performing specialities against the standard are Trauma and Orthopaedics, General Surgery and Gynaecology.

The reasons for non-compliance also vary across specialities however some common factors are:

- High demand for services which in specialities such as T&O outstrips available clinic and theatre capacity to deliver the pathway within 18 weeks.
- Access to diagnostic tests.
- Maintaining a skilled workforce to deliver treatment pathways.
- Lack of appropriate alternative treatment options in the community.

The improvement plan includes a range of initiatives and projects across primary and secondary care to improve the position, for example:

- Working with local Independent Sector healthcare providers to offer patients waiting for treatment for over 18 weeks the choice to receive NHS treatment in alternative settings (through existing NHS contracts). This has focused on the key specialities mentioned above.
- Implementing referral triage arrangements for Trauma and Orthopaedics to ensure that all alternative treatment options are considered for patients before being referred for hospital treatment.
- Implementing alternative to outpatient initiatives such as an electronic Advice and Guidance service for GPs from Consultants in certain specialities.
- Developing new Local Care models which will see the shift of some outpatient activity in the future to more appropriate local settings.
- Implementing Patient Choice initiatives to ensure that patients are made aware of all of the possible options to them when being referred for secondary care treatment (which providers offer the services locally and the current waiting times).

Appendix 5: Progress on East Kent Early Intervention in Psychosis (EIP) Standard Improvement Plan

- The current performance of the EIP service for east Kent indicates that the referral to treatment (RTT) target of 2 weeks is being met and performance is above target for the service. The provision of NICE compliant treatment by care co-ordinators however is still non-compliant and this is a similar picture across all of the Kent CCGs. KMPT have an agreed training plan in place for the service which has been funded by Health Education England (HEE) and is gradually training and enhancing the current skills of the staff to deliver the NICE compliant treatment, however this will not be completed until October 2017.

- A 'gap analysis' has been carried out which indicates that for the service to be fully accredited and NICE compliant there is a requirement for extra staff, primarily therapists and care co-ordinators, to be recruited, and in recognition of this during the recent contract negotiations with Kent and Medway Partnership Trust (KMPT) the east Kent CCGs have agreed a recurrent growth figure derived from CCG specific forecast population changes of £400k in each of the two contract years which will be invested in agreed SDIP projects; prioritising Early Intervention in Psychosis in 2017-18.

- A business case will be prepared as described above and this will facilitate recruitment to the extra staffing posts required and move the service towards full compliance.

- There continues to be a Kent wide Service Development Improvement (SDIP) Plan in place and regular monitoring meetings are held to oversee progress towards compliance.

- **It is envisaged that if the progress outlined above is maintained the service will be fully compliant by October 2017.**

Item 10: Darent Valley Hospital: MRSA (Written Update)

By: John Lynch, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 27 January 2017

Subject: Darent Valley Hospital: MRSA (Written Update)

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

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

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

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1. Introduction

(a) On 3 June 2016 the Committee considered reports regarding 14 incidences of MRSA at Darent Valley Hospital in 2015/16 and the actions being taken to reduce the incidence and improve patient safety and performance. The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the reports provided by Dartford and Gravesham NHS Trust and NHS Dartford, Gravesham and Swanley CCG be noted;

  (b) Dartford and Gravesham NHS Trust be requested to provide an update to the Committee in six months;

  (c) the Chairman write a letter to the Secretary of State for Health and Chief Executive of Public Health England requesting a review of the Department of Health guidance on targeted admission screening for MRSA.

(b) Subsequently the Vice-Chairman-in-the-Chair was made aware of Public Health England data which showed that since the introduction of targeted screening in 2014 MRSA infection rates had remained steady nationally. As a result of this infomation, the Vice-Chairman-in-the-Chair, in consultation with the group representatives, sent a letter to the Trust to say that he would not be writing to the Secretary of State for Health asking for a review of the guidance – it was felt that it was a local issue regarding infection control management at the Trust rather than the guidance.

