HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 23rd November, 2018

10.00 am

Council Chamber - Sessions House, Maidstone, Kent, ME14 1XQ

Kent County Council
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AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 23rd November, 2018, at 10.00 am
Council Chamber - Sessions House

Ask for: **Jill Kennedy-Smith**
Telephone: **03000 416343**

Tea/coffee will be available 15 minutes before the start of the meeting

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 P W A Lake, 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

Webcasting Notice

Please note: this meeting may be filmed for the live or subsequent broadcast via the Council's internet site or by any member of the public or press present. The Chair will confirm if all or part of the meeting is to be filmed by the Council.

By entering into this room you are consenting to being filmed. If you do not wish to have your image captured please let the Clerk know immediately.

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

   Members are asked to approve the minutes of the following meetings as a correct record:

   - 20 July 2018
   - 13 September 2018
   - 21 September 2018

4. Kent and Medway Strategic Commissioner (Pages 31 - 36) 10:05

5. NHS North Kent CCG: Financial Recovery Plan (Pages 37 - 56) 10:45

6. Dartford and Gravesham NHS Trust: Update (Pages 57 - 86) 11:15

7. South East Coast Ambulance Service NHS Foundation Trust (SECAmb): Update (Pages 87 - 98) 12:00

8. CCGs Annual Assessment 2017/18 (Written Update) (Pages 99 - 114) 12:30

BREAK

9. NHS West Kent CCG: Financial Sustainability (Pages 115 - 128) 13:30

10. Kent and Medway Integrated Urgent Care Service Procurement (Pages 129 - 136) 14:00

11. Kent and Medway Non-Emergency Patient Transport Service Performance (Pages 137 - 150) 14:30

12. Healthwatch Kent: Annual Report (Pages 151 - 164) 15:00

13. Future Meeting Dates

    Please note the dates and time of the Health Overview and Scrutiny Committee for 2019/20. All meetings will begin at 10am and will be held in the Council Chamber.

    Friday 25 January 2019 *(previously agreed)*
    Friday 1 March 2019 *(previously agreed)*
    Friday 26 April 2019 *(previously agreed)*

    Thursday 6 June 2019
    Tuesday 23 July 2019
    Thursday 19 September 2019
    Tuesday 26 November 2019

    Wednesday 29 January 2020
    Thursday 5 March 2020
    Wednesday 29 April 2020

14. Date of next programmed meeting – Friday 25 January 2019

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

15 November 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.

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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 on Friday, 20 July 2018.

PRESENT: Mrs S Chandler (Chair), Mr P Bartlett (Vice-Chairman), Mr N J D Chard, Mr N J Collor, Ms K Constantine, Mr D S Daley, Mrs L Game, Ms S Hamilton and Mr I Thomas

ALSO PRESENT: Mr S Inett

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

UNRESTRICTED ITEMS

63. 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) Ms Constantine declared an interest, in relation to her work with the Managers in Partnership which ends in August. She confirmed that she was not undertaking work in Kent.

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

(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. Mr Thomas declared a further interest in relation to the EKHUFT's mobile chemotherapy unit which had been funded by Hope for Tomorrow, a Freemasons' charity, which he had contributed too.

64. Minutes - 27 April 2018
(Item 3)

(1) RESOLVED that the Minutes of the meeting held on 27 April 2018 are correctly recorded and that they be signed by the Chair.

65. Minutes - 8 June 2018
(Item 4)

(1) RESOLVED that the Minutes of the meeting held on 8 June 2018 are correctly recorded and that they be signed by the Chair.

66. Transforming Health and Care in East Kent
(Item 5)

Louise Dineley (East Kent Programme Director, Kent & Medway STP), Liz Shutler (Deputy Chief Executive & Director of Strategic Development and Capital Planning, East Kent Hospitals University NHS Foundation Trust), Michael Ridgwell (Programme Director, Kent and Medway STP), Matt Jones (Consultant Anaesthetist, East Kent Hospitals), Upaasna Garharran (Consultant Geriatrician and Acting Medical Director for Urgent Care, East Kent Hospitals) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Ridgwell briefly introduced the paper and summarised progress to date. He reported that NHS England had updated the assurance process that applied to reconfiguration programmes involving changes to bed numbers and schemes requiring capital investment; capital sources needed to be identified before public consultation to ensure that they were implementable.

(2) He stated that the first draft of the pre-consultation business case is due to be presented to NHS England in October and November which will, once signed off, proceed to consultation. Senior colleagues from NHS England have visited to see the challenges being faced in East Kent.

(3) Mr Ridgwell informed the Committee, that a further report will be presented on patient in-flows to East Kent. He noted that whilst services in East Kent largely supported the East Kent population; for some residents in East Sussex, their main hospital services were provided in East Kent in addition to more specialist services, such as coronary care, which were provided to the wider population. He noted that a Joint HOSC with neighbouring authorities may be required. The Chair welcomed a discussion on this as soon as possible.

(4) A Member enquired about the establishment and membership of a Joint HOSC, engagement with community and voluntary groups and a major trauma centre. The Chair confirmed that the creation of a new committee was a decision for the local authorities involved and the power to make a referral to the Secretary of State would remain with the Kent HOSC.

(5) Mr Ridgwell welcomed the opportunity to discuss engagement with community and voluntary sectors outside of the meeting. He noted the importance of the sector particularly in supporting local care. Dr Jones explained that the major Trauma Centre for Kent was King's College Hospital and there were no plans for a Major Trauma Centre in East Kent as it would not meet the national designation criteria set by NHS England.

(6) A Member asked about the financial position, public consultation and implication on KCC's budget. Mr Ridgwell noted that a planning submission has been made to NHS England which outlined the costs of the East Kent reconfiguration;

all forms of capital opportunities were being explored. He stated that the NHS England assurance process would determine the start of public consultation. He anticipated that the delivery of local care, through the integration of and investment in health and social care, would have a cost implication to KCC.

(7) In response to specific question about PFI, Mr Ridgwell stated that whilst there was preference for public capital, main objective was for better care which required better estate.

(8) A Member expressed concerns about the length of the process and local care. Mr Ridgwell noted the importance of the process reaching of a conclusion and the delivery of local care as close to where patients live. He highlighted the ability of Encompass Vanguard in Whitstable to attract workforce; staff were attracted to the provision of modern services in modern facilities.

(9) Dr Garharran concurred stating that she has been a Geriatrician for 6 years and had seen a lot of progress in that time with access now being available in the community with functioning care pathways. She added that there was enthusiasm to deliver service models akin to those at Encompass more widely.

(10) In relation to questions on the scale of GP federations and accessibility, Ms Shutler informed the committee that it was inaccurate to assume that GPs would be in a single building, but rather that practices would be placed for easy accessibility, making sure that practices were fit for purpose, giving Whitstable as an example. Dr Garharran said that she has been talking to GPs and providers whilst looking at social mobility, identifying patients that need to access services in a different way through risk stratification. To reassure the committee Ms Garharran confirmed that this was high on everyone's agenda.

(11) There was a discussion around ensuring that the final options that went to public consultation would be deliverable and NHS representatives explained that there were a series of assurance processes to look at this, particularly more complex options such as Option 2 which has more elements to it. This was underpinned by the new NHS England assurance process outlined earlier in the meeting.

(12) A Member asked that reassurance was given to the public on the continuation of the GP-patient relationship as primary care hubs develop. NHS representatives explained that, depending on patients conditions, the planned developments would enable GPs and senior clinicians to have the named relationship that complex condition patients require and deliver a more appropriate service.

(13) The Chair welcomed the engagement of primary care in the services as described in the paper and noted GPs appeared to be positive about the changes that are going to be made. She welcomed the clinicians presenting to the committee as they had made a difference to the discussions.

(14) RESOLVED that:

(a) the report on Transforming Health and Care in East Kent be noted;

(b) East Kent CCGs be requested to provide an update in September, with the risks articulated on finance and timetables specifically addressed in the update;

(c) A report detailing the patient inflow to East Kent to be presented to the Committee in September.

67. East Kent Hospitals NHS University Foundation Trust: Update
(Item 6)

Louise Dineley (East Kent Programme Director, Kent & Medway STP), Liz Shutler (Deputy Chief Executive & Director of Strategic Development and Capital Planning, East Kent Hospitals University NHS Foundation Trust), Michael Ridgwell (Programme Director, Kent and Medway STP), Matt Jones (Consultant Anaesthetist, East Kent Hospitals), Upaasna Garharran (Consultant Geriatrician and Acting Medical Director for Urgent Care, East Kent Hospitals) were in attendance for this item.

(1) The Committee welcomed the viewing of the newly released NHS national nursing recruitment campaign filmed locally and showcasing local staff.

(2) Ms Shutler presented the paper and informed the committee that preparations were underway for winter planning to ensure that the difficult winter would not be experienced again. Investment was being made in models of care, ambulatory care, investment in beds, extending and increasing resuscitations in A & E and work to improve waiting times.

(3) Members enquired about funding for the Dementia Village.

(4) Ms Shutler reported that the funding had already been approved and that there was no risk to that. It was an exciting project and would aid discharge through a different way of working. It was based on a European model and they visited an example in Holland. The proposed scheme was smaller in scale than some sites elsewhere in the country, but the aim was for it to be a long-term home, as well as offering respite services. The facilities will use existing buildings at the back of Buckland Hospital, Dover.

(5) Members welcomed the news that a local nursery could potentially be on site as evidence had shown that there was a healing and calming effect on the mixing of ages was beneficial and that this should be encouraged across Kent.

(6) A Member enquired about the impact of personnel changes, the CQC news on reviewing scans in radiology and the potential for exploring the Dutch ambulance model for stroke provision, currently available in Essex. In relation to the personnel changes question Ms Garharran confirmed that the Clinical Decision Unit Lead Consultant was not moving and that the evening out of numbers across William Harvey and the Queen Elizabeth the Queen Mother Hospital was completed successfully without moving substantive staff. Concerning the CQC news article Ms Shutler informed the committee that two issues were being confused, the issue in question is in relation to a picture archiving and communication systems and the radiology information system and that there was an issue across Kent and Medway with the information system. The backlog has been caught up on very quickly and any backlog was within normal parameters. Ms Shutler reassured the committee that there had been no patient harm arising from any delayed reporting of scans. Mr Ridgwell said that the pilot in Essex was part of the national stroke programme and was being reviewed by the Kent and Medway Clinical Reference Group for stroke.

(7) A Member asked about Ophthalmology providers in Dover and the progress on Tier 2 services in Canterbury and Dover. Mr Ridgwell committed to provide an update to the committee. The Chair expressed disappointment that Ms Selkirk had sent apologies and was not in attendance to answer such questions.

(8) A Member enquired about the financial position. Ms Shutler stated that the Trust's failure to meet the A & E target had resulted in it being unable to access Sustainability and Transformation Fund monies which in turn had made the underlying deficit position more challenging. She explained that in order to sustain the workforce across three sites, required to deliver the current services, there was a need to use agency and locum staff who were expensive. Mr Ridgwell explained that NHS organisation across Kent and Medway were looking to approach this problem collectively to avoid cost escalation.

(9) RESOLVED that:

(a) the report on East Kent Hospitals NHS University Foundation Trust be noted;

(b) the committee welcomes the progress on the Dementia Village;

(c) a written update be requested on the progress of the Ophthalmology Tier 2 Service in Canterbury and Dover, including the impact of follow up appointments;

(d) be invited to provide an update in January 2019.

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

Louise Dineley (East Kent Programme Director, Kent & Medway STP), Liz Shutler (Deputy Chief Executive & Director of Strategic Development and Capital Planning, East Kent Hospitals University NHS Foundation Trust), Michael Ridgwell (Programme Director, Kent and Medway STP), Matt Jones (Consultant Anaesthetist, East Kent Hospitals), Upaasna Garharran (Consultant Geriatrician and Acting Medical Director for Urgent Care, East Kent Hospitals) were in attendance for this item.

(1) Ms Shutler introduced the item and stated that this proposal formed a critical part of winter planning in terms of getting the right number of emergency medical beds on sites and to be able to continue to operate and offer elective orthopaedic services. The Getting It Right First Time (GIRFT) programme was an important programme of driving quality across the country and as a way of challenging clinicians to focus on the clinical quality of care offered by benchmarking surgical specialities. Professor Briggs was the national lead and was keen to build up an evidence base and challenged the Trust to take part in a pilot in light of its experiences over the last winter. An early pilot in Gloucester has shown improvements in trauma.

(2) Members welcomed the report and enquired about staffing. Mr Jones said that this was about relocating existing services with a small amount of recruitment potentially required; Ms Garharran explained that the pilot had been driven by staff. Ms Shutler informed the committee that overall it would bring better wellbeing to staff; consultation would take place with staff, with other opportunities available if the relocation was not suitable and their usual employment rights would be covered.

(3) A Member enquired about the planning and financial process. Ms Shutler stated that the pilot was subject to the normal planning process and the Trust had had pre-emptive discussions with Canterbury City Council. Emergency capital funding had been applied for, with a business case submitted. A bid for Wave 4 Sustainability and Transformation Partnership (STP) funding had also been submitted. The outcome of this was awaited but consideration for bridging in the interim was also being looked at but that could potentially impact existing capital allocation and slow down other programmes.

(4) The Chair enquired about timelines for funding bids to which Mr Ridgwell replied that the STP Capital bidding process was not due to take place until the end of the year, but they were exploring expediting this process.

(5) RESOLVED that:

(a) the committee note the report on the Getting It Right First Time (GIRFT) Orthopaedics Pilot.

(b) East Kent Hospitals University NHS Foundation Trust provide an update about the pilot as part of their general update in January 2019.

69. Wheelchair Services in Kent
(Item 8)

Ailsa Ogilvie (Chief Operating Officer, Thanet CCG), Professor Mike Oliver (Representative of the Kent Physical Disability Forum) and Adrian Halse (Thanet CCG) were in attendance for this item.

(1) The Chair introduced the item by explaining that Healthwatch had made a request for the item to be looked at and welcomed Steve Inett and Professor Mike Oliver to the Committee.

(2) Mr Inett explained that Healthwatch supported the Kent Physical Disability Forum, who had been proactive in raising concerns with Millbrook Healthcare, the current provider, and the CCG. The forum had collected feedback from its members on the issues being raised; a summary of those concerns was presented in the report.

(3) Professor Oliver informed the Committee that he had used wheelchair services for 56 years and had a personal and professional connection with the service. He expressed significant concerns about the current service and outlined engagement between service users, the CCG and Millbrook. He stated that he did not accept the proposal for the CCG to continue working with Millbrook to resolve the problems. He noted that the forum had invited the CCG to come back in early August; the forum was also considering writing an open letter to CCG Clinical Chairs to express their view that the contract should not be continued.

(4) The Chair invited the CCG to respond. Ms Ogilvie apologised to service users and welcomed the support of Healthwatch and the continued opportunity to work with the forum. She reported that the CCG and Millbrook had agreed additional funding to clear the backlog; discussions regarding additional investment from the eight Kent & Medway CCGs were being held. She noted that the audit had been undertaken to understand the extent of the backlog. Millbrook had been asked to develop an improvement plan to deal with the backlog at pace; the availability of additional staffing had been identified as a potential risk. Millbrook had also been asked to present improved data, to distinguish between the inherited and new backlog, to the CCG. She stated that further assurance was being sought from Millbrook about complaints, risk assessments and prioritising patients with the highest needs; a quality visit had found that patients were not being harmed as a result of their wait. Ms Ogilive highlighted that she was taking personal responsibility to get the contract back on track.

(5) Members expressed concerns about service user experience; the procurement of the contract and performance monitoring. The Chair enquired if terminating the contract had been considered. Ms Ogilvie stated that it had not been considered. She explained that the backlog was not known at the time of awarding the contract and since the contract began, there had been

significant requests for powered chairs that had exceeded procurement expectations. She confirmed that a further clinical audit, to understand the categorisation of referrals, would take place in August. In response to a specific question about wheelchair fitting, Ms Ogilvie stated that a full clinical assessment by a clinician took place to determine what equipment was required.

(6) RESOLVED that the Committee:

(a) expresses grave concerns about the wheelchair services contract and its management by NHS Thanet CCG.

(b) writes to all Kent CCGs to express its concerns about the wheelchair services contract and its management by NHS Thanet CCG.

(c) requests that NHS Thanet CCG provide a written response to the Committee, within two weeks, as to whether it is considering terminating Millbrook Healthcare's contract and the reasons for that choice; and to provide an action plan detailing how the issues will be resolved in the interim.

(d) upon receipt of the written briefing, determines whether to have an additional meeting of the Committee or to have an item at the September meeting of the Committee.

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

Vincent Badu (Director of Transformation, Kent and Medway NHS and Social Care Partnership Trust) was in attendance for this item.

(1) Mr Badu began by stating that the report focussed specifically on the work that the Trust is undertaking to improve the quality of the community mental health teams for younger adults and general activities taking place across the Trust. Mr Badu wished to acknowledge the Trust's commitment to providing better services for the community in mental health services. Services overall were currently rated as 'good', but the community mental health teams 'required improvement.' To resolve this, caseloads were being reduced. Services were revisited in January 2018 and teams were inspected over a period of two days. Concerns related to variability of quality of planning for care and articulation of risks as people presented and how they planned to meet those risks. As a result, the CQC decided to issue a warning notice because of concerns. The Trust accepted the findings and were working robustly to make improvements on quality of care and to ensure that patients were safe and receiving care within agreed timeframes, ensuring those waiting have an active review of their needs so that if changes took place the care can be responsive to prevent deterioration.

(2) One of the key indicators was to receive an assessment of need within 28 days of referral to the secondary mental health service. He reported that at the end of June significant improvements had been made by the three teams visited by the CQC with the highest performing team reaching 93% against a target of 95%. The lowest performing team was recorded at 62.3%; 20 people had not received an assessment within the 28-day period. Mr Badu acknowledged that they were working to improve this and accepted that there was a need to continue to improve.

(3) Members asked about Section 136 activity and outcomes, partnership working and single point of access.

(4) Mr Badu stated that overall, there had been a reduction in Section 136 activity. He explained that at the point when a person had a full mental health act assessment, they were either detained or supported in another way; less than 50% of people seen converted to formal or informal admission under the Mental Health Act. Mr Badu noted that that Section 136 was not the best way to support patients. Work was being done as part of the Crisis Care Concordat regarding detention. Mr Badu acknowledged that it was difficult for Police Officers to make assessments and that they are working to bring expertise together for early triage and identifying individuals known to existing services. He noted that Kent Police were able to use a dedicated contact line to speak with mental health practitioners about the available options.

(5) Members asked about out of county placements and the single point of access. Mr Badu reported that whilst no one was currently placed out of area for acute adults or older people's mental health beds, women who required psychiatric intensive care were placed out of area as there was no local unit or provision in Kent and Medway.

(6) In relation to single point of access, he noted that the Trust was committed to ensuring that the services were safe and effective, but had decided that support could be provided in a different way and agreed to restrict the operation of that service. Discussion has taken place with commissioners about reducing the service as activity after 10pm was lower and alternative pathways were in place to provide support. He stated that a 24-hour switchboard service was still available. He highlighted exploration of the NHS 111 service for lower level support needs, as well as crisis resolution and a review of the home treatment service for complex needs was being conducted.

(7) Mr Inett informed the Committee that Healthwatch were collating patient experience feedback from various groups and they were meeting with the Trust regarding to share this.

(8) The Chair asked about the reported improvements to staff supervision and its sustainability. Mr Badu confirmed that Trust was reviewing if robust

supervision trees were put in place and if protected time was given supervision. Quality of supervision was assured by clinical audit checks which looked at caseload numbers, record keeping, risk assessments and the quality of the offer to patients and relatives.

(9) The Chair enquired about the Psychiatry Liaison Service. Mr Badu explained that the Mental Health Five Year Forward View set out the aspirations and requirements for such a service and that work was taking place across Kent and Medway with the CCGs and Acute Trusts to ensure that a service was available to provide the best support across acute care provision. Mr Badu continued that there might not be a Liaison Service across all sites, but it would be placed where there was a level of need, identified by admissions through A & E. This would allow services to be provided as quickly and as a swiftly as possible. Some services would be on a 24-hour basis, with increased support in East Kent, particularly in Queen Elizabeth the Queen Mother Hospital and this would continue to be discussed with partners. The key challenge is ensuring that the service in place meets the need of the local population but was commissioned to deliver an effective and robust service.

(10) In conclusion, the Chair welcomed the introduction of the new specialist Mother and Baby Unit in Kent.

(11) RESOLVED that:

(a) the Kent and Medway NHS and Social Care Partnership Trust update report be noted;

(b) the Trust be requested to provide an update to the Committee in six months.

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

(1) The committee considered a written update report regarding out of hour bases in East Kent.

(2) RESOLVED that the CCG report on out of hour bases in East Kent be noted.

72. Lizzy Adam, Scrutiny Research Officer

(1) The Chair notified Members that this committee meeting would be the last attended by Lizzy and expressed thanks for all the help and assistance that she has provided during her time supporting the committee. The committee agreed and asked for these thanks to be recorded.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber - Sessions House on Thursday, 13 September 2018.

PRESENT: Mrs S Chandler (Chair), Mr P Bartlett (Vice-Chairman), Mrs P M Beresford, Mr A H T Bowles, Ms K Constantine, Mr D S Daley, Ms S Hamilton, Mr P W A Lake, Mr K Pugh, Mr I Thomas, Cllr J Howes, Cllr M Lyons and Cllr Mrs M Peters

IN ATTENDANCE: J Kennedy-Smith

UNRESTRICTED ITEMS

73. Membership
(Item 1)

The Chair noted that Mr Lake had filled the vacancy on this Committee.

74. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 3)

There were no declarations of interest.

75. Wheelchair Services in Kent
(Item 4)

Caroline Selkirk (Managing Director, East Kent CCGs), Ailsa Ogilvie (Chief Operating Officer, Thanet CCG), Adrian Halse (Head of Performance, Thanet CCG), Adam Wickings (Chief Operating Officer, West Kent CCG), Rachel Parris (Frailty and Medical Commissioning Programme Lead, West Kent CCG) and Paula Wilkins (Chief Nurse, West Kent) were in attendance for this item.

(1) The Chair thanked everyone for attending and explained that the item had been due to come back to the Committee meeting of 21 September but that the decision was taken to move the item to an extraordinary meeting to focus on the issue given its importance.

(2) The Chair informed the Committee that she, along with Officers, had met with representatives of the Joint Wheelchair User Group on Tuesday of that week. A statement from the Group had been received and circulated to Members of the Committee. This statement was attached as a supplement to the Minutes. The Chair explained that the Group felt that they did not need to attend as the statement was comprehensive and requested that the statement be read to the Committee. The Chair read the statement to the Committee.

(3) The Chair asked if the guests had anything to add to the updated report. Ms Selkirk apologised for the service that had been provided to wheelchair users and that work was taking place to deliver solutions. She welcomed the challenge given to the Clinical Commissioning Group (CCG) and the very constructive way in which the User Group had worked with the CCG. She also thanked the Committee for how it had handled the issue and emphasised that work was taking place to rectify the identified problems. Data was showing that progress was being made but that it was still a work in progress.

