HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 5th March, 2020

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 5th March, 2020, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Kay Goldsmith**
Telephone: **03000 416512**

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

Membership

Conservative (11):	Mr P Bartlett (Chairman), Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Mrs L Game, Ms S Hamilton, Mr P W A Lake, Ms D Marsh, Mr K Pugh (Vice-Chairman) and Mr I Thomas
Liberal Democrat (1)	Mr D S Daley
Labour (1):	Ms K Constantine
District/Borough Representatives (4):	Councillor C Mackonochie, Councillor J Howes, Councillor M Rhodes and Councillor P Rolfe

Webcasting Notice

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UNRESTRICTED ITEMS

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

Item		Timings*
1.	Substitutes and apologies	10:00
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes from the meeting held on 29 January 2020 (Pages 1 - 10)	

4. Children and Young People's Emotional Wellbeing and Mental Health Service (Pages 11 - 26) 10:05

5. South East Coast Ambulance Service NHS Foundation Trust (SECAmb) - update (Pages 27 - 38) 10:35

6. Review of Frank Lloyd Unit, Sittingbourne (Pages 39 - 46) 11:05

7. East Kent Transformation Programme (written item) (Pages 47 - 84) 11:35

8. East Kent Hospitals University NHS Foundation Trust - General Update (Pages 85 - 94) 11:45

9. East Kent Hospitals University NHS Foundation Trust - Maternity Services (Pages 95 - 100) 12:05

10. Work Programme (Pages 101 - 104)

11. Date of next programmed meeting – Wednesday 29 April 2020

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

26 February 2020

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 29 January 2020.

PRESENT: Mr P Bartlett (Chairman), Mrs P M Beresford, Mr A H T Bowles, Mr N J D Chard, Ms K Constantine, Mr D S Daley, Mrs L Game, Ms S Hamilton, Ms D Marsh, Mr K Pugh (Vice-Chairman), Mr I Thomas, Cllr M Rhodes, Mrs C Mackonochie and Mr J Wright

ALSO PRESENT: Mr S Inett and Ms L Gallimore

IN ATTENDANCE: Mr A Scott-Clark (Director of Public Health) and Mrs K Goldsmith (Research Officer - Overview and Scrutiny)

UNRESTRICTED ITEMS

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

1) Mr Wright declared an interest as he was a Governor at Medway Hospital Trust.

2) Mr Chard declared an interest as a Director of Engaging Kent.

3) Mr Thomas declared an interest as a member of the Planning Committee at Canterbury City Council.

13. Minutes from the meeting held on 16 December 2019
(Item 3)

1) The Clerk pointed out that the attendees for each item had not been included in the minutes.

2) RESOLVED that the Committee agreed that the minutes from 16 December 2019 were correctly recorded, and subject to the inclusion of the attendees for each item, that they be signed by the Chair.

14. NHS North Kent CCGs - Urgent Care Review Programme - Dartford, Gravesham and Swanley CCG
(Item 4)

In attendance for this item: Ian Ayres (Managing Director), Gerrie Adler (Director of Strategic Transformation), Gail Arnold (Deputy Managing Director), Angela Basoah (Head of Communications and Engagement), Dr Nigel Sewell (Clinical Lead for Urgent Care) from NHS Dartford, Gravesham and Swanley CCG

1) The Chair thanked NHS colleagues for their update to the Bexley and Kent Urgent Care Review Joint Health Overview and Scrutiny Committee (JHOSC), which a number of HOSC members attended.

2) The Clerk informed the Committee of the recommendation of the JHOSC:

   RESOLVED that the Bexley and Kent Urgent Care Review Joint Health Overview and Scrutiny Committee support the decision of the Dartford, Gravesham and Swanley CCG Governing Body.

3) Members highlighted the problems around public transport and questioned whether the CCG had begun discussions with transport providers to improve provision. Ms Arnold confirmed that following the outcome of today's meeting those discussions would begin and would involve working with other local authorities.

4) Ms Arnold pointed out that many of the concerns raised during the public consultation around access and public transport related to if the UTC was on one site or another. The recommendation of a two-site model may have mitigated those concerns already.

5) The Chair thanked the guests for attending and wished them well for the implementation of the new model.

6) RESOLVED that the Committee endorse the recommendation of the Bexley and Kent JHOSC and support the decision of the Dartford, Gravesham and Swanley CCG Governing Body.

15. Wheelchair Services in Kent
(Item 5)

In attendance for this item: From East Kent CCGs: Ailsa Ogilvie (Director of Partnerships & Membership Engagement), Maria Reynolds (Head of Nursing, Quality and Safeguarding), Tamsin Flint (Commissioning Manager. From Millbrook Healthcare: Mike Teaney (Operations Manager), Lydia Rice (Regional Operations Manager), Clive Bassant (Service User)

1) The Chair welcomed the guests and invited them to introduce their report. Ms Ogilvie began by highlighting the improving performance of the Wheelchair service, as demonstrated by a reducing waiting list for assessment and equipment along with shortening average waiting.

2) Ms Ogilvie drew attention to two areas that were off trajectory and had remedial action plans in place: repairs within three days and children's cases closed within 18 weeks.

