HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 20th July, 2018

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 20th July, 2018, 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 (11):	Mrs S Chandler (Chair), Mr P Bartlett (Vice-Chairman), Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr N J Collor, Mrs L Game, Ms S Hamilton, Mr K Pugh and Mr I Thomas
Liberal Democrat (1)	Mr D S Daley
Labour (1):	Ms K Constantine
District/Borough Representatives (4):	Councillor J Howes, Councillor M Lyons, Councillor D Mortimer and Councillor M Peters

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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 - 27 April 2018 (Pages 5 - 16)

4. Minutes - 8 June 2018 (Pages 17 - 24)

5. Transforming Health and Care in East Kent (Pages 25 - 40) 10:05

6. East Kent Hospitals NHS University Foundation Trust: Update (Pages 41 - 52) 10:45

7. Getting It Right First Time (GIRFT) Orthopaedics Pilot: East Kent Hospitals University NHS Foundation Trust (Pages 53 - 56) 11:30

8. Wheelchair Services in Kent (Pages 57 - 68) 12:00

9. Kent and Medway NHS and Social Care Partnership Trust (KMPT): Update (Pages 69 - 86) 12:30

10. East Kent Out of Hours GP Services and NHS 111 (Written Update) (Pages 87 - 92)

11. Date of next programmed meeting – Friday 21 September 2018

    Proposed items:
    - Dartford & Gravesham NHS Trust: Update
    - Children & Young People's Emotional Wellbeing & Mental Health Service
    - NHS preparation for 2018/19 winter

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*

Benjamin Watts
General Counsel
03000 416814

12 July 2018

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 27 April 2018.

PRESENT: Mrs S Chandler (Chair), Mr M J Angell, Mr P Bartlett, Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mr N J Collor, Mr B H Lewis (Substitute) (Substitute for Ms K Constantine), Mrs L Game, Ms S Hamilton, Mr K Pugh, Mr I Thomas and Mr R H Bird (Substitute) (Substitute for Mr D S Daley)

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: Ms L Adam (Scrutiny Research Officer)

UNRESTRICTED ITEMS

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

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

(2) Mr Lewis declared an interest as his wife was employed by Kent County Council.

(3) Mrs Game declared an interest as the Chair of the QEQM Hospital Cabinet Advisory Group at Thanet District Council.

(4) Mr Bartlett declared an interest, in relation to agenda item 6 - Transforming Health and Care in East Kent, as he attended the Design by Dialogue event on 22 March 2018.

(5) Mr Thomas declared an interest, in relation to any discussion regarding a new hospital in Canterbury, as a member of Canterbury City Council's Planning Committee.

45. Minutes
(Item 3)

(1) RESOLVED that the minutes of the meeting held on 26 January 2018 are correctly recorded and that they be signed by the Chair.

(2) Members noted that the Committee would be going paper-light from 8 June 2018. The Chair thanked those who had already volunteered to trial the new paper-light scheme.

46. Kent and Medway Strategic Commissioner
(Item 4)

Glenn Douglas (Accountable Officer, Kent and Medway Clinical Commissioning Group) and Michael Ridgwell (Programme Director, Kent and Medway STP) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Douglas began by stating that all eight CCGs had now committed to establishing a strategic commissioner and sharing a single senior management team with one accountable officer for Kent and Medway. A sub-committee, comprising of the Chairs from the 8 CCGs had been created to oversee the governance of the strategic commissioner; Dr Bowes (Chair, NHS West Kent CCG) had been appointed as Chair of the Sub-Group. Mr Douglas noted that Hazel Smith had secured a new role with Health Education England; Patricia Davies would now be responsible for partnership working in addition to acute strategy as part of the new shared management team.

(2) Members enquired how the establishment of the strategic commissioner would affect the individual responsibilities and priorities of each CCG. Mr Douglas explained that all eight CCGs were committed to working together on strategic areas in order to provide consistency and reduce duplication with providers. The overall aim of the strategic commissioner function was to simplify the process of contracting and make savings.

(3) In response to a question about stroke services in Thanet, Mr Douglas confirmed that the public consultation had closed and that the responses would be independently analysed. He noted that in Thanet, a degree of support for the proposed model had been expressed however there was a desire for a Hyper Acute Stroke Unit to be sited at the QEQM. He explained that the next stage of the process would involve Tony Rudd (National Clinical Director for Stroke) working with the clinical chairs to establish a clear evaluation process around the options, taking into account public consultation responses, which would lead to the options being re-evaluated and mitigations put in place prior to a decision being taken by the Joint CCG Committee in autumn 2018. Mr Douglas reported that there had been a change in leadership within Thanet CCG and a candidate had been put forward to the Thanet CCG governing body for approval.

(4) Members sought clarity about the commissioning of primary care and the future of the strategic commissioner. Mr Douglas confirmed that primary care would remain locally, and that each individual CCG would retain responsibilities for primary care commissioning. He stated that the only change had been the creation of a shared Accountable Officer for the Kent & Medway CCGs. He informed the Committee that over the next 9 - 12 months there would be further discussions about whether the strategic commissioner would continue to act as a subsidiary to each of the CCGs or if there would be a move towards a single CCG, forming a statutory body; if that was to happen, plans would need to be put in place to determine what services would be provided locally. He stated that all CCGs were working together to map out what a future structure may look like. He reported that whilst legislative change, in terms of structure, by 2019/20 was unlikely; the local system was able to do things, such as running in shadow form, to move forward. He noted that GPs were supportive of strategic commissioning and recognised the need to work together to support services in Kent & Medway going forward.

(5) Members enquired about financial balance in Kent & Medway and the governance of strategic commissioner. Mr Douglas noted that each CCG was currently responsible for its own budget however there was a national move towards a single control total which would cover both CCGs and providers. Mr Douglas stated that each CCG had an existing governance structure which would remain in place. A new governance structure to incorporate the strategic commissioner was being developed. He noted that workshops for independent CCG members were taking place about holding the strategic commissioner to account.

(6) Members asked about joint commissioning, the cost of the restructure and overall deficit in Kent & Medway. Mr Douglas noted that he was actively engaged with KCC with regards to joint commissioning; he stated the importance of maintaining relationships with borough councils too particularly for engaging with local people and acting as a gateway into the voluntary sector. Mr Douglas explained that he anticipated that the new structure would result in savings. Mr Douglas committed to sending the Committee the total 2017/18 financial deficit for Kent & Medway when available.

(7) Mr Inett enquired about the East and West Kent commissioning split. Mr Douglas explained that commissioning took place at two levels, strategically and locally. The middle tier split was an administrative convenience and focused on the major providers in East and West Kent. He reported that there was very little overlap between the two communities in terms of NHS services. He noted that there may be greater collaboration between providers in the future as part of accountable care systems.

(8) The Chair enquired if Mr Douglas was confident in having the support to make changes to the structure going forward; he confirmed that he was. He noted his confidence in the leadership of the CCGs and their shared objective to move forward.

(9) RESOLVED that the report on the Kent and Medway Strategic Commissioner be noted and that the Kent & Medway STP provide an update to the Health Overview and Scrutiny Committee in six months' time.

47. Financial Recovery in East & North Kent
(Item 5)

Caroline Selkirk (Managing Director, East Kent CCGs) and Johnathon Bates (Chief Finance Officer, East Kent CCGs) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. A Member enquired whether the financial recovery programme had had an impact on patients. Ms Selkirk explained that the focus of the recovery programme was to reduce waste and provide services more locally. She reported that a whole systems approach would improve patient outcomes and the sustainability of services. She noted that whilst there had been an impact on elective surgery over the winter period; additional capacity had been purchased from the private sector to manage the backlog.

(2) Members asked about the reduction to the number of GP surgeries and timeline for implementing local care. Ms Selkirk acknowledged that whilst

access to primary care was challenged; she explained that it was due to the number of GPs rather than the number of practices. She explained that local care models were being implemented in East Kent, in which practices were working collaboratively to provide greater access to and delivering sustainable services to populations of 30,000 - 50,000. Ms Selkirk explained that local care models were being implemented over the next three years and involved the delivery of services from hubs by multidisciplinary teams which could include services provided by the acute and community trusts. She noted the importance of local care as part of wider service reconfiguration in East Kent.

(3) Members enquired about the external determination process with East Kent Hospitals University NHS Foundation Trust and Section 106 contributions. Ms Selkirk explained that the CCGs and the Trust had now agreed to count activity in the same way going forward. Mr Bates confirmed that Section 106 contributions had been received across East Kent, including in Thanet were the contributions had been used for local care buildings. Mr Bates noted that contributions remained relatively small in comparison to overall budget.

(4) Members raised concerns around the decision to move the macular degeneration clinics from Buckland Hospital and the consultation with the Committee. Ms Selkirk explained that when the CCG had put the service out to procurement, several companies expressed an interest. The contract was awarded but it did not specify that the service had to be provided in Dover. The CCG was reviewing a number of options to resolve the issue. In response to whether the Committee was permitted to have sight of the contracts, Mrs Chandler advised Members that advice would be sought and feedback would be provided to the Committee.

(5) The Chair expressed concerns about the deliverability of the recovery plan in recovering the deficit, delivering savings and continuing to provide services without detrimental effect to patients given the financial challenge faced in East Kent. Ms Selkirk noted that many health economies were facing deficit and stated the importance of the local care model in making services more sustainable in East Kent.

(6) Members enquired about the robustness of local care plans, business rates and governance. Ms Selkirk noted that in Medway, work had been undertaken with the Kent Fire and Rescue Service to assess patient homes and ensure that preventative measures were taken to reduce the number of frail and elderly fallers; this programme had created elective capacity through financial savings. She explained that evidence from the Encompass Vanguard showed that local care models could be implemented at scale, reduce A&E attendance and improve access to patients. Mr Bates noted that the detailed reviews had been undertaken to ensure that business rates paid by GPs were at the correct level; substantial adjustments in favour of the health service had been awarded. Mr Bates stated that he would review if CCGs were eligible for business rate exemption. Ms Selkirk reported in terms of governance, the system was more effectively working together which included reducing the number of meetings which had achieved a more focused approach.

(7) A Member raised concern about patients sitting in isolation in hospital beds without access to television rooms. Mrs Selkirk agreed that the provision of televisions was not an expensive solution and stressed the importance of

health and social care working with communities to tackle social isolation. She noted that in East Kent care navigators were being implemented who ensured that people had the correct support to help them live independently. She welcomed Paul Carter's request for social care colleagues to work in collaboration with NHS to tackle the issues around independent living at a hub level.

(8) Mr Inett asked if the saving initiatives detailed in the paper would be brought to the Committee, Mrs Selkirk confirmed that any service changes would be brought back to the Committee for scrutiny.

(9) At the conclusion of the discussion, the Chair stated that she was still concerned about the impact of the recovery plan on patients. A number of potential recommendations were discussed, and the following was agreed by the Committee:

(10) RESOLVED that:

(a) the Committee expresses concern about the financial recovery leading to a diminution of service to patients in East Kent;

(b) the East Kent CCGs be requested to provide an update about financial recovery in November;

(c) an update about direct GP access to MRI scans in East Kent be circulated to the Committee;

(d) Swale CCG be requested to provide a written response regarding acute contract overperformance at Medway NHS Foundation Trust.

48. Transforming Health and Care in East Kent
(Item 6)

Caroline Selkirk (Managing Director, East Kent CCGs), Louise Dineley (East Kent Programme Director), and Anne Neale (Deputy Director of Strategy and Business Development, EKHUFT)

(1) The Chair welcomed the guests to the Committee. In response to a question about the circulation of the letter from the Medical Directors to Paul Carter regarding the number of A&Es in East Kent, the Chair advised the Committee that the letter had been received but needed to be reviewed prior to its circulation. Ms Dineley apologised for the delay in providing the letter.

(2) Ms Neale explained that the Keogh guidelines had been used to establish the medium list of options which required ten consultants at each site supported by junior medical staff. She stated that the current number of consultants on each site was two. She noted that the Trust had faced difficulties in maintaining three emergency medical takes in conjunction with providing the required supervision and training for junior doctors which had resulted in the removal of junior doctors from the Kent & Canterbury site. Ms Neale stressed to the Committee that there was not the workforce to deliver A&E services on three sites. She reported that the uncertainty around the future configuration of acute services was hampering recruitment. She highlighted that a review was

being undertaken to look at how different competencies and skills could be used to provide different elements of care to patients across the health economy.

(3) The Chair enquired about the expected timetable for the programme, Ms Selkirk explained that commissioners undertaking a service reconfiguration had to undergo a detailed assurance process set out by NHS England before a service change could be implemented. She noted that NHS England had published updated guidance in March 2018 on service reconfiguration which included an additional assurance stage for proposals which required capital investment. She stated that the next stage for East Kent was the development of a robust and comprehensive pre-consultation business case (PCBC); external consultants had been appointed to complete a readiness assessment which would be used to develop a timetable.

(4) Members commented about the Design by Dialogue event held in March 2018. Ms Selkirk explained that a series of pre-engagement events were planned for each locality in East Kent and would provide more detail on local care models, activity and finance based on the feedback from the Design by Dialogue event.

(5) Mr Inett enquired about the implementation of local care and the potential for further emergency transfer of services. Ms Selkirk stressed the importance of the process being carried out robustly. She stated that it would take three years for local care to be fully implemented. She noted that each CCG was signing-off their local care story and would be presented at local design by dialogue events. She noted the importance of capturing feedback from the engagement events.

(6) RESOLVED that:

(a) the Committee note the report;

(b) the East Kent CCGs provide a short verbal update about the timeline at the June meeting;

(c) the Scrutiny Research Officer provide the Committee with a briefing note about NHS assurance process for service change and reconfiguration.

49. East Kent Out of Hours GP Services and NHS 111
(Item 7)

Bill Millar (Interim Director, Urgent Care and Primary Care, East Kent CCGs), Caroline Selkirk (Managing Director, East Kent CCGs) and Dr Andrew Catto (Medical Director, IC24) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee and enquired about the bases at Romney Marsh and Deal. Dr Catto explained that it had not been possible to reopen these bases due to GP availability. He noted that IC24 had increased the availability of its mobile GP visiting service to patients who were unable to travel within the Romney Marsh and Deal areas.

(2) Members enquired about access to out of hours (OOH) services, resolution of health & safety issues at the Folkestone base and GP shortages. Dr Catto explained that OOH services were historically accessed via GPs however they were now accessed through a uniformed gateway, NHS 111. He noted that all IC24 bases had policies in place to manage those patients who walked-in. Dr Catto reported that the issues at the Folkestone base were being resolved imminently. Dr Catto stated that NHS England had recognised that there was a shortage of GPs and developed an integrated care model, which could meet the needs of patients who required urgent and emergency care and would be delivered by a range of health professionals including GPs. Dr Catto invited the Committee to visit the Ashford IC24 Contact Centre.

(3) Members asked about access to extended services in South Kent Coast and 111 response times. Mr Millar explained South Kent Coast had implemented a phased introduction of a seven-day services across the locality until a full workforce was established. Dr Catto stated that the key metric to measure 111 performance was the 60 second call answering time. He noted that since IC24 had taken over the contract in December 2017, there had been a week on week improvement in performance; current performance was 81.6% against the national standard of 95% and average performance in England of 83%. He reported that the previous provider had been unable to manage the level of calls and used national contingency provisions which had created additional demands on the 111 service nationally. He stated that the other metric used to measure performance was the abandonment rate which was used as a measure of safety; if the rate was above 5% it would flag an immediate cause for concern, IC24 had an abandonment rate of 3%.

(4) RESOLVED that:

(a) the report on the East Kent Out of Hours GP Services and NHS 111 be noted;

(b) the Committee receive an update from East Kent CCGs following workshop on primary care workforce.

The meeting was adjourned at 12:30 and reconvened at 13:30.

50. SECAmb: Update
(Item 8)

Steve Emerton (Executive Director of Strategy and Business Development, SECAmb) and Ray Savage (Strategy and Partnerships Manager (Kent & Medway, and East Sussex), SECAmb) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Emerton began explaining that the Trust's new board was now in place and responding to CQC findings which had placed the organisation in special measures. He stated that the Trust had implemented the new Ambulance Response Programme (ARP) in November 2017. He noted the Trust was currently unable to consistently meet its performance targets particularly for Category 3 & 4. He; patients in these categories who were waiting for long periods of time

due to vehicles being diverted to Category 1 & 2 calls. Mr Emerton reported that a demand and capacity review with commissioners was near completion to determine the workforce and resources required to enable the Trust to be fully compliant with standards and targets.

(2) Members asked about Category 1T performance and vehicle dispatch. Mr Emerton explained that whilst Category 1T was not a national performance measure, it was a metric used by the Trust to monitor whether an automated dispatch vehicle had the correct resources to transport a patient to hospital. Mr Savage noted that a key element of the ARP was that call handlers had more time to assess the call before dispatching the right resource for Category 2 patients.

(3) A Member enquired if there was a system in place to text callers with updates during periods of high demand. Mr Emerton explained that the Trust did call people back and stated the importance of managing expectations and mitigating risk of harm during periods of high demand. He noted that for calls from residential care homes which had a no lift policy, trained call-handlers would call back to implement processes to reduce risk of harm which included moving patients so that they would be more comfortable and providing them with fluids and medications.

(4) In response to a specific question about the Kent & Medway Stroke Review, Mr Savage stated that whilst any service change where travel time increased would place a demand on the Trust; the Trust had modelled its ability to get to the patient and then to each of the proposed sites within 60 minutes. Mr Emerton confirmed that the Trust would be able to service all the proposed options. Mr Savage noted the demand & capacity review had taken the stroke review into account.

(5) Members enquired about traffic congestion particularly the impact of Sturry railway crossing. Mr Savage noted that traffic was an issue, but blue lights and sirens enabled the Trust's fleet to make progress and move quicker than other vehicles. He reiterated that real time travel was used as part of modelling for the stroke review and the Trust had confidence in the modelling. He stated that he could not provide the amount of travel time lost if the Sturry Crossing was closed but assured Members that extensive modelling using real time travel from the Thanet area to the proposed stroke sites had been undertaken.

(6) Mr Inett commented about handover delays. Mr Emerton stated that handover delays caused a disproportionate challenge to the Trust. He noted that a jointly commissioned project to reduce handover delays and provide single oversight had begun to gain traction; the Trust had seen an improved Category 2 performance resulting in a reduction in handover delays during the previous week. Mr Savage noted that he was involved in the project's task & finish group which brought together the acute trust's chief operating officers to share best practice and put in processes to reduce handover delays. He reported that there were signs of improvement.

(7) The Chair concluded by enquiring about resourcing. Mr Emerton stated that through the demand & capacity review, the Trust had been able to quantify the additional resources to meet demand in terms of workforce and vehicles. He noted that a proportion of the calls did not require a 999 response and were able to be dealt through Hear & Treat which reduced A&E attendance. He

reported that the Trust was involved in local care modelling to ensure alternative care pathways were utilised.

(8) RESOLVED that the report be noted and SECAmb be requested to provide an update at the appropriate time.

51. Patient Transport Service
(Item 9)

Ian Ayres (Managing Director, Medway, North and West Kent CCGs), Johnathon Mawer (Relationship Manager, G4S Patient Transport Services) and Russell Hobbs (Managing Director, G4S Patient Transport Services) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Ayres introduced the report and set out some of the key challenges faced under the existing contract which included a demand for higher mobility, longer distanced journeys and increased escort numbers. Mr Ayres informed the Committee that the CCGs had agreed to rebase the contract and provide additional funding which was less than 10% of the contract value. A new performance regime was being implemented to incorporate a graduated scale of consequence to reflect the severity of failing to achieve Key Performance Indicator (KPI) targets.

(2) In response to a question about the exclusion of Dartford and Gravesham from the main contract, Mr Ayres explained that the contract for that area was originally managed by North Kent CCG, however, it had now been transferred to him in his new role as the Managing Director for Medway, North and West Kent CCGs. Mr Ayres stated that the management of three separate fleets with three separate contracts was logistically inefficient and therefore an agreement was being sought with G4S to manage the fleet as an integrated system.