(4) Ms Ogilvie confirmed that work with the User Group was ongoing and that they were building on the improvement plan with additional workstreams around patient experience and quality now established. She informed the Committee that a recent meeting with Millbrook had shown evidence of improved service: in Mid-August the reported repairs waiting list was 461 and as of the previous day was 327. Of this number, 205 booked repairs were due within the next 5 days. In August spend exceeded Millbrook's monthly budget by 78% to enable equipment ordering to address the waiting list. She also confirmed that the waiting list has not reduced - 3353 reported previously with it now sitting at 3356; however the average increase of 120 per month had ceased.

(5) Ms Ogilvie confirmed that 1479 orders had been completed, 44% of the total list. 852 people had been triaged. This exceeded performance throughout the contract. She indicated that during September they would expect to see a significant reduction in the waiting list, but realised that there was a lot more work to do.

(6) Members commented on demand, procurement and data. Mr Halse informed the committee that the patient data was not fully complete at the time of procurement which had been explained to bidders. Demand was higher than expected and a backlog of patients with a higher complexity of cases than the CCG were aware of, resulted in problems with available data. Mr Wickings provided further detail about the problems surrounding data in procurements and said there were lessons that could be learnt from what had occurred.

(7) The Chair pursued this further and asked how the learning would feed in to the next procurement and be more widely shared across all CCGs. Ms Selkirk said that she had the view that they can always do better and that they would consider the wider lessons, including those around one CCG procuring a service and a second managing the contract. In addition, Ms Selkirk informed the Committee that their internal audit were looking into this and that the findings would be shared with relevant parties. Mr Wickings added that it was too soon to draw definitive conclusions about the procurement. In concluding the discussion on this aspect, Ms Selkirk expressed the view that the ultimate arbiter is those for whom the service is purchased.

(8) A Member asked about funding, additional spend and patient harm. Ms Selkirk said that the immediate waiting list funding was to be signed off by Ms Selkirk and Mr Ayres, Managing Director of Medway, North and West Kent CCGs and would not to be signed off until the robust improvement plan was seen. A second paper had gone to the eight CCG Governing Bodies across Kent and Medway to agree approval for dealing with the growth. Working with the User Group would assist with this plan being delivered.

(9) Ms Ogilvie explained that Millbrook had taken the deliberate decision to overspend by 78% on equipment ordering on the basis that they were aware that the East Kent CCG Managing Director would be signing off on funding and that they were keen to work quickly to improve the service.

(10) Ms Selkirk confirmed that following demonstration of that the contract variation would be signed off that day.

(11) In relation to patient harm, Ms Wilkin said that the same view was being taken in regard to psychological harm as physical harm and that the former was harder to pick up. She confirmed that the CCG was working with the User Group on this.

(12) The Chair informed the Committee that when meeting with the User Group, a point that had been made clearly to her was that the ethos at Millbrook and their attitude to disability was causing anxiety and the User Group had asked about equality training and sought reassurance that CCG staff would receive this as well. Ms Selkirk confirmed that this point had also been raised at the East Kent Governing Bodies and that commitment had been given to deliver that training and she was happy to extend that to other CCGs if required. Reassurance was given that this was happening already within Millbrook.

(13) A Member commented on communications and key performance indicators (KPIs). Ms Ogilvie said that KPIs will be a collaborative piece of work to enable that the right things were being measured for a positive experience. A whole review was needed on communications with those on the waiting list and prioritisation work with the User Group was the best way to do this.

(14) Members commented on the supply of equipment and personal budgets. Ms Selkirk said that the use of vouchers, personal budgets and other providers was needed to deal with the future demand as demographic data was showing that this would increase. She confirmed in relation to providers that appropriate regulatory credentials and necessary standards were met.

(15) Ms Ogilvie confirmed in relation to waiting lists that 1479 patients have had equipment ordered with a further 852 already being triaged. The next step would be equipment ordering and monitoring how the waiting list was being reduced. She confirmed that there was no reason to believe that there was not enough supply in the market.

(16) The Chair concluded the concerns with the service had been brought to the Committee by Healthwatch and hoped that this route would not be required again. She welcomed the improvements which had led to the User Group statement being issued.

(17) RESOLVED that:

(a) the reports and Joint Wheelchair User Group statement be noted;

(b) Thanet CCG, representative from Millbrook and the Joint Wheelchair User Group be requested to provide an update in January.

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber - Sessions House on Friday, 21 September 2018.

PRESENT: Mrs S Chandler (Chair), Mr P Bartlett (Vice-Chairman), Mrs P M Beresford, Mr N J Collor, Mrs L Game, Ms S Hamilton, Mr K Pugh, Mr I Thomas, Cllr J Howes, Cllr D Mortimer, Mrs R Binks (Substitute) (Substitute for Mr P W A Lake), Mr P C Cooper (Substitute) (Substitute for Mr A H T Bowles), Ida Linfield (Substitute) (Substitute for Mr D S Daley) and Mr C Simkins (Substitute) (Substitute for Mr N J D Chard)

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: J Kennedy-Smith (Scrutiny Research Officer) and Dr A Duggal (Deputy Director of Public Health)

UNRESTRICTED ITEMS

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

Mr Thomas declared an interest, in relation to agenda item 9 and any discussion regarding a new hospital in Canterbury, as a member of Canterbury City Council's Planning Committee.

78. Minutes
(Item 3)

The Chair explained that the Minutes were not available for this meeting and would be considered at a subsequent one.

79. Medway NHS Foundation Trust (Financial Recovery Plan, CQC Inspection Report & Creation of a Pathology Network)
(Item 4)

James Devine (Deputy Chief Executive, Medway NHS Foundation Trust), Glynis Alexander (Director of Communications and Engagement, Medway NHS Foundation Trust) and James Lowell, Director of Planning and Partnerships, Medway NHS Foundation Trust) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Devine began by stating that following a planned inspection in April and May and the resulting CQC Report published in July, the Trust was rated once again as 'requires improvement' with no significant change being recorded overall. Areas of outstanding practice had been recorded in the 'caring' domain within surgery. The new CQC inspection regime, rated the Trust as 'requires improvement' in the 'well led' domain and 'use of resources' rated as 'inadequate', primarily due

to the financial deficit. The supplementary paper identified 'must dos' and 'should dos' with a number of those actions now closed and tackled quickly with continuous improvements being made on core topics. He drew attention to consultant cover in the Emergency Department which requires 16.5-hour cover per day, explaining that was s significant challenge nationally but that the Trust had recruited two emergency consultants, taking the average cover to 14.5 hours

(2) Mr Devine explained that wider progress had been made on NHS constitutional targets and that a number were ahead of trajectory; caution was expressed given the impending winter period. In relation to the broader transformation agenda, the Trust was addressing the financial deficit and were reviewing unwarranted variation and redesigning referral pathways across the system. He also explained that transition arrangements were in place for forthcoming Executive changes within the Trust, including the Chief Executive and Finance Director.

(3) A Member asked about length of stay and risk of harm. Mr Devine stated that patients were not at risk and the review was on areas within the hospital that showed that some patients were staying longer within the Trust – 2 days longer – compared to the national average. Clinically led transformation teams were actively working on this through the Transformation Programme – Better, Best, Brilliant - but emphasised that the Trust requires partner organisations to help support the process for cohorts of patients. He confirmed he was happy to provide further information to the Committee on the action being taken by the Trust on length of stay and flow.

(4) Members asked about finances and payments by results. Mr Devine reported that the Trust was reporting favourable to plan but challenges would come in the second part of the year. Differences in opinion on payment by results nationally had been reported. The Trust had a longstanding financial deficit and that work was being completed on the drivers of the deficit; one being coding and accounting and that this year the Trust has entered in to a Concordat arrangement to ensure a fixed income with Commissioners to plan for 2019/20.

(5) In response to a specific question about the Kent and Medway Stroke Review, Mr Devine expressed that the Trust was disappointed not to be selected as the preferred option but that 3 hyper acute stroke units across the area was the correct number for patients.

(6) Members enquired about capital spend and staffing expenditure. Mr Devine said that work was being undertaken on system wide solutions through the transforming strategy meaning that services were being accessed in the community as well as co-located. Staff expenditure was higher than some other trusts as benchmarked against 'the model hospital' tool. The CQC had reported on a reduction on agency spend - 23/24% historically, now 9% - the redesign of the workforce was continuing to aid that reduction and on insufficient skill mix.

(7) The Chair elaborated on this point by enquiring if the workforce deficit was causing difficulties in achieving what the Trust wanted to achieve and financially recover. Mr Devine confirmed that recruitment was a challenge and that pay spend was a driver of the deficit; impacting constitutional standards but that

multi-faceted system redesign would lead to efficiencies. The Chair confirmed that workforce was an issue that the Committee would be considering in due course.

(8) RESOLVED that:

(a) the report be noted and Medway NHS Foundation Trust provide a written update on the workplan including additional information on length of stay and patient flow;

(b) Medway NHS Foundation Trust be requested to provide an update at the appropriate time;

(c) Medway NHS Foundation Trust, with relevant partners, provide an update on the Single Pathology Service for Kent and Medway in January 2019 following completion of the full business case.

80. Children & Young People's Emotional Wellbeing & Mental Health Service *(Item 5)*

Dave Holman (Head of Mental Health, Children and Maternity Services, NHS West Kent CCG) and Brid Johnson (Director of Operations for Kent & Medway, North East London NHS Foundation Trust) were in attendance for this item.

(1) The Chair welcomed the guests and noted that a letter had been received from Greg Clark MP which had been circulated to Members and Guests. Mr Holman provided a strategic context to the contract, highlighting that previous services had been disjointed and that they were working within the context of the national NHS report 'Future in Mind'. This gave the mandate to develop a whole system approach to meeting children's needs and confirmed that £3/4m resource annually was coming in to the Kent system, rising to £6m in 2021. Kent has been complimented nationally on its innovative programme of action. The key rationale is access with a benchmark currently of 32% with a diagnosable mental health condition having access to two interventions; Kent on average achieves 38%, equivalent to 11,500 patients. North East London NHS Foundation Trust (NELFT) had been awarded the contract a year ago and were given space to transform. Key achievements have been - a Single Point of Access (SPA), based in Foster Street, Maidstone, electronic patient records, pathways in place and visibility on activity. Crisis services are also being provided at A&E in relation to triage and pathways. Funding has also been secured from the Department of Health to procure a bespoke child place of safety facility in Staplehurst.

(2) Mr Holman confirmed a monthly regime was in place to scrutinise performance with levers in place to exercise contract variation, with data visible.

(3) Mr Holman said that feedback was becoming more positive and that work with schools was starting to show that the system was working. The Future in Mind Transformation Board were providing more scrutiny around NELFT. He confirmed that demand continued to be high and was so across the whole system. The NHS Ten Year Plan was currently being developed but expectations that the Future in Mind strategy would continue beyond 2020/21.

(4) Ms Johnson confirmed that 28,000 were needing care and that need was not being met due to current capacity – with work being undertaken in schools and the County Council on early intervention and prevention needs to help address this. She stated that the SPA was valuable however challenging for staff as it was important to have highly skilled people at the triage stage. She continued that there was a difference between triage and assessment but confirmed that those needing treatment receive a full assessment.

(5) Ms Johnson informed the committee about Neurodevelopment and that this area in Kent had been poorly serviced over the years with children receiving care through different providers due to lack of visibility. However, complaints particularly in relation to repeat prescriptions, were still being received. She stated that staffing continued to be an issue and that waiting times were a challenge as a result. Limitations on staffing within the County were a concern and the Commissioners were monitoring this.

(6) Ms Johnson said that out of 1062 patients in June 585 had been discharged with East Kent experiencing a high number of referrals as well as retention from previous months at the same time. This was monitored weekly.

(7) Members asked questions on Neurodevelopment and staffing. Ms Johnson reiterated that staffing was a concern, especially medical staff such as nurse prescribers, and that the most successful recruitment drives had been in shopping centres – attracting potentially ten staff in two days as an example. Currently there were 80 vacancies across the County and that financial incentives were being explored. She said that patients valued continuity of staffing and the potential for sub-contracting was being explored. Mr Holman said that engagement had taken place with private providers who provide NICE guidance in terms of assessment and diagnostics but that was short term.

(8) Members asked about waiting times, assessment and prescribing. Ms Johnson said that children do have a face to face assessment but that initially a discussion takes place with the person, referrer or family member and additional staff help to do this. She said that ideally it would be clinicians but to aid low staffing levels administrative staff had received training in mental health first aid for triaging but long-term clinicians should be answering. The full assessment then takes place after. She confirmed that waits of over 6 months but less than a year were 1794 and over 52 weeks was 700. Waits from inherited providers were clear and families have been written to, however a date could not be provided for assessment.

(9) Mr Holman said that another element was waiting times in other parts of the service and that a bespoke piece of work was being conducted on Neurodevelopment with Kent County Council on this which could be shared with the Committee once available.

(10) Ms Johnson said in relation to prescribing that getting prescriptions in advance to families within the system can be difficult due to staff placement and that families were ringing when they should not need to. A new piece of work was being established with the CCG and primary care and finding new ways of

working to resolve this. Mr Holman confirmed that pathways were being made easier through enhancing the primary care offer. This was known as Shared Care.

(11) A Member asked about discrepancies between east and west Kent and future growth. Mr Holman informed the committee that work was being completed with public health and that this could be reported to the Committee at a future date.

(12) The Chair expressed concern at 2500 waiting over 24 weeks and did not feel that this was acceptable and hoped that after a year it would not be at this level but understood that workforce was an issue.

(13) RESOLVED that the Committee:

(a) noted the report and expressed continued concern at the level of wait for young people despite efforts;

(b) receives additional written information on waiting times, discharge data and interventions within the month;

(c) invite the CCG to provide an update in six months including the All Age Eating Disorder Service.

81. NHS Preparations for 2018/19 Winter
(Item 6)

Ivor Duffy (Director of Assurance and Delivery, NHS England – South East) and Jon Amos (Head of Urgent and Emergency Care Delivery, Kent and Medway STP) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Amos introduced the item and informed the committee that the report highlighted that there was an STP wide footprint approach focussing on effective resourcing of planning, reporting, escalation and communications. Mr Duffy said that there was a significant joint communications strategy on flu vaccinations with the expectation that this would see extended access across GPs and Pharmacies co-ordinated across Kent and Medway. Mr Amos informed the committee that within the next 30 days the real focus was on bringing together good practice across Kent and Medway to make the best use of resources and that ongoing work was taking place with health and social care colleagues on health funded long-term hospital placement efficiency.

(2) A Member asked about the recently announced NHS England funding for East Kent Hospitals University NHS Foundation Trust, the delivery of this and if any funding had been secured for West Kent. Mr Duffy said that this was for resuscitation capacity and observation bays on both sites, with the expectation for these to be open in January 2019. In relation to West Kent, Mr Duffy confirmed that they do not have the same issues as East Kent and the investment was most important for the east of the County.

(3) Members enquired about access to GPs and communications. Mr Duffy said that practice staff and other healthcare workers involved in primary care would be collaborating to meet longer hours, including weekends. Advertising and linking in with the NHS 111 and other services would assist in meeting this capacity all through the winter period.

(4) The Chair pursued this point further, stating that she welcomed the communications plan but emphasised a need for increased activity to meet the desired impact on A&E attendance, highlighting bookable appointment utilisation. Mr Inett concurred that Trust and Community Health magazines were not always the best source for communicating key messages and a letter or an email would be effective in identifying service access. He commented further that few practices offered this.

(5) The Chair asked about uptake of flu vaccinations by health staff and the availability of vaccines for the general population. Mr Duffy said that there was no mandate to make staff have a flu vaccination but innovative ways of encouraging staff to increase uptake had been used in the past and could be used again. He continued that notices have been sent to GPs and pharmacies on vaccines and work was taking place on following this up.

(6) RESOLVED that:

(a) the report be noted;

(b) notification be circulated to the committee that testing has proved satisfactory towards end of October/beginning of November;

(c) NHS England and the Kent and Medway STP be requested to provide an update about the performance of the winter plans to the Committee in June.

82. NHS West Kent CCG: Edenbridge Primary and Community Care (Written Update)
(Item 7)

(1) The Committee considered an update report by NHS West Kent CCG on Edenbridge Primary and Community Care which contained details on the clinical model workstream, communications and engagement, site identification, finance workstream and next steps.

(2) RESOLVED that the report be noted.

83. East Kent CCGs - Special Measures
(Item 8)

Caroline Selkirk (Managing Director, East Kent CCGs) was in attendance for this item.

(1) The Chair welcomed Ms Selkirk to the Committee. Ms Selkirk introduced the item by informing the committee that the four east Kent CCGs had been placed in special measures – four CCGS were rated inadequate and 1

requires improvement. As part of the process an improvement plan is being implemented and NHS England monitor progress regularly. She emphasised that this was not the same as being in legal direction so NHS England could not directly instruct them.

(2) Ms Selkirk said that this had been anticipated and changes were beginning to be implemented through a detailed improvement plan. In September many NHS committee meetings across east Kent were taking place. It was recognised that working with an acute and community provider across the whole of east Kent, separate messages from four CCGs was not helpful and not the best way to buy the right services for the population and there was a need to see what was going on in terms of a place based approach. She emphasised that working with partners was key to this.

(3) Members commented on collaborative working, finance and patient safety, including overnight care. Ms Selkirk said that there was greater recognition that problems could be solved by closer working, allowing local conversations to be a lot more local. In relation to finance, she said the main concern was addressing waste variation and harm which were driving efficiencies, with the main aim being to provide the very best service. Effective hospital bed management was an example of this. Integrated care was changing the balance of how services were provided, with more care at home to make patients feel safe and comfortable. All providers were working together on different models.

(4) Ms Selkirk said in her view provision of overnight care staff was available but that it was not enough and that in terms of hospital provision they didn't have enough people in the right beds to help people more. Staffing was an issue across the whole system, with the medical school being incredibly important but that would take time to deliver. International recruitment of GPs had resulted in recruitment of three GPs across Kent. Work was being completed to collectively grow the market for support at home and social isolation and loneliness was demonstrating a need to grow the volunteer base around the vulnerable.

(5) A Member referred to the Kent County Council Select Committee on Loneliness and Social Isolation and requested any statistics collected would be beneficial. Ms Selkirk committed to do that.

(6) Mr Inett and Members asked about social prescribing and connections with communities. Ms Selkirk said that the east Kent Committee avoided duplication were giving benefits of learning and make time available for staff to spend time in practices and the local agenda. Social Prescribing was of great benefit and the work that Kent County Council was conducting on the Community Navigation Service was incredibly important. Ms Selkirk informed the Committee that communications with the public were circulated on a regular basis with engagement events leading to changes being made.

(7) The Chair emphasised that she believed that publicity needed to be wider.

(8) A Member asked about an indication of when the CCGs would come out of special measures. Ms Selkirk said that NHS England carry out an annual

assessment following moderation usually in July with ratings publicised between July and September.

(9) RESOLVED that:

(a) the report on the East Kent CCGs be noted;

(b) a written summary report on the financial recovery plan be provided to the committee as soon as possible;

(c) an update be presented to the committee in six months.

84. Transforming Health & Care in East Kent
(Item 9)

Michael Ridgwell (Programme Director, Kent and Medway STP), Caroline Selkirk (Managing Director, East Kent CCGs) and Liz Shutler (Deputy Chief Executive & Director of Strategic Development and Capital Planning, East Kent Hospitals University NHS Foundation Trust) were in attendance for this item.

(1) The Chair welcomed the guests to the Committee. Mr Ridgwell provided context on the Case for Change previously reported to Committee, highlighting changes in population, workforce and clinical outcomes. He explained about the options, consultation and decision process and stated that significant estates development was required under both options.

(2) A Member asked about capital and finances. Mr Ridgwell confirmed that public sector finance was a difficult area but that they were duty bound to explore all potential sources of finance. Ms Shutler said that all options considered passed an affordability test to progress to the next phase.

(3) The Chair enquired about the impact on the ability to deliver this due to the CCGs being placed in special measures. Mr Ridgwell said that this highlighted a need to do this work. Ms Shutler emphasised that being in special measure did restrict elements such as sign off of capital sources and would impact in terms of process and timelines.

(4) Members asked questions on population growth modelling and patient flows. Mr Ridgwell confirmed that demographic and non-demographic growth had been applied and that work undertaken is being aligned to the Kent County Council Growth Infrastructure Framework. He said that the patient flow appendices related to patients from outside of east Kent accessing services and included people visiting the County and those accessing specialist services. He confirmed that the paper will also go to Medway Health and Adult Social Care Overview and Scrutiny Committee for consideration.

(5) Members asked about planned engagement and decision making. Mr Ridgwell confirmed that announcement of public engagement events and not formal consultation would be made imminently and committed to inform the Committee when available. He emphasised that engagement on the development of options was not expected to take place until next year and following a comment regarding inadequate lead in times confirmed that at

least four weeks' notice of planned engagement was given and included using networks to engage hard to reach groups. He hoped that the Members could assist in disseminating information to the right places.

(6) A Member asked about the Kent and Medway Stroke Review and the changes in east Kent. Mr Ridgwell said the scale of changes meant it was inappropriate to wait. Ms Shutler said that everybody supported getting the stroke services in place as soon as possible to give improvement to patient outcomes. The Chair said that consistent messaging on reconsideration had been given throughout the process and had been discussed within the Joint HOSC that was considering the Stroke Review formally.

(7) RESOLVED that:

(a) the Committee deems that proposed changes in Transforming Health and Care in East Kent to be a substantial variation of service;

(b) NHS representatives be invited to attend this Committee and present an update at an appropriate meeting once the timescale has been confirmed.

85. Review of the Frank Lloyd Unit in Sittingbourne (Written Update)
(Item 10)

(1) The Committee considered an update report by Kent and Medway CCGs on the review of the Frank Lloyd Unit in Sittingbourne which contained details on a service that provides a bed based service for individuals with complex dementia with behaviours that challenge and who are eligible to receive NHS Continuing Healthcare. The unit has seen an ongoing decline in patient numbers due to the strategic shift in the direction of travel which directs support towards individuals in the community where possible. The review is due to be completed by the end of October 2018.

(2) A more detailed report is to be submitted once engagement and the review has taken place.

(3) Mr Inett informed the committee that he raised the report with the Chair of the Swale Mental Health Action Group who was not aware of this and that he would feedback directly to the Kent and Medway NHS and Social Care Partnership Trust (KMPT).

(4) RESOLVED that the report be noted and a more detailed paper be presented to the Committee following the conclusion of the review.

86. Date of next programmed meeting – Friday 23 November 2018
(Item 11)

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Item 4: Kent and Medway Strategic Commissioner

By: Jill Kennedy-Smith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 23 November 2018

Subject: Kent and Medway Strategic Commissioner

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

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

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1. Introduction

(a) On 26 January 2018 during the Transforming Health and Care in East Kent agenda item, Michael Ridgwell (Programme Director, Kent and Medway STP) confirmed that discussions were being undertaken around the shared CCG management functions in Kent and Medway; he committed to providing a paper on this to the Committee.