2. Recommendation

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

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (03/06/2016)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=38125

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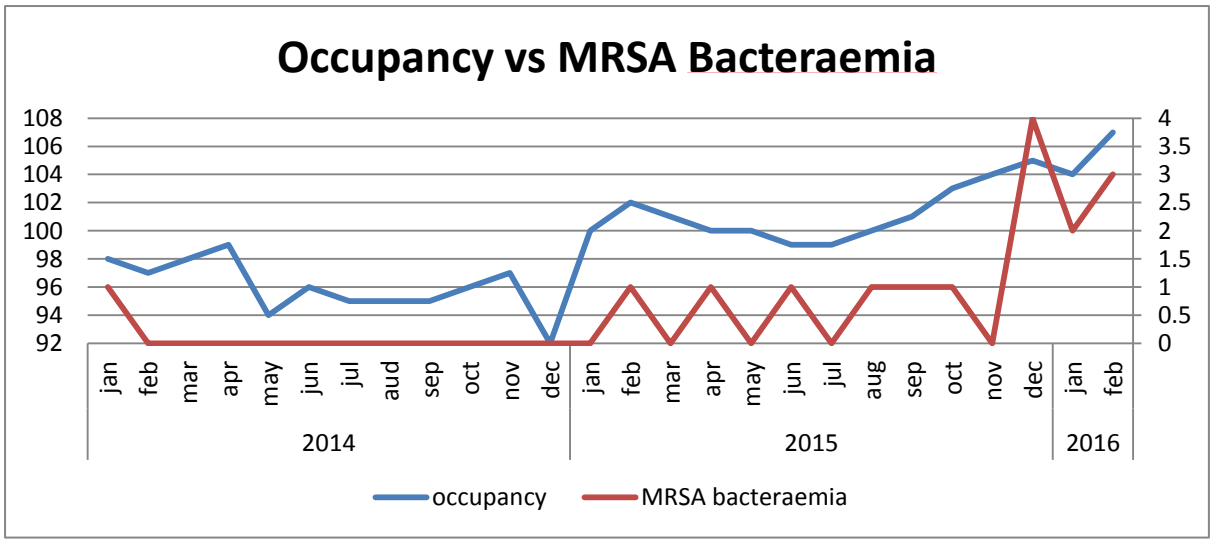
Dartford and Gravesham NHS Trust: Infection Prevention and Control Report to the Kent Health Overview and Scrutiny Committee, January 2017.

Introduction

In 2015/16, 14 patients at Darent Valley Hospital (DVH) developed an MRSA bacteraemia (bloodstream infection) during their admission, (the highest rate and number of MRSA bacteraemia cases of all Trusts in England that report submit data to the Public Health England surveillance system), and the Trust Development Authority (TDA, now known as NHS Improvement (NHSI)), were asked by the Trust to undertake an inspection / review of infection prevention and control practice at DVH. The Review, which took place on the 8th March 2016, acknowledged that there were a number of aggravating factors that contributed to the high MRSA bacteraemia rate within the Trust, such as:

- high bed occupancy (see **Figure 1** below)
- the decision to cease "universal" MRSA screening and move to modified / targeted screening based on Department of Health guidelines published in 2014, and a historically low rate / incidence of MRSA infection / bacteraemia within the Trust
- the performance of the Infection Prevention and Control Team (IP&CT) in relation to the provision of expert guidance and advice for staff. The ability of the IP&C Specialist Nursing Team, consisting of three members of staff, to work pro-actively had been hindered by long-term sickness within the Team.
- compliance with IP&C practice
- the need for greater Directorate engagement with / ownership of Infection Prevention and Control.

Figure 1: Bed occupancy DVH v MRSA bacteraemia: 2014-2016



Following the TDA Review, a 63-point MRSA / Healthcare Associated Infection Quality Improvement Action Plan (QIAP) was developed and work commenced on its implementation. The IP&C Specialist Nurses all left their posts at the end of March 2016 (planned retirement; employment with another Trust, and relocation abroad), and an interim IP&C Specialist Nursing Team were seconded to the Trust pending the appointment of a new substantive Specialist Nursing Team. On the 28th June 2016**,** the Care Quality Commission (CQC) undertook a focussed responsive inspection, supported by NHSI, and found that the Trust had made good progress in a short space of time.