3) The CCG were working with Millbrook Healthcare to better understand the data behind the repairs target. They were considering separating out the Key Performance Indicators (KPIs) in order to show standard repairs as opposed to specialist repairs, because the latter was very challenging to achieve due to the specialist nature of the equipment needed.

4) Since their attendance at the previous HOSC meeting, the CCG had undertaken a thorough review of Millbrook Healthcare using the Care Quality Commission's (CQC's) rating system. The CCG had judged the quality of the provider to be "good".

5) Steve Inett spoke of the improvements from Healthwatch Kent's perspective. He explained that Healthwatch Kent attended quarterly liaison meetings with the CCG and Millbrook. They also attended the Service User Improvement Group, and Mike Teaney regularly attended the Kent Physical Disability Forum in order to gather feedback and respond to queries.

6) In light of the rising demand for the Wheelchair service, the Kent and Medway CCGs had agreed to increase the funding for the contract and the CCG were expecting Millbrook healthcare to deliver the service within that budget.

7) Members requested that the layout of the report be adapted the next time the CCG attended HOSC. They requested clearer data (using tables) which easily demonstrated which areas were more challenging and what action was being taken. They also asked if there was comparator data with other parts of the country. Finally, Members asked for qualitative data that demonstrated users' experiences.

8) Ms Ogilvie stated that there would always be a waiting list, but it was important for them to demonstrate what "business as usual" looked like and how performance compared to this.

9) The agenda (page 239) provided some examples of the circumstances which prevented Millbrook Healthcare progressing children's cases within the required timeframe. In cases where parents were not aware of their rights to time off work, or were unable to fill out the necessary paperwork, a Member questioned if more could be done to support them.

10) Members were concerned that apparent slow procurement chains when purchasing specialist replacement parts were contributing to waiting times. They were unclear why specialist parts were taking a number of days to be delivered once ordered. Mr Teaney expressed that the company did chase suppliers for orders.

11) Mr Teaney explained that Millbrook Healthcare did have 20,000 standard parts in stock in the UK for repairs. A weekly stock review was carried out, with items that were no longer frequently required removed to make room for more common parts.

12) A Member questioned why a wheelchair was not always provided when an eligible patient was discharged from hospital. It was explained that assessments were carried out once a patient had *recovered* from their intervention at hospital, as opposed to during rehabilitation.

13) Mr Teaney explained that when a wheelchair was no longer required by a user, Millbrook Healthcare would refurbish the chair if it was in a decent condition, as opposed to always purchasing new products.

14) Ms Flint explained that a Personal Wheelchair Budget was when a service user would be given an allowance equivalent to the cost of a chair that the NHS would fund based on clinical need, but then there would be a range of top-up features available, or the ability for the user to purchase privately.

15) HOSC welcomed the improving picture in the provision of the Wheelchair Service but wanted to ensure all areas continued to improve.

16) RESOLVED that the report be noted, and that Thanet CCG return to the Committee in 9 – 12 months' time. Should contract performance decline, the CCG should alert the Chair of HOSC as soon as possible, with a view to returning to the Committee with an update sooner.

16. Procurement of Kent and Medway Neurodevelopmental Health Service for Adults
(Item 6)

In attendance for this item: Adam Wickings (Deputy Managing Director, West Kent CCG), and Michelle Snook (Integrated Transformation Manager for Neurodevelopmental Conditions, for and on behalf of Kent CCGs, Strategic Commissioning, KCC)

1) The Chair welcomed the guests and asked them to provide some background to the procurement of the Kent and Medway Neurodevelopmental (ND) Health Service for Adults. The service would provide assessment and post-diagnostic support for people living with Autistic Spectrum Condition (ASC) and or Attention Deficit Hyperactivity Disorder (ADHD). The service would not be for those individuals with a co-morbidity such as a learning disability, as there was already a clear pathway in place for that service.

2) Mr Wickings explained that the service user pathway would remain the same, but that the commissioning of the service, which was currently fragmented across Kent and Medway, would be brought under one contract. Currently, CCGs in East Kent commissioned a service through South London and Maudsley NHS Trust (SLaM), whereas CCGs in West Kent and Medway used spot purchasing arrangements with two providers.

3) Steve Inett from Healthwatch Kent corroborated the inconsistency of service provision across Kent and Medway, along with a lack of knowledge around what support was available.

4) The benefits of a new overarching contract would be:

    a. Consistent quality of service across Kent and Medway;
    b. Equal access for all residents;
    c. Allows for better integrated working between health and social care;
    d. Improvement of the pathway for service users.

5) The contract would apply to those aged 18+, though those aged 17.5 would be considered if appropriate. A longer-term project considering an all-age pathway was underway.

6) It was hoped that the new contract would be formalised within 4 – 6 months. Due to the limited number of providers in the market, it would be very important to maintain current relationships whilst building any new partnerships.

7) In answer to a question about training for professionals, Ms Snook confirmed that the Government had announced late in 2019 the introduction of mandatory training in learning disability and autism for all health and social care staff, relevant to their role. Skills for Care had also developed a framework for relevant staff. Members felt it was important that the Kent Medical School played a role in training, which Mr Wickings supported once the university was fully established.