(3) Members raised concerns about performance of G4S. Mr Ayres acknowledged that performance at 40% was not acceptable. He identified two drivers of poor performance; the first being the wrong fleet size which was in the process of being corrected through the contract variation and the second being the performance regime. He noted that a new performance regime had been introduced which would now differentiate between minor failures and more significant ones. Mr Ayres assured the Committee that recent improvements had reduced the level of complaints; he acknowledged the significant work undertaken by G4S staff to improve performance. Mr Ayres noted that the initial contract had included all journeys in and out of London hospitals which had required a vehicle to be out of use for an entire day and was therefore not efficient model. He stated that a decision was therefore taken to remove the London Hospitals from the G4S contract.

(4) In response to questions about training compliance and complaints, Mr Hobbs explained that there had been an absence of records from the previous provider. As G4S was unable to evidence training, it had decided to retrain all staff; 99% compliance of mandatory and safeguarding training was achieved by January 2018. He noted that complaints accounted for 0.2% of the 325,000

patients transported within the last year. He reported that the number of complaints had reduced from 110 in October 2017 to 60 in March 2018. Mr Hobbs stated that the average acknowledgment time was a day, and the response time was 18 days. He highlighted that G4S had now satisfied all the requirements set out in the improvement notice and this had now been removed. He stressed that G4S took complaints seriously and were not complacent.

(5) RESOLVED that:

(a) the report be noted;

(b) West Kent CCG be requested to provide a written update on the new key performance indicators to the June meeting;

(c) West Kent CCG be requested to present a verbal update on performance to the Committee in the autumn.

52. Kent & Medway Integrated Urgent Care Service Procurement
(Item 10)

Ian Ayres (Managing Director, Medway, North and West Kent CCGs) was in attendance for this item.

(1) Mr Ayres began by explaining that due to the timing of the item, the information he could provide was limited due to the start of the procurement process.

(2) The Chair enquired on behalf of Mr Chard about the integration of urgent care services. Mr Ayres stated the importance of urgent care services being integrated and having access to a wider range of services including social care and mental health. He noted integration was an integral part of the nationally mandated procurement and national specification.

(3) In response to a specific question about growth, Mr Ayres explained that in West Kent, the CCG had worked with the district councils to understand every housing development planned for the next 10 years and the impact that these would have on local health services. He noted that a draft plan on the future requirements of primary and community care services in West Kent was expected in September 2018.

(4) A Member enquired about the closure of East Peckham branch surgery which was within a growth area. Mr Ayres explained that the branch surgery had closed due to the cost of improvement works to the building; two years was spent trying to secure the capital funding required for the building works. He noted that West Kent CCG had successfully negotiated the opening of a branch surgery in Allington following two local practices giving notice on their contracts. All patients who lived within the Allington ward and were registered at the two existing practices would be automatically transferred across to the new practice providing the branch surgery. The only change was for patients who lived outside the Allington ward area; they would need to register at a GP practice which serves the area they live in.

(5) RESOLVED that the report on Kent and Medway Integrated Urgent Care Service Procurement be noted and an update be provided to the Committee at the conclusion of the procurement in September.

53. West Kent Out of Hours GP Services
(Item 12)

(1) The Chair introduced the report and explained that she had agreed for the item to be considered as urgent as the information was not available at the time of publication and the changes to the service would have been implemented prior to the next meeting of the Committee on 8 June 2018.

(2) Mr Ayres apologised for the delay in providing the report to the Committee. He explained that out-of-hours base at Tonbridge Cottage Hospital was due to relocate in spring 2018 but would now take place in June along with the relocation of the Sevenoaks base. From 1 June 2018 patients who require a face-to-face GP appointment out of hours will be seen in a dedicated and co-located facility at Maidstone Hospital or Tunbridge Wells Hospital. Mr Ayres noted that 98% of attendances to the Sevenoaks MIU was by private transport and was therefore reassured that the relocation of the Sevenoaks base would not cause too much disruption.

(3) RESOLVED that the update report on West Kent Out of Hours GP Services be noted.

54. Date of next programmed meeting – Friday 8 June 2018
(Item 11)

(1) The Chair noted that it was Mr Angell's last meeting as a member of the Committee. She personally thanked Mr Angell for the support and advice he had provided to her in his role as Vice-Chair and for all his contributions as a longstanding Member and former Chair of the Committee.

(2) RESOLVED that the date of the next programmed meeting on Friday 8 June 2018 and proposed agenda items be noted.

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KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 8 June 2018.

PRESENT: Mrs S Chandler (Chair), Mr P Bartlett, Mr N J D Chard, Mr N J Collor, Ms K Constantine, Mr D S Daley, Mrs L Game, Ms S Hamilton, Mr K Pugh, Mr I Thomas, Cllr J Howes and Cllr D Mortimer

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

UNRESTRICTED ITEMS

55. Membership
(Item 1)

(1) Members of the Health Overview and Scrutiny Committee noted the following changes to the membership of the Committee:

Councillor Mortimer (Maidstone Borough Council) and Councillor Peters (Dartford Borough Council) had replaced Councillor Searles (Sevenoaks District Council) and Councillor Hills (Gravesham Borough Council) as borough representatives on the Committee for 2018/19.

56. Election of Vice-Chair
(Item 2)

(1) Mr Pugh proposed and Mr Collor seconded that Mr Bartlett be elected Vice-Chair of the Committee.

(2) RESOLVED that Mr Bartlett be elected as Vice-Chair.

57. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 4)

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

(2) Mrs Game declared an interest as the Chair of the QEQM Hospital Cabinet Advisory Group at Thanet District Council.

(3) Ms Constantine declared an interest in relation to her work with the Managers in Partnership which supported staff in the NHS in London, the South and the South East. She confirmed that she was not undertaking work in Kent.

(4) Mr Thomas declared an interest, in relation to any discussion regarding a new hospital in Canterbury, as a member of Canterbury City Council's Planning Committee.

58. Transforming Health and Care in East Kent - Verbal Update
(Item 5)

(1) The Chair informed the Committee that following the publication of the Agenda, she had agreed to a request from East Kent CCGs to postpone consideration of the Transforming Health and Care in East Kent item until the July meeting, as the planned verbal update on the timeline was no longer available to be presented to the Committee. She read out the following statement which had been provided by East Kent CCGs:

"The request to delay the verbal update was as we wished to be able to present a more complete picture of the work required in east Kent and at this point we are midway through re-evaluating the programme. The two issues that are increasing the complexity of the programme are: understanding the requirement of the revised NHS England guidance on the assurance of major service reconfiguration; and the more complicated planning requirements of the blended capital model (i.e. the total capital cost being through a combination of public and private capital) associated with Option 2. We have commissioned external support (EY Consulting) to assist with this process and will be able to give a more detailed report to the July meeting of the HOSC."

(2) RESOLVED that the interim report be noted and that the East Kent CCGs be requested to provide a detailed update, including a timetable, to the Committee in July.

59. Medway NHS Foundation Trust: Update
(Item 6)

Lesley Dwyer (Chief Executive, Medway NHS Foundation Trust) and Glynis Alexander (Director of Communications, Medway NHS Foundation Trust) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Ms Dwyer began by stating that the Trust last provided an update to the Committee in October 2016 prior to the Trust's exit from special measures. The Trust had been re-inspected by the CQC in April and May 2018 and the inspection report was anticipated in June. She noted that there were no areas of immediate concern. She reported that whilst the Trust was not consistently meeting the constitutional targets, particularly in relation to A&E performance, there were early signs of improvement. She highlighted the closure of an escalation ward which had been open since December 2014 and the Trust's work with system partners to reduce the number of delayed transfers of care (DTOC); the Trust now had one of the lowest DTOC figures in the country and was sharing its learning with other systems.

(2) Ms Dwyer noted that workforce and vacancies had been an issue for the Trust. The Trust's ability to recruit had been particularly impacted when the Trust was in special measures. She reported that there had been a 3%

increase in the number of substantive staff and a 11% decrease in the use of agency staff. She stated that the Trust had a challenging financial position with a reported £66.4 million deficit in 2017/18 which was one of the worst NHS deficits. She reported that the Trust had agreed a control total of £46.7 million for 2018/19 with NHS Improvement. She explained that the Trust was working with commissioners about services to be provided within the available budget. The Trust had developed a three-year recovery plan to return to a breakeven financial position.

(3) Ms Dwyer reported that the Trust had commissioned a fire safety report from Kent Fire & Rescue Service which identified a number of risks and actions required which the Trust had implemented. She highlighted the Trust's Better, Best, Brilliant improvement programme. She stated that she was confident that the Trust's challenges could be addressed but stressed the importance of the wider healthcare system working together.

(4) Members enquired about integrated discharge planning, international recruitment, Kent & Medway Medical School and NHS bursaries. Ms Dwyer explained that the Trust worked in conjunction with Virgin Health, Medway Community Health, the local authorities and commissioners to improve patient discharge. Ms Dwyer explained that the Trust had undertaken international recruitment campaigns, for nursing vacancies, via local, national and international routes. She noted that recruitment from the Philippines had been particularly successful; the Trust had provided support packages to integrate overseas workers into the community and to support language and fluency skills. She reported that the Trust had played an important role in influencing a change to the English Language Test set by the Nursing & Midwifery Council to ensure it was more realistic. Ms Dwyer noted that the new Medical school would help to attract aspiring doctors within the local community to build their career in Kent and would help to address the recruitment and retainment issues of skilled medical professionals within the South East region. Ms Dwyer stated that the impact of the removal of the NHS bursary had not yet been felt; the Trust was supporting clinical support workers who were converting to nursing with study leave.

(5) In response to a specific question about the Medway area being identified as one of 32 risk areas due to below-average health outcomes *and* deficit-running NHS trusts, Ms Dwyer stated that in an area of increased health needs, in a system where there was a paucity of primary care services people would access services through the Emergency Department which would increase pressure on the Trust as there would be an increase to the number of people it delivered care to. Ms Dwyer noted that whilst Trust had a primary care practice on the hospital site, placing a GP surgery near the hospital, could help support the Trust. She reported that the Emergency Department saw an increase of 44 patients each day.

(6) A Member sought assurance that the closure of escalation beds and reduction in capacity would not impact on the Trust's ability to provide adequate services to the community. Ms Dwyer explained that hospitals operated most efficiently at 85% capacity. She confirmed that the 53 escalation beds had been closed to reinstate the day surgery at Medway Hospital. She noted that 90 of the Trust's 154 surgical beds had been used by medical patients who could have

been better cared for elsewhere. Ms Dwyer noted the Trust's aspiration to be the site of a Hyper Acute Stroke Unit. She reported that the Medway site was the only unit currently seeing the correct number of patients and provided services to the largest conurbation in South East and had a demographic need. The Trust had appointed an additional Stroke Physician to improve performance for the local community in the interim whilst the decision was being made.

(7) Members enquired about support provided to new staff including accommodation. Ms Dwyer explained that the Trust initially provided short-term on-site accommodation for staff; as part of its support package, international staff were given advice about National Insurance contributions, private renting and banking. Ms Dwyer highlighted an initiative with the University of Greenwich, whereby nursing staff in the Emergency Department were able to gain credits towards a Masters, which had reduced turnover. She noted that the Trust currently had nine physician associates and highlighted the role of nurse associates.

(8) Members enquired about the deliverability of the financial recovery plan. Ms Dwyer explained that the Trust was required to save £20 million each year for the next three years to breakeven. In order to do this, service reconfiguration would be required, and the Trust would not continue to provide all the services that it currently does. She noted that the Trust's savings, in month two, was ahead of its financial recovery plan. She reported that additional areas of savings included pay ceilings for temporary staff across Kent and Medway and reduction in the number of administration roles through the use of technology. She confirmed that the Trust met regularly with the unions as part of the Trust's Transformation Group.

(9) The Chair congratulated the Trust on its progress in many areas but expressed concerns about the risks associated with the Trust's financial recovery and the impact it would have on services.

(10) RESOLVED that:

(a) the report on Medway NHS Foundation Trust be noted;

(b) the Trust be requested to provide a detailed report to the Committee on its financial recovery plan at the earliest opportunity.

60. Maidstone & Tunbridge Wells NHS Trust: Update
(Item 7)

Miles Scott (Chief Executive, Maidstone & Tunbridge Wells NHS Trust) was in attendance for this item.

(1) The Chair welcomed Mr Scott to the Committee and asked him to introduce himself. Mr Scott explained that he joined the Trust as Chief Executive four months ago from NHS Improvement. He stated that he had worked in the NHS for over 30 years and had been Chief Executive of St George's University Hospitals Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust and Harrogate and District NHS Foundation Trust.

(2) He presented a series of slides which provided an introduction to the Trust; updates on the Trust's financial and operational performance; and recent CQC inspection. Mr Scott stated that the Trust had two main roles: it provided a range of general hospitals services to a population of 650,000 residents in West Kent and East Sussex and specialist cancer services to 2 million people across Kent and Sussex via the Kent Oncology Centre. He noted that both Maidstone and Tunbridge Wells Hospitals provided accident & emergency and general medical services; Maidstone provided cancer and complex surgery services whilst Tunbridge Wells provided trauma, maternity and children services.

(3) Mr Scott explained that the Trust was placed in Financial Special Measures (FSM) in July 2016. NHS Improvement appointed a Finance Improvement Director (FID) who identified a potential deficit of £42.7 million, which equated to 10% of turnover at the time, and worked with the Trust to construct a financial recovery plan which helped to put the Trust into the position whereby the activity growth was now greater than the pay-bill and the underlying deficit had reduced to £20 million in the last financial year. Mr Scott informed the Committee that through the combination of productivity improvements and alignment of non-recurring measures, the Trust was on track to meet its control total for the current year.

(4) In terms of operational performance, Mr Scott drew the Committee's attention to six key points:

1. There were no reported MRSA cases and only 25 cases of reported clostridium difficile at the Trust in the last year;
2. Low numbers of avoidable pressure ulcers and patient falls were two key indicators of safe nurse staffing levels;
3. There was a 10% increase in emergency admission in one year across the Trust which impacted on its ability to carry out planned work.
4. There was an increase in Referral to Treatment Times (RTT) due to planned cases being displaced by emergency cases and pressures around cancer service access standards. In response to this, the Trust had devised a programme to increase elective surgery through increased productivity in operating theatres
5. Improvements to access to cancer services were required particularly around early diagnosis. He noted that Kent ranked 19th out of 19 areas in England for access to cancer services.
6. As with other NHS Trusts, Maidstone and Tunbridge Wells NHS Trust faced a number of pressures in terms of staffing and work was continuing to be done to tackle those.

(5) Mr Scott explained that the Trust had been inspected by the CQC and there had been a significant shift in the individual ratings between 2015 and 2018 inspections. He stated that the Trust was well placed to move up through the ratings as further services were inspected. He noted that the CQC had made a series of recommendations which the Trust was working through to address.

(6) In response to a question about the impact of budget on hospital services, Mr Scott advised Members that regardless of money, the Trust would not be able to staff more beds. Instead, the Trust was finding new ways to develop services within hospitals and the local community that helped to get patients

back into their own home more rapidly such as the new Frailty Unit at Tunbridge Wells Hospital.

(7) Members enquired about the PFI funding for Tunbridge Wells Hospital and whether the Trust had been able to renegotiate its fixed PFI charges. Mr Scott explained that any new hospital would have cost more in terms of capital in comparison to operating the old hospital. Mr Scott noted that the FID had not recommended renegotiating the PFI charges in 2016 but acknowledged that it may be timely for it to be reviewed.

(8) Members asked about the Trust's ability to reduce fixed costs and the increased rate of serious incidents and emergency department attendance. Mr Scott stated there had been a reduction in costs through the use of generic drugs and a reduction in blood transfusion charges due to improved measures to conserve patient fluids and reduce internal bleeding. He reported that clinical savings were the Trust's biggest targets. Mr Scott explained that the increased rate of serious incidents was positive; it showed that staff felt confident to report incidents and enabled the Trust to make improvements, mitigate risks and be held to account. Mr Scott stated that it was important to ensure that as soon as people presented at an Emergency Department, staff were able to respond quickly and proportionately and identify the correct pathway of care. He supported streamlining processes, such as encouraging people to use the telephone or internet as the first point of call for concerns regarding their health care.

(9) Members enquired about the holes in theatre walls, safeguarding training and appraisals which had been identified in the CQC inspection report. Mr Scott stated that the hole referred to plaster damage in a wall caused by a trolley bashing into it at Maidstone Hospital which had been fixed. He noted that Maidstone Hospital had been well maintained and the condition of the hospital was much better in comparison to Wexham Park Hospital, Slough which had been built at the same template. Mr Scott acknowledged that when the Trust experienced high levels of demand, training such as safeguarding came under pressure. Mr Scott highlighted that the Trust's appraisal rate was at 90% which was positive for an NHS organisation.

(10) Members asked about complaints handling, ambulance handovers and staff turnover. Mr Scott acknowledged that the process for responding to complaints was not at the desired standard. He assured the Committee that work was being done to improve the timeliness and quality of responses and was being overseen by the Chief Nurse. Mr Scott reported that handover delays at the Trust were lower than at other trusts and SECAmb were happy with how the Trust transferred patients. He noted that in the last year rapid assessment and treatment areas had been implemented along with Fit2Sit for patients who did not need to be on a trolley. Mr Scott noted that the Maidstone and Tunbridge Wells NHS Trust had historically had a lower turnover rate compared to neighbouring hospitals in Kent, however, the Trust could not be complacent with its efforts. Tunbridge Wells Hospital had experienced issues around the cost of accommodation for its staff and was in discussions with the Borough Council about the creation of more affordable key worker accommodation.

(11) The Chair enquired about the actions being taken to improve access to cancer services. Mr Scott explained that for each tumour type, the Trust was investing in the front-end of the pathway to ensure diagnostics were completed within a quicker timeframe. As the cancer centre for Kent, the Trust was aware of the complexity of individual cases and the importance of tracking patients on an individual basis. He stated the Trust was planning to deliver the national standards by the end of the financial year.

(12) RESOLVED that the report on Maidstone & Tunbridge Wells NHS Trust be noted and the Trust be requested to provide an update at the appropriate time.

61. NHS response to winter in Kent 2017/18
(Item 8)

Ivor Duffy (Director of Assurance and Delivery, NHS England), Bill Millar (Interim Director, Urgent Care and Primary Care, East Kent CCGs) and Mark Atkinson (Head of Acute Commissioning, West Kent CCG) were in attendance.

(1) The Chair welcomed the guests to the Committee and noted that the North Kent CCGs had been unable to provide a representative. Mr Duffy began by stating that winter had been challenging. There had been a severe outbreak of seasonal influenza which had an unusual strain. He highlighted a successful vaccination scheme at East Kent Hospitals University NHS Foundation Trust which had donated a tetanus vaccination to UNICEF for every staff member who had the flu jab; as a result, the Trust had one of the highest flu jab uptakes in the country.

(2) He stated that a number of reviews had been undertaken to pull together the key learning which included a greater need for consistency around escalation and working together as a system through the STP. He noted that whilst NHS England had historically been responsible for coordinating the system, local systems had now taken on the leadership role and NHS England was providing more of an advice and support role. He stated that further work to improve communication with the public on accessing primary and urgent care services was required.

(3) Mr Millar explained that the winter and Easter periods had been challenging in East Kent with A&E performance at 60 – 70% against a standard of 95%. There was also a system focus to address discharge; EKHUFT worked with SECAmb to put in place mitigating actions for handover delays and additional funding from NHS England had been received to work with the voluntary sector to support discharge. He noted that an improvement plan had been submitted to NHS England which described the collective action being undertaken.

(4) Mr Atkinson stated that the position in West Kent was slightly better as there were only two hospitals and flow could be moved between the sites. He highlighted a number of initiatives which had been implemented using winter monies including primary care centres at the hospital sites being managed by MTW, additional medical team to support delayed transfers of care and the introduction of a Home First scheme by a private provider to support patients

in their own homes. He recognised that there needed to be better engagement with primary care; he reported that the relationship and collaboration between health and social care had developed over the winter.