(b) On 27th April 2018 Glenn Douglas, Accountable Officer, Kent and Medway Clinical Commissioning Groups attended and informed the Committee that all eight CCGs had committed to establishing a strategic commissioner and sharing a single senior management team with one accountable officer for Kent and Medway. The Committee agreed the following recommendation:

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.

(c) A written report on the Kent and Medway STP is attached for information.

2. Recommendation

RECOMMENDED that the report be noted, and the Kent & Medway STP be requested to provide an update in six months' time.

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (26/01/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7639&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (27/04/2018)*',https://democracy.kent.gov.uk/mgAi.aspx?ID=47975

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Kent and Medway Strategic Commissioner Update

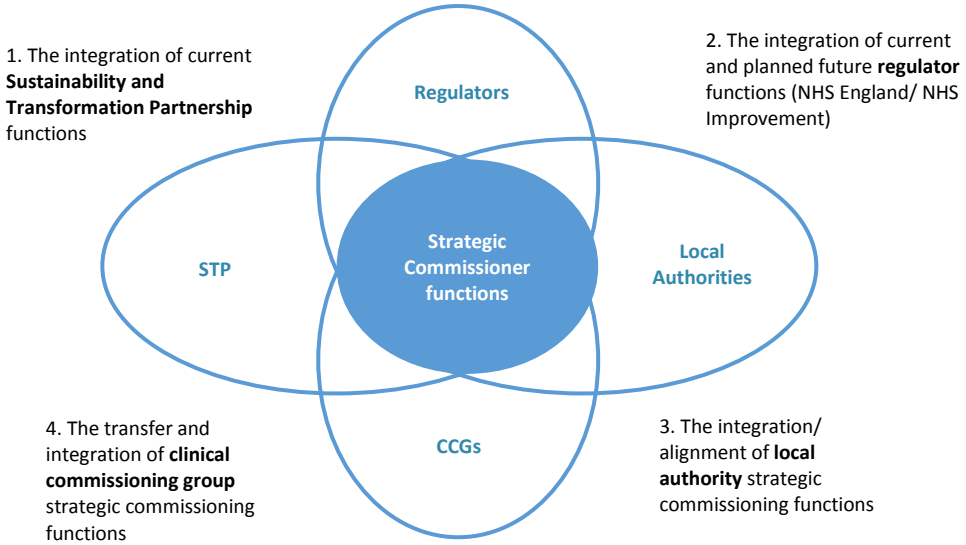
November 2018

Why are we establishing a Strategic Commissioner?

Delivering local care, improving prevention, investing in mental health services and supporting our providers to delivery clinically and financially sustainable services that meet national standards requires changes in commissioning.

We are working to develop a Strategic Commissioner for Kent and Medway which would see the alignment/integration of functions in order to improve outcomes for the population of the area. Figure 1 outlines the contribution from regulators, commissioners and providers in the establishment of a Strategic Commissioner.

Figure 1: Future alignment & integration of functions to a Strategic Commissioner



The Clinical Commissioning Groups (CCGs) across Kent and Medway have been working since April of this year on the development of a strategic commissioner function to work across all eight CCGs. The establishment of a Strategic Commissioner is part of a national programme to drive improvements in care through alternative commissioning arrangements and wider system transformation. The aim of this programme is to look at how current contributions from regulators, commissioners and providers can be developed, updated and strengthened to support and drive improvements in the services accessed by the local population. For commissioners, the focus has been on strengthening how the CCGs and local authorities can work together to drive service improvement, improve patient outcomes and address health inequalities by transforming the way we both commission and provide services across Kent and Medway.

There are a number of advantages to the CCGs working together. Making strategic commissioning decisions once across multiple CCGs will help in providing consistency across commissioned services to the population of Kent and Medway. Further intended

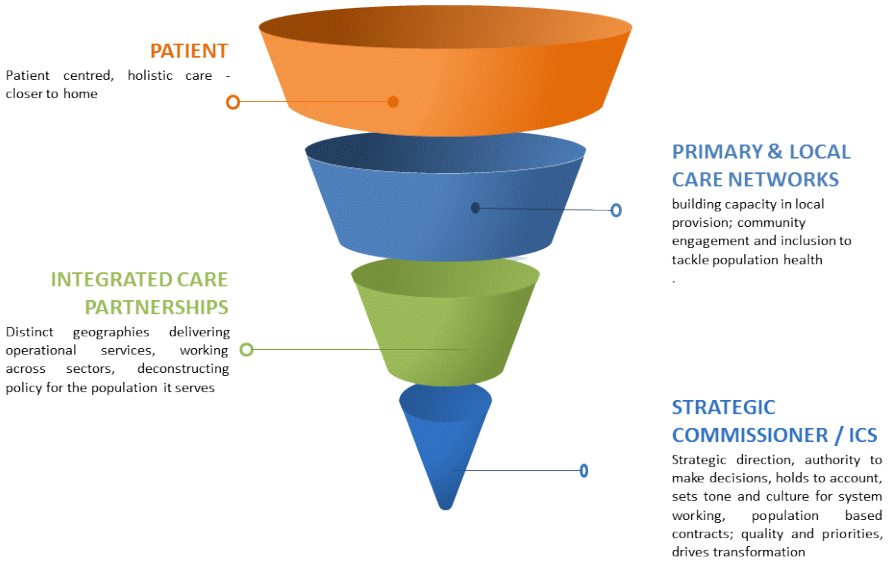
benefits include more efficient use of resource through reduced duplication in local commissioning efforts and the provision of services, the opportunity to commission services at scale, the potential to attract new and alternative models of care and service provision and the opportunity to further strengthen the integration of care and services accessed by patients. It will help improve services for patients by reducing variation in quality and access to care and will drive up standards across all providers.

Designing and Developing the Strategic Commissioner for Kent & Medway

During 2018/19 we have been working to co develop and design the future functions and form of a Strategic Commissioner, using the learning and insight from twelve Integrated Care System (ICS) vanguards across England. This work remains ongoing and will continue to evolve with input from system leaders and providers of health and care. Whilst the intention is to commence the transition arrangements from April 2019 with some key priorities, full transition and "go live" to the Strategic Commissioner and the transformation of the wider system architecture is not planned until April 2020.

The establishment of the Strategic Commissioner is not an isolated act. Further development and wider transformation of the system across Kent and Medway will be needed. Figure 2 provides an illustration of how national organisational forms used elsewhere could be applied to Kent and Medway.

Figure 2: Illustration of organisational forms and functions supporting a Strategic Commissioner



Input to the design and transition to future arrangements requires further engagement and the input and support of providers across the county. It is therefore intended to use 2019/20 as a year of continued engagement and to refine the organisational forms and functions as well as the operational arrangements of the Strategic Commissioner and Integrated Care System, Integrated Care Partnerships and Primary Care Networks.

Progress to date

At a workshop in July the group considered prevention and local care aspirations at the local, Intermediate and Kent and Medway levels and how to address the combined financial gap. From this work it was agreed that the commissioning functions at each level should be summarised, draft terms of reference developed for a joint decision making committee and that work should be initiated on how the CCG functions and additional strategic functions can be delivered within reduced running costs.

In August the Kent and Medway Strategic Commissioner Steering Group chaired by the Clinical Chair of NHS West Kent CCG agreed that cancer services were the right subject to start working together on and that a Joint Committee to do this should be established. There is increasing recognition that more significant and faster progress in the development of commissioning and wider system integration is required.

Actions to date towards development of this function include:

- a Steering group of eight CCG chairs, Kent County Council representative, a Medway Council representative, CCG Lay members, the Accountable Officer for Kent and Medway CCGs and a Patient and Public Advisory Group (PPAG) representative are meeting regularly alongside the Governance Oversight Group tasked with the development of governance arrangements for Kent and Medway wide working
- the Director of System Transformation has been appointed. Simon Perks commenced his role at the beginning of October;
- an initial set of priorities have been agreed in principle, and will be discussed with CCG Governing Bodies;
- a draft governance framework has been developed to support the initial priorities and
- the development of the Operating Framework that will include the operational detail to the implementation of the strategic commissioner has been drafted.

Next Steps – co design process for system architecture

During December, we will undertake a co-design process to explore the interface between the strategic commissioner function and integrated care partnerships which broadly looks at the development within the provider landscape.

The purpose of the initial session will be to engage system stakeholders in the development of an Integrated Care System in Kent and Medway and for commissioners to incorporate the feedback from this session and other associated inputs in the development of the Strategic Commissioning and Integrated Care System for Kent and Medway.

This will be the first of a series of sessions and we will be engaging more widely with stakeholders as the work evolves. A move to a Strategic Commissioner and the Kent and Medway system's readiness would need to be authorised by NHS England. The authorisation process is a formal process which requires the support of all Governing Bodies.

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Item 5: North Kent CCG: Financial Recovery Plan

By: Jill Kennedy-Smith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 23 November 2018

Subject: North Kent CCG: Financial Recovery Plan

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

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

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1. Introduction

(a) On 27 April 2018 a written report on Financial Recovery was provided for the Committee with no guests in attendance. Questions were asked by the committee and submitted to the CCG at the end of the meeting for response.

(b) Members raised concerns generally about impacts on patients and functionality and the CCG has been asked to address these concerns as part of their report.

(c) A written report on the Trust is attached for information.

2. Recommendation

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

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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Financial Recovery Plan North Kent CCGs

HOSC

November 2018

Dartford Gravesham and Swanley (DGS) CCG and Swale CCG……

- …relate to two discrete acute systems – Darent Valley Hospital and Medway Maritime Hospital
- Both systems face considerable financial challenges
- To achieve clinical and financial sustainability requires:
    - Better allocation of resources
    - Better cost control
    - Reduced wastage

Context

- Similar health needs and socio-economic landscape across DGS and Swale:
  - DGS CCG recently taken out of Special Measures and NHS England Directions
  - Significant growth in population, especially over 65s
  - 10 year gap in mortality across wards in each CCG
  - Cancer and heart disease remain greatest challenges
  - Major workforce constraints in primary, community and social care, especially Swale
  - Large portions of primary care estate in poor condition
  - Good examples of excellent progress in some services - diabetes in Swale; medicines management in both CCGs
  - DGS Healthy New Towns programme seen as a national demonstrator in community building and infrastructure
  - Notwithstanding finances, significant forward investment is being made into local care across both CCGs focusing on multidisciplinary teams (MDTs), Rapid Response and Home Visiting services

Context

- DGS population growth:
  - Over 60,000 population increase forecast – huge increase in housing already happening
  - Concern that CCG revenue funding not keeping up with growth (increasing distance from target)

- DGS and Swale CCG Leadership Team have seen biggest turnover in last six months – new AO, MD, Chief Finance Officer, Chief Operating Officer and Chief Nurse

CCG priorities

- Further improvements in patient care and outcomes
- Supporting the development and strengthening of GP services
- Enhancing integrated working with our partners, both locally and across the country, with a particular focus on local Care
- Engaging with local people in important issues
- Ongoing delivery of system financial recovery

Previously reported to HOSC

- DGS
  - 2017/18 plan was a deficit position of £7.3m (2.1%)
  - CCG faced additional risks/challenges that had the potential to lead to a deficit of £20.8m
  - Final outturn position was a deficit of £9.1m (2.6%), with an accumulative deficit for the CCG of £22.6m
  - The underlying position carried forward into 2018/19 was therefore a recurrent deficit of £10.6m
  - Special Measures
- Darent Valley Hospital
  - Deficit position of £15.8m

Previously reported to HOSC

- Swale
  - 2017/18 plan was a break-even position
  - CCG faced additional risks/challenges that had the potential to lead to a deficit of £7.7m
  - Final outturn position was a deficit of £3m (1.9%), with an accumulative deficit for the CCG of £5m
  - The underlying position carried forward into 2018/19 was therefore a recurrent deficit of £4.5m
  - Special measures
- Medway Hospital
  - Deficit position of £61.8m

2018/19 position

- CCG financial positions continue to be tight
- Achievement of NHS England agreed control totals is a considerable challenge

CCG	Plan	Risk based position at month 6
	£m	£m
DGS	-	(9.9)
Swale	-	(1.9)

- Achievement of balance for Swale is possible, but Dartford likely to overspend

- Acute Trust positions are similarly challenged
  - Darent Valley planned deficit £10.6m (£5.1m after access to Provider Sustainability Fund)
  - Medway Hospital planned deficit £48.2m (£34.2m after access to Provider Sustainability Fund)
  - Risk to both organisations in achievement of these plans

QIPP programmes – both CCGs

- Both CCGs developed **robust Financial Recovery Framework, Governance and Plans** in 2017/18. Many of the schemes have continued into the current year as part of a two year operational plan.
- Based on **top to bottom review of all expenditure** as part of a value for money programme
- **Ten key programmes initially identified**, focused on delivering
  - Improved contractual efficiency
  - Better use of clinical resource
  - Reduced internal management costs

QIPP programmes

- **Improved Medicines Management**: Reducing wastage, facilitating over the counter medicines, and prescribing generic drugs: £3.7m savings in 2017/18 / £5.5m in 2018/19
- **Improved Orthopaedic Triage**: Enhanced community triage and therapy services, resulting in circa 20% reduction in secondary care referrals (over 65% of referrals to triage service have resulted in community care rather than secondary care). Improved waiting times and recurrent financial savings of over £2.6m in 2017/18
- **Continuing Health Care Assessments**: Increased staffing to support more timely reviews of patient care, enabling step down where appropriate. Expected savings in 2018/19 over £1m

QIPP programmes

- **Unwarranted Clinical Variation**: Benchmarking GP referral information and auditing secondary referrals to understand current service provision and what could be better provided in the community.

  Key services identified: Gynaecology, Ear, Nose and Throat (ENT), Paediatrics and Cardiology (DGS only). Respiratory medicine also an area of opportunity.

  Excellent progress, but savings this year have been minimal due to Medway Foundation Trust block contract (Swale) and need to expand community and primary care services (both CCGs). Expected financial savings in 2019/20

QIPP programmes

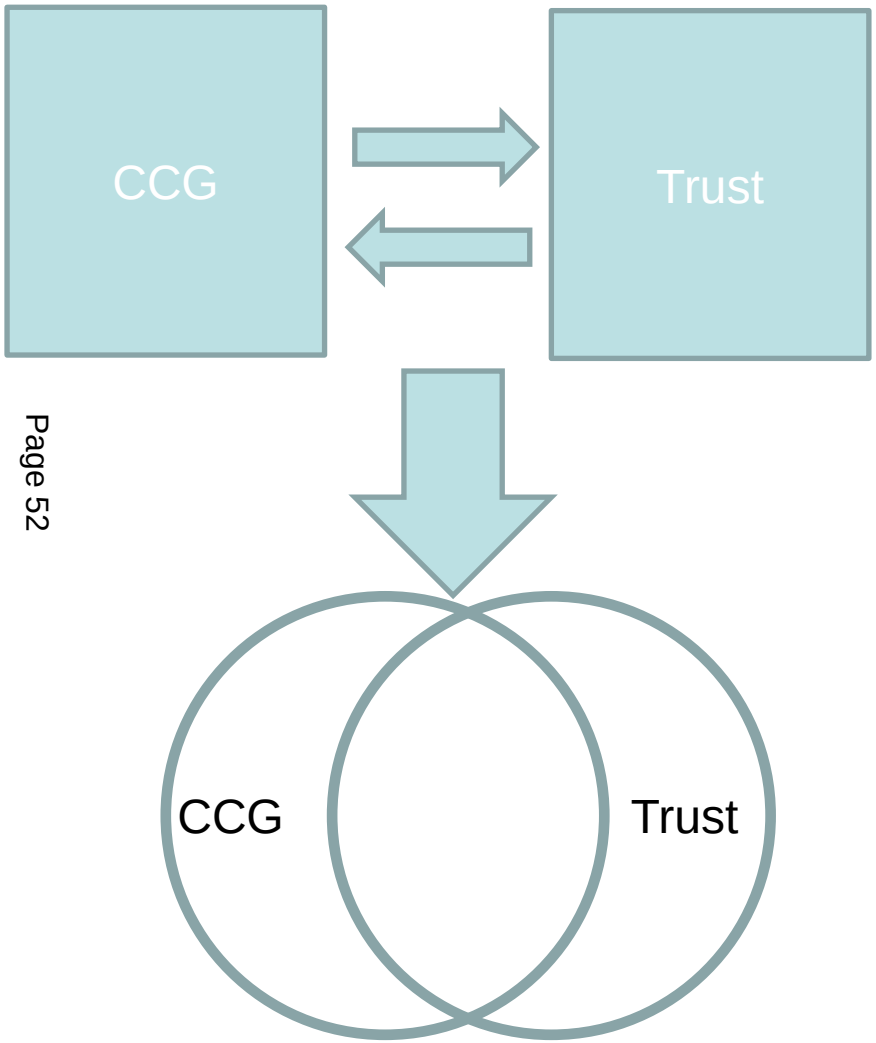
- **Improved contract management**: Holding providers to account for the quality of patient care through Commissioning for Quality and Innovation (CQUIN) payments; sharing efficiencies through joint working and improved patient care pathways, such as ambulatory care; ensuring counting and coding of patient activity is accurately invoiced; encouraging routine, non-specialist care to be provided locally rather than at tertiary centres whilst recognising patient choice. Savings of circa £4m
- **Reducing running costs**: Review of all CCG and NHS estate locally – sweating good assets and disposing of very poor estate; sharing management resource where this is beneficial; collaboration across Kent and Medway in areas such as Information Management and Technology (IM&T); human resources (HR); corporate functions; etc. Savings of circa £250k

Performance to date and forecast achievement

DGS QIPP	Full Year Plan	YTD Plan	YTD Actual	Variance	Full Year Forecast	Variance
	£000	£000	£000	£000	£000	£000
Clinical Variation	2,640	1,186	39	(1,147)	260	(2,380)
Medicines Management	3,556	2,255	2,401	146	3,832	276
New Models of Care	1,939	1,050	964	(86)	1,074	(865)
Improved Contract Management	3,978	2,321	2,211	(110)	3,894	(84)
Specialist Assessments and Placements Team	695	355	233	(122)	695	0
Orthopaedics and Pain Services Review	286	260	84	(176)	89	(197)
Corporate Services	170	76	8	(68)	50	(120)
	13,265	7,501	5,940	(1,561)	9,895	(3,370)

Swale	Full Year Plan	YTD Plan	YTD Actual	Variance	Full year Forecast	Variance
	£000	£000	£000	£000	£000	£000
Clinical Variation	1,753	786	0	(786)	0	(1,753)
Medicines Management	1,550	1,029	1,077	48	1,700	150
New Models of Care	812	467	413	(54)	498	(314)
Improved Contract Management	730	426	233	(193)	400	(330)
Specialist Assessments and Placements Team	550	299	119	(180)	550	(0)
Orthopaedics and Pain Services Review	139	80	0	(80)	0	(139)
Corporate Services	73	32	33	1	200	127
	5,606	3,120	1,876	(1,244)	3,348	(2,259)

New approaches required



- Characterised by competition
- Win/Lose
- Organisation before system
- Transactional
- Silo thinking and working – not aligned
- Internal market has arguably driven services and costs beyond the level that is affordable

- Characterised by collaboration
- Win/Win
- Patient and System before organisation
- Transformational
- Joined up thinking and working
- Transparency

Development path

- National context is that NHS England and NHS Improvement is viewing systems as a whole rather than judging individual organisations
- Requires change in culture and relationships between CCGs and providers
- Development of an Integrated Care Partnership proposition with Darent valley Hospital
  - System wide approach
  - Early stages of joint PMO arrangements
- Medway - Host CCG and provider currently working on a combined recovery plan for the system. Swale needs to play a role in this
- These new approaches and change in behaviours will take time

Towards sustainability – Dartford PACS (1)

- PACS (Primary and Acute Care System)
  - Driving
    - Productivity improvements from better ways of working/best use of workforce
    - Reduce duplication and waste through better co-ordination of services
    - Cost base reduction

Towards sustainability – PACS (2)

- Local Care
  - Delivering care through six Local Care Hubs
  - System default should be to deliver care in the community rather than hospital
  - Primary Care Risk Stratification of practice populations
  - Personal Care Planning with support from MDTs, earlier diagnosis, rapid access to crisis intervention/rapid response to avoid admission to hospital or long term care

Towards sustainability – PACS (3)

- PACS accountable for delivering all health care for local population, linking in with more specialist services in the county where appropriate
- New approach to system wide contracting, leadership and governance
- To include development of professional networks and relationships between primary care and secondary care, community hubs
- Need to consider
  - Ways of managing risk
  - Allocation of resources for the population
  - Incentivising of best practice
  - Supporting governance

Item 6: Dartford and Gravesham NHS Trust: Update

By: Jill Kennedy-Smith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 23 November 2018

Subject: Dartford and Gravesham NHS Trust: Update

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

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

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1. Introduction

(a) Dartford and Gravesham NHS was established as a legal entity on 1 November 1993 with headquarters based at Darent Valley Hospital in Dartford, Kent.

(b) In October 2013, the Trust took on several services at Queen Mary's Hospital, Sidcup and Erith and District Hospital as part of the dissolution of the South London Healthcare Trust. The Trust also provides services in Gravesham Community Hospital in Gravesend as well as several community locations across the local area. The Trust offers a range of acute services, with a bed-base of 544, to around 350-400,000 people in North Kent and South East London.

(c) On 28 March 2018 the Trust were given a CQC overall rating of 'Requires improvement':

Safe	-	Requires improvement
Effective	-	Requires improvement
Caring	-	Good
Responsive	-	Requires improvement
Well-led	-	Requires improvement

2. Previous Committee Attendance and Requested Information

(a) The Trust was last considered by the Committee in June 2016 and January 2017 regarding incidences of MRSA at Darent Valley Hospital in 2015/16. NHS Improvement were asked by the Trust to undertake an inspection / review of infection prevention and control practice at the hospital. As part of the Committee report the Trust have been requested to provide an update.

(b) In addition, the Trust were also requested to provide information for a general overview of the key services provided, performance against NHS constitutional access targets, update on CQC inspection report and associated action plan, staffing and current financial position.

(c) From April 2016 to March 2018 the Trust collaborated with Guy's and St Thomas' NHS Foundation Trust on the Foundation Healthcare Group Vanguard as part of NHS England's New Care Models programme. Foundations for Change was subsequently published and tells the story of the programme. It led to the creation of the Guy's and St Thomas' Healthcare Alliance. Information on the programme and the Alliance was requested.

(d) A written report on the Trust is attached for information.

3. Recommendation

RECOMMENDED that the report be noted, and Dartford and Gravesham NHS Trust be requested to provide an update at the appropriate time.