8) There was currently a waiting list for services. The guidelines were for a wait of three months from the point of referral. In some cases, individuals were waiting up to two years. Mr Wickings confirmed that the CCGs had invested additional money in order to clear any backlog, which they hoped to do within 6 – 12 months.

9) Ms Snook explained that a Single Point of Access (SPoA) would be the method by which professionals including GPs referred individuals to the service. It was intended for this to be easy to use and its design would be worked through with the provider(s).

10) The Chair thanked the guests for their update.

11) RESOLVED that

    a. the Committee does not deem the procurement of the Neurodevelopmental (ND) Health Service for Adults to be a substantial variation of service.

    b. Kent and Medway CCGs be invited to submit a report to the Committee at the appropriate time.

17. Strategic Commissioner Update
(Item 7)

In attendance for this item: Simon Perks, Director of System Transformation, K&M STP

1) The Chair welcomed Mr Perks to the meeting and invited him to update the Committee on the establishment of a single CCG across Kent and Medway from 1 April 2020.

2) Mr Perks explained that since the last update to HOSC, the 8 Kent and Medway CCGs had voted to establish a single entity. NHS England had authorised the move, subject to a number of conditions. Their final decision was expected soon.

3) He outlined some of the benefits a single CCG would bring:

- A consistent approach to decision making;
- A move away from the commissioner/ provider split with a fresh focus on collaboration;
- An opportunity to ensure consistency of contracts and service provision across the county, by way of a single entity having oversight of the whole county;
- The capability of commissioning services at scale;
- A real opportunity to realise integration across the NHS as well as social care.

4) Recruitment to posts was underway, with some roles already recruited to.

5) One Member voiced concern over the large size of the new CCG, along with an inherent disparity in funding across the county and the cost of recruiting to the new posts. She questioned what consultation would be held, and Mr Perks explained that formal consultation was not required for back-office reorganisation such as this, but they had been engaging stakeholders.

6) Steve Inett explained that Healthwatch Kent had produced a report entitled "Focus on Commissioning: A Healthwatch Kent report", which was appended to the agenda. The report drew on six years of HOSC documents and feedback to Healthwatch Kent in order to highlight key lessons learnt during the commissioning process, in the hope that the new single CCG would learn from these lessons.

7) Members questioned if the move to a single entity would reduce local choice. Mr Perks explained that the 4 Integrated Care Partnerships (ICP) and Primary Care Networks (PCN) would provide that local input. In addition, GPs sat on the CCG Board and they were drawn from across the county.

8) Going forward, the ICPs would be responsible for the health of the population in which they operate. That was currently the responsibility of the CCG.

9) Mr Perks referred to the CCG ratings shown in item 8 of the agenda and explained that the new CCG was not the sum of those eight bodies but an entirely new commissioning entity. Some of the reasons behind the poor ratings would be addressed by the establishment of a single CCG; for example, some CCGs were not currently large enough to absorb risk.

10) Mr Perks concluded by saying that the move to a single CCG was in response to a national agenda. Given the many challenges facing the NHS, doing nothing was not an option. Finance alone would not solve the issues, and there was a great need to learn from past experiences.

11) RESOLVED that the Committee note the report.

18. CCG Annual Assessment (Written Update)
(Item 8)

1) The Committee discussed the CCG annual ratings as part of its discussion under item 7.

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

19. General Surgery reconfiguration at Maidstone and Tunbridge Wells NHS Trust
(Item 9)

In attendance for this item: Dr Amanjit Jhund (Director of Strategy, Planning and Partnerships, Maidstone and Tunbridge Wells NHS Trust), Dr Greg Lawton (Chief of Surgery, Maidstone and Tunbridge Wells NHS Trust), Adam Wickings (Deputy Managing Director) West Kent CCG

1) Mr Wickings began by clarifying that the reconfiguration was down to the sustainable delivery of the service, not a change in the provision of that service.

2) Dr Lawton explained that when the surgery department was configured in 2011, complex emergency inpatient surgery was allocated to Tunbridge Well Hospital (TWH) whilst complex elective gastrointestinal surgery went to Maidstone Hospital (MH). The emergency surgery saw around 6,000 patients a year compared to around 230 for elective surgery. Despite this, the team of 12 consultant surgeons was split nine to MH and just three to TWH.

3) The drawbacks of the current configuration were:

    a) The three consultant surgeons based at TWH were near burn-out;
    b) Patients at TWH were seen by numerous consultants, adding to their length of stay at the hospital and reducing their quality of care (as each consultant wanted to understand the background to the case);
    c) Difficulty in recruitment.

4) The proposed reconfiguration would see the complex elective surgery patients (the 230) treated at TWH, with all 12 consultants being based from that one site.

5) Dr Lawton pointed out that a proportion of the 230 patients were closer to the TWH site the MH, so the additional travel would only impact around half that number. Both sites in the Trust were increasing their car parking capacity which would benefit those families having to travel further.