The Chief Executive Officer (CEO) and the Director of Infection Prevention and Control (DIPC) attended the Kent Health Overview and Scrutiny Committee (HOSC) in June to provide assurance on the actions that had been taken to improve IP&C practice, and were asked to provide an update in January 2017. Therefore the intention of this Report is to provide the HOSC with further assurance regarding the systems and processes that have been established within the Trust in relation to IP&C.

The Infection Prevention and Control (IP&C) Specialist Nursing Team

A new substantive Infection Control Team are now in place.

- Director Infection Prevention and Control (DIPC); joined the Trust on the 31st May 2016 as Assistant DIPC, also fulfilling the IP&C Lead Nurse role, and was appointed to the DIPC post in October 2016 following the retirement of the previous post-holder.
- IP&C Clinical Nurse Specialist. Joined the Team on the 26th September 2016
- IP&C Sister (designated training post). Joined the Team on the 20th June 2016.
- Generalist Matron seconded form adult medicine with an IPC background

The Trust is now in the rather unique position of having a full-time DIPC who is also a highly experienced and senior IP&C Specialist Nurse, and a Business Case is being developed for the recruitment of an IP&C Lead Nurse during 2017/18. The post holder will be the operational lead for the IP&C service and will manage the work of the Team on a day to day basis. This will enable the DIPC to concentrate on developing the IP&C strategy, and strengthen reporting, surveillance and assurance / governance arrangements. With the appointment of a Lead Nurse in addition to the full-time DIPC, the IP&C Specialist Nursing Team will be better resourced than it has ever been.

The Specialist Nursing Team have a very high clinical profile, reviewing the IP&C management of patients who are known to have infections or be carriers of organisms such as MRSA and C. difficile, and acting as an expert, specialist resource for staff. They are also challenging staff with regard to poor clinical practice / non-compliance with policy, and utilising every opportunity during clinical visits to engage with nursing, medical and allied health teams in order to embed practice, move to the implementation of Best Practice standards and foster a culture of ownership of, and engagement with, IP&C.

An additional Consultant Medical Microbiologist joined the IP&C Team in October 2017, and also holds the post of Infection Control Doctor. This has further strengthened the IP&C service, and enhanced engagement with the medical teams.

MRSA bacteraemia

At the time of writing, there have been four Trust-assigned cases of MRSA bacteraemia (June – November 2016), compared to 11 Trust assigned cases occurring between April 2015 - January 2016. Table 1 below records the number of Trust-assigned cases in 2015/16 and 2016/17.

Table 1: Trust-assigned cases of MRSA bacteraemia 2015/16 and 2016/17

	2015/16	2016/17
April	**1**	0
May	0	0
June	**1**	**2**
July	**0**	0
August	**1**	**1**
September	**1**	0
October	**1**	**0**
November	0	**1**
December	**4**	0
January	**2**	0 (to date)
February	**3**	
March	0	

MRSA bacteraemia Post Infection Reviews (PIRs) are now lead by the IP&C Specialist Nurses, which ensures that the entire process is undertaken robustly, and that Trust-wide actions / learning are identified. Action plans are then developed with the appropriate ward(s) and learning is shared Trust-wide, with the PIRs reported at the Infection Control Committee (ICC).

MRSA screening

The decision to cease universal screening within the Trust in 2015 was taken in response to recently published guidance in 2014 from the Department of Health, which advised Trusts that they could adopt "a more focused, cost-effective approach to MRSA screening, in order to promote a more efficient and effective method for identifying and managing high risk MRSA positive patients" (*Implementation of modified admission MRSA screening guidance for NHS*). The guidance stated that "….importantly, focussed screening should be adopted in line with local risk assessments to ensure that Trusts concentrate on reducing negative patient outcomes for their own populations. Changes to current practice need to be undertaken with a commitment to improved compliance with focussed screening." During

the summer of 2016, the DIPC submitted a Freedom of Information request to other NHS trusts regarding uptake of the Department of Health guidance. 139 responses were received; of these, only 23 Trusts had adopted the guidance. 90 Trusts had made no changes to their MRSA screening policy, and the remainder had made very minor changes but had not adopted the guidance.