(5) The Chair enquired about additional resources for primary care. Mr Duffy explained that there had been a number of initiatives had been implemented which included GP triaging at A&E departments and extended primary care opening hours. He recognised that more work was required to tie-in these resources with the wider system and effectively communicate with the public as there had been some underused capacity. He stated that the growing demand for the 111 service was being addressed as part of the Integrated Urgent Care Service Procurement. Further work was also being undertaken to identify where the peak periods for 111 would fall as part of planning; the 2017/2018 peak came sooner than anticipated which had a knock-on effect to other services.

(6) Members enquired about elderly fallers, staff vaccinations and the strain of flu and the effectiveness of the vaccination. Mr Duffy reported that hospitals planned for increased falls and fractures such as the procurement of additional orthopaedic surgeons at EKHUFT for anticipated periods of high demand. Mr Duffy explained that staff vaccination was personal choice and not compulsory. He noted the work done with care homes to ensure that staff knew the benefits to them and the wider system of having the vaccination. He committed to sharing with the Committee, the percentage of staff in Kent & Medway who had the flu vaccination and the learning from the influenza debrief. Dr Duggal explained that the strain for the flu vaccine was determined a year in advance, based on global evidence, by the World Health Organisation, Centre for Disease Control and UK Health Authority. She noted that a new strain arose whilst the 2017/18's vaccination was in production and it was therefore not able to be included in the vaccine.

(7) RESOLVED that the report be noted and NHS England and the Kent & Medway STP be requested to provide an update about preparations for 2018/19 winter to the Committee at its September meeting.

62. Patient Transport Service: Key Performance Indicators (Written Briefing)
(Item 9)

(1) The Committee considered an update report from NHS West Kent CCG which detailed the new Key Performance Indicators for Patient Transport Services.

(2) RESOLVED that the report on the new Key Performance Indicators for Patient Transport Service be noted, and that the CCG be requested to present an update on performance to the Committee in the Autumn.

Item 5: Transforming Health and Care in East Kent

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 20 July 2018

Subject: Transforming Health and Care in East Kent

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

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

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1. Introduction

(a) On 27 April 2018 the Committee considered an update about Transforming Health and Care in East Kent. The Chair enquired about the timescale and progress of the transformation programme, it was explained that external consultants had been appointed to complete a readiness assessment which would be used to develop the timescale. It was agreed that a verbal update, to give further detail about the timescale, would be presented to the Committee at its June meeting.

(b. On 8 June 2018 the Chair informed the Committee that following the publication of the Agenda, she had agreed to a request from East Kent CCGs to postpone consideration of the Transforming Health and Care in East Kent item until the July meeting, as the planned verbal update on the timeline was no longer available to be presented to the Committee. The Committee agreed the following recommendation:

- *RESOLVED that the interim report be noted and that the East Kent CCGs be requested to provide a detailed update, including a timetable, to the Committee in July.*

2. Recommendation

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

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (27/04/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7846&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (08/06/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7918&Ver=4

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Transforming health and social care in Kent and Medway

Transforming Health and Care in East Kent Update July 2018

Background

1. This paper updates the Kent Health Overview and Scrutiny Committee and focuses on the:
    - Context - case for change
    - Updated NHS England assurance process
    - Clinical Senate Review
    - Revised programme arrangements
    - Service models and options under consideration
    - Programme plan
2. The paper brings together a number of areas of discussion into one document and updates on the next steps.

Context - case for change

3. On 4th August 2016 local health and social care leaders from east Kent published a technical document and public facing leaflet called *"Better health and care in east Kent: time to change",* describing the reasons why health and social care in east Kent need to be transformed and set out a future vision for health and social care:

    https://kentandmedway.nhs.uk/where-you-live/plans-east-kent/case-change-east-kent/

4. This identified that:
    - In some areas we are struggling to deliver the quality of care we want to consistently (e.g. local people tell us they find it hard to get a GP appointment, and too many people have to wait too long in A&E or to see a specialist);
    - That our population is changing, both growing and the number of elderly people with multiple comorbidities is increasing (i.e. the number of people with one or more additional diseases in addition to their primary disease or disorder);
    - Whilst we are living for longer, we are also living with more long-term conditions, such as diabetes, dementia and heart disease which increases demand for health and care services but requires a different sort of service to those of the past;
    - More treatments nowadays can be offered out of hospital or with shorter hospital stays because of new medicines and medical techniques, but our services are not designed to take the full advantage of these new developments;
    - We struggle to find enough staff to deliver services in east Kent and we need to attract staff with the right skills and experience to deliver the best quality services;
    - We don't have unlimited financial resources, so we need to use what we have wisely and spend our funding in a way that will maximise outcomes for the people we serve.

5. The east Kent case for change, was further supplemented by a Kent and Medway Case for change published in April 2017, which was updated in March 2018:

   https://kentandmedway.nhs.uk/stp/caseforchange/

6. We believe health and social care services in east Kent can and should be better. Finding new and innovative ways of working, and at the very least, ensuring we can consistently deliver services to the quality standards expected nationally, will make east Kent more attractive to potential employees and help us keep hold of the great staff we already have. The East Kent Transformation Programme has been established to plan and deliver the changes we need to deliver the best possible healthcare to the population we serve.

Updated NHS England assurance process

7. In order to progress to consultation the CCGs will need to present a pre-consultation business case to NHS England, which outlines proposals and how they build on the case for change. This document is the focus of the NHS England assurance process and needs to be approved by NHS England before we, through the East Kent CCG Joint Committee, can take a decision on whether to proceed to consultation. It also forms the starting point for a Strategic Outline Case (SOC) as required by NHS Improvement.
8. In March 2018 NHS England updated its guidance detailing how it will undertake the assurance of substantial service developments or variations, *"Planning, assuring and delivering service change for patients"*:

   https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

9. The previous iteration of the guidance identified four key tests of service change:
   - Strong public and patient engagement;
   - Consistency with current and prospective need for patient choice;
   - Clear, clinical evidence base;
   - Support for proposals from clinical commissioners.
10. Meeting these four tests remains a requirement and there must be clear and early confidence that a proposal satisfies these. The amended guidance formalises a requirement for proposals to meet a set of additional requirements:
    i. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of any bed closures, and that the new workforce will be there to deliver it; and/or
    ii. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).
11. Of particular relevance to the development of the east Kent proposals, is the increased focus outlined in the revised guidance around capital implications of proposals. In order to get approval from NHS England and NHS Improvement to launch a formal consultation exercise, revenue and capital implications need to be detailed in the pre-consultation business case and there needs to be confidence that these implications are sustainable (i.e. that costs can be met). The guidance emphasises that it is essential that only those options that are sustainable in service, economic and financial terms are offered publicly to consultation. No service change option can be taken forward to public consultation:

- Unless there is a high degree of confidence that it would be capable of being delivered as proposed;
- If it implies an unsustainable level of capital expenditure and/or projected spend profiles that cannot be reconciled to available resources, and the revenue will not be affordable;
- Unless all options are affordable within commissioner revenue allocations and provider revenue financial targets.

12. The guidance also acknowledges that capital resources available to the NHS for transformational change are currently severely constrained and a degree of national phasing/prioritisation will be inevitable at least for the remainder of the current government Spending Review Period. Service change schemes which require capital financing, such as the proposals under development in east Kent, will require the explicit support of NHS England and NHS Improvement in writing and, where appropriate, following discussion with the Department of Health and Social Care before public consultation can commence.
13. To enable the revised requirements relating to assurance around capital intense schemes to be met, the pre-consultation business case will need to set out for all options going to consultation an assessment of capital and revenue affordability for each option which includes:
    - Summary financial statements and supporting financial modelling which shows the impact of each option on commissioners/providers revenue financial position supported by activity, income and cost modelling, which is sufficiently robust for both commissioners and providers to be confident that options would be sustainable;
    - Confirmation of assumptions made in the financial modelling for both commissioners and providers, e.g. commissioner growth in allocations, provider inflation, efficiency savings;
    - Reconciliation of the scheme's financial impacts to the STP financial plan;
    - Credible activity/throughput analysis that translates sustainably to the scale of infrastructure change anticipated;
    - A clear assessment of the financial benefits of the scheme, e.g. provider efficiency savings, system reductions in activity levels and the basis of these calculations;
    - A high-level source and application of capital funds, to demonstrate capital costs and how these are expected to be funded (it should be noted that every effort should be made to generate local capital funding including land disposals or internally generated capital and initial assessments of this should be included);
    - Indicative capital costs recorded using the mandated Department of Health process and recognisable benchmarks and which assume compliance with all applicable design, technical, building and space standards and known site constraints, and key adjacencies should be identified;
    - Indicative designs that demonstrably reconcile to up-to-date estates strategies at site, provider and STP levels;
    - Confirmation of support from all commissioners proposing the scheme and acknowledgement from all providers who will be significantly affected by the scheme that their views on any impact on them have been sought.
14. Through the assurance process, all options requiring capital will be assured prior to consultation by NHS Improvement and NHS England, and, where appropriate, through them the Department of Health and Social Care to ensure for each option that:
    - It would be sustainable in service and revenue and capital affordability terms, with an identified source of capital;
    - The scheme size is proportionate;

- It would be capable of meeting applicable Value for Money (VfM) tests and Return on Investment (ROI) criteria.

15. We are clear that the options being considered in east Kent will require large volumes of capital (e.g. within the definition within the guidance all options under consideration require over £100m or more of capital to be sourced by the NHS, including Option 2 that would require this in addition to the potential gift of the shell of a hospital to NHS). The new guidance indicates these schemes will be required to provide more detail and be subject to higher levels of scrutiny and assurance than previously, prior to going out to consultation. This will include where options require capital above £100m the scheme being considered by the NHS Improvement Resources Committee and requiring a letter of support from the NHS Improvement Chief Finance Officer.
16. In summary, this means prior to being given permission to move to formal public consultation by NHS England and NHS Improvement, we will need to identify in detail the capital and revenue implications of all proposals and identify that these costs are affordable. In addition, the source of capital will need to be identified ahead of proceeding to consultation in order to provide confidence that a proposed option could be delivered. As part of the process around identifying sources of capital, and in-line with the revised guidance, we are seeking advice from NHS Improvement and NHS England (and through them, the Department of Health and Social Care and HM Treasury).
17. Whilst we understand and welcome the need for this additional level of detail and assurance, the key implication for our programme of work in east Kent is that it requires more work ahead of formal public consultation and across a number of potential options.

South East Coast Clinical Senate Review

18. The NHS England guidance on assurance also identifies, "*Where the clinical case for change is complex, commissioners may require an independent clinical review. For CCG led schemes this would most likely be through the clinical senate, although in some cases (for example, very specialist services) it may be appropriate to obtain a review from another independent source such as a royal society or clinical networks."* Clinical Senate have been established to be a source of independent, strategic advice and guidance to commissioners and more information can be found at:

    www.england.nhs.uk/ourwork/part-rel/cs/

19. In recognition of the complexity of the proposed changes in east Kent we are commissioning an independent review from the South East Coast Clinical Senate and this is built into the programme plan. The outcome of this process will be included within the submission of the pre-consultation business case to NHS England.
20. The Clinical Senate Review will focus on the tests that will be applied through the NHS England assurance process but will not look at the financial aspects of the proposal. Rather the Senate review will focus on ensuring there is a:
    - Clear articulation of patient and quality benefits;
    - The clinical case fits with national best practice;
    - An options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations.
21. The exact terms of reference for each review will need to be agreed with the Clinical Senate by the CCG Joint Committee but as a minimum will include reviewing the clinical evidence base underpinning proposals so that the review meets NHS England's requirements for the assurance process.
22. The Clinical Senate will establish a team of independent clinical experts to undertake the review. The review team will be formed by professionals with relevant experience of the clinical issues

under consideration (e.g. covering primary care; public health; community and social care; secondary care; and tertiary care).

Revised programme of work

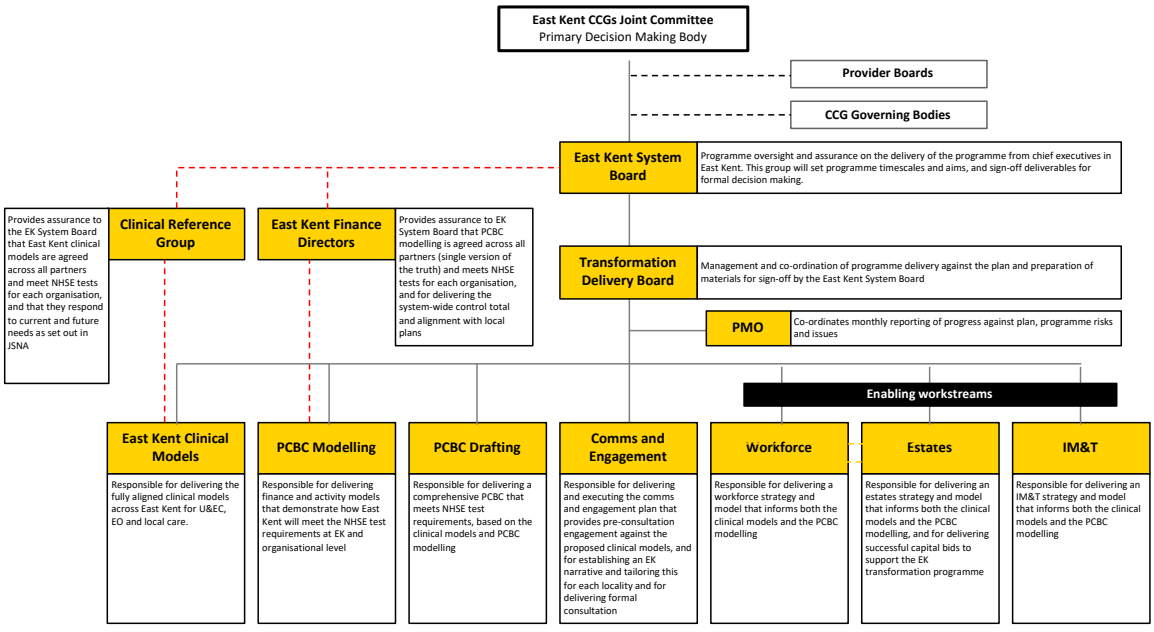
23. We have been undertaking a readiness assessment in order to better understand what more needs to be done to deliver the pre-consultation business case for changes to the way services are delivered in east Kent. This has highlighted a number of areas for further development and strengthening, including:

    - Ensuring that planning discussions are joined up in recognition that that the pre-consultation business case will need to present a system proposal and not be sector or organisationally focused (e.g. in recognition of the revised NHS England planning guidance we cannot just be acute service focused in how we describe and align our plans for change);
    - Ensuring the Case for Change is focused on hospital changes but also needs to reflect the wider changes required, for example in local (out of hospital) care;
    - Reviewing and updating our internal governance arrangements Ensuring that evidence, information and documentation underpinning any proposals is more specific to east Kent;
    - Ensuring that 'whole system' engagement can be described in the pre-consultation business case.

24. These findings have been reviewed, along with the output of the emerging actions in response to these, at the East Kent Systems Board as well as the East Kent Joint Committee of Clinical Commissioning Groups. These finding have been used to inform a revised governance structure and work plan for the programme, the aim of which is to:

    - Strengthen clinical engagement (including clinical leadership and contribution) within the design and delivery of the programme; with the re-establishment of a clinical models group and clinical reference group.
    - Refresh membership across all workstreams to ensure full system representation, engagement and contribution to the work (thinking, planning and delivery), i.e. so that the work is wider than just an acute focus.

25. The outlined new governance structure is shown on the following diagram:



26. The governance structure reports to the East Kent CCGs Joint Committee, which has overall responsibility for the programme of work delegated to it by the four east Kent CCGs. Reporting to this is the East Kent System Board that is a chief executive level group and will have two streams of work reporting to it:

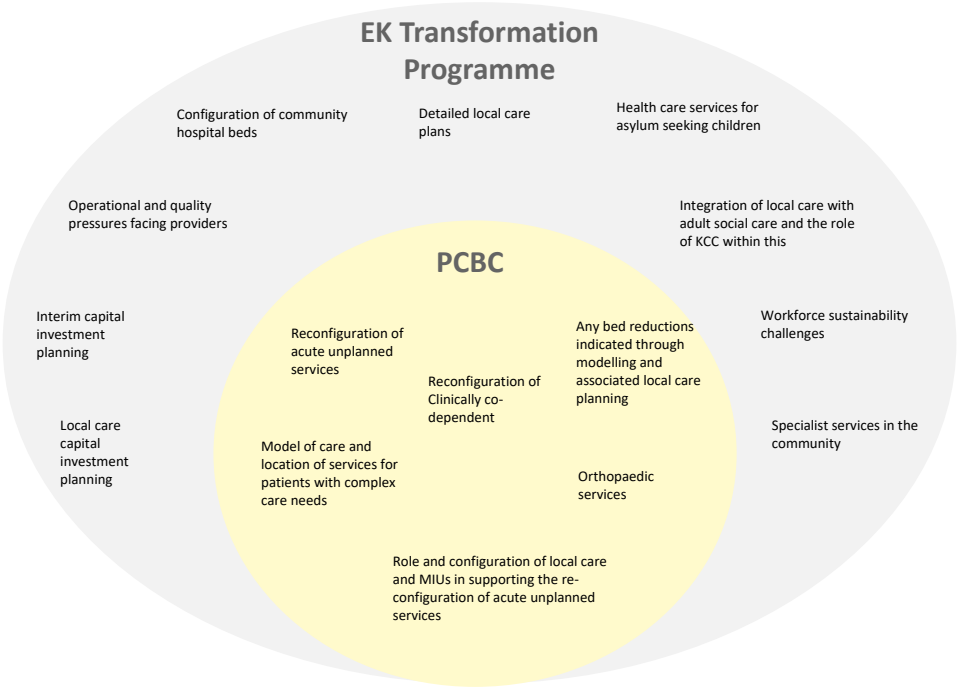
    - the strategic change programme (as outlined in this paper);
    - the shorter-term service improvement work that we have underway to deliver improvements on our immediate activity and financial performance objectives.

27. In recognition of the additional tests associated with the NHS England assurance process, we have been reviewing the scope of the Transformation Programme specifically to confirm what now needs to be additionally covered by the pre-consultation business case. We have therefore reconfirmed the scope of the services for inclusion within the pre-consultation business case as:

    - The reconfiguration of acute unplanned (e.g. emergency) hospital services;
    - Co-dependent clinical services that need to be reconfigured to support the new service model for unplanned care (including more specialist and planned services where there is an interdependency in relation to supporting clinical services or bed base, e.g. orthopaedic services);
    - The model of care and location of services for patients with complex care needs;
    - The role of local (out-of-hospital) care and minor injuries units (MIUs) in supporting the re-configuration of acute unplanned hospital services.

28. The configuration (as opposed to role) of minor injuries units and community hospital beds is currently out-of-scope for the East Kent Transformation Programme.

29. A distinction is being made between the scope of the programme as outlined above that will require consultation, and therefore included within the pre-consultation business case, and the services that are part of the wider transformation programme and subject to ongoing development and refinement but do not necessarily equate to substantial variation. This is shown in the following diagram:



Revised service models and options under consideration

30. Local care is a new model of delivery of integrated health and care services, delivered close to where people live. It will be developed through a collective commitment of the health and care system in Kent and Medway to fundamentally transform how and where we will support people to keep well and live well. This involves redesigning health and care services specifically around the needs of local populations, whether for an older person, someone with complicated health problems, a busy parent or carer with young children or others who need support, or a vulnerable young person.