6) The benefits of the reconfiguration included:

    a) A better service to patients who would have one dedicated consultant surgeon;
    b) Less time on the ward for patients, due to the efficiencies of just having one surgeon;
    c) Better teaching opportunities for junior doctors;
    d) Improved recruitment prospects;
    e) The possibility of developing the service in the future, in order to become a specialist provider.

7) A Member questioned if there were enough beds at TWH to deal with the elective patients. It was explained that the length of stay for the emergency patients was expected to reduce (because there would not be numerous consultants assigned to one case) and therefore beds would become available more quickly. The site had also expanded its Intensive Treatment Unit (ITU) for one additional dependency, as well as creating six enhanced level care beds in the ward for elective patients. Dr Jhund confirmed the changes would not be implemented until after the winter pressures had passed.

8) Mr Inett questioned the urgency behind the need for change, particularly from a non-clinical point of view. He was unclear what made this change different to those that had happened at other Trusts, where public consultation (or at least engagement) had taken place. His concern was that if this approach was increasingly taken for smaller changes, there be an erosion of opportunity for patients to be involved unless it was a consultation.

9) Dr Lawton explained that one need for the urgency was that the three surgeons based at TWH were almost burnt out due to the size of their workload. This was unsustainable and he went so far as to say if no action was taken there was a real risk that there would be no surgical service offered at the Trust in the future. This was in large part down to the difficulty in recruitment. He added that the Deanery was behind the move in recognition of the difficulty of training doctors across two sites. He felt the surgery should never have been configured in such a way back in 2011.

10) Whilst Mr Inett accepted the premise that staff should not be burnt out through workload, he questioned how this differed to similar pressures on staff in Stroke services or at the East Kent Hospitals University Foundation Trust, where consultations had been held. However, Mr Inett felt the risk around the Deanery added a different complexion to the situation and suggested that the best way to describe the change was that it was in fact needed to manage an imminent risk to patient safety.

11) Members questioned if transport links between the two hospital sites would remain. Dr Jhund confirmed that they would, and the Trust were also considering enhancements to the service.

12) The Chair, who had visited both sites with the Clerk the previous week, expressed the mixed view from nursing staff, but said that he felt the Trust had dealt with the reconfiguration in a professional manner.

13) RESOLVED that

    a) the Committee deemed that proposed changes to the configuration of general surgery services across the Maidstone and Tunbridge Wells NHS Trust sites were not a substantial variation of service.

    b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

20. Proposed changes at Moorfields Eye Hospital (written update)
(Item 10)

1) Members had no further comments or questions arising from the report included in the agenda.

2) RESOLVED that the Committee considered and noted the report.

21. Work Programme
(Item 11)

1) Members discussed the work programme as per the printed agenda.

2) Following the recent inquest into the death of a baby boy at East Kent Hospital University Foundation Trust, the Committee agreed that an item on the performance of maternity services at would be added to the 5 March agenda. The coverage of this report would depend on the outcome of a report by the Care Quality Commission and Healthcare Safety Investigations Branch to Parliament which was due in two weeks' time.

3) A Member requested a report on the delays in discharge of patients from hospitals across Kent. The Chair committed to looking into the best way of doing this, as it would involve contacting each Trust individually.

4) A Member welcomed the inclusion of the Frank Lloyd Unit on 5 March agenda.

5) RESOLVED that the work programme be noted.

22. Date of next programmed meeting – Thursday 5 March 2020 at 10am
(Item 12)

(a) **FIELD**
(b) **FIELD_TITLE**

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Item 4: Children and Young People's Emotional Wellbeing and Mental Health Service

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 5 March 2020

Subject: Children and Young People's Emotional Wellbeing and Mental Health Service

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

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

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1. Introduction

a. In a generic sense 'children and young people's mental health services' is an umbrella term covering a wide range of services commissioned by the NHS and local Government.

b. In the specific sense for this item, Children and Young People's Mental Health Services (CYPMHS) is the name of a service commissioned by West Kent CCG on behalf of all CCGs in Kent and Medway. NELFT were commissioned to provide the CYPMH service in September 2017.

c. The HOSC remit extends to the commissioning and provision of this NHS service only.

2. Previous visits to Kent's HOSC

a. On 4 March 2016, HOSC deemed the new service specification for the NHS commissioned aspect of the Children and Young People's Mental Health Service to be a substantial variation of service.

b. HOSC have raised a number of concerns about the CYPMHS. These concerns have centred around waiting times; service provision because of capacity issues; and communication during waiting times.

c. West Kent CCG and NELFT were requested to provide a performance update to HOSC in September 2019. Unfortunately, it was not possible to secure the necessary personnel for that meeting and therefore NELFT provided an informal update to Members in September.

d. In addition, members from HOSC and the Adult Social Care Cabinet Committee will be attending a workshop on the 28 February 2020 to discuss the wider context of children and young people's mental health services – combining both KCC and NHS.

e. The provider and commissioner have been requested to attend this formal HOSC meeting to provide an update.

3. Recommendation

RECOMMENDED that the report on Children & Young People's Emotional Wellbeing & Mental Health Service be noted and West Kent CCG and NELFT be invited to provide an update in six months.