The Trust re-introduced “universal” screening in January 2016. With the exception of some *very* low-risk patient groups, all elective and emergency admissions are screened for MRSA on admission, and then every seven days until discharge. The routine screening of patients at seven day intervals allows the prompt identification and management of patients who have acquired MRSA during their in-patient stay, and ensures that IP&C interventions are implemented to prevent cross-infection.

Wards are required to audit compliance with MRSA screening weekly, and this is reported to the Quality and Safety Committee; an MRSA Report is also submitted to the Trust Board. While there are still improvements to be made regarding compliance with screening, progress has been made. Acquisitions have fallen since June 2016, with 13 cases being the highest number of acquisitions occurring in month. Although this is above the internal Trust “target” of ≤ 10 cases, it represents a significant reduction in the number of acquisitions that were seen during January – May 2016 when 19 – 25 acquisitions / month were reported.

The number of new acquisitions each month is monitored by the IP&C Specialist Nurses and reported to the Directorates. Where there are two or more new acquisitions on a ward in a calendar month, the Ward Manager and Matron are required to complete the “MRSA Ward-Acquired Checklist”, which assess compliance with IP&C policy and clinical practice, and results in the development of an action plan, which is then monitored by the IP&C Specialist Nurses.

Clostridium difficile

The Trust has an objective / target of no more than 24 cases of C. difficile (cases occurring ≥72 hours post admission to hospital), and to date there have been 17 cases. A Root Cause Analysis (RCA) is undertaken using on new C. difficile cases. and the RCA process is led by the IP&C Specialist Nurses to ensure that it is undertaken robustly. All cases of C.difficile infection are reported to the Quality and Safety Committee.

Meticillin-Sensitive *Staphylococcus aureus* (MSSA) bacteraemia

There are no NHS reduction targets for MSSA bacteraemia, although the Trust has a year-end target of 12 post-48 hour cases. To date, there have been eight cases of MSSA bacteraemia occurring 48-hours post admission to hospital during 2016/17.

E. coli bacteraemia

There have been 125 cases of E. coli bacteraemia occurring pre-48 hours admission to hospital in 2016/17 to date, compared to 27 cases occurring post-48 hours admission.

Further information is pending from NHS England / Public Health England regarding a 50% reduction in Gram-negative bloodstream infections, to be achieved by 2020. Whilst this is understood to be primarily a community / CCG focussed target, strategies and interventions to support this reduction will be required from acute Trusts, and this will be a key area of

focus for NHS Bexley and NHS North Kent CCGs, and the IP&C Team, and will be included in the IP&C Annual Programme for 2017/18/

The Intensive Therapy Unit at Darent Valley Hospital (DVH) have registered to participate in the Public Health England led *Infection in Critical Care Quality Improvement Programme* (ICCQIP) – Surveillance of Blood Stream Infections in Patients Attending ICUs in England, commencing in April 2017.

The MRSA / HCAI Quality Improvement Action Plan (QIAP), MRSA Task Force and the IP&C Focus Group

Progress with the implementation of the 63-point Quality Improvement Action Plan that was developed following the inspection in March 2016 was monitored via the "MRSA Task Force" and the Infection Control Committee, and reported to the Quality and Safety Committee. Now that the levels of MRSA are under control, work has been ongoing to re-develop and simplify the QIAP so that it can now be used to monitor *individual* Ward / Department compliance by rag-rating their performance against 10 metrics. The QIAP will be owned by the wards , and continue to be monitored via the ICC and reported to the Quality and Safety Committee.