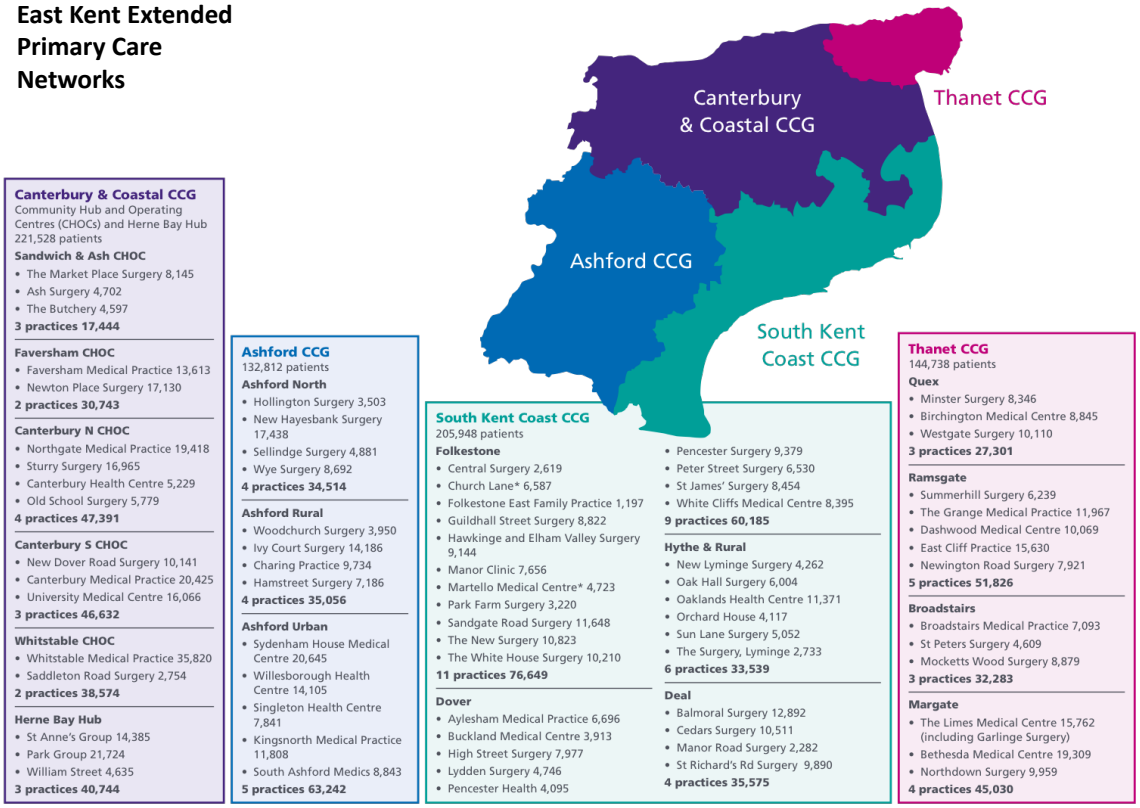
31. In 2018/19 the focus is to develop integrated teams, around GP practices working at scale for populations of 30-50,000. Generically for planning purposes these are being termed extended primary care networks (previously known as community hub operating centres (CHOCs), primary care homes (PCHs), hubs, localities). These networks will work in an integrated way with and across all local stakeholders to support the local population.

32. The extended primary care network will:

- Support the long-term provision of primary care services including practices working together as federations (virtually and/or physically) and through this provide more specialist clinics in their surgeries, reducing the need for patients to go to hospital, and provide easier access to services that patients can contact from their home, or via their GP to provide an alternative to what would otherwise be an A&E attendance;
- Provide joined-up care, from an entire team of health and care experts, so patients can see the right professional first time, enabling the delivery of coordinated and integrated health and social care services so that they provide care around a centrally held care plan in an efficient and holistic way;
- Use integrated case management for frail patients to ensure proactive support that can respond to patients needs in a timely manner;
- Work with local hospitals to ensure patients are only admitted when necessary and are able to return home as quickly as possible with the right support;
- Make best use of technology, develop new roles with different skills, and share specialist skills across their area;
- Collaborate to offer more appointments, opening some surgeries until 8pm Monday to Friday and having some slots at weekends too;
- Work with community and voluntary groups, social care and district and borough councils to develop support for people's wellbeing, helping them to look after their own health and develop stronger communities;
- Make a really strong case for improved facilities where the population can get modern care in a modern setting;
- Educate and facilitate the population in monitoring and improving their own health and promote self-care, as well as engaging with patients and provide the education and basic skills needed to allow them to manage and provide their own care;
- Provide the short-term level of care needed immediately upon discharge to allow a patient to live independently in their place of residence;
- Position mental health staff consistently in all care settings to support and direct care for patients with mental health issues and prevent mental health issues developing especially among those with long-term physical health conditions.

33. The following map details the current proposed extended primary care networks in east Kent (these have been referred to under a range of different names including clusters, primary care homes, community hub operating centres (CHOCs), hubs or localities):

East Kent Extended Primary Care Networks



34. The majority of care delivered by the NHS is provided outside the acute hospital setting. It is estimated that currently 90 per cent of contacts with the NHS is within primary and community care such as GP services, community nursing and therapy services (such as physiotherapy). However, when an individual needs more specialised acute care we want to deliver the best and most effective care possible, that consistently meets national quality standards . The acute hospitals in east Kent generally provide good care but this isn't the case for everyone all of the time as outlined in the case for change documents. There is a recognition that an unacceptable number of people have:

    - To wait too long to be seen in an emergency;
    - Their planned operations cancelled;
    - To come to hospital for treatment or advice that could be provided closer to home or at home;
    - To stay longer in hospital than is best for them because other services are not available;
    - Experienced a variable quality of care depending on where and at what time they are seen.

35. As part of delivering good acute hospital care we believe:

    - For acutely unwell patients this means consultant-led and delivered services which will give people the best treatment and chance of recovery if they are taken seriously ill or have a catastrophic injury;
    - For patients who need a routine operation this means excellent, accessible and predictable services which take place on time, all year round, enabling people to get back to normal life sooner;

- We could make routine appointments, tests and screening services more readily available, using technology to bring services closer to where people live.

36. For patients this means the individual:
    - Will only come to hospital if that is the best place for them;
    - Will access highly specialist care when it's needed;
    - Will be treated sooner – with shorter waits for planned surgery;
    - Will spend less time in hospital as they will be seen and treated by a specialist team;
    - Will get home sooner with the right support to continue their recovery.
37. We are proposing to create a specialist hospital in east Kent (a major emergency centre, where all the specialist services, including for the most serious emergencies, are based on one site). The options currently under consideration are:

Potential Option 1	**Potential Option 2**
This option involves an estimated £170million NHS investment, which is under review, to enable three vibrant hospitals, including: • A much bigger, modern, A&E (a major emergency centre) at William Harvey Hospital, Ashford, which would also provide services for people that need highly specialist care (such as trauma, stroke, vascular and specialist heart services) in east Kent; • An expanded, modern A&E (an emergency centre) at Queen Elizabeth the Queen Mother Hospital (QEQM), Margate, with inpatient care for people who are acutely unwell, emergency and day surgery, maternity and geriatric care; • Investment in beds and services at Kent and Canterbury Hospital which would have a 24/7 GP-led Urgent Treatment Centre, and services including diagnostics (such as X-ray and CT scans), day surgery, outpatient services and rehabilitation. Under potential option 1, current estimates[1] suggest that 97 in every 100 hospital visits (more than 1.2million) for advice and treatment would see patients continue to go to the same hospital as they do now. In the future. All three hospitals would continue to be vibrant sites, where patients would continue to get	This potential option involves an estimated £250million NHS investment, which is under review and in addition to the shell of a hospital being made available to the NHS, to develop: • a new hospital at the Kent and Canterbury Hospital and refurbishment of some of the current hospital buildings, which would provide a single 24/7 A&E and all specialist services (such as trauma, vascular and specialist heart services) for the whole of east Kent; • 24/7 GP-led Urgent Treatment Centres at both the William Harvey and QEQM hospitals, as well as diagnostics (such as X-ray and CT scans), day surgery, outpatient services and rehabilitation. Option 2 has been included because a private developer has offered to donate to the NHS land and the shell of a new hospital in Canterbury, as part of a development of 2,000 new homes, which includes an access road from the A2. It would be subject to planning permission. Under this option, current estimates[2] suggest that approximately 65 in every 100 hospital visits for advice and treatment (65 per cent / over 855,000) would see patients

[1] Based on modelling of 2016-17 hospital activity,

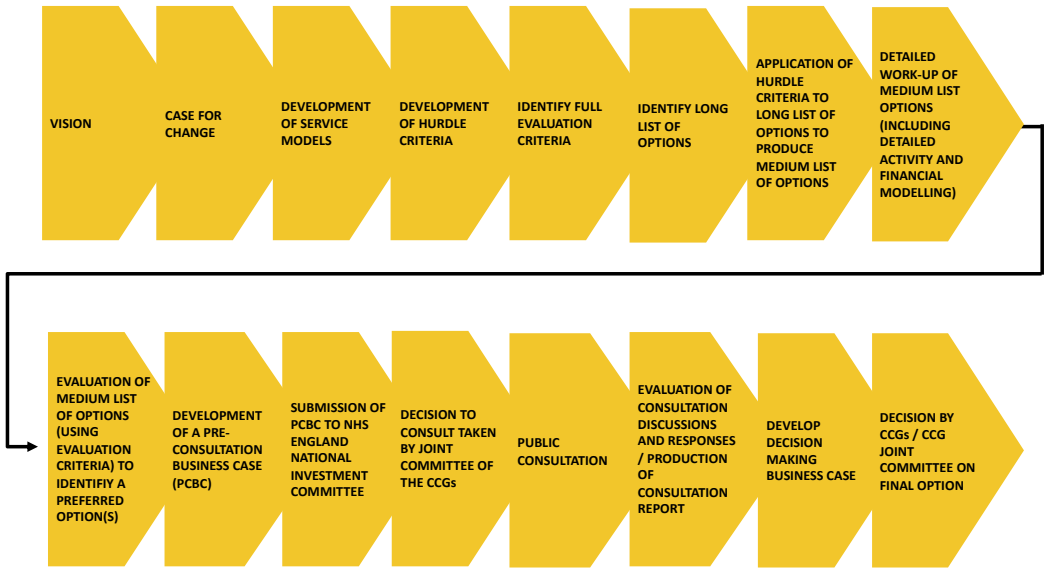
[2] Based on modelling of 2016-17 hospital activity

most of their care locally, with a small proportion of patients travelling to a different hospital for the most specialist care (i.e. the sort of care that most of us don't need routinely).	continue to go to the same hospital as they do now. In the future.

38. The creation of a specialist hospital (as a major emergency centre for east Kent) is proposed because evidence shows that you are more likely to survive and recover well if you are treated by a highly specialist team, available 24/7, who see and treat sufficient patients to keep up their skills. This already happens for many services for seriously ill patients:
    - If you are really badly injured (a trauma patient) or have the most serious kind of heart attack you would already now be taken straight to the William Harvey Hospital in Ashford;
    - If you need treatment for gynaecological (women's) cancer you would have this now at the QEQM;
    - If your child is born prematurely they will be cared for now at the William Harvey Hospital, or if they need a complex operation would be treated in London;
    - If you need treatment in hospital for kidney disease or blood disorders, this would currently be undertaken at the Kent and Canterbury hospital.
39. By combining specialist services into one hospital, we can improve care by giving patients the highly specialist treatment they need, more quickly, from a single expert team available 24/7, whose expertise is built up by seeing lots of patients with the same condition, instead of stretching specialist services across multiple hospitals.
40. Evidence shows that being treated by a specialist team, who are experts in their field who see and treat a high volume of similar conditions, is more important for a better outcome and recovery than the travel time to the hospital itself.

Programme Plan

41. The process we are following has been developed based on the learning from other areas on how to deliver NHS service reconfigurations. This is summarised in the following diagram:



42. Our process for change has reached the 'medium list' stage and detailed evaluation and development of the pre-consultation business case is now taking place to meet the requirements of the new NHS England assurance process. In summary:

- We started with a detailed assessment of clinical standards for each service to identify which services needed improving first – these were urgent and emergency care (including acute medicine) and planned orthopaedic services;
- We then considered in detail how services could change, identifying the best models of care that would improve standards;
- Then, we worked to design and agree a set of questions and criteria (hurdle criteria) against which we could assess many possible options for where services could be organised;
- We tested these questions and criteria with clinicians, health and care partners, patients, carers and the public earlier this year;
- They helped us refine the questions and criteria and told us how important they felt each of them to be in assessing the options available to us;
- This process resulted in one potential option for where future urgent, emergency and specialist hospital services could be located;
- An additional potential option has been added at the medium list stage as a developer offered to donate to the NHS the shell of a hospital connected to the Kent and Canterbury Hospital.

43. As outlined in the section of this paper on the NHS England assurance process, a key component of the work focuses on refining the capital requirements and building the case that this is an accurate reflection of the required investment and that east Kent is the priority for this investment. A key component of this is to understand how demand on services changes. The approach being adopted is outlined in the following diagram:

44. The above outlines the approach we are adopting. Namely, we identify current demand for services and:

i. Project how this increases over time based not only on demographic growth but also in relation to non-demographic growth, e.g. to take account of the planned increase in the number of houses in east Kent (changes in health technology and prevention are also considered where these are likely to have an impact on demand for healthcare services);

ii. Through considering the planned service models in relation to the development of both local and acute services, future demand is then re-apportioned to the appropriate settings of care;

iii. By understanding the future demand on services by setting of care, within the context of the revised service models, it is then possible to model the required estates and workforce;

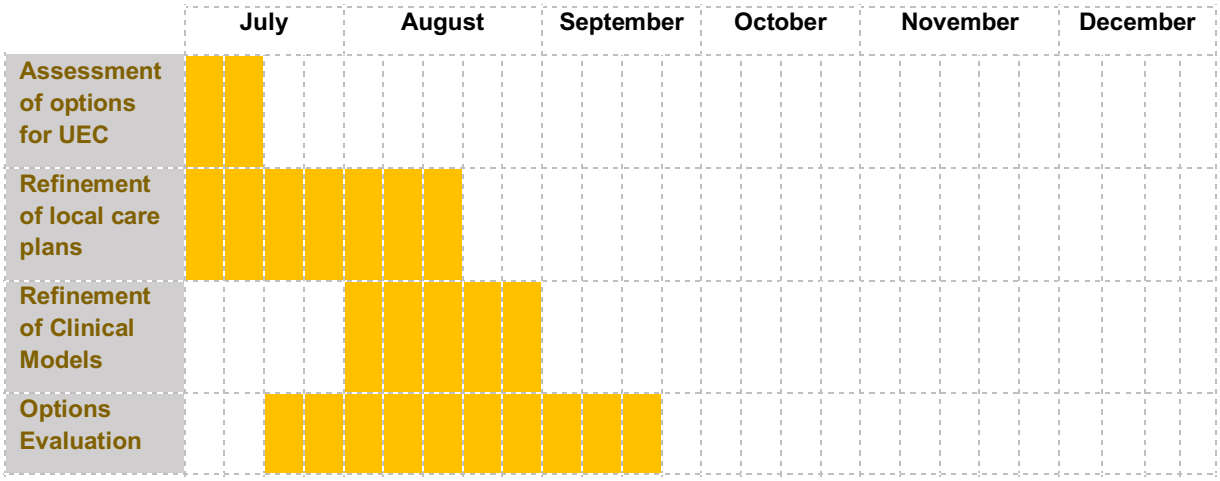
iv. Through understanding the estates and workforce requirements, along with a range of other costs, it is possible to develop the financial model (this needs to be considered from both a commissioner and provider perspective, i.e. to ensure providers are able to deliver the services within the funding available to them through the contracts they enter into and that the commissioners are able to afford the services within the allocations they receive from NHS England).

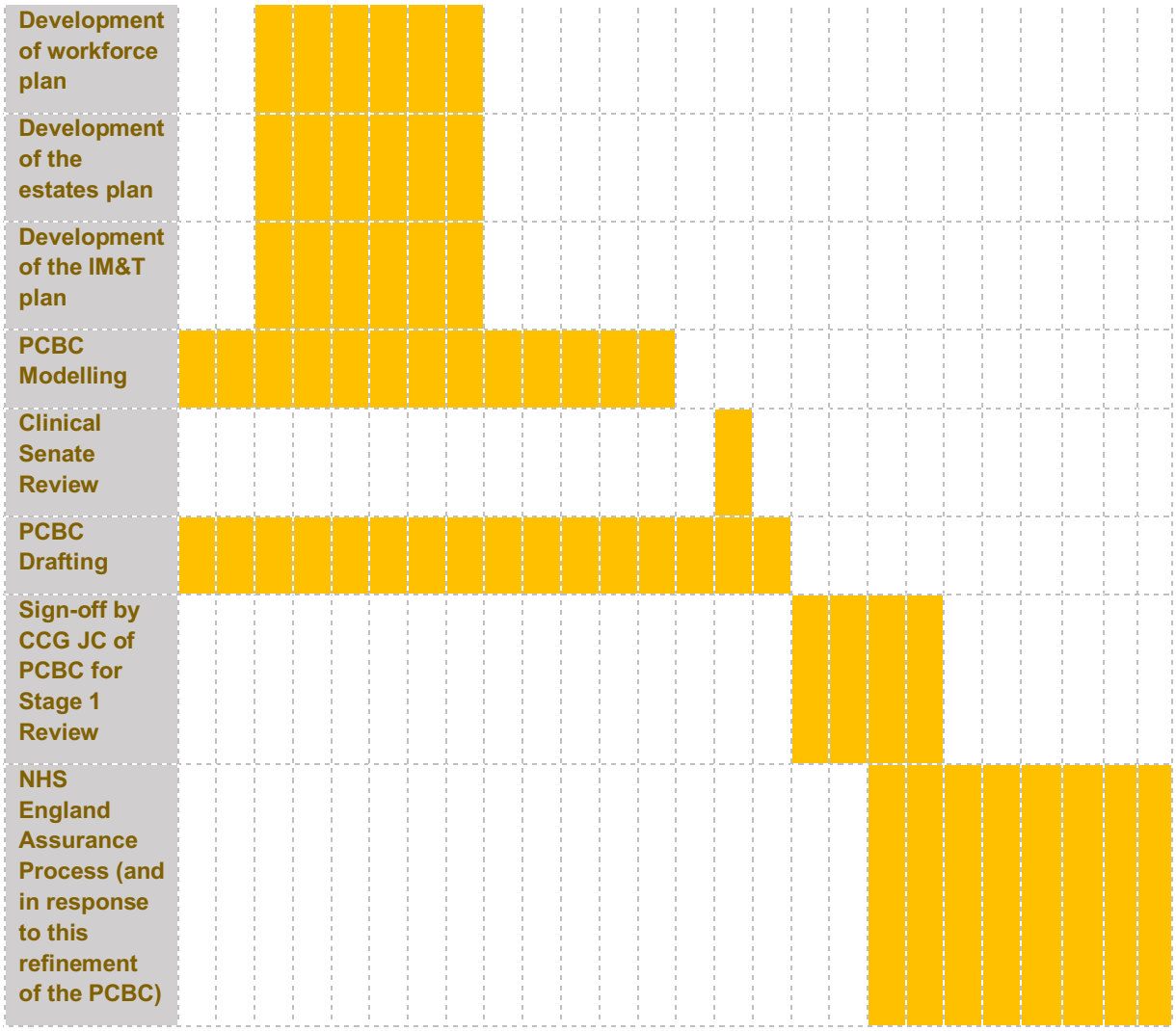
45. Detailed modelling in line with the above is in progress, this includes assessing the two current potential options before we decide what to consult on formally.

46. The key inputs and deliverables we are focusing on in order to establish the pre-consultation business case cover:

- Refinement of urgent and emergency care options;
- Refinement of local care plans;
- Refinement of clinical models;
- Options evaluation;
- Development of the workforce plan;
- Development of the estates plan;
- Development of the digital plan;
- Business case modelling;
- Draft of the pre-consultation business case (bringing together the component parts into the business case document).

47. The above items are outlined on the high-level programme plan detailed below:





48. The above anticipates the submission of the draft pre-consultation business case to NHS England, for it to be taken through the assurance process detailed earlier in this document, in the autumn of this year. Engagement with stakeholders and the HOSC will be an ongoing process but we would look to formally consult and present the pre-consultation business case to the HOSC once it has been through the NHS England assurance process.