Background Documents

Kent County Council (2016) *'Health Overview and Scrutiny Committee (04/03/16)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6257&Ver=4

Kent County Council (2016) *'Health Overview and Scrutiny Committee (02/09/16)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=6261&Ver=4

Kent County Council (2017) *'Health Overview and Scrutiny Committee (20/09/17)'*, *https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7788&Ver=4*

Kent County Council (2018) *'Health Overview and Scrutiny Committee (21/09/18)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7921&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (01/03/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7926&Ver=4

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

NHS
West Kent
Clinical Commissioning Group

Children and Young People's Mental Health Service (CYPMHS)

5 March 2020

Patient focused,
providing quality,
improving outcomes

Kent Children and Young People's Mental Health Service (CYPMHS)

March 2020 Health and Overview Scrutiny committee

Summary

This paper provides commissioner and health trust provider update regarding the North East London NHS Foundation Trust (NELFT) Children's and Young People's Mental Health (CYPMHS) services in Kent. The briefing provides information on the current position, challenges and opportunities to meet the ambition of sustained transformation in Kent for children and young people in the context of increased demand for services.

Recommendation

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

Members are reminded of their statutory duty to declare any conflict and have it properly resolved.

Introduction

This paper provides commissioner and health trust provider update regarding the NELFT Children's and Young People's Mental Health (CYPMHS) services in Kent. The briefing provides information on the current position, challenges and opportunities to meet the ambition of sustained transformation in Kent for children and young people in the context of increased demand for services This report also provides an update on the needs, referral, discharge, waiting times and challenges for NELFT CYPMHS services in Kent.

Referral to Treatment (RTT) standard

All routine locality team referrals are due to meet the 18 week standard by Q3 2020. Currently all emergency and urgent referrals are seen within RTT standards.

The CCGs in Kent and Medway recognise that the time children and young people are waiting to access mental health services generally is not good enough and we are committed to working with Kent County Council (KCC) and NELFT to achieve national standards.

All referrals to the CYPMHS are managed through a single point of access (SPA).

The introduction of the SPA in in September 2017 has meant that CYPMHS are much more accessible and this has led to a doubling of demand for assessments, largely driven by:

- Self-referrals – this was not possible previously
- Current system pathways particularly in the school environment leading to health becoming the first point of access for schools and parents.

The increase in demand comes at a time when there is a national workforce shortage where NELFT are struggling to recruit a full complement of permanent staff and are highly reliant of agency and locum staff.

To meet this increased demand, the CCGs are investing an extra £2.0m (13 per cent of the total contract value) per annum for each of the next three years.

We are also working with KCC to design a new neurodevelopmental pathway to increase the range of early help available so that schools and parents have less need to refer to health. This will be the key factor in reducing demand.

Contract Performance Management

NHS West Kent CCG, as coordinating commissioner, has a NHS Standard Contract with NELFT to provide CYPMHS/ emotional health and wellbeing (EHWB) services across the Kent clinical commissioning areas. The contract is a five year contract, with an option to extend by a further two years. The contract commenced in September 2017, with a total value over the five year term of £82m. The contract has an Expected Annual Contract Value which is paid in 1/12 payments. As well as seven CCG localities being associates to the contract, KCC also make a financial contribution via a Section 76 agreement.

The scope of services provided under the contract is set out in the service specification and includes but is not limited to three main services within the required operating model:

1. The Single Point of Access (SPA) - provision of guidance, signposting, support, care and treatment advice.
2. Targeted services – Giving children improved emotional resilience and better mental health and where necessary, receive early support and treatment to prevent problems getting worse

3. Specialist services – there are five core elements, within which a number of specific care and treatment pathways may exist:
    a. General, applicable to all specialist services
    b. Neurodevelopment
    c. First Episode in Psychosis
    d. Crisis Care
    e. Intensive Support
    f. Place of Safety.

A monthly contract performance and quality meeting reviews:

Activity – Performance reports cover monthly referral, assessment, treatment pathway and caseload data. In addition, the reports include the numbers of those experiencing first episodes in psychosis, crisis and neurodevelopment needs. Monthly, year to date data and trend analysis is monitored.

Key Performance Indicators – Much work has been done to refine the Key Performance Indicators (KPIs) in the contract. The current list of KPIs measure:

- Access, looking at the timeliness of initial response, assessment and treatment, with a focus on vulnerable groups like Looked After Children (LAC).
- Crisis and Urgent needs, prioritising those young people in urgent need.
- Outcomes, seeking feedback from the young person as to whether they have found the service offered worthwhile.

Each KPI performance rating is based on an associated target and achievement against target is reviewed monthly alongside any exception reporting prior to any agreed remedial actions being set.

Quality – The Provider submits a quality report which includes: service and operational reports on complaints, serious issues, service user feedback and workforce.

Any under or over performance is monitored with the required rectification being implemented. The parties are keen to take forward the contract under the alliance model, with providers sharing risks and holding collective responsibility for the performance of all.