Background Documents

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

Kent County Council (2017) 'Health and Overview and Scrutiny Committee (27/01/2017)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7507&Ver=4

Overview and CQC inspection ratings and report – Dartford and Gravesham NHS Trust
https://www.cqc.org.uk/provider/RN7

Vanguard – Foundation for Change
https://www.dgt.nhs.uk/about-us/vanguard/

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Dartford and Gravesham
NHS Trust

Dartford and Gravesham NHS Trust

Louise Ashley & Siobhan Callanan
Chief Executive Director of Nursing & Quality

Care with compassion | Respect and dignity | Striving to excel | Professional standards | Working together

Dartford and Gravesham NHS Trust

Contents

1. Introductions
2. 17/18 Achievements and Performance
3. Update on Care Quality Commission visits
4. Foundation Healthcare Group update
5. Performance in 18/19 so far
6. Questions

2017/18 Achievements and Performance

LOUISE ASHLEY

CHIEF EXECUTIVE

Dartford and Gravesham NHS Trust

About Dartford and Gravesham NHS Trust

- Acute services with over 2000 staff across three main sites – Darent Valley Hospital in Dartford, Queen Mary's Hospital in Sidcup and Elm Court in Dartford
- 463 inpatient beds at Darent Valley Hospital, a PFI hospital
- Provide specialty services at Darent Valley including, day-care surgery, general surgery, trauma, orthopaedics, and cardiology, maternity and general medicine
- At Queen Mary's Hospital we provide day care and short stay inpatient surgery and orthopaedics as well as outpatients and radiology services
- At Elm Court we provide intermediate care for patients transitioning from hospital to home or other care setting
- Serve a population of c.350,000 across Dartford, Gravesham, Swanley, Ebbsfleet and an increasing proportion of Bexley

Achievements in 2017/18

- Establishment of our service for elderly patients to optimise preparation and recovery post operatively

- Official opening of the Planned Care Centre at Queen Mary's Hospital

- Additional beds opened at Darent Valley Hospital

Achievements in 2017/18

- Establishment of healthcare alliance with Guys and St Thomas's Hospital

- New gamma camera to improve Nuclear Medicine Service

- The highest (best) 20% of staff recommending the Trust as a place to work or receive treatment and the staffs' ability to contribute towards improvements at work

Dartford and Gravesham NHS Trust

Key statistics for 2017/18

39,000+ Emergency Admissions. An increase of 7% from 16/17.

326,000+ Outpatient Attendances. A reduction of 1.2% from 16/17

4,800+ Births. A small reduction 0.8% from 16/17.

41,000+ Elective (Overnight & Day Case) Admissions. A reduction of 2% from 16/17.

104,500 Emergency Attendances. 2.4% increase from 16/17

Dartford and Gravesham NHS Trust

Operational and Clinical Performance in 2017/18

- 4 Hour wait in Accident and Emergency – 90% average, below the standard of 95%
- Cancer waiting times – standards were achieved
- Referral to Treatment within 18 weeks – standard was achieved
- C Difficile – 15 cases (5 fewer cases than in 16/17)
- MRSA – 6 cases (1 more case than in 16/17)

Financial Performance in 2017/18

- The Trust ended the year with a £18.6m deficit – the plan was to deliver a £1.6m surplus
- We delivered a £6.5m savings programme
- Income increased by 1.9% compared to a 10.6% increase in 2016/17
- Costs increased by 7.6%, similar to the increase in 2016/17
- We invested £8.2m of capital funding including £3m for medical equipment, £3.5m for estates and £1.7m for Information, Management and Technology.

Care Quality Commission Update

SIOBHAN CALLANAN
DIRECTOR OF QUALITY AND NURSING

Dartford and Gravesham NHS Trust

Care Quality Commission Update

CQC visited DGT in November 2017, report was published in March 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Darent Valley Hospital	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018	Good →← Mar 2018	Requires improvement →← Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement →← Mar 2018
Queen Mary's Hospital	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Elm Court Ward	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Overall trust	Requires improvement ↓ 2018	Requires improvement ↓ 2018	Good →← 2018	Requires improvement →← 2018	Requires improvement ↓ 2018	Requires improvement →← 2018

Quality Improvement Plan

- Clarity about **structures, policy and standards** – with a plan to ensure these are communicated clearly
- Increased **inspection of standards** are being met to ensure high quality patient care
- **Support** for staff to meet standards, but also clarity around **holding to account fairly**
- Ensure **consistent learning** from incidents is shared
- Consistent application of the **Trust's Behaviours** – including support for constructive challenge

Quality Improvement Plan – Clinical Standards

- Ensuring a consistent high standard of care for patients
  - Adhering to best practice in infection control at all times
  - Following safeguarding practices at all times
  - Improving knowledge of Mental Capacity Act – and applying it
  - Demonstrating high standards of clinical records – consistent and contemporaneous
  - Ensuring confidentiality of clinical notes
  - A focussed and proactive approach to ensuring patient privacy and dignity - single sex bays, time in recovery
- Midwifery
  - Obstetric theatre nurses 24/7
  - Midwife: birth ratios – Birth-rate + review

Our 5 Priorities For 2018/19

- Organisational development and culture
- Improvements to infection prevention and control
- Compliance to mental health capacity act and safeguarding standards
- Organisation communication including translation services
- Learning from incidents patient complaints and feedback

Monitoring Our Plan

- Trust leads feedback to monthly Improvement and Implementation Working Group
- Reports to Quality and Safety Committee which reports directly to the Trust Board
- CCG and NHS Improvement monthly challenge and review
- Monthly visits
- CQC engagement visits
- Quality inspections

Foundation Healthcare Group Update

SIOBHAN CALLANAN
DIRECTOR OF QUALITY AND NURSING

Foundation Healthcare Group Update

- NHS England provided funding for the first two years as together with Guy's and St Thomas' NHS Foundation Trust we developed a group model and explored how we could support each other
- We focused on three clinical and three non-clinical workstreams:
  - Paediatrics - Governance for group model
  - Cardiology - Information, Management & Technology
  - Vascular - Location (first year only)
- The three clinical workstreams have now become business as usual
- The group model was approved by the Trust Boards in March 2018 and is now in its "proof-of-concept" year

Foundation Healthcare Group Update

- Focus for this year is on the following 10 workstreams:
  - Job planning and clinical leads development
  - Education, training and development
  - Leadership
  - Improvement
  - Research
  - Outpatient / digital transformation
  - Queen Mary's Hospital, Sidcup
  - Nursing development
  - Radiology reporting
  - Referral to treatment management best practice
- These workstreams have been resourced and progress is being made
- Next steps include developing: an implementation plan for the five year strategy, a financial strategy and an annual plan for 19/20

Performance in 2018/19 so far

LOUISE ASHLEY

CHIEF EXECUTIVE

Performance 6 months into 18/19

- 4 Hour wait in Accident and Emergency – 89% average, below the standard of 95%
- Cancer waiting times – standards continue to be achieved
- Referral to Treatment within 18 weeks – 91.1%, below the standard of 92%
- C Difficile – 10 cases
- MRSA Bacteraemia – 1 case

Finance 6 months into 18/19

- Control Total given to the Trust – £5.1m deficit
- This includes the Provider Sustainability Fund (PSF) funding of £5.1m (received quarterly) and is linked to meeting the key performance milestones of A&E and Finance
- Savings programme of £13.3m, to date achieved the plan of £3.8m
- Performance against A&E and Finance are not being met so we are unlikely to continue to receive any of the PSF funding
- Forecast deficit is £20.1m

Dartford and Gravesham NHS Trust

What are we doing to improve performance?

- Financial controls in place, reviewed the drivers of the deficit for both the Trust and Dartford, Gravesham and Swanley Clinical Commissioning Group
- Ongoing focus on infection prevention and control
- Ongoing delivery of CQC action plan, updated following October visit
- Providing additional clinics where possible to improve waiting times for outpatient appointments
- Maximising use of Queen Mary's Hospital for surgery
- Working with health and social care providers to reduce A&E attendances and improve discharges

Questions

LOUISE ASHLEY
CHIEF EXECUTIVE

SIOBHAN CALLANAN
DIRECTOR OF NURSING AND QUALITY

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Dartford and Gravesham NHS Trust

Directory of Services

Service	Site	How to Access
Accident & Emergency	Darent Valley Hospital	**EMERGENCIES ONLY** 01322 428100 (switchboard)
Ageing and Health	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital (Outpatients)	GP Referral Contact number: 01322 428357
Ambulatory Emergency Care Unit (AEC)	Darent Valley Hospital	GP Referral through an Ambulatory Emergency Care Coordinator: 07925 173747 08.00-22.00 Monday to Friday 08.00-20.30 Saturday and Sunday
Anaesthetics / Chronic Pain Services (Outpatients)	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Referral
Breast Care	Empress Breast Unit at Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital (Outpatients)	GP Rapid Access Referral and GP Referral
Cancer Services (Outpatient and Elective Day Case Surgery Service)	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Rapid Access Referral
Cardiology	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital (Outpatients)	GP Referral
Colorectal Rapid Access (Outpatients)	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital (Outpatients)	GP Rapid Access Referral
Dermatology	Darent Valley Hospital (provided by Medway NHS Foundation Trust)	GP Referral
Diabetes	Darent Valley Hospital	GP Referral
Dietetics and Nutrition (Outpatients)	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Referral
Ear, Nose and Throat (ENT) Outpatients	Darent Valley Hospital (provided by Medway NHS Foundation Trust)	GP Referral
Gastroenterology	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital (Outpatients)	GP Referral
General Surgery	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Referral
General Surgery AQP Clinics (Outpatient and Elective	Planned Care Centre, Queen Mary's Hospital	GP Referral

Day Case Surgery)		
Gynaecology (Outpatients and Elective Day Surgery)	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital Gravesham Community Hospital	GP Referral
Gynaecology AQP Clinics (Outpatients and Elective Day Surgery)	Planned Care Centre, Queen Mary's Hospital	GP Referral
Haematology Services	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital (Outpatients)	GP Referral
Early Pregnancy Unit (EPU)	Darent Valley Hospital	GP Referral 01322 425378 Once your referral has been received, we will contact your patient within 24 - 48 hours If symptoms require urgent attention, your patient is advised to attend A&E
Maternity Services: • Maternity Triage • Delivery Suite	Darent Valley Hospital	Self- referral/ GP or Obstetrician referral following telephone contact: 01322 428278 /8280, 01322 428273
Maternity Services: Foetal Assessment Unit	Darent Valley Hospital	On-line maternity self-referral at https://www.dvh.nhs.uk/our-services-specialists/a-to-z-of-services/maternity-services/having-your-baby-at-darent-valley-hospital/self-referral-form/ or GP/ Obstetrician referral following telephone contact: 01322 428278/8280
Maternity Services: Birth Centre	Darent Valley Hospital	On-line maternity self-referral at https://www.dvh.nhs.uk/our-services-specialists/a-to-z-of-services/maternity-services/having-your-baby-at-darent-valley-hospital/self-referral-form/ following telephone contact: 01322 428425
Maternity Services: Antenatal Clinic	Darent Valley Hospital	On-line maternity self-referral at https://www.dvh.nhs.uk/our-services-specialists/a-to-z-of-services/maternity-services/having-your-baby-at-darent-valley-hospital/self-referral-form/ / GP Referral
Maternity Services: Community Midwifery Service	Dartford, Gravesend, Swanley and Bexley Areas	On-line maternity self-referral at https://www.dvh.nhs.uk/our-services-specialists/a-to-z-of-services/maternity-services/having-your-baby-at-darent-valley-hospital/self-referral-form/ or through the Community Midwives Office: 01322428753/8754
Maternity Services: Neonatal Unit/Special Care Baby Unit	Darent Valley Hospital	GP/Consultant referral
Maternity Ultrasound	Darent Valley Hospital Planned Care Centre, Queen Mary's	GP Referral

	Hospital	
Mental Health Team for Older People (Dartford Community)	Darent Valley Hospital (provided by Kent And Medway NHS and Social Care Partnership)	GP Referral
Neurology	Darent Valley Hospital	GP Referral
Occupational Therapy (musculoskeletal services only)	Darent Valley Hospital	GP Referral/ Consultant referral
Ophthalmology (Outpatient and diagnostic services; day-case surgery)	Darent Valley Hospital (Service provided by Moorfields Eye Hospital NHS Foundation Trust)	GP Referral
Oral and Maxillofacial Surgery	Darent Valley Hospital Service (provided by Queen Victoria NHS Foundation Trust)	GP Referral
Orthopaedics (Inpatients)	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Referral
Orthotics (Outpatients)	Darent Valley Hospital	GP/Consultant referral
Orthodontics	Darent Valley Hospital (provided by Medway NHS Foundation Trust)	Dentist (GDP) Referral
Paediatric Services (Outpatients) Provided by Dartford and Gravesham NHS Trust and Evelina London Children's Healthcare	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Referral
Phlebotomy Service (Adult 16 years and older)	Darent Valley Hospital, Outpatients Department, level 2 Planned Care Centre, Queen Mary's Hospital, Outpatients Phlebotomy	GP Referral Darent Valley Hospital Appointment booking: 01322 425391 08.30-17.00. Appointments are available 08.30-16.55 Monday to Friday Planned Care Centre, Queen Mary's Hospital Open from: Mon/Thurs 08:45 – 16:30 Friday 09:15 – 16:30 Contact number for any queries: Direct dial: 0203 910 7266 Ext: 107266
Paediatric Phlebotomy Darent Valley Hospital (Children under 16 years)	Darent Valley Hospital (By appointment only)	GP Blood Test Referral Clinic Book on NHS e-Referral Alternatively you can call 01322 428232 between 12.00-13.30 Clinics all day Monday-Thursday, morning only Friday Please prescribe your patient with skin-numbing cream as this is not provided
Paediatric Phlebotomy Planned Care Centre, Queen Mary's Hospital (Children under 16 years)	Planned Care Centre, Queen Mary's Hospital ACORNS Children and Young People Outpatients (By appointment only)	DVH Consultant blood tests only Clinic: Wednesday 14.00 – 16.00 Call 020 83083269 Please prescribe your patient with

		skin-numbing cream as this is not provided NO GP BLOODS TAKEN AT THIS LOCATION
Physiotherapy	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Referral / Self-Referral: 01322 428588
Plastic Surgery Service (provided by Queen Victoria Hospital NHS Foundation Trust)	Darent Valley Hospital	GP Referral
Podiatry (specialist diabetes only)	Darent Valley Hospital	GP Referral; Community Podiatrist Referral; Self-Referral
Diagnostics: X-Ray, Ultrasound and MRI Scan**,** Flow Rate Test, Urodynamic	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Referral
Endoscopy	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Referral
Renal/Nephrology (Dialysis Service provided by King's College Hospital NHS Foundation Trust)	Darent Valley Hospital	GP Referral: 01322 428861
Renal/Nephrology Services (Outpatients)	Planned Care Centre, Queen Mary's Hospital	GP Referral
Respiratory Medicine	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital (Outpatients)	GP Referral
Rheumatology	Darent Valley Hospital (provided by Medway NHS Foundation Trust)	GP Referral
Speech and Language Therapy Outpatients	Darent Valley Hospital	Consultant referral only
Stroke and Transient Ischemic Attack (TIA) Services	Darent Valley Hospital For patients who have had a TIA, a rapid access TIA clinic is available at Darent Valley Hospital. We aim to see patients at high risk within 24-hours from referral and low risk patients within seven days from referral.	GP Referral
Urology	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital (Outpatients)	GP Referral
Urology AQP Clinics	Planned Care Centre, Queen Mary's Hospital	GP Referral
Vascular (Outpatients)	Darent Valley Hospital Planned Care Centre, Queen Mary's Hospital	GP Referral

If you would like any further information about any of our services please contact:

Gemma Knights, Marketing Manager: gemma.knights@nhs.net

Updated 02/04/18

Item 7: South East Coast Ambulance Service NHS Foundation Trust (SECAmb): Update

By: Jill Kennedy-Smith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 23 November 2018

Subject: South East Coast Ambulance Service NHS Foundation Trust (SECAmb): Update

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

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

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1. Introduction

(a) South East Coast Ambulance Service NHS Foundation Trust (SECAmb) was formed in 2006 from the merger of Kent, Surrey and Sussex ambulance services and in 2011 became a Foundation Trust.

(b) They receive and respond to 999 calls from the public, urgent calls from healthcare professionals and receive and respond to calls to NHS 111 as well as providing the regional Hazardous Area Response Team (HART). They provide services to 4.7 million people over the 9,400 square kilometres of Kent, Medway, Surrey, Sussex and North East Hampshire.

(c) On 8 November 2018 SECAmb were given a CQC overall rating of 'Requires improvement':

Safe	-	Requires improvement
Effective	-	Requires improvement
Caring	-	Good
Responsive	-	Requires improvement
Well-led	-	Requires improvement

(d) The Trust remains in special measures.

2. Previous Committee Attendance and Requested Information

(a) The Trust last presented to the Committee on 27 April 2018 following the decision to revert to individual scrutiny of the Trust by each health scrutiny committee.

(b) SECAmb have requested to provide an update to the Committee. As part of the report SECAmb were requested to provide information on CQC action planning, performance targets including the Ambulance Response Programme, winter planning including vehicle dispatch

strengthening, fleet investment and renewal, an overview of the Five-Year Strategic Plan and the Trust's finances.

(c) A written report on the Trust is attached for information.

3. Recommendation

RECOMMENDED that the report be noted and SECAmb be requested to provide an update in June 2019.

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

Overview and CQC inspection ratings and report – South East Coast Ambulance Service NHS Foundation Trust
https://www.cqc.org.uk/provider/RYD

South East Coast Ambulance Service NHS Foundation Trust Five Year Strategic Plan 2017-2022
http://www.secamb.nhs.uk/about_us/our_vision_and_strategy.aspx

Contact Details

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Scrutiny Research Officer
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03000 416343

South East Coast Ambulance Service NHS Foundation Trust
23rd November 2018

Ambulance Response Programme

Following the NHS England commissioned review of urgent and emergency care in 2013, it was recognised that the ambulance service response standards (England) had not been reviewed since the mid 1970's.

In 2015, NHS England commissioned Sheffield University to undertake a study into ambulance responses. The result of this study was the introduction of the Ambulance Response Programme.

The Ambulance Response Programme (ARP) is a change to the way in which ambulance services (in England) receive and respond to emergency calls. In November 2017, ARP went live at the South East Coast Ambulance Service (SECAmb).

A key element of ARP was the re categorisation of 999 call priorities whilst maintaining a clear focus on the clinical needs of patients and ensuring that the right resource is dispatched (Table 1).

Performance

The variance in performance for SECAmb across the three counties (Kent, Surrey, Sussex) is minimal, however the Trust recognises that achieving C1, C2, C3, and C4 performance measures continues to be challenging (table 2).

C1 performance achievement for ambulance services in England during August 2018 was 7 minutes and 17 seconds (mean). Only three ambulance services achieved the 7 minutes response time. SECAmb was positioned 8th out of the 10 ambulance trusts.

C2 performance for England during August was 20 minutes 42 seconds (mean), with SECAmb achieving 18 minutes 15 seconds. Three ambulance services achieved the 18-minute performance target. SECAmb was positioned 4th out of the 10 ambulance Trusts.

C3 & C4 performance (90th percentile) for SECAmb has continued to perform below the national average for the month. C3 performance nationally (England) was 2 minutes 15 seconds, with SECAmb achieving a C3 performance of 3 hours 8 minutes. C4 performance nationally (England) was 2 hours 56 minutes, with SECAmb achieving a C4 performance of 3 hours 37 minutes.

Demand and Capacity Review

During 2017- 2019, following the identification of a gap in funding, for SECAmb to deliver its existing model and achieve all performance targets, Commissioners and SECAmb jointly commissioned (with the Support of NHS England and NHS Improvement), Deloitte and ORH to undertake a review of existing and future operating models.

The approach from Deloitte and ORH was in the form of a 'Demand and Capacity' review to understand the relationship between resources, performances, and finances.

The focus of the review was on two operating models: 1) Paramedic Led Ambulance Model and 2) The Targeted Dispatch Model. Both identified a requirement to increase not only the number of front line staff but also the fleet resource.

The conclusion of this review was for the recommendation of the 'Targeted Dispatch Model', which focused on getting clinically appropriate resources to patients by using specialist paramedics in cars, paramedics on ambulances and the introduction of a lower acuity mode of ambulance to specifically support those patients that fall into category 3 & 4 calls.

Another key element of the 'Targeted Dispatch Model' is that it builds on our work with the wider system to enable and facilitate alternatives to conveyance to an Emergency Department. That is, increase 'hear and treat' and 'see and treat' or refer into jointly developed and clear care pathways to deliver continued benefit to patients and the system.

Work has already begun on the delivery of this model with staff recruitment and fleet procurement underway. A key part of the delivery is that Q1 2019/20 will see C1 performance achievement on a sustainable basis, and the introduction of the full model for all categories of performance, with sustainability fully achieved by Q4 2020/21.

As we move forward, the opportunity to collaborate on what experience and skill sets are deployed in the pre hospital and out of hospital settings of care is truly exciting.

Fleet

SECAmb has invested in a 101 new ambulances with a vehicle roll out programme during the next 12 months. July saw the first of 42 new ambulances, 'Mercedes Sprinters', being rolled out at a rate of 3 to 4 per week and will replace some of the Trust's older vehicles by October. The Trust is also in the process of trialling 16 new Fiat van conversion ambulances across the Trust.

In addition and to further support ARP, the Trust has invested in 30 second-hand Fiat ambulances, which are currently being converted to attend to the more non-life threatening calls and will carry slightly different equipment. These vehicles are being introduced in a phased approach commencing mid December 2018: full operational roll out is expected to be complete by March 2019.

During 2019/20 further investment is planned in up to a further 50 ambulances as well as a replacement programme for the Trust's rapid response cars and 4x4 vehicles.

Computer Aided Dispatch

During 2017, a new Computer Aided Dispatch (CAD) system was introduced into the Trust's Emergency Operations Centres. This replaced the existing CAD, which had been in use for the previous 10 years. The new CAD, supplied by 'Cleric', will greatly enhance the information capabilities to plan and forecast activity, as well as delivering a higher level of performance, ultimately enabling SECAmb to deliver a better service to its patients.

Handover Delays

SECAmb is leading on a system wide programme of work focusing on reducing ambulance hours lost at hospital sites due to handover delays. The programme is led by a Programme Director.

Some good progress has been made overall, and for the month of August 2018 the total ambulance hours lost >30 minute turnaround was 4496 hours which is equivalent to 375, 12-hour ambulance shifts for the month or 12 per day. This is a reduction when compared to the same period last year (5222) but is still of significant concern. Most hospital sites are losing fewer hours than in August last year but there are some significant outliers where hours lost are more compared to the same time last year.

A key part of the work stream has been to develop with each acute hospital, a handover action plan that aims to streamline the process of handover delays including best practice e.g. dedicated handover nurse and admin, Fit2Sit, front door streaming and direct conveyance to non ED destinations. To support the development of the plans, a number of live conveyance reviews have taken place where a representative from the ambulance service, hospital, primary care, community trust, and CCG have reviewed all decisions to convey to hospital with an aim to ensuring that all community pathways are maximised.

The results from the reviews, gives a clear indication that in the majority of cases conveyance to hospital was appropriate, and in a few cases, had an alternative pathway been available a conveyance may have been avoided. The results of the reviews to be taken forward for further discussion with system partners to see if further

work may help in maximising existing community pathways or to explore establishing new pathways.