49. We have a detailed communications and engagement plan that sits alongside this programme of work. There has, to date, been a significant amount of engagement and involvement of stakeholders, staff, patients, carers and local communities in the:

    - Case for change;
    - Development of evaluation criteria for assessing potential options;
    - Early thinking around the 'model of care' that would see the development of a major emergency centre for east Kent, alongside enhanced local care delivered in local communities and closer to people's homes.

50. There is more work to be done as we start to develop more granular detail on the model of care and potential options that would deliver it, and our communications and engagement work will continue alongside this. We are keen to work with our local communities to find solutions together to the challenges we face in delivering high quality, sustainable services for the long-term. This work will continue ahead of formal public consultation on our shortlisted proposals.

51. We would like to present to the HOSC at its next meeting an assessment of in-flows to East Kent University Hospitals NHS Foundation Trust in relation to the impacted services (e.g. an assessment of patients from CCGs other than the four in east Kent who use the trusts services). The majority of these patients will be from other parts of Kent. However, some patients will be from areas covered by other local authority areas, e.g. Medway Unitary Authority whose patients use the William Harvey Hospital for some coronary care and East Sussex County Council where some of their population look to the same hospital for their acute care. We would also look to present this information to the HOSCs covering these other areas. This will allow the committees in the other areas to form a view on the materiality of potential changes in relation to their populations and whether there is a case to form a joint committee.

Summary

52. The HOSC is:

- asked to discuss and note the contents of this report; and
- we also request that the HOSC receives a paper at its next meeting detailing the number of patients from other council areas that look to East Kent University Hospitals NHS Foundation Trust to provide acute care.

Item 6: East Kent Hospitals NHS University Foundation Trust: Update

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 20 July 2018

Subject: East Kent Hospitals NHS University 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 NHS University Foundation Trust.

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

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1. Introduction

On 24 November 2017 the Committee considered an update on operational performance at East Kent Hospitals NHS University Foundation Trust. An update on the Trust has been requested for this meeting as part of the Committee's review of acute services. The Trust has asked for the attached report to be presented to the Committee.

2. Recommendation

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

Background Documents

Kent County Council (2017) *'Health Overview and Scrutiny Committee (24/11/2017)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=46495

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East Kent Hospitals University NHS Foundation Trust

EKHUFT update report July 2018

Performance and capacity planning for Winter 2018/19

1. Background

1.1 East Kent Hospitals University NHS Foundation Trust (EKHUFT) is one of the largest acute Trusts in England. The Trust serves a population of 695,000, employing around 8,000 staff and has more than 1,000 beds across three main hospital sites in Ashford, Canterbury and Margate.

1.2 We provide local access to services with a range of outpatient and diagnostic services in our two community hospitals in Dover and Folkestone, as well as a range of services throughout the local area in facilities owned by other organisations, covering a large geographical area.

1.3 As with other acute Trusts, we are facing significant demand for services from an ageing population with complex needs. The reconfiguration of hospital services has remained largely unchanged for over a decade, impacting on the performance of some services and the Trust's ability to recruit staff, leading to very high spend on agency staff.

1.4 We also have a large, diverse and ageing estate, which requires considerable capital investment. The clinical strategy for the future of healthcare in east Kent includes significant capital investment in the hospital's estate.

1.4 Despite these challenges staff work incredibly hard to provide good patient care, 97% of inpatients say they would recommend our hospitals to their friends and family.

2. Investment and improvement in our services

2.1 In March 2017, NHS Improvement confirmed that the Trust had exited special measures for quality and by September 2017 there had been big improvements in the annual inspection of reports for hospital food, cleanliness and environment.

2.2 There have also been a number of investments made to support service improvements:

- May 2017: The new chemotherapy unit at William Harvey Hospital (WHH) was officially opened, and blood transfusions were made available to patients using the mobile chemotherapy service.

- July 2017: The haemophilia centre at Kent and Canterbury Hospital (K&CH) was the first in the country to recruit patients to a new clinical trial.
- October 2017: The maternity bereavement suite opened at Queen Elizabeth The Queen Mother Hospital (QEQM).
- October 2017: funding approval was given for a joint partnership to provide a Dementia centre of excellence at Dover.
- October 2017: Two new MRI scanners were unveiled at Kent and Canterbury Hospital, as part of a £4m investment into diagnostic facilities at the hospital.

3. Improving performance on NHS constitutional access targets

3.1 We have a clear focus and plan in place to improve performance in waiting times in A&E, for planned care and cancer treatment and the experience for patients this represents, although these measures will only go some way to improving the situation. Long-term sustainable transformation of hospital services, supported by local care, is essential.

3.2 In May the Trust's performance for the percentage of patients being seen, treated and discharged or admitted within 4 hours was 80.8% against the national target of 95%. The Trust last reached 80% in March 2017.

3.3 67.2% of patient's treatment for cancer started within 62 days of an urgent referral by a GP, against the national target of 85% and 76.7% waited less than 18 weeks for a planned operation, against a national target of 92%.

3.4 In order to improve performance in the A&E four-hour standard, we need to have enough bed capacity to improve the flow of patients through the emergency department and ensure that patients are not staying in hospital for longer than they need to.

3.5 Having the right capacity in the right places, for example the right mix of surgical and medical beds, improves flow, reduces length of stay and improves performance across all target areas.

3.6 In order to plan ahead for next winter the Trust has allocated further investment this year for additional beds and staffing as part of its operational plan, see table below for details.

2018/19 Winter Improvement Plan

Standard	What the change is	What impact this will have
Meeting the 4 hour standard	Extending ambulatory care	To provide a more sustainable service and increase the number of patients who are seen and treated in a day, without needing to be admitted to hospital.
	Additional nurses to work alongside senior emergency doctors in the Rapid Assessment and Treatment area	To ensure timely assessment of patients, support early diagnostics and streaming, 24/7 dedicated nursing service for children, support the decongesting of emergency department and stream patients direct to Majors or AMU/SEAU.
	Provide additional resources to our radiology departments	This will extend operating hours of the second CT scanner at WHH into the weekend 12 hours per day, speeding up diagnosis for patients arriving in the emergency department.
	Additional staff resources for medical beds	Providing 28 additional medical beds at QEQM and 31 additional medical beds at WHH. This will improve patient flow across the whole emergency medical pathway reduce length of stay (LOS), decrease the risk of harm events, improve patient experience and A&E performance.
	Increase capacity for elective orthopaedics at Kent & Canterbury Hospital	Install two temporary theatres at K&CH supported by 22 ring-fenced beds. This will allow the Trust's orthopaedic surgeons to improve the quality of their service and will remove the risk of unplanned activity forcing the cancellation of planned surgery.
	Reduce delayed transfers of care	Whole-system plan to improve discharges, reduce the number of stranded patients and reduce length of stay.
Improve compliance with RTT targets	Reduce backlog in key specialities. Align capacity to better meet demand. Improve productivity in theatres, outpatients, pathways.	Reduce 52 week breaches for patients on an active RTT pathway in line with the NHSI submitted trajectory and reduce waiting times for outpatient services
Improve Cancer Targets	Improvements in capacity and demand planning.	This will enable the Trust to achieve its 62 day cancer target for its patients

4. Financial performance

4.1 The Trust continues to work hard to improve its financial position. At year end 2017/18, we had delivered a £33.1m cost improvement plan with a final financial deficit of £19.4m at the end of the year.

4.2 This involved considerable effort from staff who worked extremely hard to put in place efficiency schemes, all schemes involving clinical services are assessed to ensure that they maintain or improvement patient care, for example by providing treatment which is more effective and leads to quicker recovery times.

4.3 The main operational drivers of the Trust's financial performance in 2017/18 included the failure to secure the full allocation of Sustainability and Transformation Funding due to our inability to remain within budget and for not hitting the 4- hour A&E target. Increasing operational pressures during the winter period meant our costs on staffing were higher than planned.

4.4 The increased pressure on our services and continuing difficulties in recruiting permanent staff led to the Trust being reliant on agency and locum staff in order to maintain safe staffing levels to meet CQC requirements. £29.4m was spent on agency staff and medical locums (including direct engagement), in the year and in addition £13.5m spent on Bank Staff largely for medical support and to address challenges in A&E.

4.5 For 18/19 EKHUFT has a planned annual consolidated turnover of £590million for 2018/19 and a cost improvement (savings) plan of £30m. Although the Trust's financial position has been stabilised, this means we are still forecasting a £30.9m deficit as we are unable to access Sustainability and Transformation funding.

4.6 The Trust continues to work closely with NHS Improvement under financial special measures.

5. Ophthalmology in Dover

5.1 Ophthalmology is a high volume specialty. The Trust provides the full range of out-patient services from its hospitals in Dover, Canterbury and Ashford. Buckland Hospital in Dover has specialist cataract theatres where 3-4,000 cataract operations are carried out annually, along with other eye surgery procedures.

5.2 The range of sub specialities within Ophthalmology provides services from cradle to grave and is predicted to grow by 30.7% in the over 70s and 13.5% in children under 10 by 2021.

5.3 In addition to demographic growth, is the demand that will continue to grow with treatment options for several diseases that were previous untreated, such as Wet Age related Macular Degeneration (wAMD), Diabetic Macular Oedema (DMO) and Macular Oedema due to Retinal Vein Occlusion (RVO).

5.4 The Wet AMD injection treatment service was first commissioned in 2008 when injectable anti-veg F drugs became effective and available. In the 10 years since it started, there has been a huge increase in patients requiring the service. Patients also require multiple appointments each year to ensure minimum loss of sight and involve a programme of follow-up appointments for life.

5.5 The injection service, which was run by East Kent Hospitals University NHS Foundation Trust, was available at Kent and Canterbury Hospital, with a follow-up service at Buckland Hospital in Dover. However the increase in demand placed significant pressure on hospital services.

5.6 The service has now successfully been divided into two parts to increase the number of locations and providers of the service and so that the Trust can focus on the initial diagnosis and start of treatment:

- Tier 1: Diagnosis of Wet AMD and initiation of treatment – continues to be provided by East Kent Hospitals.

- Tier 2: Follow-up monitoring and treatment continuation - is provided by ophthalmologists in the community from the following providers:
  - Spencer Hospital, Queen Elizabeth the Queen Mother Hospital, Margate
  - Spencer Hospital, William Harvey Hospital, Ashford
  - New Hayesbank Surgery, Kennington, Ashford
  - St Anne's Surgery, Beltinge, Herne Bay
  - Whitstable Medical Practice, Estuary View, Whitstable

5.7 Commissioners are currently seeking providers to deliver the Tier 2 service in Canterbury Dover.

5.8 Once the initial diagnosis is confirmed and treatment is started by the hospital, patients can choose which providers they want to be treated by for their subsequent follow-up, monitoring and injection appointments and can change providers at any time.

5.9 Patients who are eligible for NHS-funded patient transport to an east Kent hospital are also eligible for patient transport to the new Wet AMD clinics, this also applies to patients who are eligible for NHS-funded travel expenses for hospital treatment.

6. Radiology review of scans

6.1 The Trust's Radiology Department identified an administrative issue with the Radiology electronic management systems on 23 March 2018. This affected 5,581 examinations out of circa 6million dating back to 2007.

6.2 The Trust has two standard electronic management systems for radiology, the picture archiving and communication system (PACS) and the radiology information system (RIS).

6.3 On 23/3/2018, during a routine review, Radiology identified a number of examinations on PACS that do not have the information from an associated examination attendance record on the RIS.

6.4 All the examinations will have been reviewed by the requesting clinician at the time they were taken and all have always been available on the system for clinicians to view at any time.

6.5 The Radiology team has reviewed all of the 5581 images and reports as a precautionary measure and we are updating each of these records to make sure the information is recorded consistently across our systems.

6.6 No harm has been identified. The process of reviewing these images has been extensive and the process is almost complete.

6.7 As part of our assurance process to ensure that this problem cannot happen again, reports are now run on a weekly basis to identify any images that do not have an associated examination.

7. Update on Dementia Village

7.1 Working with Local and European health, local authority, education and research partners, East Kent Hospitals Trust has secured funding from the Interreg 2 Seas programme (co-funded by the European Regional Development Fund). The four year project is called "Community Areas of Sustainable Care and Dementia Excellence in Europe" (CASCADE).

7.2 The project will see the construction of new facilities for the elderly and for people living with dementia and will create a Centre of Excellence for dementia suffers across the partner regions, behind Buckland Hospital in Dover, based on existing housing.

7.3 The overall objective of the project is to develop a new sustainable model of care for People Living with Dementia (PLWD) that can be applied across Europe.

7.4 Designs for modifications to the existing housing and a community centre were submitted to Dover District Council in December 2017, and planning approval received in May 2018.

7.5 A construction contract was tendered and a contractor has been selected. The aim is for an April/May 2019 opening. The site will be connected to the Buckland Hospital power supply which has generator back-up. The Dementia Village will also use space and facilities at the Buckland hospital.

7.6 Dr Phil Brighton has been appointed as the clinical lead for the project and the Trust successfully applied for Darzi Fellowship support for the Dementia Village and as a result Dr Jo Seeley and Dr James Hadlow are supporting the project.

7.7 Two meetings have been held with local residents around the Dementia Village site and the feedback has been very supportive. A resident has volunteered to represent the local neighbourhood and support the development of community resources.

7.8 Supportive technology will be a core part of the model of care and a research programme on its use will be conducted. It will be unobtrusive and used to support staff decision-making and to give PLWD at the Dementia Village as much freedom as possible. The intention is that staff time will be used more productively and interactions between PLWD and staff will be enriched.

7.9 Feedback from the focus groups and from our Dutch project partners is that the name “Dementia Village” has negative connotations. We are currently working on several ideas for a name for the Dover facility.

Appendix 1

Our services	Kent & Canterbury Hospital	William Harvey Hospital	Queen Elizabeth The Queen Mother	Royal Victoria Hospital	Buckland Hospital	Estuary View Whitstable	Other community sites
Surgical services							
Critical Care Intensive Therapy Unit (ITU) / High Dependency Unit (HDU)	✓	✓	✓				
Day case surgery	✓	✓	✓				
Inpatient acute coronary care		✓	✓				
Inpatient breast surgery		✓	✓				
Inpatient emergency general surgery		✓	✓				
Inpatient emergency trauma services		✓	✓				
Inpatient ENT (ear, nose and throat), ophthalmology and oral surgery		✓					
Inpatient maxillofacial		✓					
Inpatient orthopaedic services		✓	✓				
Inpatient urology services	✓						
Inpatient vascular services	✓						
Orthopaedic rehabilitation		✓	✓				
Urgent care and long-term conditions							
Accident and emergency		✓	✓				
Minor injuries unit		✓	✓		✓		
24/7 minor injuries unit	✓						
Acute elderly care services		✓	✓				
Acute stroke		✓	✓				
Diagnostic + interventional cardiac		✓	✓				
Endoscopy services	✓	✓	✓		✓		
Inpatient cardiology		✓	✓				
Inpatient diabetes service		✓	✓				
Inpatient gastroenterology services		✓	✓				
Inpatient neurology	✓	✓	✓				
Inpatient neurorehabilitation	✓						
Inpatient respiratory		✓	✓				
Inpatient rheumatology		✓	✓				
Neurophysiology services	✓						

Ortho-geriatric services		✓	✓				

Our services	Kent & Canterbury Hospital	William Harvey Hospital	Elizabeth The Queen Mother	Royal Victoria Hospital	Buckland Hospital	Estuary View Whitstable	Other community sites
Clinical support services							
Interventional radiology	✓	✓	✓				
Outpatient and diagnostic services	✓	✓	✓	✓	✓	✓	✓
Therapy services	✓	✓	✓	✓	✓		✓
Inpatient rehabilitation	✓	✓	✓				
Specialist services							
Cancer care (chemotherapy)	✓	✓	✓				✓
Cancer care (radiotherapy)	✓						
Child ambulatory services	✓	✓	✓		✓		
Community child health services	✓				✓		✓
Haemophilia services	✓						✓
Inpatient child health services		✓	✓				
Inpatient clinical haematology	✓						
Inpatient dermatology	✓						
Inpatient obstetrics, gynaecology and consultant-led maternity		✓	✓				
Midwifery-led birthing units		✓	✓				
Neo-natal intensive care unit		✓					
Special care baby unit		✓	✓				
Inpatient renal services	✓						
Renal dialysis	✓	✓	✓		✓		✓[1]

[1] *Also provided by EKHUFT at Maidstone and Tunbridge Wells NHS Trust and Medway Maritime Foundation NHS Trust*

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Item 7: Getting It Right First Time (GIRFT) Orthopaedics Pilot: East Kent Hospitals University NHS Foundation Trust

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 20 July 2018

Subject: Getting It Right First Time (GIRFT) Orthopaedics Pilot: East Kent Hospitals University NHS Foundation Trust

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

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

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1. Introduction

(a) The East Kent Hospitals University NHS Foundation Trust has requested that the attached report is presented to the Committee.

(b) The Trust's report refers to the Getting It Right First Time (GIRFT) programme which is designed to improve clinical quality and efficiency within the NHS. The programme was designed following the publication of Professor Tim Briggs' report, of the same name, published in 2012.

2. Recommendation

RECOMMENDED that the report be noted and that East Kent Hospitals University NHS Foundation Trust be requested to provide an update in January 2019.

Background Documents

Getting It Right First Time (GIRFT) Programme
http://gettingitrightfirsttime.co.uk/what-we-do/

Professor Briggs' Report - Getting It Right First Time – Improving the Quality of Orthopaedic Care Within the National Health Service in England
https://www.hfma.org.uk/docs/default-source/our-networks/healthcare-costing-for-value-institute/external-resources/getting-it-right-first-time---improving-the-quality-of-orthopaedic-care-within-the-nhs-in-england-(professor-timothy-briggs)

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Reducing waiting times for planned inpatient operations and improving patient outcomes in Orthopaedics – GIRFT (Getting it Right First Time) pilot

1. Background

1.1 Demand for planned orthopaedic inpatient surgery such as hip and knee replacements has increased. We now see 3,000 planned inpatient operations each year at the William Harvey Hospital, Ashford (WHH) and the Queen Elizabeth the Queen Mother Hospital, Margate (QEQM), with growing waiting lists due to increased cancellations, especially during winter, when the NHS is required to stop planned operations to increase capacity for emergency patients.

1.2 National standards are moving to physically separating emergency care from planned care because routine procedures are protected from cancellations when there are surges in emergency admissions, this is better for both planned and trauma patients.

2. GIRFT pilot

2.1 The Trust has been invited to take part in a national pilot aimed at improving the experience and outcomes for orthopaedic patients suffering a trauma as a result of a fall or accident, as well as those undergoing planned orthopaedic inpatient operations. The pilot is part of the national GIRFT (Getting it Right First Time) programme, led by the National Director for Clinical Quality and Efficiency, Professor Tim Briggs and is commissioned by the Department of Health.

2.2 GIRFT covers more than 30 medical and clinical specialties and aims to deliver improvements across England by identifying areas of unwanted variation in clinical practice and/or divergence from the best evidence to deliver a series of national recommendations aimed at improving quality of care and efficiency.

2.3 The aim is to provide planned orthopaedic inpatient surgery at Kent and Canterbury Hospital (K&C), separate from emergency patients who would continue to be seen at WHH and QEQM. Participating in this pilot would enable the Trust to improve services by carrying out more planned orthopaedic inpatient surgery, continue operating throughout the winter and improve its capacity to treat trauma patients more quickly.

2.4 Evidence shows that dedicated facilities for trauma, with separate dedicated facilities for planned orthopaedic inpatient surgery, improves the outcomes and experiences for both sets of patients. Where these changes have already taken place in other parts of the country, waiting times have reduced, fewer patients have had their operations cancelled and recovery times are quicker.

2.5 The pilot project requires capital investment for new theatres and this is being sought nationally.

2.6 This is an exciting opportunity to invest in better facilities and equipment which will help patients be seen more quickly for both planned and emergency care in all our hospitals. The pilot, as part of the national GIRFT programme, will be fully evaluated.