Single Point of Access (SPA)

All referrals to the CYPMHS are managed through a SPA. The introduction of the SPA in in September 2017 has meant that CYPMHS is much more accessible and this has led to a doubling of demand for assessments largely driven by:

- Self-referrals – this was not possible previously
- Current system pathways particularly in the school environment leading to health becoming the first point of access for schools and parents
- An increase in referrals to facilitate Educational Health Care Plans (EHCPs) for children with special educational needs.

Autistic Spectrum Disorder (ASD)

On the specific area of Autistic Spectrum Disorder (ASD) that has been highlighted, we reported at the March 2019 Health Overview Scrutiny Committee (HOSC) that ASD waits were down from four years to two years and we can now confirm that this improvement trajectory continues. Currently, 75 per cent of referrals are seen in less than two years which will help to improve the outcomes of children by putting support in place earlier. However, as with all CYPMHS services, if demand were to continue to rise then the rate of improvement would unfortunately be expected to slow.

The recent Kent County Council (KCC) Special Educational Needs and Disabilities (SEND) joint Care Quality Commission (CQC)/Office for Standards in Education, Children's Services and Skills (Ofsted) inspection highlighted the issue of increasing demand in ASD referrals and enabled the system to understand the reasons. The two key issues are a large increase in Education, Health and Care Plan (EHCP) requests and the current open referral system offered by North East London NHS Foundation Trust's (NELFT) SPA. This is now being tackled in the 'neurodevelopmental pathway development' action within the SEND improvement plan which is monitored through KCC and the SEND Improvement Board.

Under this action there are a number of work streams being developed at pace, including clinical pathway redesign, pre and post assessment support offer for families including the roll-out of the Canterbury pilot and a programme to reduce the length of time children and families are waiting for assessment.

The outcome is likely to mean an improved pathway with more support in schools and the assessment process. Clinical Commissioning Groups (CCGs) and NELFT are working with

and listening to families across Kent who are supporting the redesign of the diagnosis process for the future which includes children and young people being able to access the right support while they wait for a diagnosis.

Kent's CCGs recognise that the time children and young people are waiting to access mental health services generally is not good enough and we are committed to working with KCC and NELFT to achieve national standards.

National workforce shortage

The increase in demand comes at a time when there is a national workforce shortage, where NELFT are struggling to recruit a full complement of permanent staff and are highly reliant on agency and locum staff.

To meet this increased demand, the CCGs are investing an extra £2.1 m (13 per cent of the total contract value) per annum for each of the next three years. NELFT have been actively trying to recruit staff and have won a number of centrally-funded workforce development training opportunities for existing staff, as well as training places for new staff.

Kent CCGs joined the London and South East Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) Collaborative in 2016 alongside Addaction (a voluntary provider commissioned to deliver the Mind and Body Programme) and Sussex Partnership NHS Foundation Trust, our previous Child and Adolescent Mental Health Services (CAMHS) provider. North East London NHS Foundation Trust, our current CAMHS provider, joined the Collaborative in 2017 once awarded the contract.

A number of the existing Kent children and young people's mental health workforce has benefitted from the training opportunities available. Seven senior clinical and operational leaders have been trained in CYP-IAPT Leadership and Management. Nineteen senior clinicians have been trained in CYP-IAPT clinical supervision. Sixteen Cognitive Behaviour Therapists have been trained (one specialising in autism spectrum disorder and learning difficulties) as have seven systemic family practice clinicians and three interpersonal therapy for depression clinicians.

NELFT have been able to recruit and train 14 Children's Wellbeing Practitioners and 16 Education Mental Health Practitioners which are all new posts. These posts have been created to help reduce the workforce issues seen nationally, and particularly in Kent.

Education Mental Health Practitioners in particular are a real achievement, as they are being used to staff Mental Health Support Teams (MHST) in education settings; a flagship priority for children's mental health within the NHS Long Term Plan. North Kent CCGs were successful in a bid to be a Trailblazer site, with each CCG being awarded one team. NHS Canterbury and Coastal CCG and NHS West Kent CCG were successful in a bid to become Wave 2 sites, with each CCG being awarded one team. NELFT are leading the work around MHST development and implementation, working closely with CCG commissioners and other partners.

The large numbers of staff now receiving training is the result of a collaborative approach taken by Addaction, NELFT and CCGs which has included joint applications for training places and a recruitment panel featuring representatives from all three organisations. In 2020 we will be working closely to agree a shared vision around our approach to the bidding of any further Children's Wellbeing Practitioners and MHSTs in Kent.

Mental Health Support Team (MHST) initiative in schools

Finally, NELFT were successful in bids submitted in partnership with NHS Canterbury and Coastal CCG, NHS West Kent CCG and HeadStart Kent to be part of the second wave of the Mental Health Support Team (MHST) initiative in schools. This follows the success of the Trailblazer wave sites in North Kent (NHS Dartford, Gravesham and Swanley and NHS Swale CCGs).

Backed and funded by the NHS, the MHST programme will explore ways of delivering care and advice for young people's mental health, in the familiar environment of their school or college. Each MHST will support several education settings, covering a population of around 8,000 children and young people.

Each MHST will contain four new Education Mental Health Practitioners (EMHPs) who will work with education settings to provide early intervention on mild to moderate mental health issues and provide help to staff in schools and colleges. Teams will also act as a link with local children and young people's mental health services and will be supervised by senior NELFT staff. This programme is being delivered jointly with the Department for Education (DE).