Peer reviews looking at the handover process at individual sites have also taken place at some hospitals, where the Chief Operating Officer from another acute hospital, supported by Emergency Care Intensive Support Team (ECIST), visits another hospital and reviews the ambulance pathway through the department. The peer reviews have been received positively and have been a good way sharing best practice across hospital sites.

Finances

At the year-end (2017/18), the Trust achieved its control total of £1.0m deficit, this includes the agreed Sustainability and Transformation Funding (STF) of £1.3m. In addition, the Trust achieved a further STF (incentive plus bonus) of £1.3m and a CQUIN risk reserve of previously held by commissioners of £0.8m, resulting in a reported surplus of £1.3m.

The Trust also achieved Cost Improvements of £15.5m. This was greater than the target of £15.1m.

For 2018/19, the Cost Improvement Plan (CIP) target remains at £11.4m.
At September, £7.9m of fully validated savings have been transferred to the Delivery Tracker as at the Month 6 reporting date, of which £4.2m have been delivered against the Plan delivery of £4.1m.

Winter Planning

SECAmb has a proven methodology in its approach to winter preparedness. This is achieved through the use of historic data and current activity trends, combined with 'lesson learnt' from previous years.

An overarching Trust winter plan has been developed, supported by a tactical plan as well as local 'Operating Unit' (OU) plans. The local OU plans feed in to local system plans i.e. East Kent, West Kent, and North Kent.

The SECAmb 111 winter plan covers North and West Kent as well as Surrey and Sussex (excluding East Kent). Table 3.

As the Trust moves towards winter (November 1st to March 31st), the Senior Operations Leadership Team (SOLT) will constantly review the level of resource available against predicted demand enabling the Trust to predict, monitor and mitigate to maintain service delivery during surges in demand or reduced capacity.

In line with Trust policy, the level of annual leave abstraction will be reduced to 50% of normal levels and as in previous years, enhanced rates or incentives will be offered, if required, to ensure that priority shifts are covered.

Five-Year Strategy

The Trust has developed a strategic plan for the next 5 years, 2017-22, and is focussed on the delivery of 4 strategic themes; Our People, Our Patients, Our Partners, and Our Enablers. We are currently refreshing our strategy to take account of internal and external developments since publication in July 2017.

Our People - The Trust recognises that a supported and developed workforce, led by good leaders who can set clear expectations, as well as holding them to account will develop a positive culture and behaviours. Also ensuring that staff feel valued and cared for as well as knowing how to get support when required. Our approach, aimed at improving this to enable provision of a consistent and quality service to our patients.

Our Patients - We are continually developing our services to improve provision of consistent care that achieves quality and performance standards and ultimately benefits the patent though the delivery of an integrated clinical model that ensures that the patient get the right response first time. During September 2018, the Trust also published its Clinical and Quality strategy.

Our Partners - Our aim is to further integrate and share best practice between NHS 111 and 999 services, to deliver a clinically led process, which prioritises the patient's need at the point of call. A key driver will be to improve clinical outcomes through clear process and structures that support shared decision making not only within the Trust but also with external partners. This will reduce fragmentation of care. SECAmb is involved in partnership working at a local level with NHS and blue light partners, and is a key partner in the Sustainability & Transformation Partnership for Kent & Medway. Partnership working aimed at the development of appropriate general and specialist care pathways to ensure that our patients receive the best possible care delivered by the right people in the right place

We are also working with our partners to deliver a plan that supports the integration of digital systems enabling access to patient care information to enable better clinical decision making and ultimately improving patient outcomes.

Our Enablers – The Trust is fully committed to developing key enables that will support, maintain and deliver an effective and progressive service delivery. Some of the key enablers are:

- ICT - the development of robust informatics systems using the latest technology
- Fleet – a programme of vehicle replacement as well as new fleet
- Estates – a continued rationalisation of existing estate and the development of Make Ready Centres, strategically placed from which our frontline staff operate
- Finance – financial sustainability whilst enabling investment in programmes that ultimately provide better care to patients.

CQC Update

Following the CQC visit in May 2017 and their published report on the 29th September 2017, the result of which saw the Trust placed into special measures, SECAmb has been on an improvement trajectory. Further unannounced visits from the CQC saw their formal recognition of the progress that the Trust was making, largely achieved through a comprehensive work programme overseen by the Trust's Project Management Office (PMO).

July and August of this year saw the return of the CQC inspectors and the recently published report (8th November) of their findings sees the Trust move from 'inadequate' to 'requires improvement'.

The inspectors recognised the number of areas where the Trust has made significant progress and again rates the care given by staff to patients as good with several areas recognised as outstanding.

Some of the key areas of feedback are:

- Staff cared for patients with compassion. All staff inspectors spoke with were motivated to deliver the best care possible and feedback from patients and those close to them was positive
- The Trust promoted a positive culture that supported and valued staff. Inspectors found an improved culture across the service since the last inspection. Most staff felt the culture had improved and felt able to raise concerns to their managers
- Medicines management was robust and effective with a marked improvement since the previous inspection. Inspectors found elements of outstanding medicine management, for example, the way the Trust handled Controlled Drugs. An external review also recognised the impressive turnaround in performance
- A new Well-Being Hub, which enables staff to access support in a variety of areas. The service was widely commended by staff during the inspection.
- A significant improvement in the process for investigating complaints and the quality of the Trust's response to complaints since the previous inspection

Following the publication of the report and its findings, the Trust will be working with its PMO on a delivery plan to continue the progress and improvements required.

Table 1:

ARP Performance Categories

Category	Types of Calls	Response Standard	Likely % of Workload	Response Details
Category 1 (Life-threatening event)	**Previous Red 1 calls and some Red 2s including** • Cardiac Arrests • Choking • Unconscious • Continuous Fitting • Not alert after a fall or trauma • Allergic Reaction with breathing problems	**7 Minute response** (mean response time) **15 Minutes 9 out of 10 times** (90th Centile)	Approx. 100 Incidents a day (8%)	Response time measured with arrival of first emergency responder Will be attended by single responder and ambulance crews
Category 2 (Emergency, potentially serious incident)	**Previous Red 2 calls and some previous G2s including** • Stroke Patients • Fainting, Not Alert • Chest Pains • RTCs • Major Burns • Sepsis	**18 minute response** (mean response time) **40 minute response** (90th centile)	(48%)	Response time measured with **arrival of transporting vehicle** (or first emergency responder if patient **does not** need to be conveyed)
Category 3 (Urgent Problem)	• Falls • Fainting Now Alert • Diabetic Problems • Isolated Limb Fractures • Abdominal Pain	**Maximum of 120 minutes** (120 minutes 90th centile response time)	(34%)	Response time measured with arrival of **transporting vehicle**
Category 4 (Less Urgent Problem)	• Diarrhoea • Vomiting • Non traumatic back pain	**Maximum of 180 minutes** (180 minutes 90th centile response time)	(10%)	May be managed through hear and treat Response time measured with **arrival of transporting vehicle**

Table 2:

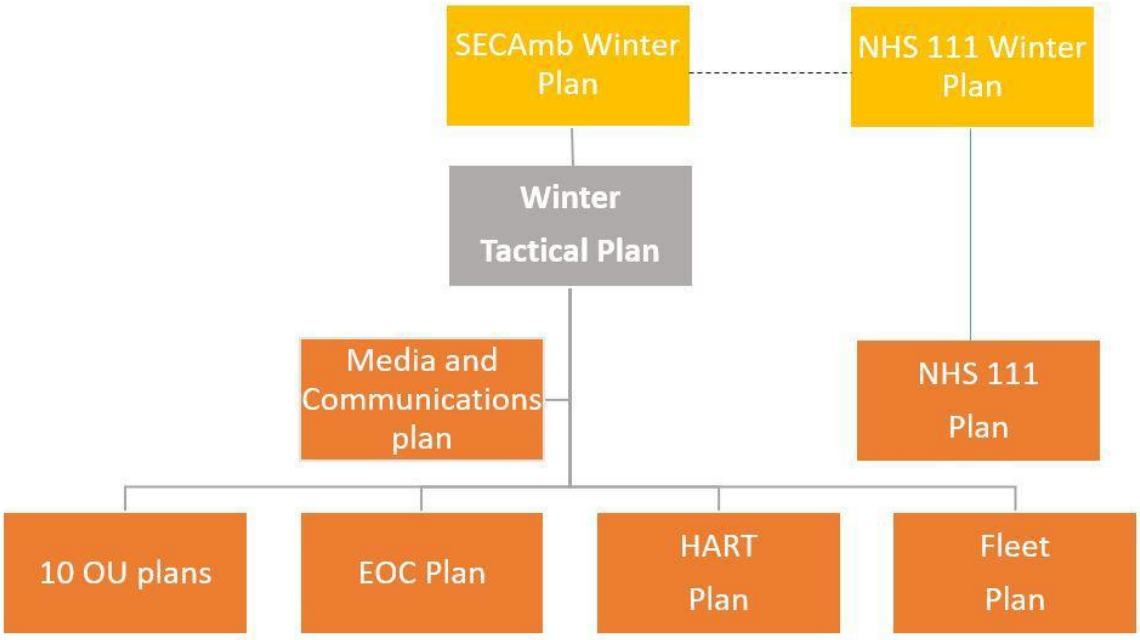
SECAmb Performance for August and Year to Date

SEAmb Year to Date Performance						
April - August 2018	Cat 1 Mean Response Time (00:07:00)	Cat 1 90th Centile (00:15:00)	Cat 2 Mean Response Time (00:18:00)	Cat 2 90th Centile (00:40:00)	Cat 3 90th Centile (02:00:00)	Cat 4 90th Centile (03:00:00)
Kent & Medway	00:07:54	00:14:37	00:18:12	00:34:15	03:16:51	04:38:36
SECAmb	00:07:44	00:14:21	00:17:45	00:33:48	03:01:20	04:27:34

SECAmb August 2018 Performance						
August 2018	Cat 1 Mean Response Time (00:07:00)	Cat 1 90th Centile (00:15:00)	Cat 2 Mean Response Time (00:18:00)	Cat 2 90th Centile (00:40:00)	Cat 3 90th Centile (02:00:00)	Cat 4 90th Centile (03:00:00)
Kent	00:07:58	00:15:14	00:19:15	00:36:48	03:37:51	03:57:59
SECAmb	00:07:32	00:14:15	00:18:15	00:35:06	03:08:36	03:37:01

Table 3:

Winter Plan Structure Framework



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Item 8: CCG Annual Assessment 2017/18 (Written Update)

By: Jill Kennedy-Smith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 23 November 2018

Subject: CCG Annual Assessment 2017/18 (Written Update)

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

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

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

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1. Introduction

(a) NHS England has a statutory duty to undertake an annual assessment of CCGs. This has been done under the auspices of the Improvement and Assessment Framework (IAF), with the overall assessment derived from CCGs' performance against the IAF indicators, including an assessment of CCG leadership and financial management.

(b) The seven Kent CCGs have been asked to provide the key actions from their improvement plans to the Committee. A written report is attached for information.

2. Recommendation

RECOMMENDED that the report be noted, and the Kent CCGs be requested to provide an update to the Committee annually.

Background Documents

NHS England (2018) *'CCG Improvement and Assessment Framework 2017/18 (14/06/2018)'*, https://www.england.nhs.uk/publication/ccg-improvement-and-assessment-framework-2017-18/

NHS England (2018) *'CCG Annual Assessment 2017/18 (13/07/2018)'*, https://www.england.nhs.uk/publication/ccg-annual-assessment-2017-18/

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Kent Health Overview and Scrutiny Committee (HOSC) Briefing: Annual assessment 2017/18 of Kent CCGs

November 2018

1. Introduction

The CCG annual assessment for 2017/18, carried out by NHS England (NHSE), provides each CCG with a headline assessment against the indicators in the CCG improvement and assessment framework (CCG IAF). The IAF aligns key objectives and priorities as part of delivering the Five Year Forward View.

The CCG IAF comprises 51 indicators selected to track and assess variation across policy areas covering performance, delivery, outcomes, finance and leadership.

CCGs are rated in one of four categories: 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

Each CCG receives a letter detailing the assessment by NHSE and confirming the annual assessment, as well as a summary of any areas of strength and where improvement is needed from a year-end review.

The 2017/18 annual assessments were published on the CCG Improvement and Assessment page of the NHS England website in July 2018. At the same time, they were published on the MyNHS section of the NHS Choices website.

2. Kent CCG ratings

The headline rating for each of the CCGs is as follows.

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

As an automatic result of being rated inadequate, NHS Ashford, NHS Canterbury and Coastal, and NHS South Kent Coast CCGs were place in Special Measures. NHS Thanet CCG was rated 'requires improvement' but was placed in special measures with its neighbours because it shares the same challenges and this ensures the whole system can move ahead together.

All CCGs have improvement plans in place.

The four east Kent CCGs briefed HOSC members on their improvement plans and progress in September 2018.

A summary of key actions for all of the Kent CCGs is included in Appendix 1.

Appendix 1 - Summary of key actions in CCG improvement plans for Kent CCGs.

CCG	Key actions	Current status
East Kent CCGs (NHS Ashford, NHS Canterbury and Coastal, NHS South Kent Coast and NHS Thanet CCGs)	Implement the actions outlined in the Governance, Capability and Capacity review	Following our 2017/18 annual assessment by NHS England, the four east Kent CCGs were placed in special measures. The key reasons for this are: the financial position of the CCGs, issues with the quality of services they commission, the need for more effective east Kent-wide working to resolve these challenges. We see this as an opportunity to develop a shared approach to the challenges we face, both as CCGs and with our partners, and to transform the way we look after frail older people and people with complex health and care needs. We have already created a shared management team across the CCGs, developed a shared financial recovery plan, and continuing to strengthen and streamline the way we work. We commissioned a Governance, Capability and Capacity review. As a result of this review, the CCGs established a Joint Executive Team with east Kent-wide portfolios (now appointed to), and brought its main committee meetings together to meet jointly or as committees in common. The CCGs have continued to implement the actions to improve governance arrangements as per the timescales recommended in the report. We are confident that through this improved executive oversight we will be able to affect the quality improvements required to deliver the NHS Constitutional Standards in addition to improving the delivery of quality, innovation, productivity and prevention (QIPP).

	Prioritise the submission of the Pre Consultation Business Case (PCBC) and accelerate our tier two local care programme.	The CCGs' major priority, because of the clinical quality, financial and system impact it will have, is to transform the way we look after frail older people and people with complex health and care needs. This priority is shared with all system partners. We have established an East Kent Programme Management Office (PMO), appointed a PMO Director and during October and November we have been holding a series of public events to discuss potential options for changing hospital and local care services in east Kent. For those that are not able to attend, there is a survey available on the website - www.kentandmedway.nhs.uk/eastkent There will be a full public consultation on the proposals in future, during which we will be running more public events in other locations across east Kent alongside further activities to collect as wide a range of views as possible. A detailed Local Care Delivery Plan for each locality has been developed and agreed that identifies the following priority areas: • Frailty/ At Risk • GP at Scale • Pathway redesign – unplanned care • Prevention The assessment identified that all four CCGs had made good progress in

		engaging all practices in local care and the hub models
	Engage NHS England in the recruitment of a Director of Nursing on a more permanent basis.	There had been two interim appointments to the position of Chief Nurse; with effect from September 2018, this is now substantially appointed to.
	Review the Expert Determination process, including but not exclusive to advice sought, how this advice was used and reporting to Governing Body members	The CCGs commissioned their internal auditors to review the Expert Determination process. A lead Executive Director of Contracts has been appointed to oversee the contract management regime. A development programme for Governing Body members has been established, and the financial reporting providing to the Governing Bodies has been reviewed and approved.
	Accelerate the delivery of the digital strategy including the range of universal capabilities that will support primary care transformation including e-referrals through hubs or shared back office and develop further patient engagement in using digital systems.	East Kent element of digital work stream added to STP digital prioritisation funding framework and submission made to NHS England in September 18. GP Clinical Leads are now attending both local and STP meetings. The Local Digital Roadmap is being refreshed and will be complete by December 2018. Key areas include: 1) a single clinical system for east Kent; 2) Full implementation of the Medical Interoperability Gateway (MIG); 3) Embedding mobile and virtual Multidisciplinary Team (MDT) technologies' 4) Refreshed digital platform for website We are supporting practices to implement e-referrals, and are piloting new functionality with NHS Digital to allow referrals from hubs across a locality to the EKHUFT.
	Create a strategy for developing relationships with East Kent Hospitals University NHS Foundation Trust as the leadership changes to support and encourage a system approach	We have established regular meetings between the EKHUFT Chief Executive Officer and the east Kent CCGs' Managing Director. A Joint improvement plan for east Kent has been submitted to NHS England and NHS Improvement. We have established a Clinical Reference Group with

	to resolving problems and to support cultural change 4 hour Accident and Emergency Constitutional Target	representation from our main providers and will be commencing Board to Board meetings during Quarter 3. The East Kent Integrated Improvement Plan identifies four key actions to strengthen performance in urgent care: • Improved demand management through availability of local care • Targeted programme to expedite discharges for frail and elderly cohorts • Internal process improvements within the East Kent Hospitals University NHS Foundation Trust including rebalancing capacity across its three sites • Resetting system capacity imbalance across all parts of the care pathway. 2018/19 began with a five month continuous improvement trend in this target, which is the longest continuous period of improvement to date. However, the past three months have shown deterioration Implementation of the system's winter plan within the governance of the Accident and Emergency Delivery Board will be pivotal to regaining an improving position to meet the target's trajectory. Overall, effective flow within the system is the key goal. An impact assessment of the key interventions supporting flow has been conducted and high level system metrics agreed, which are monitored weekly. The interventions planned to have greatest impact include : • Introduction of observations wards within Accident and Emergency Departments • Redesign of integrated discharge service to provide a focus on front and back 'doors'

		• Seven day working capacity across the health and social care system.
	62 day Cancer Treatment Standard	Performance against the 62 day Cancer Treatment Standard in September showed an improvement to previous months and October reflects further improvement. EKHUFT have worked hard to reduce the number of patients waiting passed 62 days and this is reflected in the amount of patients waiting passed 104 days which has significantly reduced to previous months. The 2 week cancer waits have been compliant but EKHUFT were non-compliant in September due to increased referrals and implementation of new PAS system. New cancer team leadership within the Trust has supported improved clinical engagement with a focus on timed pathways and ownership of the Cancer Improvement plan and cancer Patient tracking lists to reduce breaches and improved capacity at the front end of the pathway. The Improvement plan has key oversight by NHSI and is closely monitored by CCG cancer clinical, commissioning and quality leads. Each EK CCG now have cancer clinical leads that work collaboratively between primary and secondary care to reduce inappropriate referrals and improved communication to support faster diagnosis. Implementation of timed pathways for colorectal, lung and prostate have been supported with Transformation Funds and system wide agreement.
	Work with providers to improve performance on constitutional standards, in particular on	The performance against the RTT standard for the year remains significantly below the constitutional standard of 92 per cent and there are still a number of patients waiting more than 52 weeks.

	Referral to Treatment times (RTT)	The number of patients waiting more than 52 weeks has dropped from 228 in May to 149 in September. Performance against the 18 week standard has dropped in recent months but remains better than in March 2018. The four east Kent CCGs are working with East Kent Hospitals University Foundation Trust continue to progress its RTT recovery by reviewing its waiting lists, increasing clinical capacity and developing a sustainable workforce to manage the demand. The performance of the Trust was impacted by the roll-out of a new PAS system which, whilst successful, has impacted on waiting times and on the reporting of waiting times data. The four East Kent CCGs also continue to work with providers to identify capacity to ensure that the elective care programme required to support the RTT standard can be delivered. This has included consideration of increasing the use of the Independent Sector beyond the level planned at the start of the year. The four east Kent CCGs have developed practice dashboards to help GP practices address variation in referral. All GP practices are now fully utilising ERS to make referrals. Each of the CCGs also has a triage service for trauma and orthopaedics referrals to ensure that they managed within the community where it is appropriate to do so. Referral and treatment criteria have been reviewed and scrutiny around the application of these criteria has been tightened. The four east Kent CCGs have identified opportunities within the Rightcare tools to further reduce pressure on the planned care pathways and a number of projects have been identified within the East Kent transformation programme. These will support the

		reduction of referrals and the increased use of community based services to treat patients.
NHS West Kent CCG	Work with providers to improve performance on constitutional standards, in particular on Referral to Treatment times (RTT), demand management and the delivery of elective care and the cancer standards.	NHS West Kent CCG (NHS WKCG) has an assurance process in place to regularly monitor performance against the statutory standards through the Governing Body which meets on a monthly basis, receiving, reviewing and discussing the Internal Performance Report (IPR), which includes the Referral to Treatment times (RTT), demand management and the delivery of elective care and the cancer standards. The performance against the RTT standard for the year remains significantly below the constitutional standard of 92 per cent. However, it has shown an improvement compared to the performance in the Quarter 1 of this financial year. Maidstone and Tunbridge Wells NHS Trust (MTW) continue to progress its RTT recovery plan by reviewing its waiting lists, increasing clinical capacity and developing a sustainable workforce to manage the demand. MTW is also increasing the management and operational capacity by recruiting to substantive posts for Theatre Utilisation Manager and Outpatient Operational Transformation Manager. NHS WKCCG continues to work with MTW to manage waiting lists effectively through a Transforming Outpatient work stream which has seen the introduction of a number of one stop clinics and an increase in non-face to face follow up clinics to improve the use of clinical capacity, with a greater number of telephone clinics, nurse led clinics and virtual clinics. In addition WKCCG has been working with Business Intelligence partners to identify opportunities for further improvement using tools such as NHS Improvement's Model Hospital and Right Care. The CCG will also continue to promote and develop the demand management schemes it has in place, effectively directing some activity to primary care

		services including GPs with special interests or extended skills. NHS WKCCG has adopted a proactive approach to working with GPs to address variation in referral, practice packs are utilised to identify where undue variation exists and practices are visited by commissioners to discuss performance and understanding of referrals patterns. All GP practices are now fully utilising ERS as the front door to referrals and KINESIS for advice and guidance. Performance against the 62 Day Cancer Treatment standard in August 2018 shows an improvement since April 2018, but still remains significantly below the national target. The 2-week cancer waits show deterioration in August 2018 compared to previous months in this financial year. Achieving a sustainable level of improvement is clearly a key aim of the system. The Trust is progressing with its Cancer Services immediate action plans. MTW has continued to increase clinic and diagnostics capacity to reduce the number of people waiting and has also commenced out-sourcing MRI scans for prostate cancer and CT scans for other cancers. Additionally, system-wide agreement has been reached on further investment in the service. The CCG's cancer leads continue to monitor progress and develop joint plans with Trust cancer leads on a regular basis driven forward by the Executive Aligned Incentive Contract Group, and overseen by the CCG Performance & Finance Committee.
NHS Dartford, Gravesham and Swanley CCG	Continue to make changes and improvements to ensure our assurance ratings improve year on year	• In September 2017 the CCG was formally placed into special measures and under directions by NHS England. This was primarily due to the financial position of the organisation during the year and concerns with leadership capacity.