3. Bridging solution to increase capacity for Winter 2018/19

3.1 The first stage would see planned hip and knee replacement operations currently undertaken at WHH, taking place at the K&C in time for next winter.

3.2 Planned orthopaedic inpatient operations would take place at K&C using day surgery theatres, supported by dedicated beds and two additional temporary theatres to enable existing day case operations to continue on site.

3.3 Doing this means the Trust will be able to carry out more planned orthopaedic inpatient operations this winter, as well as being able to see trauma cases at WHH more quickly, improving patient outcomes and experience.

3.4 It will also give the Trust an opportunity to increase theatre capacity for other specialties such as General Surgery and Gynaecology to help reduce the number of people waiting over a year for an operation, and people waiting for cancer treatment.

3.5 Spine surgery, day case surgery and trauma will continue at WHH. Planned shoulder, foot and ankle operations will also remain at WHH.

3.6 Day case and inpatient operations would continue without change at QEQM, potentially using some extra capacity in the Spencer wing.

3.7 Patients would continue to have all outpatient care before and after their operation at their local hospital, as they do now, which means musculoskeletal services, which handle large volumes of clinic appointments, day surgery, joint injections, imaging and rehabilitation, are unaffected.

3.8 This change would also mean we have more beds for medical patients at WHH which would increase flow through the hospital and help reduce waits in A&E.

4. Pilot stage - 2019

4.1 During the bridging stage, the Trust would build four modular, laminar flow theatres at K&C, supported by dedicated beds.

4.2 This would enable patients having planned orthopaedic inpatient operations to have their procedures in new and dedicated facilities at K&C by the end of next year.

4.3 All emergency operations (for example fractures sustained in a fall) would continue as now at WHH and QEQM; and day cases would continue on all three sites.

4.4 Patients would continue to have all outpatient care before and after their operation at their local hospital, as they do now, which means musculoskeletal services, which handle large volumes of clinic appointments, day surgery, joint injections, imaging and rehabilitation, are unaffected.

4.5 This change would mean we have more theatre capacity and capacity for medical patients at WHH and QEQM and separate orthopaedic teams dedicated to trauma and planned orthopaedic care.

5. Implication for the future

5.1 The permanent reconfiguration of orthopaedics will be the subject of public consultation as part of the east Kent clinical strategy. Additional theatres on the K&C site will be of benefit under any of the current potential options for the future reconfiguration of hospital services as the theatres can be used for different types of surgery.

5.2 GIRFT pilots have not been the subject of public consultation and instead have been used to inform future reconfigurations which are subject to public consultation, for example the GIRFT pilot in Cheltenham and Gloucester.

5.3 Although the pilot will not be the subject of public consultation itself, patient engagement will be undertaken, working with partners, as part of this work and regular updates provided to the Health Overview and Scrutiny Committee.

Item 8: Wheelchair Services in Kent

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 20 July 2018

Subject: Wheelchair Services in Kent

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

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

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1. Introduction

(a) The Committee received notification in June 2018 from Thanet CCG, as lead CCG for wheelchair services for patients in Kent & Medway, that there was pressure on the service provided by Millbrook Healthcare; patients were experiencing longer waiting times for equipment, repairs and assessment.

(b) Subsequently Healthwatch Kent notified the Chair about concerns received from service users at the Kent Physical Disability Forum regarding access to wheelchair equipment and repairs.

(c) The Chair has therefore requested to have this issue as an additional agenda item for this meeting in order for the Committee to receive assurance that action, to reduce the backlog and improve access to equipment, repairs and assessment for wheelchair users in Kent, is being taken to resolve this issue.

(d) The attached reports have been prepared for the Committee's consideration:

2. Recommendation

RECOMMENDED that the reports be noted and Thanet CCG be requested to provide an update to the Committee in three months.

Background Documents

None

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Report to:	Health Overview and Scrutiny Committee		**Agenda Item:**	
Date of Meeting:	20 July 2018			
Title of Report:	Kent and Medway Wheelchairs Service Briefing			
Author:	Ailsa Ogilvie, Chief Operating Officer			
Action Required:	~~Approval~~	~~Decision~~	Discussion/ Assurance	~~Information~~

Context

Millbrook Healthcare took over the contract to provide NHS funded wheelchairs for children and adults in Kent and Medway on 1 April 2017 following a comprehensive procurement process. NHS Thanet Clinical Commissioning Group (CCG) manages the contract on behalf of the eight Kent and Medway CCGs.

The service is for people with a long-term need for a wheelchair (six months or more). It provides manual and powered wheelchairs to children, young people and adults, following referral by a healthcare professional such as a GP or physiotherapist and an eligibility check. The service does not provide wheelchairs for short-term use (less than six months). These are loaned by organisations such as the Red Cross.

Approximately 24,000 people in Kent and Medway use the NHS-funded wheelchair service at any given time.

Contract mobilisation

In the first year of the contract Millbrook Healthcare raised concerns regarding the people waiting to be seen who had been inherited at the start of the contract. CCGs also became aware that patients were experiencing long waits for equipment and repairs and concerns were being raised by patients. Millbrook Healthcare informed the CCGs that the backlog was affecting their ability to meet waiting time targets and requested additional funds. At the time the CCGs could not agree additional funding as the data provided by Millbrook Healthcare was not conclusive, and CCGs could not discount the possibility that Millbrook Healthcare may have underbid during the procurement.

Instead, the CCGs requested additional data and agreed with Millbrook Healthcare a plan to ensure that patients with an urgent need for equipment or repairs were treated as a priority. An urgent need is defined as:

- If the service user has pressure ulcers of grade 2 and above (i.e. broken skin) and already has equipment provided

- If the service user already has equipment provided and is falling from it or having breathing difficulties when in it
- If the service user has a rapidly deteriorating condition (e.g. MND)
- If the service user has received an end-of-life prognosis, i.e. less than 6 months
- If the service user is a child
- If the service user is being discharged from hospital to their own home and provision of a manual wheelchair will enable them to be independently mobile (i.e. self-propel) and reduce or eliminate the need for a care package

When additional data was provided, it was still not conclusive so the CCGs and Millbrook Healthcare agreed for an audit to be carried out with the following aims:

- To evaluate the impact of the caseload inherited by Millbrook Healthcare at the start of the contract
- To consider whether there are any issues regarding the ongoing delivery of the service
- To review the quality of the data provided for managing the contract and make recommendations for data improvement.

At the same time a quality visit was initiated by the Deputy Chief Nurse for Thanet CCG to review the impact on patient safety and patient experience.

The outcomes of the audit and quality visit would enable the CCGs to then agree an improvement plan with Millbrook Healthcare to tackle the long waits experienced by some patients.

Results of the Audit

At the point when Millbrook Healthcare took over the contract, there were 210 referrals relating to children and 1046 referrals relating to adults on the waiting list for the wheelchair service, for assessment, repairs or provision of NHS-funded wheelchairs. It is estimated that 40 per cent had been waiting for more than 18 weeks at that point in time.

By the end of March 2018, Millbrook Healthcare had:

- Closed 3,855 referrals including 499 relating to children
- Ordered and issued 3,225 prescriptions including 7,356 items (i.e. wheelchairs or pieces of equipment)
- Ordered a further 803 items to be issued
- Ordered a further 2,811 items so that repairs were carried out for a further 903 patients

However, by the end of March 2018, the waiting list had increased. There were 443 children and 1,971 adults waiting for assessment, repairs or provision of equipment. Of these, 251 children and 999 adults had been waiting for more than 18 weeks. This includes 272 adults and 62 children who were on the waiting list inherited from the

previous provider, who have thus been waiting for more than a year. The service is therefore not achieving its target for equipment issues within 18 weeks for either children or adults.

The audit found that the caseload inherited by Millbrook Healthcare included both a backlog of long waiters and a much higher complexity case-mix (i.e. a much higher proportion of patients requiring powered and specialist wheelchairs) than had been expected during the procurement. This higher complexity required a higher spend affecting the ability of the service to manage the ongoing referrals, hence leading to a growth in the size of the waiting list and an increase in the length of waits experienced. The CCGs have recognised that in order to resolve this, additional funds will need to be provided to Millbrook Healthcare to cover the additional cost pressure that has been absorbed. The exact value of the additional cost pressure to Millbrook Healthcare is currently under discussion but agreement is expected by the end of the month.

The audit also found that there appeared to be an imbalance in the case-mix of the monthly referrals received since the contract started but further work is needed to confirm that the categorisation of referrals and patients has been correctly applied. Initial findings estimate that:

- The demand for low and medium complexity equipment prescriptions is 16 per cent less than expected although average costs are higher than expected
- The demand for high complexity manual wheelchairs is 26 per cent lower than expected and average costs are lower than expected
- The demand for power wheelchairs is 79 per cent higher than expected although average costs are lower than expected
- The demand for specialist wheelchairs is 154 per cent higher than expected although average costs are lower than expected

Overall, any impact of an ongoing imbalance in referral case mix appears to be much less significant than the impact of the inherited caseload, but CCGs are mindful that any potential imbalance is quickly confirmed so that mitigation actions can be taken to avoid further backlogs developing in the future.

The audit work highlighted inadequacies in the regular data provided for contract management, but also led to significant work being undertaken by Millbrook Healthcare to improve data quality for the purposes of the audit.

Results of the Quality Visit

The Quality visit found that Millbrook Healthcare were prioritising patients with the highest needs in line with the mitigations agreed with the CCGs. It also found that patients were not being harmed as a result of their wait. The clinical assessments and triage process have ensured that the risk around the wait for assessment and waits for equipment is reduced. The visit also concluded that patients' experience was not good and that waits were having a significant impact on their daily activities of living and

independence. It was also clear that clinical leads were fully aware of these issues and while they were doing everything within the resources available, staff morale was being affected by these concerns.

Next Steps

The CCGs are treating this situation very seriously and have welcomed the involvement of Healthwatch Kent in highlighting patients' concerns. The time it has taken to get to this point is very regrettable but has been necessary given the issues with data quality and the very significant risks to service delivery for patients if due process is not followed.

The CCGs are pleased to now be able to set out the following next steps:

- Thanet CCG is in discussions with Millbrook Healthcare regarding the value of the additional cost pressure that came with the inherited caseload. Once a figure is confirmed the CCG will seek approval from all eight CCGs to release the funds on the condition that they are attached to a clear improvement plan to be delivered by Millbrook Healthcare. The funding and associated improvement plan is expected to be agreed by the end of July.
- Millbrook Healthcare is developing an improvement plan to attach to additional funds which will give a clear timeline for the issuing of equipment to all those patients who have been waiting for 18 weeks or more, prioritising those who have been waiting over a year initially. This improvement plan will enable the backlog to be tackled separately from the business as usual service, preventing new backlogs from growing. Consequently the improvement plan will include consideration of the additional staffing requirement and the risks and costs associated with recruiting those staff.
- The CCGs are commissioning a further audit in collaboration with Millbrook Healthcare to review the categorisation of the referrals received within the life of the contract from the beginning to the end of the pathway, to give clarity on whether there is a risk relating to the case-mix of the ongoing demand for the service.
- The Deputy Chief Nurse for Thanet CCG is working closely with Millbrook to continue to receive assurance that harm is not happening to patients while they wait for their assessment and receipt of wheelchairs.
- A single communication regarding these steps will be provided to all stakeholders by the end of the month.
- In addition, we are exploring options for a communication to those who have been waiting in excess of 18 weeks giving an indication of the time that their equipment is likely to be issued.
- The CCGs and Millbrook Healthcare have also committed to agreeing a data quality improvement plan so that much better assurance can be provided regarding the delivery of the service in the future.

Improving Wheelchair Services: Kent Physical Disability Forum

One of the priorities of the Kent Physical Disability Forum (PDF) is to advocate for members and highlight their experiences of wheelchair services in the county.

Members have provided their experiences since the contract was re-tendered and there were some serious concerns.

The Kent PDF heard concerns regarding:

Long waiting times for calls to be answered, examples of up to 30 minutes, messages left but no response

Long waiting lists for appointments with no indicative dates given. One example of requesting an appointment for a child who had outgrown their chair and was well known to services, not getting an assessment until July which was only an assessment and then the chair was not provided until September. Frequent phone calls were needed to progress things.

Poor communication around appointments

Chairs provided that are not fit for purpose

Long waits for repairs, even urgent repairs

Repairs not done effectively

Service users with complex needs not being treated in a holistic way e.g. example of a young wheelchair user being told his chair would have to be taken away immediately as it's tyres were worn, but as it was their only chair it meant potentially stranding the child in the school.

There were also two bits of positive feedback received by the forum where service users had been pleased with the service.

Healthwatch Kent fund the support for the Kent PDF and has also been collating feedback from wheelchair service users for the last year:

Summary of Feedback Millbrook Healthcare: April 2017 – March 2018

Key for outcomes:
A=Assisted Information
S= Signposted
R= Referral
C=Complaint
L=Issue Logged
ESC=Escalation

Client Location	Service	Topic	Issue	Out come
ME17	Wheelchair services	Waiting time	It has taken over 330 days since I was referred by my MS nurse for the Wheelchair Advisory Service to visit me. It will then take another 69 working days to supply a wheelchair. Over a year to supply a wheelchair!	S - Millbrook
CT9	Wheelchair services	Waiting times	Contacted as has hassle when wife was in hospital over 2 years ago. Stated that they would not leave wife without a care package. They are still having problems today following the discharge such as the wheelchair. They were refused an electric wheelchair and given a Manual wheelchair. However, they are still waiting for alterations to be made.	L
Same Client	Wheelchair services	Equipment, Waiting times, Patient Choice.	The wheelchair had one part ordered but then was the wrong part and a new part ordered. Still waiting and currently the only way to take his wife to see a specialist is on a stretcher. As she is bed bound.	L
ME15	Wheelchair Services	Complaint Management, Information &Engagement, Coordination of Service, Personalisation, Staff Attitudes.	I hadn't heard anything from Millbrook healthcare since they had acknowledged my letter of complaint. So I emailed them again on the 18th October asking how the investigation to my complaint was going as I hadn't heard anything. The operations manager from the Kent service centre phoned me and said that there must have been some kind of mistake and that he would sort me out an appointment. I told him that I was going on holiday and the dates that I was away. Then I phoned before I went away in October, he didn't phone me back. So I phoned again today and I was assured that he would phone me today which he has not done. I don't think that my complaint has been dealt with correctly.	R - Kent Advocacy
CT10	Wheelchair Services	Waiting times, Access to information,	The service they are providing is diabolical". Client is waiting for an Anti-static strip for her motorised wheelchair, she has been waiting for three months and when she called on Friday Nov 3rd they had no idea when the part would arrive. Client is getting static shocks from the chair and so are her carers. the other part she is waiting for (same	L

			3 month wait) is arm pads for her manual wheelchair. Both these items do not need fitting they could be sent by post.	
Same Client	Wheelchair Services	Theft, Staff Attitudes, Complaint Management, Complaint Waiting times.	Client has asked that they not send one of the engineers as she has had problems with him in the past but he is still sent. client finds him rude, he leaves her wheelchair sitting on her drive for an hour while he is in his van then test drives her chair up and down the street, he also does not listen to her. Client has made a written complaint but after 10 days has had no response.	L
CT3	Wheelchair Services	Waiting times, Appointment Change of service	Have been waiting months for re-assessment since provider changed earlier this year.	L
Same Client	Wheelchair Services	Change in service, Records Management, Equipment.	There has been no routine review, there were no records of existing service users available following the change in provider. Neither is there any parts available for existing wheelchairs and equipment.	L
Same Client	Wheelchair Services	Appointments Waiting times, Coordination of Service, Suitability of provider (Individual)	Appointment was made incorrectly as daughter should have a band 7 assessment and booked in for band 6. This meant it wasn't the right OT so has to be rebooked, has been reassured that the appointment will be given priority.	L
TN2	Wheelchair Services	Lack of services, waiting times, Appointment	1st visits - Did not turn up.	L
Same Client	Wheelchair Services	Appointment, Suitability of staff, Staff training & Development, Equipment.	2nd visit - Unable to fit the tyres due to lack of training.	L
Same Client	Wheelchair Services	Appointment, Equipment, Quality and risk monitoring.	3rd visit - Wheelchair delivered to us, screws missed spokes out of wheels.	L
Same Client	Wheelchair Services	Staff Training & Development.	Lack of experience of staff.	L
Anon	Wheelchair service	Appointments, Equipment, Suitability of Quality of	Client stated that he had someone from the wheelchair service visit to change the tires on his wheelchair on Monday. The person who came was	L

		treatment, Involvement and engagement.	unsure how to remove the tires and was going to get them off with a saw. Client had to step in and remove the tires himself to prevent potential damage to his wheelchair.	
Same Client	Wheelchair service	Equipment, Staff training and development, Quality and risk monitoring.	Client advised that he looked at the tires yesterday and that one was not fitted properly. Client stated that he has since managed to put it on properly. Client stated that the staff are not trained properly.	L
Same Client	Wheelchair service	Waiting times, Access to information, Information and engagement.	Client contacted the Wheelchair service regarding the tires not being fitted properly and they were not very quick to respond.	L
Same Client	Wheelchair service	Staff training and development, Information and engagement.	Client stated that he feels that any staff who can fix a bicycle tire could change a tire on a wheelchair and this is not the case. Client stated that staff needs to have the appropriate training and perhaps this can be delivered with wheelchair users involvement. Client stated it would not be difficult to involve the wheelchair users as they have a wheelchair meeting group there frequently.	L
ME18	Wheelchair service	Access to services, Equipment repairs, Equipment, Waiting times, Access to information.	Client has been waiting since September 2016 for her new motorised wheelchair. She was referred 16th sept 2016 and she has been contacting wheelchair service every month since to ask about progress. She has been promised call-backs which have not been returned. In September 2017 she contacted her MP who informed her that the wheelchair service were not responding to her secretary.	E - Escalation
Same Client	Wheelchair service	Appointments, Equipment repairs, Equipment, Waiting times.	Jan 22nd, 2018 Client had appointment at Gillingham where her new chair was adjusted for her needs now has to wait for it to be delivered. Client contacted wheelchair service, 29th 30th when computers were down & today 31st and was told that she should have picked up her chair from Gillingham, she then spoke to O T who told her that they were picking up chair today and will contact her when it will be delivered, possibly Friday 2nd February. When client gets her chair she will then have to wait again for the hoist in her car to be adjusted. Client feels that if she had had her powered	E - Escalation

			wheelchair the accident would not have happened. She also stated that her confidence in going out alone has been lost.	
Anon	Wheelchair service	Equipment	We were advised by a friend to contact you regarding our experiences with the Medway Wheelchair Clinic. X is a full time electric wheelchair user. He has accessed the Clinic recently regarding seat discomfort issues and has also needed parts fixed and fitted.	L
Same Client	Wheelchair service	Waiting times, Access to information, Appointments, Coordination of services, Access to services	Currently he is waiting for some new parts and his Mum has had to chase them up and call a number of times, still to be told the person who needs to book the appointments is not responding to emails. Even though he has been told the parts are in, he cannot be booked into the Clinic to receive them.	L
Same Client	Wheelchair service	Waiting times, Appointments, Equipment,	X himself is unhappy about the long wait for appointments, especially when he is in pain and discomfort and can't be seen. There were a couple of occasions we waited all day for an engineer and no one came - we understand there can be mix ups, but it is frustrating when someone is in pain and you have waited in all day.	L
Same Client	Wheelchair service	Complaint, Complaint Management, Equipment.	The Team have worked with X for a number of years and ultimately, they do solve his issues. They come up with some innovative ideas, however, the length of time between appointments and once a month availability combined with not getting parts when needed is unsatisfactory.	L

Action Taken so far:

The Kent Physical Disability Forum (PDF) has been extremely proactive in raising these issues with the provider and commissioners:

They have encouraged service users to use the Millbrook complaints process

Together with other wheelchair user groups, Kent County Council and the Medway Physical Disability forum they have met with Millbrook to raise the concerns directly.