EMHPs are new members of Kent's workforce and will work alongside other professionals who provide emotional wellbeing and mental health support to students including: teachers, school nurses, educational psychologists, school counsellors, voluntary and community services and social workers.

NHS England estimates each MHST will deliver 500 evidence-based interventions per year. This work builds on the NHS local transformation programme already underway and means children who may be struggling with issues like anxiety about friendships or family pressures can be supported, alongside friends and family members, thereby helping to build their understanding of mental health and how to manage their wellbeing.

We are maintaining strong strategic and clinical links with leaders at the Anna Freud Centre, University College London and King's College London who are the Higher Education Institution (HEI) providers for our new EMHP workforce

NELFT activity update

This is an update on NELFT's services progress with requested waiting time data, broken down by locality for children and young people awaiting assessment and treatment across Kent and will include Quarter 3 (Q3) data (October to December 2019) and performance updates with supporting narrative.

NELFT CYPMHS Performance data – October 2019 to December 2019 (Q3)

Appendix 1 includes the full detailed breakdown of all the undernoted data by CCG area.

Activity table 1 is a Kent wide summarised position within the seven CCG localities; Activity Table 2 and Table 3 provide a further breakdown of the east and west Kent neurodevelopmental and learning disability services (NLDS).

Activity Table 1 – Locality

Kent Locality-wide Activity
Oct 18 - Dec 19

	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
Caseload - CYPMHS (inc Neuro)	11,554	12,668	12,993	12,495	12,428
Caseload - Looked After Children (LAC)	479	666	573	747	932
Referrals received	4,311	4,034	4,447	3,733	4,404
Number waiting for first assessment	464	630	1,161	643	594
Number waiting for routine treatment	1,483	1,546	2,114	1,487	1,614

- Overall caseload showing slight decrease in this quarter reflective of the intense management and monitoring of waiting times and service throughput.
- Referrals have increased as this is a high referral period for schools.
- Reduction in waiting times for first assessment has an adverse impact on waiting times for treatment this is due to the service utilising the same staffing resource.

Table 2 - East Kent commissioned NLDS service for 0-18 years old

Neurodevelopment & Learning Disability Service (NLDS) East Kent Oct 18 - Dec 19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
Caseload	5,866	6,406	6,936	6,924	6,656
Referrals	754	353	428	246	237
CYP Waiting for First Assessment (start of treatment)	4,190	4,034	4,261	3,069	2,882

Table 3 - West Kent commissioned NLDS service for 12-18 years old (the 0-11 service in west Kent is provided by Kent Community Health NHS Foundation Trust)

Neurodevelopment & Learning Disability Service (NLDS) West Kent July 2019 to September 2019	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
Caseload	1,715	1,821	2,094	2,118	1,985
Referrals	314	171	209	143	118
CYP Waiting for First Assessment (start of treatment)	1,050	1,214	1,202	913	825

- Overall increase in caseload year on year. The service continue to manage waiting times and caseload closely and have recently secured highly skilled psychologists (employed on a temporary basis) to complete a significant number of ASC assessments over the coming months.
- In addition, due to the lack of shared care arrangements in East Kent, a number of children and young people continue to remain on caseload where 3 monthly reviews are required due to medication.
- Decrease in referrals due to improved and streamlined processes embedded within the front door function SPA. This includes a number of NLDS clinical and admin staff re-located within the SPA to complete clinical triage and screening of all NLDS referrals for

appropriateness. Although the process is relatively new (commenced in November 2019), early successes include; timeliness of screening resulting in early signposting where referrals do not meet service criteria and improved communication. Staff are able to contact referrers at this early stage to determine interventions previously been undertaken prior to referral and requesting further information from schools. Once additional information is received, screening is completed to determine if the child or young person referred meets the threshold for ASC/ADHD assessment.

- Assessment waiting times continue to improve as the team work hard on managing caseloads, reviewing waiting times and working within set trajectories service wide.

Locality Team key indicators as at 31 December 2019:

	East Kent: Referral to Assessment (RTA)			
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q3 (Oct 18 to Dec 18)	82	203	12	297
Q4 (Jan 19 to Mar 19)	189	159	10	358
Q1 (Apr 19 to Jun 19)	536	102	6	644
Q2 (Jul 19 to Sep 19)	317	32	2	351
Q3 (Oct 19 - Dec 19))	181	49	4	234

	West Kent: Referral to Assessment (RTA)			
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q3 (Oct 18 to Dec 18)	66	95	6	167
Q4 (Jan 19 to Mar 19)	202	64	6	272
Q1 (Apr 19 to Jun 19)	487	64	3	554
Q2 (Jul 19 to Sep 19)	296	58	2	356
Q3 (Oct 19 - Dec 19))	457	33	0	490

	East Kent: Referral to Treatment (RTT)			
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q3 (Oct 18 to Dec 18)	244	463	49	756
Q4 (Jan 19 to Mar 19)	385	303	41	729
Q1 (Apr 19 to Jun 19)	753	188	33	974
Q2 (Jul 19 to Sep 19)	618	112	16	746
Q3 (Oct 19 - Dec 19))	547	133	17	697