	Work with service providers, GP members and our partners to deliver future financial sustainability. Continue to work with our service providers to achieve key performance standards as set by the NHS Constitution	The CCG redoubled it efforts to improve the financial position and strengthen the leadership team with a new Chief Operating Officer and a Turnaround Director. As a result, the CCG reduced its deficit in 2017/18 from £13.5million the previous year to £9.1 million. We achieved this through QIPP schemes, efficiencies, and better management of contracts. As a result of the hard work and effort by all our staff the CCG was taken out of Special Measures and Directions on 1 April 2018. This is to be celebrated. We continue to work hard to reduce this deficit with a view of reaching long term financial balance. Strong financial leadership is key to improving this. • The CCG has had some changes in leadership as part of the wider Kent and Medway STP programme, and is keen to continue to drive improvements through. • The local acute provider is achieving the majority of NHS Constitution targets. • A&E remains a significant challenge although we are seeing improvements in delivery. We are working closely with our local provider to create an Urgent Treatment Centre to relieve pressure on A&E and have put A&E streaming in place to redirect some patients to GPs or emergency nurse practitioners. • We have recently implemented improved access across all primary care services which offers additional GP appointments to local people during the week and at weekends

		• We have a cancer plan which includes focusing on cancer education through GPs' protected learning time. Our Strategic Cancer Lead will drive this work and we have put new work plans in place to improve suspected cancer referrals and give GPs direct access to specific diagnostic tests. • Targeted assessments in nursing homes is being undertaken to improve dementia diagnosis rates. We are putting in a revised referral pathway for post diagnostic support and establishing effective care plans following diagnosis. Improvements in communication between GPs and providers will also enable better support. • We are working closely with providers to improve mental health services and to achieve our recovery rate targets. • The CCG was recognised as the first in the country to achieve 100 per cent participation in the National Diabetes Audit. This has given us a clearer picture of the achievement of treatment targets. The IAF rating for the CCG has improved and should be celebrated. However, further improvements are being planned, particularly around attendance at structured diabetes education.
	To develop long term sustainable and integrated local care services, working with our GPs through the DGS Federation, our local acute provider and community services.	• The creation of a GP Federation is continuing to help us develop our patient care pathways. By actively involving local doctors in shaping healthcare, we are developing joint plans for closer partnership, potentially through a primary and acute care model. We have recently approved investment cases to create effective multi-disciplinary teams to provide wrap around care, support for the elderly frail and people with co-morbidities, and working closely with GPs to identify people who can benefit from this approach.

		We are also implementing enhanced rapid response services and additional home visiting teams across the CCG. This is a major programme of work that is expected to transform local care services and strengthen clinical and professional workforce across health and care services. We plan for these services to be fully implemented during the autumn and winter of this year. • We are continuing to roll out our repeat prescribing service Prescriptions Ordering Direct (POD). This enables patients to order their repeat prescription via telephone, without having to leave their homes. Considerable savings have been made in medicine spend in the past year and we plan to continue this work. • We are working with colleagues in Public Health to improve maternity services with a particular focus on smoking in pregnancy and breastfeeding. We also have a plan which aligns with the Better Births agenda.
NHS Swale CCG	• Continue to work with our service providers to achieve key performance standards as set by the NHS Constitution. • Work with service providers, GP members and our partners to deliver future financial sustainability.	• At the time of reporting the local acute provider is achieving some NHS Constitution targets and trajectories agreed with NHS England. However, A&E and some cancer and elective services remain a challenge. • We are working with service providers, GP members and our partners to deliver long term financial sustainability. The CCG finished 2017/18 with a deficit of £3million and is currently forecasting breakeven for the current year. However, there remain considerable risks to achieving this and we are working extremely hard to mitigate these.

		• We continue to work with local GPs in supporting the development of our patient care pathways through our Clinical Strategy Committee and the Swale GP Federation. We are also developing plans to continue towards closer partnership working between our primary care colleagues and other providers. These plans focus on improving join-up of healthcare and maximising the financial benefits that accompany integration and improvements in quality. We have recently approved investment cases to create effective multi-disciplinary teams to provide wrap around care, support for the elderly frail and people with co-morbidities, and working closely with GPs to identify people who can benefit from this approach. We are also implementing enhanced rapid response services and additional home visiting teams across the CCG. This is a major programme of work that is expected to transform local care services and strengthen clinical and professional workforce across health and care services. We plan for these services to be fully implemented during the autumn and winter of this year. • The creation of a GP Federation is continuing to help us develop our patient care pathways. By actively involving local doctors in shaping healthcare, we are developing joint plans for closer partnership, potentially through a primary and acute care model. • Tackling diabetes is one of our key priorities and last year we were rated outstanding by NHSE. This is a testament to the hard work of our GP member practices, our other partners in health such as primary care nurses and our commissioning team. We were considered as 'top performing' under the previous rating scheme and have now sustained this – the only CCG in the south of England.

		• During the past year we have continued to make a number of investments in mental health, children's services, diabetes, palliative care and discharge planning and as a result, we have seen improvements both in terms of access and clinical outcomes. For example, improvements in the outcomes for patients receiving psychological therapy; significant improvement in the detection and management of diabetes; and the early diagnosis and detection of cancers, focusing on saving lives and the reducing disability.

By: Jill Kennedy-Smith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 23 November 2018

Subject: NHS West Kent CCG: Financial Sustainability

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

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

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1. Introduction

(a) NHS West Kent CCG has been requested to provide an update regarding its Financial Sustainability Plan.

(b) A written report is attached for information.

2. Recommendation

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

Background Documents

None

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Financial Sustainability – NHS West Kent CCG

HOSC

November 2018

Financial overview

- National context is that NHS England is viewing systems as a whole rather than judging individual organisations
- The local health system has operated in a challenging financial context for some while, in common with other areas within the NHS and other parts of the public sector
- The needs of the population are changing (e.g. age profile) and so is the demand
- The 'internal market' system within the NHS over the past decade or so has in part stimulated service provision and cost
- All members of the local health system have struggled to live within their means and have often relied on non-recurrent measures – not sustainable

2017/18 outturn

Across the west Kent system:

- The 2017/18 plan was to achieve a combined surplus of £6.6m, representing just over 1 per cent of the total CCG allocation.
- The 2017/18 outturn position was a deficit of £8.7m
- This meant a total shortfall of £15.3m

2018/19 control totals and plans

- The 2018/19 plan across the whole health system is a surplus of £11.8m.

- To achieve this will require £13.4m of non-recurrent sustainability and transformation funding (STF) being made available

- We will also need to make significant cost savings

- **The CCG is under an obligation to balance the various competing demands on the NHS locally, while living within the budget Parliament has allocated**

Approach to contracting and system based working

- Previous approaches to contracting within the NHS internal market were not always conducive to collaborative approaches being taken between members of the local health system
- We have moved towards new style agreements – 'Aligned Incentive Contracts', designed to encourage new behaviours and facilitate system transformation
- Already in place with Maidstone and Tunbridge Wells NHS Trust (MTW) and Kent Community Health NHS Foundation Trust (KCHFT)
- Collaborative agreement between CCG, MTW, KCHFT, Kent and Medway NHS Social Care and Partnership Trust (KMPT) and GP Federation
- Potential to extend the approach to the wider system, including social care from next year

System based cost savings opportunities

- Right Care
- Medicines Optimisation
- Getting It Right First Time
- Model Hospital
- Continuing Health Care
- Procedures of Limited Clinical Effectiveness
- Menu of Opportunities
- Productivity
- Local Care
- Other…?

QIPP as at Month 6 2018/19

- CCG planned Quality, Innovation, Productivity and Prevention (QIPP) programme £13.2m
- £2.2m transactional schemes for NHS Continuing Healthcare placements reviews
- £11m of transformational schemes
- Includes £6.1m of Aligned Incentives Schemes with MTW
- Medicines Optimisation Scheme of £2.2m
- Forecast at Month 6 to deliver although Year-to-Date currently £0.5m below plan

In the past year, the CCG has…

- Extended Aligned Incentive Contracting and established a Collaborative Agreement with four provider partners
- Commissioned a new falls service
- Commissioned Improved Access to primary care across the CCG
- Reviewed support to care homes and invested in tiered levels of medical support for homes across west Kent
- Introduced Home First Pathway 3 provision for complex frail patients, enabling discharge from acute wards
- Introduced a new acute frailty service with MTW
- Introduced new musculoskeletal (MSK) pathways: integrated pain management, rheumatology and additional orthopaedic, reduced referrals into MTW
- Outpatient transformation at MTW: two One-Stop clinics, a virtual fracture clinic, new nurse led clinics
- Invested in innovative local care services to support frail patients and those with mental health issues in the community

In the past year, the CCG has…

- Established seven cluster teams with cluster multidisciplinary team (MDT) meetings in every one
- Commissioned and begun new integrated diabetes care
- Expanded Improving Access to Psychological Therapies (IAPT) programme provision for people with mental health and long term conditions
- Invested in children's mental health preventative and schools programmes
- Commissioned new all-age specialist eating disorder service
- Established integrated primary care services in both A&E Departments and relocation of out-of-hours (OOH) services
- Expanded the Frequent Users Service
- Joint formulary prescribing committee set up with MTW, Infliximab biosimilar and Rituximab biosimilar rolled out

Looking forward: securing best possible value from our investments e.g. Local Care investment should enable the following:

- Reconfigured medical cover to care homes - improve quality of care to older people in care homes by making better use of existing resources and improving primary care
- Progression of recruitment plans for additional workforce - community frailty nurses and dementia nurses, geriatrician support
- A new falls prevention service (to start early 2019) – improving patient outcomes and experience whilst also being clinically effective and financially efficient; reducing admissions and attendances due to falls, soon to be augmented by a Fracture Liaison Service
- Reactive Local Care through additional capacity for rapid response and home treatment services supporting people with complex needs who are experiencing a health or social care need that left unattended would result in a possible hospital admission, designed to complement the Virtual Ward

Looking forward: securing best possible value from our investments e.g. Local Care investment should enable the following:

- Investment in creating additional capacity to support delivery of local care
- Home First Pathway 3 beds supporting people who have completed an acute episode of care but are unable to return to their previous place of care and need an ongoing assessment of their long term care needs
- Integrated MSK service - ensuring patients are seen in the right place, at the right time, by the right person. Supported by a “Single Point of Access” (SPA) through a clinical decision making and management unit
- Progression of plans for cluster therapists, pharmacists and increased capacity to support mental health local care

Looking forward: securing best possible value from our investments e.g. enhancing our alliance with local partners should enable the following:

- Development of Prime Provider contracts to secure clinical and strategic leadership for Planned Care, Proactive Local Care and Urgent Care
- Establishment of effective clinical governance and a local model of integrated urgent care, maximising the efficacy of the new 111/ Care Clinical Assessment Service (CAS) service
- Shared ownership and more efficient delivery of major change programmes and pathway redesign
- Reduced CCG workload and associated resourcing for contracting, procurements, business intelligence

Item 10: Kent and Medway NHS 111 and Clinical Assessment Service Procurement

By: Jill Kennedy-Smith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 23 November 2018

Subject: Kent and Medway NHS 111 and Clinical Assessment Service Procurement

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

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

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1. Kent and Medway NHS 111 and Clinical Assessment Service Procurement

(a) On 20 September 2017 the Committee was provided with an update regarding East Kent Out of Hours GP Services and NHS 111. As part of the Committee's deliberations, it agreed the following recommendation:

> *RESOLVED that the Committee receives a report about the joint procurement of the Kent & Medway 111 service at its January meeting.*

(b) On 26 January 2018 the Committee considered a written report about the procurement of Lot 1 (NHS 111 and Clinical Assessment Service telephony services across Kent and Medway) and Lot 2 (face-to-face services in North Kent including out-of-hour services and urgent treatment centres). The Committee agreed the following recommendation:

> *RESOLVED that the report be noted and Adam Wickings, Senior Responsible Officer for Kent and Medway Integrated Urgent Care Service Programme, be invited to provide a verbal update to the Committee on 2 March 2018.*

(c) Due to inclement weather, attendance was deferred to 27 April 2018. The Committee was provided with an update but due to the timing of the item the information provided was limited due to the start of the procurement process. The Committee agreed the following recommendation:

> *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.*

2. NHS Dartford, Gravesham and Swanley CCG: Urgent and Emergency Care

(a) The Committee considered the changes to face-to-face services in North Kent (Lot 2) at its meeting on 14 July 2017. The Dartford, Gravesham and Swanley CCG model option looked to relocate the walk-in centre to the same location as the minor injury unit to form an Urgent Care Centre at the Gravesham Community Hospital site, allowing the Fleet Healthcare Campus to be re-designed to increase primary care access. The Committee agreed the following recommendation:

RESOLVED that:

(a) the Committee does not deem the proposed changes to urgent and emergency care by the North Kent CCGs to be a substantial variation of service.

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

(b) The Committee received notification from the CCG on 24 October 2018 that the regional and local landscape has changed and that a requirement to go out to a full public consultation is required. The CCG wish to inform the Committee prior to providing a full update at a later meeting.

3. Recommendation

RECOMMENDED that:

(a) the Committee receive a written update regarding north west Kent and Medway interim arrangements for the NHS 111 contract;

(b) an update be provided to the Committee at the conclusion of the procurement for the Kent and Medway NHS 111 and Clinical Assessment Service;

(c) NHS Dartford, Gravesham and Swanley CCG be invited to present a comprehensive update on the Local Urgent Care Programme in January 2019;

(d) the outcome of Swale and Medway CCGs Local Urgent Care Programme procurement be presented to committee at the appropriate time.

Background Documents

Kent County Council (2017) *'Health Overview and Scrutiny Committee (14/07/2017)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=44860

Kent County Council (2017) *'Health Overview and Scrutiny Committee (20/09/2017)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7788&Ver=4

Kent County Council (2018) *'Health Overview and Scrutiny Committee (26/01/2018)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7639&Ver=4

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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Update Report to Kent Health Overview and Scrutiny Committee (HOSC)

Kent and Medway NHS 111 and Clinical Assessment Service Procurement

Briefing for the meeting on 23 November 2018

Adam Wickings, Deputy Managing Director, West Kent CCG and Procurement Senior Responsible Officer (SRO) - on behalf of all Kent and Medway CCGs.

Introduction

This paper provides the Kent Health Overview and Scrutiny Committee with an update on the Kent and Medway NHS 111 and Clinical Assessment Service Procurement.

Background

The HOSC received a briefing in April 2018 on the planned procurement across Kent and Medway for the nationally mandated Integrated Urgent Care Services (IUCS). The IUCS – aims to deliver an improved NHS 111 service, enhancing it with the inclusion of a Clinical Assessment Service (CAS). Patients calling NHS 111 who need clinical input will be transferred to a CAS. They will speak directly to a clinician who will seek to complete the call there and then, without the need to transfer the patient elsewhere.

The CAS will include a wide range of clinicians, including GP's Nurses, Paramedics, and Pharmacists. The CAS team will be able to directly book patients into an appointment at an Urgent Treatment Centre, another urgent care service or patients own GP, following a clinical assessment over the phone. With an increased focus on integration of the NHS 111 service with local urgent care in and out of hours, the aim is to drive a higher level of clinical intervention, improved support to outcomes for patients and also a reduction in unnecessary Emergency Department (ED) attendances and hospital admissions.

Scope

The Procurement originally included the following Lots:

- Lot 1: NHS 111 Telephony and Clinical Assessment Service (CAS);
- Lot 2: Face-to-face Urgent Treatment Centre for Dartford Gravesham and Swanley (DGS), Medway and Swale.

This briefing is to update members on the *NHS111 Telephony and Clinical Assessment Service for Kent and Medway (formally Lot 1)*.

This update does not include a broader update on Local Urgent Care Programmes.

NHS 111 and Clinical Assessment Service Procurement process update

Kent and Medway CCGs are working together to procure the NHS 111 and CAS. An IUC programme board has been meeting monthly, which includes clinical leads, CCG executive leads and Healthwatch colleagues. This board is steering the IUC procurement programme, with the decision making remaining with individual CCG governing bodies. Due to the commercial sensitivity of procurement, the case is being considered in Part 2 of the private governing body meetings.

In March 2018, all eight CCG governing bodies approved the commencement of the formal procurement process. The process began and commissioners were due to issue the second stage of the process, the Invitation to Tender, on 23 April. However, following an assessment of the Pre-Qualification Question (PQQ) evaluation, the IUC Programme Board Executive Leads took a decision to discontinue the process. This followed a concern that the process to date would not adequately demonstrate Value for Money (VFM) and could not result in a contract award across all of the services for which suppliers had been sought. Our procurement partners took legal advice and it was agreed that discontinuing the process then was a proportionate response and was the best way to guarantee that any future contract award for an IUCS will be able to demonstrate VFM.

The Programme Board intend to re-start the procurement process in full in early 2019.

Interim contract award due to delays in procurement

As a consequence of these complications the procurement timescales/options for the delivery were reconsidered over concerns about excessively short mobilisation.

As a result the IUC Programme Board agreed to an interim contracting arrangement for the period of one year, from 1st April 2019 – 30th March 2020. For east Kent, a contract extension has been agreed with their current NHS 111 provider, IC24. For north west Kent and Medway, commissioners have proceeded to negotiate with the current providers for the NHS 111 contract, SECAmb, to achieve an interim contract arrangement, as the current contract ends on the 31st March 2019. Commissioners are still in negotiations with SECAmb over these interim contracting arrangements.

Change to the Lot 2 bundle

Further, these delays resulted in a reassessment of Lot 2 for face-to-face Urgent Treatment Centres and out of hours primary care services for the NHS Dartford, Gravesham and Swanley, NHS Swale and NHS Medway CCG areas.

It was agreed at the IUC Programme Board that the face-to-face services for NHS Dartford, Gravesham and Swanley, Medway and Swale would be de-coupled. This procurement for Swale and Medway has continued and is in its concluding phase; it will be bought to the HOSC with an outcome at a later date.

Additionally NHS Dartford, Gravesham and Swanley CCG has agreed to pause the procurement of face-to-face services in its area for 12 months or more. This period of pause will allow the current urgent care model to be reshaped in Dartford, Gravesham and Swanley, to meet national standards by December 2019, whilst also allowing the CCG sufficient time to explore the potential of locating the UTC at the Darent Valley Hospital A&E site. The CCG will bring a comprehensive update about these plans to the HOSC on 25 January 2019.

Proposals to combine NHS 111 and CAS procurement with Sussex

Originally a combined Kent and Sussex procurement/contract had been discounted as the delivery models were different. At the time Surrey were also being considered but the complexity of governance across (then) 21 CCGs was felt to be unmanageable, and the savings tested in the previous procurement were not significant.

NHS England asked commissioners whether, if it was agreed that the interim contract be for 12 months, it would be prudent to reconsider a future footprint covering Kent and Sussex. An update on the potential benefits of collaboration were submitted to the September and October IUC Programme Boards and the board agreed that further scoping should be undertaken to firm up the potential benefits.

Commissioners are still working through the advantages and logistics of a combined approach.

Implementation of IUC National Standard, a coordinated approach

NHS England's timetable for implementation of IUC National Standards is 1 April 2019. In the absence of a new procured contract, we have been working to establish the Kent and Medway position against these national standards. We have undertaken a gap analysis in order to formulate a mitigation plan and this gap analysis has highlighted several project streams where work is required in order for us to meet national standards by the end of March 2019. It seemed appropriate for a co-ordinated approach to managing and delivering these projects. In light of this, CCG leads across Kent and Medway have agreed that these projects should be co-ordinated via the IUC Programme Board. Progress is being made against each work stream which includes development of:

- Integrated urgent care clinical governance across Kent and Medway
- Clinical activity counting
- Digital interoperability – including direct booking
- Development of the workforce and assurance of a link between out of hours (TC)/UTC and NHS 111.

Timescale and next steps

A final decision on whether Kent and Sussex should procure together will be made over the coming month and then a re-commencement of the longer term procurement process will begin.

The expectation is for the procurement to commence in the New Year, with evaluation of the providers in the spring of 2019 and approval of preferred bidders in the summer of 2019. This will allow for almost eight months of mobilisation prior to new go live date of April 2020.

Healthwatch, clinicians and the relevant specialists are working with the commissioners on designing the next steps alongside the procurement criteria and participating in the evaluation process.

Once the preferred bidder is identified and the contract awarded, a detailed mobilisation plan will be agreed and implemented, working with a wide range of partners in the system.

We would be pleased to come back to HOSC to provide further updates in due course.

Item 11: Kent and Medway Non-Emergency Patient Transport Service Performance

By: Jill Kennedy-Smith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 23 November 2018

Subject: Kent and Medway Non-Emergency Patient Transport Service Performance

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS North & West Kent CCGs (Lead for Kent & Medway Patient Transport Service).

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

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1. Previous Committee Attendance and Requested Information

(a) On 27 April 2018 the Committee considered an update about the Patient Transport Service. The Committee was informed that the CCG was in the process of signing a contract variation with G4S which would include new Key Performance Indicators (KPIs). The Committee agreed the following recommendation:

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.

(b) On 8 June 2018 the Committee considered an update report from NHS West Kent CCG which detailed the new Key Performance Indicators for Patient Transport Services. The Committee agreed the following recommendation:

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.

(c) The CCG as part of their report to Committee have been requested to provide an update on fleet management, staffing, Key Performance Indicators, contract monitoring/management, activity levels and patient engagement including compliments/complaints received incorporating where possible hospital feedback.

2. Recommendation

RECOMMENDED that the report be noted, and NHS North and West Kent CCGs be requested to provide an update in June 2019.

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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KENT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

NOVEMBER 2018

KENT AND MEDWAY NON-EMERGENCY PATIENT TRANSPORT SERVICE PERFORMANCE

Report from: Stuart Jeffrey, Deputy Managing Director, North & West Kent CCGs (Lead for Kent & Medway Patient Transport)

Author: Valerie Jopson, Deputy Head of Contracts, Optum

Executive Summary

The non-emergency patient transport service (PTS) has been provided by G4S across Kent and Medway CCGs from July 2016.

This report aims to give an overview of the previous contract performance challenges and the remedial actions to date by both the Commissioners and the provider. The current performance reports are encouraging and demonstrate G4S's commitment to their service development and improvements in the overall patient experience.

Where were we?

The G4S provision experienced significant pressure from commencement of the contract, throughout 2017 and into early 2018, with increasing demand on services. The journey profile, which was used to predict the number and variation of resource, proved no longer an accurate reflection of the demand and was the primary reason for substandard performance across the contract. Analysis of activity showed:

- Increase in ambulance journeys by 3.5 per cent
- Increase in Patient escorts by 9 per cent
- Increase in journey length.

In addition, urgent care and hospital bed pressures resulted in a rising demand for on-the-day bookings and discharges, despite the service being commissioned predominantly as a pre-planned service. This was particularly evident in Medway and areas of east Kent, which saw activity significantly above the commissioned levels.

What did we do?