They have been in contact with the lead commissioners (Thanet CCG) from December 2017 and eventually met with them in April. The commissioners appeared unaware of any problems with the service as performance monitoring reports from Millbrook did not give any indication of concerns.

The Kent PDF is having a follow up meeting with Thanet CCG on 12 July and will be able to provide an update to the Kent Health Overview & Scrutiny Committee on 20th July.

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Item 9: Kent and Medway NHS and Social Care Partnership Trust (KMPT): Update

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 20 July 2018

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

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

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

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1. Introduction

(a) Kent and Medway NHS and Social Care Partnership Trust (KMPT) specialises in caring for people with a wide range of mental health needs including substance misuse, forensic and other specialist services. It is one of the larger mental health trusts in the country covering an area of 1500 sq. miles and serves a population of 1.8 million. The Trust's annual revenue is £183.1 million and it employs 3,502 staff who are located in 69 buildings on 36 sites (KMPT 2017).

(b) Following the publication of the CQC inspection report and the issue of a warning notice in May 2017 into community-based mental health services at the Trust, the Chair invited the Trust to present an update, including the improvement plan to address issues raised in the inspection report, to the Committee at its July meeting.

2. Recommendation

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

Background Documents

None

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

Mental Health Update

Report prepared for:

Kent County Council
Health Overview and Scrutiny Committee (HOSC)
20 July 2018

Version: 5.0
Date: 08 July 2018

Reporting Officer: Vincent Badu
Director Transformation and Partnerships, KMPT

Report Compiled By: Sarah Day, *Programme Manager, KMPT*

1. Introduction

1.1. This report has been prepared at the invitation[1] of Kent County Council's Health Overview and Scrutiny Committee (HOSC).

1.2. It will provide an update on the Care Quality Commission (CQC) inspection report and the Trust (KMPT) improvement plan to address issues raised in the inspection report. It will also provide a general update on KMPT current activities and priorities, new initiatives and opportunities.

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

2. CQC inspection report and improvement plan

2.1. The CQC, in January 2018, undertook a three-day unannounced inspection of three of KMPT's nine community mental health teams (CMHTs) for younger adults. This included the Canterbury and Coastal, and South Kent Coast CMHTs.

2.2. Since the inspection the CMHTs have been working in a focused way to resolve the serious concerns raised by the CQC and to significantly improve the consistency of the quality of care provided.

2.3. The CQC returned in May 2018 to revisit these three teams and test progress; the CQC confirmed they could see progress is being made and KMPT had addressed the concerns raised. At this May 2018 inspection the CQC also visited the Maidstone CMHT as they had identified from performance data that this is one of the higher performing teams in terms of meetings targets, recruitment, sickness absence rates and supervision support. Although this team received positive individual feedback, the CQC noted there were still inconsistencies across all teams.

2.4. In 2017 the CQC findings highlighted KMPT needed to improve its CMHT services across a number of elements. The January 2018 inspection was to test progress. The CMHTs had done an enormous amount of work and some really good progress had been made. However, the CQC were very clear, and were able to evidence, progress was not consistent across all required elements. The team of inspectors checked whether these services were safe, effective and responsive to people's needs. They also considered whether they were well-led. Their overall finding was that the quality of healthcare being provided required significant improvement. KMPT was consequently issued with a Warning Notice. This was immediately shared with the teams and an intensive work programme to resolve issues commenced. This included putting in place a comprehensive improvement plan and making some significant changes within the teams to ensure that they had sufficient support and strong, effective leadership.

2.5. Regular reporting is in place to the Executive Assurance Committee and Trust Board on the improvements made to safety and governance in CMHTs following the warning notice from CQC. In addition performance is scrutinised by internal operational service management teams, the Finance and Performance Committee and Quality Committee to ensure both the improvement plans and sustainability issues are progressed robustly.

2.6. Positively, the CQC's findings were not all focussed on areas needing improvement. They found several areas of good practice including staff having a good understanding of safeguarding and lone working, and CMHT staff being experienced, caring and hard working.

2.7. KMPT fully accepted the CQC's findings. The inspection and report have been instrumental in helping the teams focus and step up the pace of the improvements they are making. This work continues to progress and staff continue to be fully supported to ensure KMPT is consistently providing persons who use services with good quality care.

[1] Email to Sharon Tree (Senior Executive Assistant to Helen Greatorex, Chief Executive and Andrew Ling, Chairman, KMPT) from Georgina Little (Democratic Services Officer, KCC) dated 18 May 2018

2.8. The final CQC inspection report from the January 2018 inspection was published on the CQC website on 9 May 2018 and the warning notice remains in place until a further inspection is received by the CQC and improvement formally noted. The report can be found at https://www.cqc.org.uk/sites/default/files/new_reports/AAAH2785.pdf

2.9. Progress on delivery of all the key "must do and should do" recommendations highlighted by the CQC are now robustly underway. A summary of the key improvements delivered by the Trust to date include:

2.9.1 Continued reduction in care coordinator case loads, reasons for exceptionally high case loads are fully understood by service managers and there are plans in place for management and ongoing support.

2.9.2 Communications with people using services and referrers have been improved to ensure all new appointment letters contain details of how people can access help whilst waiting for formal assessment or treatment and the actions they can take if their condition deteriorates.

2.9.3 28 day referral to assessment performance has improved across all teams since January 2018. 28 day wait for assessment is on average 73.3%, with the lowest performing team at 62.3% (this equates to 20 patients not seen within 28 days for a routine appointment). The highest performing team is at 93.8% which equates to 2 people not being seen within the timeframe. Almost all teams are scheduling first appointments well within the 28 day window except for teams where slots are unavailable due to short term absence or vacancies.

2.9.4 Teams now routinely book patients within 10 days of referral and there are a number of 'reminder' actions taken at regular points in order to reduce non attendance at appointments. These include reminder texts, telephone contact and letters.

2.9.5 Daily red board meetings are in place across all teams to enable multi-disciplinary discussions to take place around people who are assessed as high risk, those who did not attend (DNA) appointments and to ensure 7 day follow up is completed as planned following an episode of acute care.

2.9.6 Mandatory training is on average 88% compliant against a target of 85% with the exception of 3 courses that are below 85%.

2.9.7 Supervision improvements for all staff and significantly for clinicians has improved from an average of 31% in January to 89% in May 2018, set against a 95% internal target.

2.9.8 Clinical mitigations are in place for patients waiting for assessment and or specialist treatment.

2.9.9 Core assessment, care plans, risk assessments, Care Programme Approach (CPA) and Health of the Nation Outcome Scales (HoNOS) all show an improvement over the last 4 months.

2.9.10 Reduction of overall vacancies from whole time equivalent (wte) 58.9 (16%) in January 2018 to 45.6 (13%) in May 2018. However staffing pressures remain evident in some teams due to long term absence.

2.10. Appendix A sets out the focussed inspection improvement plan for all CMHTs as the 'must do' and 'should do' actions identified cover all teams.

2.11. Unannounced CQC inspections: The CQC visited the Older Adult Inpatient services at Jasmine ward on 18 April 2018 and The Orchards on 19 April 2018. The Care Group leadership team received feedback at the end of each visit and the feedback was overwhelmingly positive in relation to the clinical delivery of the service, with particular reference to the excellent handover process. The CQC inspectors identified a number of estate related issues on both wards, which were either immediately rectified or are being actioned. Publication of the final CQC inspection report is awaited.

3. Current activities and priorities

3.1. Care Pathways Delivery Programme:

3.1.1. KMPT's Care Pathways Delivery Programme aims to support the Trust evolve its brand over the coming years through the development and implementation of quality care pathways, expanding and developing the use of information management technology, and through a closer alignment of its built environment to the needs of services. These developments align with the national themes for the NHS as health and care systems are subject to increasing demand and downward financial pressure and will be taken forward through the development of a two year cost improvement plan (CIP), commencing in 2018/19 and being fully functional by the end of 2019. The programme will ensure that patient care remains the ultimate priority and focus and will draw on national work and pathways work completed in KMPT in 2016/17 to develop streamlined clinical care pathways affording efficacy and efficiency to meet a range of diagnoses. The programme is working with local clinicians, people that use services and local stakeholders to ensure developments meet local need in line with locality planning within the Sustainability and Transformation Partnerships (STP).

3.1.2. The Care Pathway Delivery Programme is being formally rolled out during July 2018. The work will be supported by a new Programme Management Office (when fully in place) and will deliver the Trust's Clinical Strategy through clearly describing the care the CMHTs and Acute services will provide. This is a two year programme in terms of full implementation and some aspects are beginning to progress now, including: the Active Review Programme, the Personality Disorder Programme and the Initial Interventions Programme. KMPT's Chief Operating Officer is the executive sponsor for this work and presented initial outline plans at the Joint Commissioning for Mental Health meeting on 6 July 2018 with commissioners positively responding to the idea of clearly described clinical interventions.

3.1.3. As part of the Care Pathway Delivery Programme, KMPT is seeking to build more robust links with partners. Scoping meetings are starting to take place with third sector providers, such as Porchlight, Live It Well Kent and Healthwatch, to ensure thinking is joined up and together KMPT and its partners deliver whole pathways that reduce the current fragmentation. This work is welcomed and positively supported by the Mental Health Commissioning Group.

3.2 Single Point of Access service:

3.2.1 On 23 June 2018 the Single Point of Access service reduced its hours of operation. The service will continue to operate 7 days a week, 08.00 to 22.00 hours rather than 24 hours a day. People on a caseload will continue to access the Crisis Home Treatment service, as they currently do, out-of-hours. The Police will continue to be able to access 24 hour advice and guidance as is required under the Policing and Crime Act 2017.

3.2.2 In terms of the future for the Single Point of Access, KMPT is working with commissioners to develop a mental health component into NHS 111 and Urgent Care Centre services. This work is supported by the Care Pathways Delivery Programme and Mental Health work stream of the Kent STP.

3.3 Inpatient bed occupancy:

3.3.1 Bed occupancy has increased since Easter 2018, in line with the national picture, and consequently on-call and out-of-hours services have been busy. Despite these challenges KMPT has not had a single person requiring an acute inpatient admission admitted to a bed out-of-area. This is likely related to a number of interventions supporting transformation to day-to-day operations including a high functioning Patient Flow Team and medical staff working over the weekends and on the wards at times of peak activity such as Bank Holidays.

3.3.2 KMPT has generally been able to meet its acute inpatient bed occupancy standard of 94%, whilst operating on 6 reduced beds for some time as a result of ongoing estate refurbishment works. KMPT is commissioned to provide 174 beds (with only 173 beds available) and currently uses c152.5 beds.

3.3.3 KMPT is conscious one of its Older Adult Inpatient wards (Cranmer) at Canterbury is at the end of its estate life cycle and the environment needs significant improvement. KMPT is currently considering how these beds will be re-provided on the St Martin's site in Canterbury to ensure good quality care for people using services in fit for purpose facilities. Proposals, which will aim to reduce any unnecessary change for people using services, their carers are under development.

3.3.4 NHS England is requiring KMPT to review its use of out-of-area placements for people who require an Acute Inpatient service with a view to cease out-of-area placements by 2021. At this point in time KMPT has no person who needs an acute inpatient bed out of area other than women requiring Psychiatric Intensive Care (PIC). Currently KMPT cannot fully comply as there is no Kent and Medway female PIC unit. To fully meet these requirements, over the next year, KMPT will work proactively with commissioners to find solutions.

3.4 Psychiatric Liaison service:

3.4.1 Currently KMPT is being asked by Acute General Hospitals to provide 24/7 Psychiatric Liaison services. KMPT does not have the resources to provide this level of service however the STP signed up to the provision of Core 24 Psychiatric Liaison services in all Kent (and Medway) hospitals. The work to deliver this ambitious programme will be challenging; the development of the Urgent Care Pathways will provide a means to support implementation. The delivery of this programme will need to be fully supported by commissioning colleagues and key stakeholders.

3.4.2 Additionally KMPT is pro-actively seeking to find ways to work differently within existing resource to better support partners, for example better utilising its Crisis Resolution Home Treatment (CRHT) resource. A 'test of change' project is currently running around the provision of liaison psychiatry at the William Harvey Hospital.

3.5 Urgent Care Pathway: Aligned to the overarching Care Pathways Delivery Programme, work to develop clearly defined Urgent Care Pathways is in progress. There are a number of opportunities to test both preventative interventions, as in preventing hospital admission, and alternative crisis response. The initial work is in partnership with Medway Foundation NHS Trust with project support provided by the Clinical Commissioning Group (CCG).

3.6 Section 136:

3.6.1 A key area of concern for KMPT is the high number of recommendations made under Section 136 of the Mental Health Act (MHA). In April 2018, 164 people were subject to the use of Section 136 powers by the Police. This is an increase overall with data indicating an upward trend. Use of Section 136 is, on occasion, an appropriate intervention however its use is not always the best therapeutic intervention for people in mental distress. The Police, KMPT and other key organisations are committed to reduce its use, where appropriate, working together to find solutions ensuring a partnership response.

3.6.2 A number of initiatives are in place including joint mental health awareness training with Kent Police and an evaluation of the former Street Triage pilots across Kent (and Medway) with commissioners, the Police and Ambulance services in order to agree a future service model based on 7 days a week operation.

3.6.3 Further work on the multi-agency response to supporting frequent presenters in mental distress is also being prioritised.

3.7 Dementia service:

3.7.1 Older Adult Community services are working in partnership with CCG colleagues to improve the dementia diagnosis rate across Kent. Funding has been secured for a new, time limited initiative commencing in September 2018 focusing on care home diagnosis rates for West Kent.

3.7.2 KMPT has been invited to join the Dementia STP forum. The forum aims are to streamline and standardise processes across Kent (and Medway) and to encourage greater partnership working.

3.7.3 There are a number of opportunities to develop new posts including a Dementia Primary Care Nurse. Early scoping discussions are taking place in East Kent around the possible development of Primary Care Dementia Coordinators.

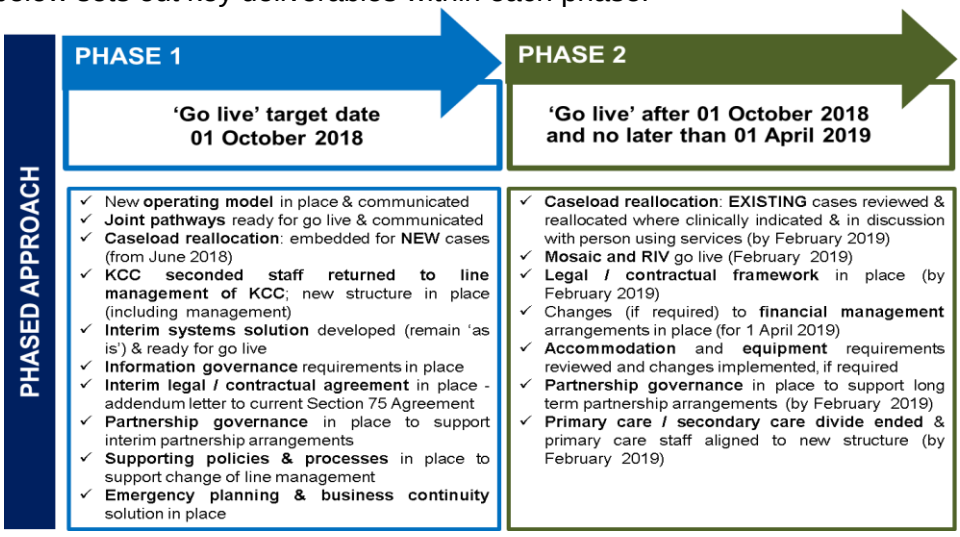
3.8 **Older Adult Community service:** Following an approach by West Kent CCG, KMPT's Older Adult Community service is piloting Kinesis - a secure web based solution that directly links general practitioners (GPs) to hospital specialists for rapid access to expert clinical advice. The tool enhances engagement and supports GPs in making the right decisions for "when and how to treat and when to refer" their patients. Enabling GPs to contact specialists via email provides a safer option for recording advice previously given over the telephone. It also enables improved monitoring of volume and nature of communications.

3.9 **Partnership Transformation Programme:**

3.9.1 In October 2017 the KCC / KMPT Partnership Board agreed, in principle, a new approach to the partnership which will ensure an integrated response within secondary care and the more robust delivery of both social care and health statutory responsibilities. A key element of this new approach will be to realign the management of seconded Adult Mental Health social work staff directly into KCC. This will move the day-to-day operational management of the KCC seconded staff in the CMHTs and Approved Mental Health Professionals (AMHP) service under the direct management of KCC. This is a significant change that will impact across the health and social care delivery functions of the CMHTs and will require the two organisations to ensure the shared vision to work in partnership remains intact.

3.9.2 KMPT and KCC have agreed a shared goal is for the new arrangement to commence by October 2018. To achieve this, a Partnership Transformation Programme was established in November 2018, led jointly by KCC's Corporate Director Adult Social Care and Health and KMPT's Director of Transformation and Partnership. A project management approach to delivering this work has been adopted and a number of workstreams established.

3.9.3 The programme is progressing to plan with engagement of clinicians and front line staff in developing future operational delivery models. A phased approach has been agreed for 'go live' in order to ensure safe and effective services are maintained including timely communications with key stakeholders. Phase 1 has a 'go live' target from 1 October 2018 with Phase 2 'go live' following after 1 October 2018 and no later than 1 April 2019. The diagram below sets out key deliverables within each phase.



4. New initiatives and opportunities

4.1 **Mother and Baby Mental Health:**

4.1.1 In April 2017 NHS England confirmed that KMPT had been successful with its bid to provide a new mother and baby mental health inpatient unit in the South East for patients from across Kent, Surrey and Sussex. The expansion in mother and baby unit capacity is part of

NHS England's work programme to improve the access and quality of perinatal mental health services across the country.

4.1.2 KMPT's existing Mother and Infant Mental Health service (MIMHs) already provides an excellent community service to mothers across Kent and Medway who need mental advice and treatment during pregnancy and up to one year after birth. However previously when admission to a specialist inpatient unit was needed, new mothers could face being placed in a unit up to 200 miles away from loved ones, or if no specialist bed was available to accommodate them with their new born, mother and baby would have to be separated.

4.1.3 The new specialist Mother and Baby Unit (MBU) will be located in Kent. The programme of work to develop the new facility and recruit to the multi-disciplinary team has progressed successfully and is on track for the new service to open during July 2018.

4.2 Recovery and Wellbeing Learning Community Partnership:

4.2.1 The Recovery and Wellbeing College will offer educational courses to support mental, physical and emotional wellbeing in shared learning environments in the community. It will support people to identify and build on their own strengths and make sense of their experiences. This helps people take control, feel hopeful and become experts in their own wellbeing and recovery. Whether you are experiencing health challenges yourself, are a family member, friend or carer, or work in associated services, the Recovery and Wellbeing College will be open to all. Recovery Colleges were introduced following a recommendation by Implementing Recovery through Organisational Change (ImROC) programme in 2010. There are over 83 colleges across the country and the economic evidence suggest that for every £1 invested over £16 of benefit is achieved for the health and social care economy.

4.2.2 Preparation for roll out of first Kent programme of the Recovery College courses commencing in September 2018, in Thanet, is progressing well. The whole course programme has been developed through extensive consultation with people who use services and key stakeholders. Sixteen co-facilitators with a mix of lived and learned expertise are now fully trained to co-design and co-deliver the educational courses between September 2018 and December 2018. All sessions follow a strengths based approach, supporting people to recognise their own strengths, develop skills and make best use of community resources. An evaluation team has been established to ensure the pilot is well evaluated and that qualitative, quantitative and cost benefit data are produced.

4.2.3 Work is progressing with a diverse range of external stakeholders to develop the Kent-wide cross-boundary Recovery and Wellbeing Partnership. This will widen the learning community provision across Kent, thus diffusing the innovation and creating resources which are transformative and sustainable.