Key IP&C actions – June 2016 to date

A number of changes in practice / new initiatives have been introduced by the new IP&C Specialist Nursing Team since June 2016, including:

- Re-launch of the IP&C Link Practitioner Programme
- The IP&C Link Practitioners are receiving training in hand hygiene (correct technique and indications for undertaking hand washing; correct technique and indications for using alcohol hand rub / foam sanitiser; understanding the "5 Moments for Hand Hygiene"; care of the hands), and being taught how to undertake hand hygiene competency assessments. With effect from April 2017, it will become mandatory that all clinical staff within the Trust will be required to undergo an annual hand hygiene competency assessment (practical hand hygiene training) by the Ward / Department IP&C Link Practitioner. Compliance with this will be a Directorate Key Performance Indicator, and the number of staff who have undergone this assessment will be reported via the IP&C Dashboard.
- IP&C training delivered via e-learning from December 2016 for clinical and non-clinical staff.
- Development of an "MRSA Bacteraemia Alert Label" (in conjunction with the Medical Microbiologists) to ensure that Medical / Nursing / Pharmacy staff are aware that patients with a bacteraemia, regardless of the causative organism, must complete 14 full-days of appropriate IV antibiotic therapy.
- Implementation of a new IP&C audit tool that audits compliance with 19 environmental, and 29 clinical practices, standards. The IP&C Specialist Nurses are in the process of ensuring that all wards at Darent Valley Hospital are audited using the new audit tool by the end of March 2017. Action plans are being developed by the Ward Managers and Matrons, and once a period of time has been allowed for implementation, the wards are being re-audited against their action plan.

Departments at DVH, Queen Marys Sidcup and Erith District Hospital will be audited during 2017/18.

- Development of “Key / Important Points” and “Simple Messages”, as A4 posters, to help staff understand key aspects of IP&C practice and their practical application. Examples include hand hygiene at the point of care; important points for the prevention of MRSA infection and the prevention / management of MRSA bacteraemia; the correct use of disposable gloves and aprons; the infection control management of patients in open bays where isolation in a single room cannot be undertaken; guidance on stool specimen collection; the care of peripheral intravenous cannulae
- The development of new “Isolation Door Signs” that clearly illustrate the IP&C precautions that need to be taken by staff
- Development of a new “Peripheral Cannula Insertion and Ongoing Care Record” to improve the documentation of peripheral cannula management and care
- Introduction of Clinell Sporicidal Wipes for the cleaning of commodes
- Introduction of new disinfect wipes for the cleaning of equipment

In addition to the above, the following actions will be completed by the end of March 2017:

- IP&C Manual review - 18 IP&C policies and guidelines will have been revised / developed (of which seven are new); the remaining policies will be reviewed during 2017/18.
- A prevalence audit of all in-patients with a urinary catheter in-situ (indications for insertion / ongoing care). The Urinary Catheter Guidelines will then be re developed during 2017/18.
- A prevalence audit of all in-patients with a peripheral intravenous cannula in situ prior, to ensure that peripheral cannulae are inserted and managed strictly in accordance with Best Practice standards.

Strengthening Ward ownership and engagement in 2017/18

This will be a key area of focus for the DIPC, Director of Nursing and Quality and the Medical Director during 2017/18, along with the embedding of IP&C Best Practice to ensure that the improvements seen during 2016/17 are further developed and, crucially, sustained. The Clinical Directors have been asked to identify Department IP&C Leads, and these individuals will play a key role in helping to support the IP&C agenda within the Directorates. Robust Directorate IP&C Key Performance Indicators (KPIs) are in the process of being developed by the DIPC.

Conclusion

The majority of the IP&CT’s work described in the IP&C Annual Programme 2016/17 will have been implemented by year end, although there are some planned elements of the programme that will be carried over to 2017/18. The focus for the IP&C Specialist Nurses will be embedding the changes in relation to clinical practice, IP&C policies, and learning from root cause analysis. The systems and processes that are now in place in relation to how the IP&C Specialist Nursing Team work, and the move towards implementing Best Practice, has raised the profile of IP&C within the Trust, and restored credibility and confidence in the IP&C service overall.

While significant improvements have been made during 2016/17, there is still more work to be undertaken. The Executive Team and the Trust Board are committed to ensuring that profile of IP&C continues to increase and that, over time, the Trust becomes known as a centre for excellence regarding the prevention and control of healthcare associated infections.

Debbie Weston

Director Infection Prevention and Control

Dartford and Gravesham NHS Trust

12th January 2017

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