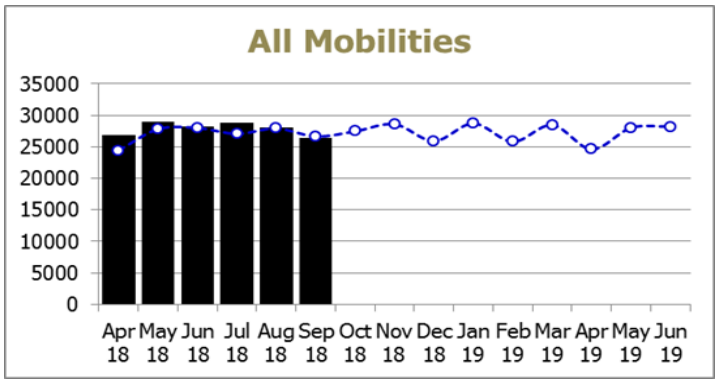
Commissioners had built in a provision for revisiting the contract if activity levels varied significantly from those commissioned. This process was known as the "true up". Through this process, activity levels and other system pressures were reviewed and detailed modelling was undertaken for G4S, by an independent body, to ascertain the number of vehicles and staff needed to deliver full compliance against the contracted **key performance indicators** (KPIs), based on detailed journey data. Within the NHS and Social care focus on service improvements and new ways to ensure care is delivered right time and right settings is therefore essential that patient transport services are also able to deliver what is needed within the overall systems of increased NHS efficiencies and health outcomes for people.

Throughout the process of the true up, and following the alert of significant variance of activity, the CCGs agreed to fund G4S for the utilisation of third party vehicles to support the service in circumstances where the challenges related to additional pressures from the originally commissioned service volume and resource mix.

The CCGs and G4S jointly developed remedial action plans to address some of the weaknesses that were identified within the service. These included the complaint management processes, local management presence and local stakeholder engagement. To support this, G4S employed a dedicated relationship manager to work with providers on challenges and issues.

The "true up" was finalised in March 2018 and additional funding of £1.6m was agreed. The CCG agreed an approach of consolidation of all contract lots, instead of previously individual services. This was supported with a revised set of KPIs that was felt to hold a better focus on key indicators of patient experience and safety. These changes allow greater flexibility and efficiency, which in turn will result in an improved service and performance, once fully implemented.

The chart below covers the Kent and Medway total activity following the true up process covering the merger of all three lots. The blue dotted line is the Year 3 trajectory taking into account seasonal phasing adjustments.



As a result of the additional funding into the contract, there has been direct investment into additional vehicle and people resources to support the increased service demand. A mobilisation period of three months for outpatient activity and six months for discharge/ transfer activity was agreed and 16 new ambulance vehicles will be deployed in Kent as part of this agreement. These vehicles are a mixture of

Stretcher and Wheelchair Accessible Vehicles (WAVs) with the first 10 delivered before the end of August. These vehicles were chosen as a result of both patient feedback and consultation with staff, with specific attention given to patient comfort and patient journey time.

G4S continue to utilise the rest of their PTS fleet, which adds greater flexibility and resilience, whilst improving performance levels. The fleet size for Kent and Medway will increase from 190 to 206, with access to the wider business fleet of a further 170 vehicles to support unplanned demand. It is anticipated there will be at times up to 230 vehicles used to support the Kent and Medway contract. This is all with further support from approved third party suppliers, where appropriate.

In line with the increased number of vehicles, there has also been an investment in more Ambulance Care Assistants (ACA's), who are required to operate the additional vehicles. As the contract demands greater flexibility, a mixture of both full and part-time roles has been offered. G4S has set their establishment at 395 FTE's, which does not include their access to up to 40 bank staff to support demand.

Where are we now?

Call Centre Operations

One of the complaint trends prior to the "true up" was the length of time taken to answer calls. This was recognised as being the result of a high volume of enquiry calls during peak hours, which resulted in difficulty for patients trying to make their bookings. To resolve this, action was taken in May to redirect the appointment booking calls to its call centre operation in Wath on Dearne. This is a fully dedicated call handling facility, owned by G4S and led by vastly experienced call handling management teams. Since implementation, there has been a significant improvement in call waiting times across the service. The table below shows the key improvements.

Details of Service Levels and KPIs [Inbound calls]	KPI	Apr-18	May-18	Jun-18	July-18	Aug-18	Sep-18
No of calls offered		31898	12145	10916	12384	11925	11740
No. of calls answered		19125	10053	10463	11870	10979	11189
Average Handling time [seconds]		350	409	372	304	312	285
Average speed to answer [overall]		00:05:21	00:03:20	00:00:42	00:01.17	00:47:00	00:01:02
Average speed to answer [K&M future bookings]	**<20 secs**	00:05:15	00:04:05	00:00:41	00:00:55	00:00:34	00:00:55

The April call volume of 31,898 includes booking calls, enquiry calls and miscellaneous calls. Booking calls represent approximately 11,000 – 12,000. The average call handling time shows a reduction. The main complaint theme was average speed to answer which is the amount of time patients wait for calls to be answered. This shows a dramatic improvement from five minutes in April, to just over four in May, to less than a minute more recently. The September performance of 55 seconds includes some individual days involving specific external line issues with Vodafone which were well communicated at the time and are subject to full root cause analysis. Without these exceptions the underlying performance trend continues to improve.

Performance

The table below shows the trend of improvement with patients arriving on time for appointments:

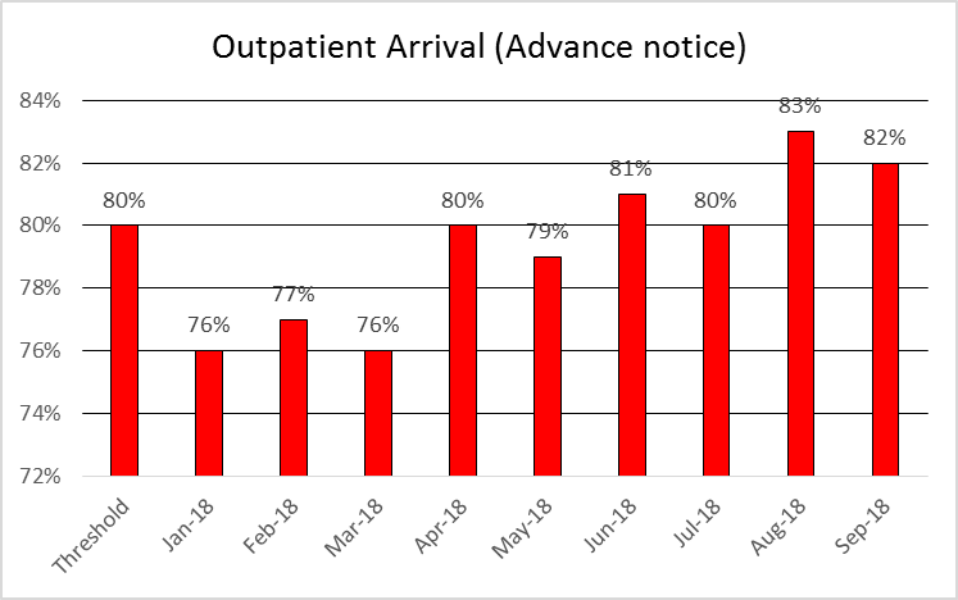
KPI	Threshold	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Outpatient Arrival [advance notice]	80%	76%	77%	76%	80%	79%	81%	80%	83%	82%
Outpatient Return	80%	76%	78%	76%	91%	91%	90%	88%	94%	95%
Discharge [advance notice]	80%	45%	41%	42%	72%	69%	66%	61%	86%	98%
Discharge [on the day]	80%	70%	69%	66%	82%	78%	72%	69%	74%	76%
Transfer of care [advance notice]	80%	57%	54%	65%	79%	93%	71%	81%	100%	83%
Travel time (exc renal)[less than 10 miles, not to exceed 90 minutes]	80%	83%	89%	88%	97%	97%	98%	98%	98%	97%
Travel time (exc renal) [11-35 miles, not to exceed 180 minutes]	80%	76%	83%	83%	99%	99%	98%	99%	99%	99%
Travel time (renal patients) not to exceed 60 minutes *	80%	NA	NA	NA	81%	81%	81%	81%	82%	80%

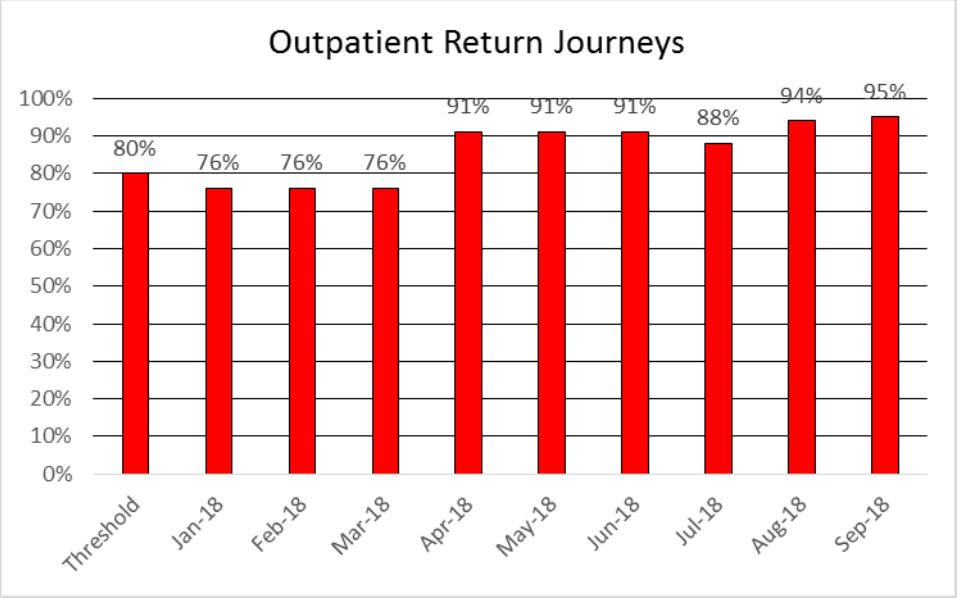
*The time on vehicle for renal patients is impacted currently due to a number of patients travelling longer journeys as a result of renal units in some regions not having capacity to treat locally. This has been further impacted by the ongoing M20 smart motorway works and more recently the lane closures on the M2.

In addition to the standard performance reporting, the commissioners have recognized that whilst a KPI is a general measure of performance, it is not indicative of the full service provided. As an example, for September 82 per cent of patients arrived for their appointments within the contractual KPI, and a further 12.8 per cent of patients arrived within 30 minutes of their allocated appointment time. Where patients may be running late processes are in place to liaise with the clinics to ensure there is no effect on the appointment and the patient is re-assured. This is a further indication of the on-going improvements made over the last period and the positive impact this has had on the patient experience.

The immediate focus was around outpatient inward journeys and outpatient outward journeys. G4S has been liaising with key stake holders within the hospital to ensure all discharges and transfers are moved as soon as possible. G4S has also introduced new control methods that allow G4S to be more proactive and flexible with resources across Kent. A new process has been introduced for the Patient Transport Liaison Officers (PTLOs) where they proactively encourage morning discharges. G4S also attend bed meetings and chase medicines for patients to take home to try to ensure discharges are spread throughout the day, this trial was very successful within William Harvey Hospital and is being rolled out across Kent.

Performance continued





Staffing and Fleet

G4S has recruitment and fleet plans in place to deliver the revised service in the new funding envelope.

31 additional FTE's will be added to the base line of 364 in line with the 3 and 6 month agreed mobilization trajectory. 10 new vehicles were deployed by the end of August with the latest design features, responding to feedback from patients and experienced staff.

In addition to this, a full detailed review of journeys, including base locations, mobility types, and to/from addresses, has produced an improved set up for G4S's operating system. This means that areas of coverage and vehicle type distribution have changed to more accurately reflect the current pattern and patient need. The outcome is intended to improve vehicle availability and reduce travelling times.

A further six High Dependency Unit vehicles (with Stretcher capability) are currently in the design phase and expected for delivery in the New Year.

Patient Engagement

In line with G4S's commitment to improving the patient experience, it has developed a 2018/19 Patient Engagement Strategy. G4S accept that to confidently understand the needs and challenges
that patients' face, they need to engage in a more meaningful way; encouraging and supporting patients to share their views.

Whilst the patient experience survey demonstrates a consistently positive trend, it is recognized that this mechanism is limited and as a result, the strategy expands their face-to-face engagement pathways.

The initial response to this approach has been hugely positive and the dedicated G4S Relationship Manager has spent time at each Renal Dialysis Unit, capturing views from patients about their experiences and their suggestions. This is a quarterly commitment and outcomes from the sessions will be formally shared with all patients to demonstrate continuous improvement.

In additional to the renal dialysis engagement, G4S have met with Healthwatch Kent and have agreed regular planned meetings to establish a relationships and utilize their expertise for objective feedback.

The Patient Engagement Strategy was formed using outcomes from existing patient feedback. The strategy is a 'live' plan, which will continue to evolve in line with themes and trends from the patient survey, complaints data and patient forums.

[Please see Appendix A for detailed patient experience outcomes]

Engagement initiatives

- Engagement continues to grow between G4S, the hospitals and community trusts with regular meetings now set so we can constantly review progress and collaborative working opportunities.

- Specific meetings have been held with each individual renal unit within Kent which have been well received and identified some areas for improvement including specifically vehicle design and movements on a Saturday which have both been addressed (the latter being a change in shift patterns to better meet demand). Regular follow up meetings are now being conducted with specific information by unit being provided.

- Drop in clinics have been conducted with Maidstone and Tunbridge Wells NHS Trust with the relationship manager and representatives from the G4S team from Chelmsford. This gave hospital staff the opportunity to ask questions they may have about bookings, process and the contract in general.

- A specific mental health pathway workshop has been conducted with all stakeholders invited and a revised and defined process has been agreed for both risk assessment and bookings. This has resulted in the setting up of local arrangements in north and west Kent, all of which provide further information about developments and requirements for amendments to resource deployment.

- Bi-monthly meetings are held now with Strode Park Foundation to improve the patient experience and to work together to support each other's service. One of the outcomes of these meetings was to improve the rapport between Strode Park and the Margate base, to achieve this the Strode Park team have direct contact with their local controllers or service delivery manager. This allows for improved communications regarding transport of patients as well if either service has issues they can be addressed sooner to ensure the patients do not suffer any anxieties regarding therapies or packages of care. To further improve the service and on the back of these meetings we also meet with Wheelchair Services bi-monthly. This is as a result of patients travelling between the sites and further learning opportunities.

- All the senior management team has undertook appropriate training and are completing a programme of 'Back to Greens' to spend full shifts working in direct contact with front line operational employees and direct contact with patients. This is to understand better the first impressions patients have of the quality of service and care they receive. This is designed to think more carefully about quality of care from a patient's point of view. This programme is currently in progress.

Patient Engagement and Complaints Management

G4S acknowledge that they had a number of challenges with their complaints and feedback process throughout 2017, which resulted in a Contract Performance Notice. Working with the CCG, the following positive changes were made:

- Investment in additional resource for the Patient Experience Team; expansion from 1 Full time equivalent (FTE) to 3.5 FTE
- Creation of accountable investigators and investigation pathways
- Implementation of a dedicated Free phone feedback line, outside of the main call structure so there are no delays in call waiting times
- Implementation of a risk matrix, with associated quality assurance processes to prevent patient harm.
- Further development of 'cause codes' to support more meaningful investigation and analysis to ensure learning and continuous improvement
- Creation of communication material for 'how to complain' displayed in each vehicle
- Weekly G4S Senior Management call to review complaint volumes, response times and themes

- Dedicated detailed Complaint Management report, provided monthly to the CCG.

As a result of these changes, G4S now report a consistent achievement of their acknowledgment and response KPI. The Contract Performance Notice was removed in April 2018.

G4S acknowledge that there has been an increase in the number of complaints received over the last 6 months. Analysis has suggested this is a result of increased awareness/accessibility of the complaint pathway, and increased media attention in a small number of specific cases.

The main themes of patient complaints are identified as timeliness (such as late for appointment or long wait for collection), and communication linked to those experiences; such as difficulty getting in contact with the enquiries team.

All trends and outcomes including analysis of specific complaints are reviewed at the Senior Management Team meeting. In addition all Service Delivery Managers in Kent have had review days involving the Chief Operating Officer (COO) and patient experience team to ensure full understanding, root cause analysis and outcomes.

As a result all operational managers now spend time within the planning and patient experience function to not only be fully immersed but to identify areas for improvement. This has seen a reduction in complaints during September.

Type	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Complaint	54	57	63	64	73	91	103	134	98
Journeys by month	28242	25349	28117	26871	28693	28311	28693	28956	26477
% Against Journey	0.19%	0.22%	0.22%	0.24%	0.25%	0.32%	0.36%	0.46%	0.37%

Feedback and complaints are known to be the best evidence for bringing about sustainable change and forms the basis for any quality improvement within the service. Patient complaints offer us grassroots level raw data that can be used to change and improve patient experience and outcomes.

Examples of learning outcomes from complaints

- Policing of communications to patients to reduce anxiety levels – dedicated resource monitoring any delays and liaising with clinics and patients
- Potential longer waits highlighted by exception and escalated to a senior manager for action and monitored on a daily, weekly and monthly basis
- Resource levels and timings at week-ends adjusted to fit with current demand.

- Service Delivery Managers attending education days with the complaints/patient engagement team
- More face to face resolution with more challenging complainants
- Improvements to the controlling process where a cause within complaints.

Where do we want to be/ how do we get there?

Whilst the accurate profile plus ensuring achievement of contractual KPI's is essential for the overall service to succeed, G4S continue to strive for success across a much wider remit. Innovation and improving the patient experience remains a key focus for the service.

G4S has continued to increase and enhance its management expertise with expansion specifically in the following:

a) Resilience within its Governance team

b) Business Intelligence

c) Call Centre capabilities

G4S has an open and transparent relationship with both the CCG and the CQC in reporting of incidents to support a culture of learning. There are engagement conversations taking place with the Independent Safeguarding Service to support G4S with independent specialist services to enhance their Safeguarding agenda. Similarly, Health Assure has been approached to see how it can support G4S PTS using technology, assurance and audit tools across the business.

Conclusion

This report provides an updated position statement on the performance of the contracts with G4S for non-urgent patient transport. The report has been based on data available up to September 2018.

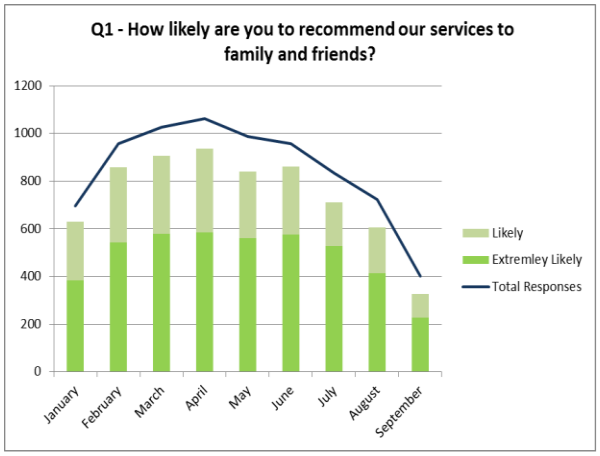
Commissioners are actively working with G4S to ensure that the contract accurately reflects the level and type of activity required and that the operational structure of the service is robust. The trajectories for the revised KPIs are actively monitored through monthly contract meetings and following the agreed dates of achievement (July and September); the commissioners may exercise their right to apply financial penalties for non-compliance. Both the CCG and G4S are pleased to report that the current performance has improved in line with expectations.

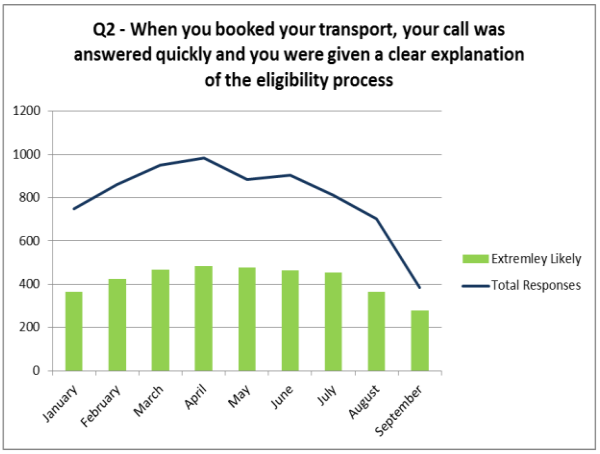
G4S has further stated their on-going commitment to partnership with providers and stakeholders and are demonstrating increased engagement across the region. We hope to work congruently with them to ensure the service supports the hospitals in optimal patient flow and enhances patient experience and safety.

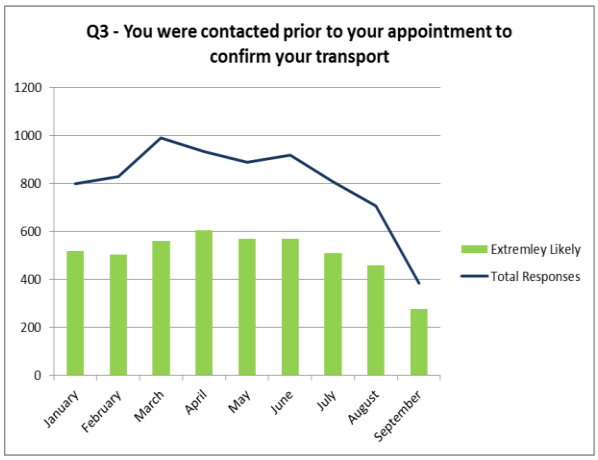
Appendix A – Patient Experience Data

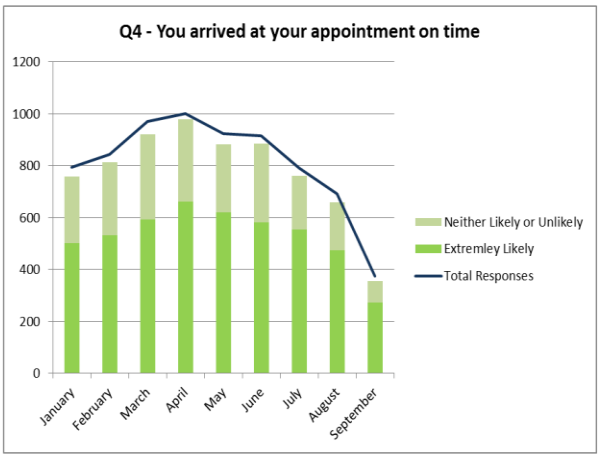
Question	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total
We would like you to think about your recent experiences of our service. How likely you are to be to recommend our service to friends and family if they needed to use a similar service?	226	100	52	7	16	0	401
When you booked the transport, your call was answered quickly and you were given a clear explanation of the eligibility process?	196	0	156	0	28	10	390
You were contacted prior to your appointment to confirm the transport?	277	0	96	0	4	6	383
You arrived at your appointment on time?	273	0	82	0	10	8	373
If not, someone informed you that your transport was running late?	83	0	62	0	14	10	169
The ambulance you travelled in was clean and tidy?	281	0	107	0	3	0	391
The member of staff driving you to your appointment was polite and courteous at all times, offering assistance where needed?	347	0	42	0	0	0	389
You felt safe and comfortable throughout your journey?	332	0	50	0	0	1	383
Total	**2015**	**100**	**647**	**7**	**75**	**35**	**2879**

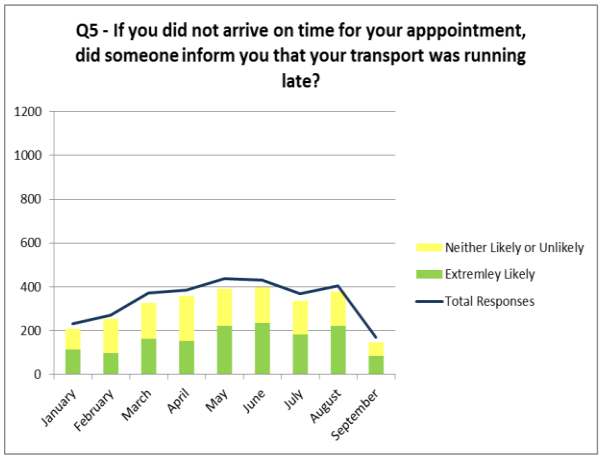
* 0 is a reflection of questions where the scale of answer is not applicable as these are reported on a yes/no basis. This has been updated for the newer version of the Patient Experience Survey.