5. Conclusion and Recommendation

5.1. The KCC HOSC is requested to note the content of this mental health update report.

APPENDIX A : KMPT ADULT CMHTs FOCUSSED INSPECTION ACTION PLAN – June 2018 v4

This action plan has been developed in order to urgently address patient safety issues identified during the unannounced CQC] focussed inspection conducted on 22-24 January 2018 at three adult CMHTs (Canterbury and Costal [C&C], Medway, & South Kent Coast [SKC]). Improvement will be monitored & tracked at a fortnightly meeting to be chaired by the Executive Director of Nursing & Quality which includes operational colleagues involved in the delivery of the plan. Onward reporting consists of the Executive Assurance Committee, Quality Committee & to the Board. The action plan now includes all of the Enforcement Actions following the report publication.

Improvement plan owner:	Chief Operating Officer (COO)
Implementation monitoring:	CQC Oversight Group / Care Group Senior Management Team (SMT)
Executive approval:	Executive Assurance Committee (EAC)
Executive sponsor:	Executive Director of Nursing and Quality
Reporting to:	Quality Committee and Trust Board

RAG KEY:	
Purple	**Embedded**
Green	**Complete**
Amber	**In progress**
Red	**Overdue**
Requirements:	
Must do	
Should do	
Further improvement / supportive actions	

STAFF KEY:

AMD	Assistant Medical Director	EDoN	Executive Director of Nursing & Quality	HRBP	Human Resources Business Partners
COO	Chief Operating Officer	ER Manager	Employee Relations Manager	MD	Executive Medical Director
DCOO	Deputy Chief Operating Officer	HoN	Head of Nursing	QM	Quality Manager
DoF	Executive Director of Finance	HoS	Head of Service	DWOD	Director of Workforce and Organisational Development

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
1. SAFE CARE AND TREATMENT Regulation 12 (HSCA 2008)						
	1.1 The Trust must ensure that staff assess the risks to patients' health & safety or respond appropriately to meet people's individual needs to ensure their welfare & safety during any care or treatment.	1. Develop & deliver clinical risk assessment & management training to all 9 younger adult CMHTs 2. Ensure all patients receiving care coordination have a valid risk assessment in place & that this is reviewed & updated as & when risks change.	**HoN CRCG**	1. End July 18 2. Ongoing	1. Attendance sheets 2. Performance reports / CliQ checks	1. Training dates in the diary – to be fully delivered by 03/07/18 2. CliQ checks in place - 2 weekly reporting to monthly Quality Care Group meeting 3. Weekly performance report to all managers demonstrating compliance 4. Compliance monitored through Care Group Performance meeting & Integrated Quality & Performance Review (IQPR) chaired by Executive
	1.2 The Trust must ensure that staff provide safe care & treatment to patients' receiving, or awaiting to receive, a service from the adult community mental health teams.	1. Develop an Active Review programme Standard Operating Procedure (SOP) 2. Roll out Active Review methodology to all teams with a current waiting list 3. All patients on care coordinator case loads should have a relevant & up to date care plan 4. All people waiting for psychological therapies to be transferred to psychological therapies colleagues caseload 5. Administrative staff to ensure all patients waiting for a service receive a waiting list letter / Keep Safe plan 6. Administrators to audit 20 case files a month of people waiting to ensure: □ People receive the waiting list letter □ Receive a Keep Safe plan □ Have been reviewed at 28 days & 56 days wait (part of Active Review programme) 7. All persons waiting 56 days to be reviewed & allocated 8. Review & action any did not attends (DNAs) at Red Board meetings 9. Audit adherence to DNA policy	**COO supported by DCOO, HoS, HoN & Director of Therapies**	5. 31/07/18	1. Case loads transferred to therapies staff 2. Audit results 3. Performance reports 4. Audit results 5. SOP	1. 2. 3. 4. Psychological therapies services have clearly defined wait lists for therapies proactively managed 5. Teams instructed to action waiting list letter & review process. To be audited in June 18 & July 18 to evidence safe plan 6. Waiting list project group reviewing this data in June 18. 7. Adherence to the DNA policy to be audited by Quality Managers across June 18 and July 18. 8. SOP for Active Review in place & rolled out in SKC & Medway end of July 18. Active review in place as necessary in psychological therapies teams

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	1.2 The Trust must ensure that staff provide safe care & treatment to patients' receiving, or awaiting to receive, a service from the adult community mental health teams.	10. Develop an Active Review programme Standard Operating Procedure (SOP) 11. Roll out Active Review methodology to all teams with a current waiting list 12. All patients on care coordinator case loads should have a relevant & up to date care plan 13. All people waiting for psychological therapies to be transferred to psychological therapies colleagues caseload 14. Administrative staff to ensure all patients waiting for a service receive a waiting list letter / Keep Safe plan 15. Administrators to audit 20 case files a month of people waiting to ensure: □ People receive the waiting list letter □ Receive a Keep Safe plan □ Have been reviewed at 28 days & 56 days wait (part of Active Review programme) 16. All persons waiting 56 days to be reviewed & allocated 17. Review & action any did not attends (DNAs) at Red Board meetings 18. Audit adherence to DNA policy	**COO supported by DCOO, HoS, HoN & Director of Therapies**	6. 31/07/18	6. Case loads transferred to therapies staff 7. Audit results 8. Performance reports 9. Audit results 10. SOP	9. 10. 11. 12. Psychological therapies services have clearly defined wait lists for therapies proactively managed 13. Teams instructed to action waiting list letter & review process. To be audited in June 18 & July 18 to evidence safe plan 14. Waiting list project group reviewing this data in June 18. 15. Adherence to the DNA policy to be audited by Quality Managers across June 18 and July 18. 16. SOP for Active Review in place & rolled out in SKC & Medway end of July 18. Active review in place as necessary in psychological therapies teams

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	1.3 The Trust must have systems in place to ensure patients are aware of any changes in their care provision & alternative plans that have been put in place to ensure their safety. This would include long or short term change of care coordinator & discharge to primary care.	**Handover of care** 1. Embed the CMHT SOP for use in the follow up of patients in case of staff planned & unplanned absence known as 'handover of care' process. 2. Audit a sample of letters to patients, indicating where changes to care coordinators have been made. 3. Continue to grant CMHT new administrators rights to input to electronic records at the request of the clinician. All RiO entries to be validated by the clinician to confirm that they have checked the record.	**DCOO**	1. Completed 2. & 3 Ongoing	1. Daily planning meeting actions points 2. List of administrators granted rights	1. DGS model known as "handover of care" across the teams was rolled out to service managers on 19 February 18. This is now embedded in all teams. The procedure has been added to the 'a day in the life of CMHTs' guidance disseminated to all teams & to the CMHT Operational policy that is currently being reviewed. An audit of compliance with take place in June 18. 2. 3. Administration can now document in RiO, with clinicians being responsible for validated entries (agreed at Trust-wide Patient Safety and Mortality Review Group).
		Communication with general practitioners (GPs) 1. Revise the CMHT Operational policy to clarify access criteria to CMHT & good discharge processes 2. Continue communication to GPs through Local Medical Committee (LMC) & Clinical Commissioning Groups (CCGs) including briefings on progress with Choice and Partnership Approach (CaPA) implementation 3. All staff to use standardised letters to GPs on discharge & following assessments signed by assessing clinician. Where a patient is not accepted for ongoing care by CMHT, a letter must be sent to GP, clearly indicating reasons for not accepting a patient on CMHT caseload & signpost to services where patient might be able to get help & support	**COO, MD & Director Communications**	1. 31/07/18 2. Ongoing 3. Ongoing	1. Flowchart / checklist for CMHT criteria 2. Briefing sessions, dates & attendees 3. Audit of letters	1. The CMHT Operational policy has been revised to include some of the process changes that have occurred & reference to CaPA implementation. This has been updated with ratification by end of June 18. 2. Communication & briefings continue via the local medical committee & via CCGs. Discussion to be had with the communications team regarding the production of a formalised briefing. 3. An audit to ensure that they are being used consistently will be conducted in June 18 to check that the process is embedded in practice.
2. GOOD GOVERNANCE Regulation 17 (HSCA 2008)						

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	2.1 The Trust must have effective audit & governance systems & / or processes in place that ensure care & treatment is provided in line with their policies.	**Policies** 1. Ensure compliance audits are conducted against key policies to include DNA policy & Transfer Discharge policy & results reported through relevant Trust-wide group & committee 2. Ratify & implement updated CMHT Operational policy 3. A named administration manager to review all audits in place to ensure fit for purpose & assure / provide evidence against policy compliance 4. Check the quality of clinical documentation via CliQ checks	**DCOO, AMD & HoS**	1-4. 30/07/18	1. Audit results 2. CMHT operational policy 3. Report 4. CliQ checks	1. Compliance is audited within each team. Audits of DNA activity & transfer activity are scheduled for end of June 18. 2. Draft policy has been reviewed, final amendments, due for ratification end of June 2018. 3. CliQ checks are conducted every 2 weeks.
		Audit / performance 1. Revise the available performance data to ensure it is fit for purpose. 2. To ensure performance data distinguishes those persons on active caseload & those persons waiting for services 3. To ensure data provides greater detail on waiting lists (what people are waiting for) 4. Ensure data can pull out people on depot clinic caseloads, on doctor only caseloads seen in outpatient department, out of area caseloads & in other alternative care	**Director of Contracting supported by DoF, COO, Head of Performance & Head of RiO**	1-4. 09/07/18	Improved data set available to team level	

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
3. Operations						
	3.1 The Trust should ensure that staff follow consistent criteria for deciding whether a patient requires care coordination following initial assessment.	1. QMs to lead on audit to demonstrate a consistent approach to management of caseloads through daily & weekly team meetings 2. Develop a brief summary guide for Care Programme Approach (CPA) which will be shared with all CMHT staff. CliQ checks to incorporate a review of CPA.	**DCOO supported by QMs** **HoN, QMs**	1. 31/08/18 2. 31/07/18	1. Report to be provided by QMs 2. CPA brief guide & CliQ checks	1. DCOO has instructed QM to commence audit with a report due August 18. 2. To be developed & implemented.
	3.2 The Trust should ensure that staff follow up clients who did not attend appointments appropriately	1. Audit compliance with DNA policy. 2. Performance team to routinely provide data on patients attending Depot Clinics & to audit attendance & follow up against DNA policy. 3. Develop & implement a Depot Clinic SOP.	**DCOO supported by HoS, QMs & Performance Team**	1. 31/07/18 2. Ongoing 3. 31/07/18	1. Audit results 2. Data set identifying people attending depot clinics 3. Depot Clinic SOP	1. Audits of DNA activity are scheduled for June 18.
	3.3 Ensure consistency in practice across of CMHTs	1. Implement & embed all SOPs included in the 'day in the life of CMHT' pack. 2. Audit compliance against the SOPs within the above.		1. 31/07/18 2. 31/08/18	1-2. Audit results & performance reports	1. To be monitored at weekly meeting with service managers & at Care Group Governance meetings.
4. Workforce						
	Overarching workforce actions to meet the should do's in 4.1, 4.2 and 4.3 below:	1. HRBP to complete a monthly workforce dashboard to include information regarding 4.1, 4.2 & 4.3 2. DWOD to continue to develop relevant policies to support positive recruitment & retention processes	**CRCG HRPB with support from DWOD**	1-2. 31/07/18 & ongoing	1-2. IQPR Report	1. Review at weekly Care Group SMT meeting & review at July 18 Care Group Quality Performance Review meeting 2. The Human Resource Dashboard has been improved to include appraisals & supervision compliance & is updated on a monthly basis & taken to the Care Group Performance meeting on the 1st Friday of the month & to the Human Resource Clinics that are held with the service managers for monitoring.

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	4.1 The Trust should ensure that sufficient numbers of permanent staff are recruited & retained to enable the CMHTs to operate effectively.	1. Recruit substantively to the CRHT HoS post for East Kent 2. Recruit substantively to CMHT service manager posts in line with cost improvement programme (CIP). 3. Continue with centralised nursing recruitment	**COO**	1. 31/07/18 2. 31/07/18 3. 31/08/18	Both posts are recruited to & start dates confirmed.	1. Agreed at EAC to recruit to HoS post 2. Agreed with DCOO to progress with SKC and Medway service manager recruitment by end of June 18.
	4.2 The Trust should ensure that staff meet the Trust's target for completion of their mandatory training courses.	1. Monitor mandatory training compliance at monthly Care Group / Trust-wide Quality and Performance Review meetings and Workforce and Organisational Development Committee.	**HoS CRCG & DWOD**	1. Ongoing	1. 85% compliance target completed for all mandatory training courses	All training reviewed at monthly IQPR meetings – currently the Care Group has achieved 88% compliance rate for mandatory training with 2 teams outstanding, discussions have taken place with Learning & Development Team regarding the outstanding elements & they are currently working with the teams to provide additional sessions to improve the compliance levels.
	4.3 The Trust should ensure that all have regular access to supervision & that these sessions are recorded & stored appropriately.	**Staff supervision** 1. All staff to schedule management supervision 4-6 weekly on a quarterly basis 2. All CMHTs to display supervision tree & supervision monitoring form in staff team areas 3. Monitor management supervision uptake on monthly basis & report performance to HRBPs 4. All CMHT clinical staff to complete a case file audit as part of supervision 5. Each CMHT to keep a log of group / reflective supervision or case discussions dates & attendees & case discussed 6. Audit a random sample of the quality of supervision notes & actions	**DCOO, H0S, QMs, Service Managers & HRBP**	1. Completed & ongoing 2-7. Ongoing	1. Booked supervision dates 2. Audit of supervision tree on display 3. Supervision uptake reports 4. Audit reports 5. Supervision log, dates & attendees 6. Audit report	Supervision trees are in place for each team & dates have been scheduled for the whole year. Supervision uptake is being monitored & an improvement seen from 37% in January 18 to 78% end of April 18 .

RAG	ISSUE IDENTIFIED	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		Supervision policy & process 1. Relaunch revised Supervision policy 2. Develop an electronic supervision recording system which includes an escalation process 3. Identification of managers requiring additional support in their roles	**ER Manager, Head of Workforce Information & HRBP**	1. Ongoing 2. 31/08/18 3. 30/06/18 ongoing	1. Revised supervision policy in place with supporting managers guides 2. Electronic supervision 3. Training course attendance / records of support offered	The electronic system is moving forward, this will enable managers to directly report their supervisions at the time they are completed & a report can then be generated. In the meantime, teams update an agreed Trust template spreadsheet, if any teams are either low or do not submit any returns then this is picked up by the HRBP who escalates to the HoS for the area Monitoring & oversight is at Care Group and Trust IQPR . A new Human Resource Dashboard has been devised & supervision completion rates form part of the key performance indicators. Human Resource Clinics with service managers as a way of supporting recruitment processes & those staff. 3 service managers are exploring NHS Leadership Coach / Mentor courses.
5. Additional areas for improvement						
	5.1 Staff development	1. Develop an outline Practice Improvement programme plan based on cultural audit 2. Develop a middle management leadership course (including developing capable teams, 'PIP') 3. Conduct a gap analysis for middle management course (band 7 and all 8s = 599 staff) 4. Deliver middle management course (prioritised) 5. Review need for external support or intervention to deliver practice improvement programme.	**DWOD, COO, EDoN**	1. Ongoing 2. Ongoing 3. Ongoing 4. 30/04/19 5. Ongoing	1-2. Improvement programme 2. Gap analysis 3. Programme outline & attendees 4. Recommendation from review	1-4. Met with Enable East to look at the Developing Capable Teams programme & also researching work that Wrightington & Wigan Trust has done on improving teams. DWOD & COO are meeting w/c 18 June 18 to discuss & agree away forward.
	5.2 Culture	1. Explore external support to undertake a cultural audit & make recommendations for improvement	**DWOD**	1. End June 18	Audit report	Specification for creating a just learning culture has been finalised & is with procurement to send out to 4 organisations. An organisation will then be selected to work with & the work plan will be formalised. This also links to 5.1 above.

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Item 10: East Kent Out of Hours GP Services and NHS 111 (Written Update)

By: Lizzy Adam, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 20 July 2018

Subject: East Kent Out of Hours GP Services and NHS 111 (Written Update)

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

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

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

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1. Introduction

(a) On 27 April the Committee considered an update about the out of hour bases provided by IC24 and East Kent CCGs. The Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the report on the East Kent Out of Hours GP Services and NHS 111 be noted;

  (b) the Committee receive an update from East Kent CCGs following the urgent and out of hours workshop.

2. Recommendation

RECOMMENDED that the written update on the East Kent Out of Hours GP Services and NHS 111 be noted.

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (27/04/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7846&Ver=4

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Health Overview and Scrutiny Committee Briefing

East Kent NHS 111 and GP out of hour's services

July 2018

Author: Sue Luff, Head of Contracts

Sponsor: Caroline Selkirk – Managing Director East Kent

Background

Integrated Care 24 Limited (IC24) took over the provision of the Integrated 111 and Out of Hours Service (OOH) on 1st December 2017. This was as a result of the previous provider exercising its right to serve an accelerated notice period.

IC24 is a not-for-profit social enterprise and has more than 25 years' experience providing healthcare services, including GP OOH care and NHS 111 services across the east and south of England.

The mobilisation period of the contract was reduced due to the circumstances therefore the original Out of Hours bases provided by the previous provider were not utilised.

The Clinical Commissioning Groups within east Kent were challenged by HOSC to open all bases.

The table below documents the bases which did not open at the start of the contract in December 2017.

Base	Weekday Opening Mon-Fri	Weekend Opening Sat-Sun	Bank Holiday Opening	Grade of staff delivering service
Canterbury and Coastal – Herne Bay QVMH	None	08:00 – 18:00 Sat 09:00 – 18:00 Sun	09:00 – 18:00	GP
Deal	None	09:00 – 14:00 Sat and Sun	09:00 – 14:00	GP
Romney Marsh	None	09:00 – 16:00 Sat and Sun	None	Nurse Practitioner

Current situation

Following the last update to the HOSC where the committee was assured that there would be OOH presence in all localities, the CCG has worked with the provider to support the ability to provide access to the bases across east Kent.

The following bases are now operational:

- William Harvey Hospital - Ashford
- Kent & Canterbury Hospital – Canterbury
- Queen Elizabeth the Queen Mother Hospital – Margate
- Queen Victoria Memorial Hospital - Herne bay
- Buckland Hospital - Dover
- Royal Folkestone Victoria

It has not been possible at this at this stage to open the Romney Marsh and Deal bases. This is primarily due to lack of available GPs to ensure there is consistent and robust cover across all areas.

A workshop was held on 27th June at which all localities and providers were represented. The aim of the workshop was to:

- Identify the number of services across the localities where GP involvement is required.
- Identify the key challenges in each locality with delivery of integrated OOH
- Identify key actions required to ensure that patients have equity of access across all localities

A mapping exercise demonstrates that across east Kent there are over 50 services where GPs are required to support delivery. These include:

- 50 GP practices delivering extended hours with 11 practices delivering at weekends
- Localities based local care hubs
- GP streaming within the acute sites with GP streaming
- There is one Urgent Treatment Centre
- The Out of Hours Service delivered by IC24

The result of the development of the various models is that:

- Delivery is fragmented across different services
- GPs are unable to support every element of service delivery
- Services are not integrated leading to duplication
- Pathway delivery is not consistent

It was agreed that there needs to be an integrated approach to the delivery of the various services to ensure that delivery is consistent, safe and equitable. In addition, it will support providers to work in unison to deliver the required elements from all of the existing services, thereby ensuring that the GP workforce can be utilised effectively across all required areas of delivery.

The locality leads therefore agreed that further review is required at locality level and will support development through locality based meetings.

These will include representation from the patient participation groups within the localities. In the interim IC24 will continue to deliver services from the following bases:

- Buckland Hospital Dover
- Royal Victoria Folkestone Hospital
- William Harvey Hospital - Ashford
- Queen Elizabeth the Queen Mother Hospital – Thanet
- Kent and Canterbury Hospital
- Queen Victoria Memorial Hospital – Herne Bay will be supported by the Integrated Care Service
- Patients in Deal and New Romney will be supported through the home visiting service from IC24 and the locality GP led hubs

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