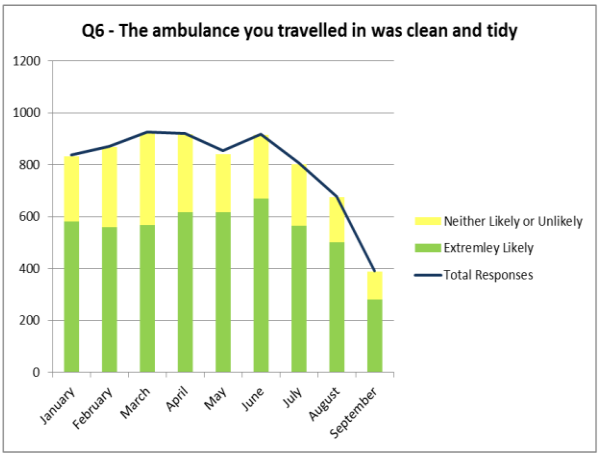

Q1 - How likely are you to recommend our services to family and friends?
1200
1000
800
600
400
200
0
January
February
March
April
May
June
July
August
September
Likely
Extremley Likely
Total Responses

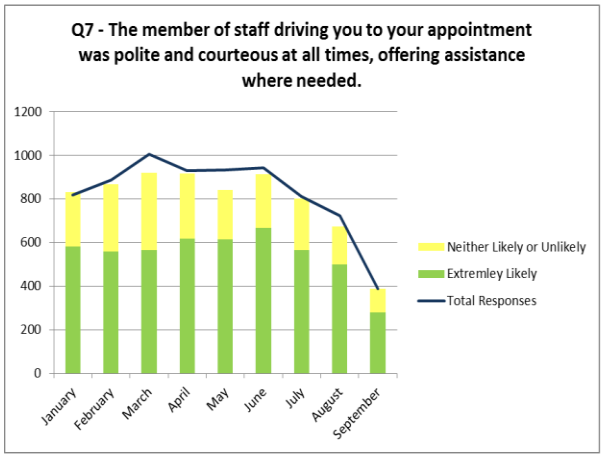

Q2 - When you booked your transport, your call was answered quickly and you were given a clear explanation of the eligibility process
1200
1000
800
600
400
200
0
January
February
March
April
May
June
July
August
September
Extremley Likely
Total Responses

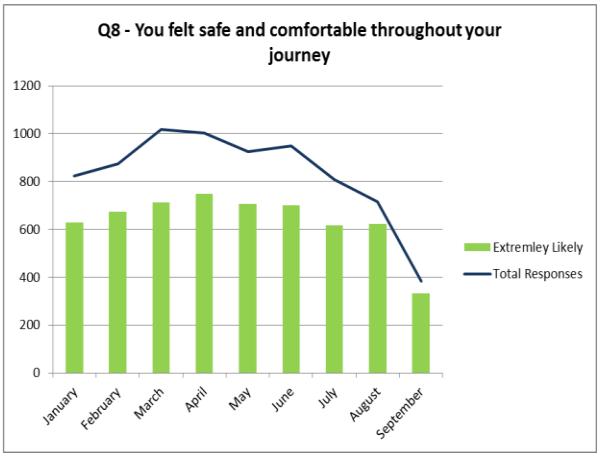

Q3 - You were contacted prior to your appointment to confirm your transport
1200
1000
800
600
400
200
0
January
February
March
April
May
June
July
August
September
Extremley Likely
Total Responses


Q4 - You arrived at your appointment on time
1200
1000
800
600
400
200
0
January
February
March
April
May
June
July
August
September
Neither Likely or Unlikely
Extremley Likely
Total Responses


Q5 - If you did not arrive on time for your apppointment, did someone inform you that your transport was running late?
1200
1000
800
600
400
200
0
January
February
March
April
May
June
July
August
September
Neither Likely or Unlikely
Extremley Likely
Total Responses


Q6 - The ambulance you travelled in was clean and tidy
1200
1000
800
600
400
200
0
January
February
March
April
May
June
July
August
September
Neither Likely or Unlikely
Extremley Likely
Total Responses


Q7 - The member of staff driving you to your appointment was polite and courteous at all times, offering assistance where needed.
1200
1000
800
600
400
200
0
January
February
March
April
May
June
July
August
September
Neither Likely or Unlikely
Extremley Likely
Total Responses


Q8 - You felt safe and comfortable throughout your journey
1200
1000
800
600
400
200
0
January
February
March
April
May
June
July
August
September
Extremley Likely
Total Responses

Appendix B – Kent & Medway CCG KPI performance – September 2018

Journey Type	KPI Area	Required Standard	Minimum Standard		Actual performance
Outpatient	All outpatient arrivals	Patients to arrive on time and no more than 75 minutes prior to their appointment time	80%		82%
Outpatient	Outpatient arrivals - pre-booked journeys	Patients to arrive on time and no more than 75 minutes prior to their appointment time	80%		82%
Outpatient	All outpatient pre-booked return journeys	All patients to be collected within 75 minutes of the booked or made ready time whichever is greater	80%		95%
Outpatient	All outpatient on the day booked return journeys	All patients to be collected within 75 minutes of the made ready time providing a minimum of 2 hours' notice of the booking	80%		98%
Outpatient renal	Patients to arrive on time and no more than 15 minutes prior to or later than their scheduled appointment	Patients to arrive on time and no more than 15 minutes prior to or later than their scheduled appointment	80%		87%
Outpatient renal	Return Journey patients to be collected within 30 minutes of the identified booked ready time.	Return Journey patients to be collected within 30 minutes of the identified booked ready time.	80%		92%
Discharge	Discharge journey booked in advance	All patients to be collected within 75 minutes of booked time	80%		98%
Discharge	Discharge journey booked on the day	All patients to be collected within 120 minutes of booked ready time	80%		76%*
Transfer	Journey booked in advance - Transfer of care.	All patients to be collected within 75 minutes of booked ready time	80%		83%
Transfer	Kent and Medway bound journey booked on the day - Transfer of care.	Patient to be transported within 120 minutes of the identified booked ready time	80%		77%*

* Further work is being undertaken with acute hospitals by liaison officers to support and manage the number of patients being discharged or transferred later in the day causing bottlenecks. This involves proactive following up for patient medications, assessments of mobility and situation regarding packages of care and cut off times. Long waits for patients in this category have reduced from 6 per cent to 1.2 per cent.

Item 12: Healthwatch Kent: Annual Report

By: Jill Kennedy-Smith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 23 November 2018

Subject: Healthwatch Kent: Annual Report

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

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

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1. Introduction

(a) Healthwatch Kent has asked for the attached reports to be presented as part of their annual update to the Committee.

2. Recommendation

RECOMMENDED that the report be noted and Healthwatch Kent be requested to provide an update to the Committee annually.

Background Documents

None

Contact Details

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03000 416343

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healthwatch Kent

Healthwatch Kent

Annual Report 2017/18

The year at a glance

Through our Helpline we have empowered 5,140 people to make informed choices and get the right care that they need

Our 66 volunteers have donated 1,540 hours of their valuable time to help make a difference

We've spoken to 3,500 people in depth about specific issues

We've done 40 Enter & View visits including 25 to Care Homes

We've visited 72 community groups and spoken to around 1,440 people

Over 400,000 people have heard about Healthwatch and our work this year

What have we achieved?

Created a patient group to influence the STP and the future of our health & care services

We have shared 158 stories to inform Kent County Council's review of Carer services

Improved care for Parkinson's patients in West Kent

Improved information available to patients with learning difficulties in East Kent

We've shared 470 stories from people who have been discharged from hospital

Launched the Healthwatch Help Cards which have helped 7,685 people so far

How do we bring about change?

The answer is simple... By listening

We listen to people through a number of different ways:

- When people contact our Helpline directly.
- By proactively visiting communities and groups. especially those who are classed as seldom heard and may not share their feedback.
- Through our regular Information stands at public places including libraries and hospital foyers.
- By using our statutory powers to Enter & View any adult health or social care service and talk to patients and users about their experience.
- Talking to people in supermarkets and high streets about their experiences of services and their thoughts about how services could change.

Through this work we have been able to listen to people from all ages from young to old. We've also heard from people who would be classed as 'seldom heard or vulnerable plus people who may not live within Kent but who use Kent's services.

Here's just a few examples of where we have been this year:

- Mental Health support groups
- Gypsy & Travellers sites
- Older People's Groups
- Pensioners Information Fair
- Rural Libraries
- Kent Physical Disability Forum
- Macular Support Groups
- Dover Big Local Fete
- Canterbury Pride
- Carers Forums
- RBLI Information & Advice Days
- East Mencap Fun Day
- Age UK Hythe & Lyminge Festival
- Canterbury & District Early Years Project
- Maidstone Dementia Cafe
- Foodbanks
- Ashford Homelessness Forum

What we've learnt from visiting services:

We've learnt so much from talking to people but here are a few snapshots.

- Access to a British Sign Language. Interpreter continues to be a problem.
- Many people continue to be stuck in hospital while they await a care package to enable them to go home.
- Psychological wellbeing was the biggest issue faced by the Carers we spoke to.
- Services do not always work as efficiently or as joined up as they could be.
- If people cannot get an appointment from their GP, they are twice as likely to go to A&E.
- People are confused and fearful of changes to services. They want to understand what services will look like in the future.
- People don't feel they are being engaged and involved in changes to services.
- There is currently a lack of provision for adults with autism.
- GPs and District Nurses do not always receive discharge information on their patients so they don't have the details they need to treat them.
- Test results are not always ready for peoples' appointments.
- People can experience lengthy delays for appointments.
- Information is not always available to people in the format that they need.

Strategic Priorities

This year we have tried to reduce the number of priorities to enable us to focus and commit the time needed to make a real difference to services. This list is not exhaustive and we will continue to respond to issues as the year goes on.

Adult Autism: Although we don't hear a huge amount about adult autism services, we have heard a number of concerns. Kent County Council and the NHS are going to be reviewing the services they provide to adults with autism in Kent this year, so this is a great opportunity to ensure that people can share their views and thoughts so that they can be considered while a new service is being developed.

Autism in Children: Two years ago, we published a report about mental health in children and young people. During that work we heard a number of issues about autism in children particularly around diagnosis and waiting time. We want to see if this situation has improved for young people and their families.

The Sustainability & Transformation Partnership (STP): We will continue to have an active role in the STP and the changing face of commissioning within Kent & Medway. Our role is to champion the involvement of patients and service users in these changes and to ensure all parts of our communities are involved. A key way that we do this is to support the STP Patient & Public Advisory Group which involves members of the public.

Discharge from hospital for homeless patients: We have done a lot of work around hospital discharge over the past two years but we have yet to address the issues faced by homeless people across Kent. We will be proactively seeking to understand their experience of being discharged from hospital and helping to improve their experience.

Mental health in the community: We often hear about issues with mental health services in the community both from providers and service users. We will be exploring these issues in greater detail and working with the relevant services to make improvements.

End of Life Care: We will be visiting some Kent hospices this year to talk to patients and their families about End of Life Care. We will also be working in partnership with the Kent Community Health Trust to gather feedback from Kent residents about current End of Life care services.

Accessible Information for All: Last year we worked in partnership with East Kent Mencap to visit hospitals in East Kent through the eyes of someone with learning difficulties. This year we will continue a series of visits to other organisations to explore how they are supporting patients and service users who may be Blind, Deaf or have communication issues.

Listening to you: As always, we will continue with our programme of visiting communities particularly those who are often harder to reach. These visits will enable us to hear directly peoples' experiences of health and social care services. We have a regular presence in all Kent NHS Trusts talking to patients, but we also visit community and local groups as well as travelling around Kent on our Coffee Caravan. The Coffee Caravan,, in partnership with Rural Kent, visits rural communities to reduce social isolation, provide information and support and enables us to hear directly from communities.

The patient and user voice: Working together with established user forums such as the Older Peoples' Forum, the Mental Health Action groups and service user forums and the Kent Physical Disability Forum, we will ensure that these existing forums are involved and listened to as part of the health and social care system.

What difference have we made?

What do we do with what we have heard?

We share EVERYTHING that we have heard. We share the loud voices and the not so loud voices. We share the positive stories and the not so good stories. Here are just a few places that we share the feedback you tell us:

- Directly with the Care Quality Commission especially if we have serious concerns about a service.
- We meet with Kent County Council every month and raise issues with a panel of KCC officers.
- At the Kent Health & Well Being Board and the seven local Health & Well Being Boards.
- If relevant at the Kent Health Overview & Scrutiny Committee which is made up of Kent County Council Elected Members.
- Directly with the relevant organisation and commissioner of the service.
- All our information is shared with our umbrella organisation, Healthwatch England.
- We are part of the Kent & Medway Sustainability & Transformation Partnership (STP). Any issues we hear that relate to the future of services we share here.
- We work with all of these organisations and more to ensure your voice is heard by the right people at the right time to influence and inform improvements and changes to services.

In our hospitals: Our trained volunteers have completed 13 Enter & View visits to talk to patients in hospital. We also regularly visit Kent hospitals to hear from patients about their experiences. Here are just a few of the things we have achieved;

- Better support for Parkinson's patients in West Kent.
- More disabled parking at Kent & Canterbury Hospital.
- Better information for patients waiting in Outpatients.
- Improved signage to help patients find their way in West & East Kent.
- Better appointment information for Royal Victoria Hospital patients.
- Improvements are being made in East Kent to ensure information is more readily available to patients in different formats should they need it.
- New policy at Darent Valley Hospital to stop dialysis patients missing meals.
- A new leaflet is being created for new and expectant Dads.

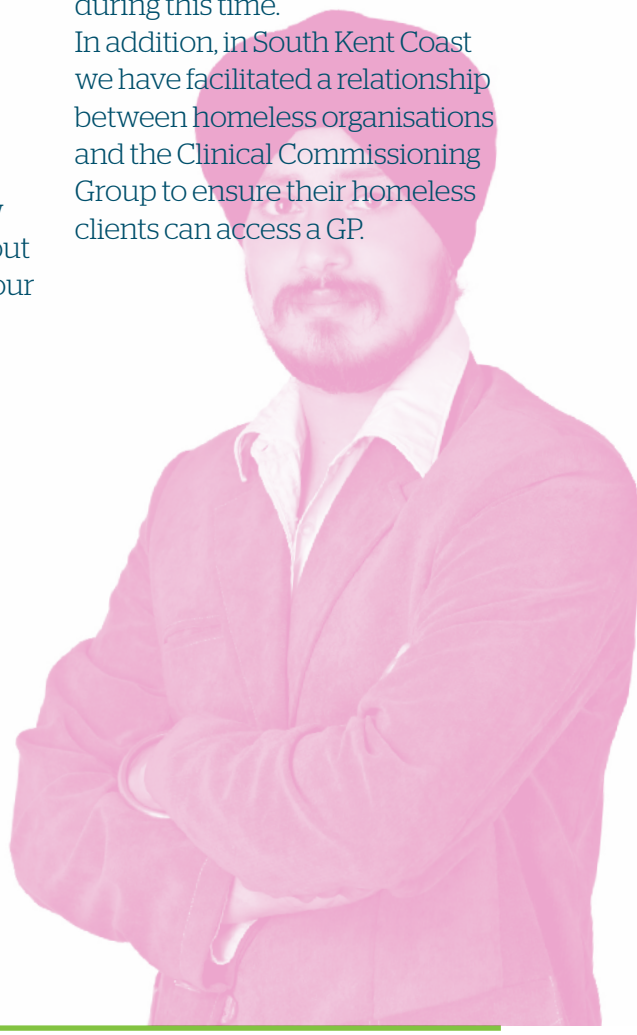
In our Care Homes : We have visited 25 Care Homes across Kent this year to talk to residents, families and staff. Our findings have only just been published so it is too early to say what difference it will have made but we are confident changes will be made as a result. We have also escalated **18** cases of concern for safety to the Care Quality Commission and Kent County Council this year. All of our escalations have been investigated.

Mental health patients and carers : We work closely with the Kent Mental Health Action Group (MHAG) as well as the local groups which are made up of patients and carers. On behalf of the Kent MHAG we asked questions about the readmission rate for mental health patients. Following on from the response, we facilitated a direct relationship between the MHAG and the Mental Health Trust to strengthen their relationship. We are now embarking on large piece of work in conjunction with our parent company, Engaging Kent, to strengthen the voice of mental health patients and ensure the mental health forums are heard and involved in the development of services.

Changes to our services :
Services are undergoing a huge amount of change across the country and we can't be involved in every development. We have however focused our efforts on the Kent & Medway Sustainability & Transformation Plan or STP. Our work in this area focuses on the following aspects;

- We have been instrumental in setting up and developing the Patient & Public Advisory Group for the STP which is a group of patients and voluntary sector representatives that ensure the voice of patients in firmly centred within the STP. We have been asked to Chair that group. We have ensured members of the public are involved in every work stream of the programme, we have improved consultation documents and ensured engagement is carried out to a high level wherever possible. We have gained commitment from the programme to work in a 'co-production' model going forward and we are helping them draft their strategy and recruit their communications and engagement team.
- We also have a statutory responsibility to scrutinise changes to services to ensure people are involved and informed about any changes. Our volunteers who are not actively involved in the STP undertake this scrutiny work and they are trained by the Consultation Institute. Most recently they have scrutinised the Kent & Medway Stroke review and felt it adequately involved people from across Kent.
- This year we established the Kent County Council Peoples' Panel which is a group of informed members of the public. They meet monthly to discuss and test ideas around service improvement and development.
- In addition we have actively promoted and encouraged hundreds of people to get involved in the stroke review and share their thoughts about the options for the future of our stroke services.

GP services : We have heard from people across Kent about the concern caused when their GP surgery is closing or merging with others. We have worked with Healthwatches across the South East to produce our Checklist for GP closures and mergers. This details how we would expect patients to be informed and involved in any potential changes. It also enables us to have a clear framework that we would expect Clinical Commissioning Groups to follow during this time.
In addition, in South Kent Coast we have facilitated a relationship between homeless organisations and the Clinical Commissioning Group to ensure their homeless clients can access a GP.



What difference have we made?

Dentists : We have been raising the concerns of Care Home residents who either couldn't physically get to a dentist from the care home or who found it difficult to get someone to take them to a dentist. In these cases, many older people were going without seeing a dentist. From 2019, the Care Quality Commission will be including access to dental care in their inspections of care homes. This is great news and should help more older people across the UK to receive the dental care that they need.

Physical Disabilities: We have escalated concerns about wheelchair services across Kent. On behalf of the Kent Physical Disability Forum we have facilitated direct conversations between patients, commissioner and the organisation who provides that service. We have clearly stated the issues and the improvements that we expect to see.

In the community: We spoke to 158 Carers recently many of whom were not involved in traditional carers groups. All the feedback we heard has been used to directly inform a KCC's review of Carer services.

Following feedback from people especially the Gypsy & Traveller community we have developed the Healthwatch Help Cards. These are to enable people to discreetly ask for help should they need. Over 8,229 have been distributed across Kent to better support people.

Together with our parent company, Engaging Kent, we have worked with the Kent Coffee Caravan this year reaching 105 people from rural and potentially isolated communities.

All of our reports and recommendations can be found on our website. We work with the relevant provider and commissioner to influence the recommendations that we have made. To date, no provider or commissioner has declined to work with us, although some have taken some time to respond. All our intelligence and reports are also shared with Healthwatch England and the Care Quality Commission.

Our Volunteers

Our volunteers are central to everything that we do. They are involved in every level from administration through to decision making.

Here's just a few examples of what our volunteers do for us:

- Hold regular sessions in Kent hospitals talking to patients about their experiences.
- Represent Healthwatch at key meetings including all seven local Health & Well Being Boards ensuring that patient voice remains on the agenda .
- Work with us to shape the work plan for the Kent Health & Well Being Board.
- Visiting services as part of our Enter & View remit to talk to patients about their experiences.
- Visiting community and seldom heard groups to understand their experiences of services.
- Read, distil and analyse reports and information.

Our Steering Group is made up of volunteers..

They identify themes and trends for our future work.

Together they agree our priorities and projects .

They define and shape our project work and allocate resources.

Our local Area Teams discuss and examine local issues.

They work with local organisations and commissioners.

They determine our local activity within each Clinical Commissioning Group area.

They are made up entirely of volunteers.

Finances

Table heading showing statement of activities for the year ending 31 March 2018

Income	
Funding received through local authority to deliver Healthwatch statutory activities	£511,000
Additional Income	£0
Total income	**£511,000**

Expenditure	
Operational costs	£106,598
Staffing costs	£330,043
Office costs	£17,278
Volunteer costs, expenses & training	£18,956
Total expenditure	**£472,875**
Balance brought forward	**£38,125**

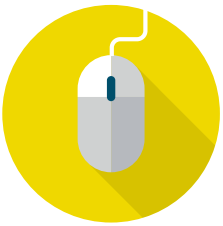
Engaging Kent CiC is the legal entity which holds the Healthwatch Kent Contract.
www.engagingkent.co.uk | Seabrooke House, Church Rd, Ashford, TN23 1RD

Your comment counts
We want to hear from you

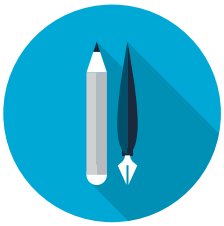
Tell us your experiences of health & social care services in Kent

By Telephone:
Healthwatch Kent
Freephone 0808 801 01 02

By Email:
Info@healthwatchkent.co.uk

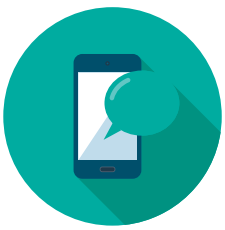


Online:
www.healthwatchkent.co.uk



By Post: Write to us or fill in and send a Your Comment Counts form. **Freepost RTLG-UBZB-JUZA** Healthwatch Kent, Seabrooke House, Church Rd, Ashford TN23 1RD

Face to Face:
Call 0808 801 01 02 to arrange a visit



By Text: Text us on **07525 861 639**.
By texting 'NEED BSL', Healthwatch's British Sign Language interpreter will make contact and arrange a time to meet face to face.

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