	West Kent: Referral to Treatment (RTT)			
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q3 (Oct 18 to Dec 18)	254	414	59	727
Q4 (Jan 19 to Mar 19)	474	300	43	817
Q1 (Apr 19 to Jun 19)	709	209	49	967
Q2 (Jul 19 to Sep 19)	524	197	20	741
Q3 (Oct 19 - Dec 19))	751	144	22	917

Neurodevelopmental and Learning Disability Service (NLDS) key indicators as at 31 December 2019:

	East Kent: Referral to First Assessment (Start of Treatment)			
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q3 (Oct 18 to Dec 18)	1163	2072	955	4190
Q4 (Jan 19 to Mar 19)	920	2073	1600	4593
Q1 (Apr 19 to Jun 19)	776	1693	1792	4261
Q2 (Jul 19 to Sep 19)	326	1126	1617	3069
Q3 (Oct 19 - Dec 19))	309	720	1853	2882

	West Kent: Referral to First Assessment (Start of Treatment)			
	Under 18 weeks	Over 18 weeks	Over 52 weeks	Total
Q3 (Oct 18 to Dec 18)	470	463	117	1050
Q4 (Jan 19 to Mar 19)	383	615	216	1214
Q1 (Apr 19 to Jun 19)	337	579	286	1202
Q2 (Jul 19 to Sep 19)	170	416	327	913
Q3 (Oct 19 - Dec 19))	112	294	419	825

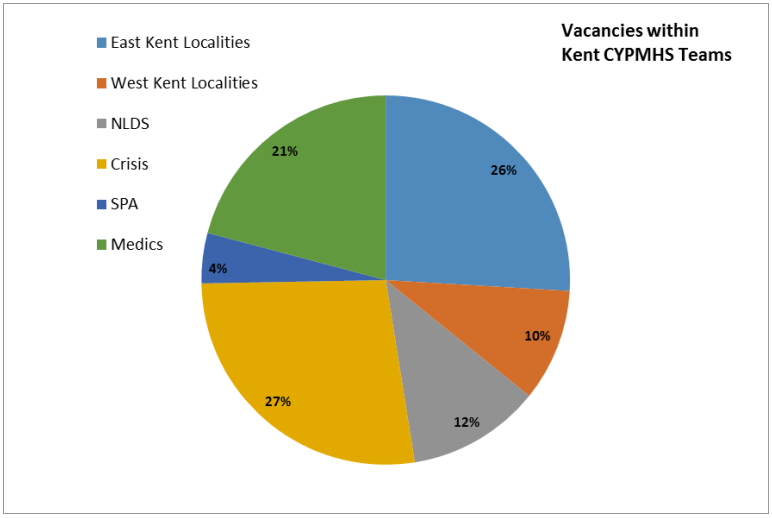
- The services note the improved position for number of CYP waiting under 52 weeks.
- The distribution of waiters within length of wait categories has shifted in line with operational practices of seeing longest waiters and most clinically urgent first, i.e., under 18 week category has reduced due to the fore mentioned changes in SPA and over 18 weeks have decreased due to the move of waiters within this cohort into the 52 week category.
- Additional funding has recently being secured for some targeted work to increase number of ASC assessments completed for NLDS waiters, however, this is a short term solution.

Looked after Children (LAC)

- Looked after Children (LAC) caseload continues to increase, the service has recently completed a joint review of cases with Kent County Council (KCC) to ensure accuracy. In addition, management teams have ensured that services continue to have a good focus on vulnerable groups ensuring that these are prioritised for early assessment.
- Volume from the out of area LAC remains high, most notably within London boroughs for placements in Kent. This had had an impact on the service and the need to see all LAC children within in the 10 working days.

Recruitment

All teams have a rolling recruitment programme but recruitment remains a challenge particularly for NLDS due to its high caseload of those waiting for assessment. We continue to use a high number of agency nurses to support the teams. In addition, NELFT recently approved a recruitment incentive at board level to allow operational leads the opportunity to incentivise hard to recruit posts.



We are making great progress with Trailblazers in Kent work, the North Kent Wave 1 – Mental Health Support Teams (MHST) Trailblazer is 9 months into the training year and will go-live in December 2019. Quarterly assurance returns are being submitted for the North Kent Wave 1 MHST.

West Kent and east Kent have both been successful in Wave 3- MHST bids, and the new teams will be established in Maidstone and in Canterbury in January 2020. We are maintaining strong strategic and clinical links with leaders at the Anna Freud Centre, University College London and Kings College London.

Inpatient mental health beds

NELFT has recently been awarded the contract for Kent Tier 4 inpatient mental health beds for children and young people (11 inpatient beds plus 3 intensively managed within the community and a Section 136 suite to be situated within the unit).

The standalone Unit situated at Woodland House in Staplehurst Kent is currently run by South London and Maudsley NHS Foundation Trust (SLaM) and will transfer to NELFT on 1 April 2020. This is a great opportunity, enabling the complete management of a mental health pathway for children and young people in Kent.

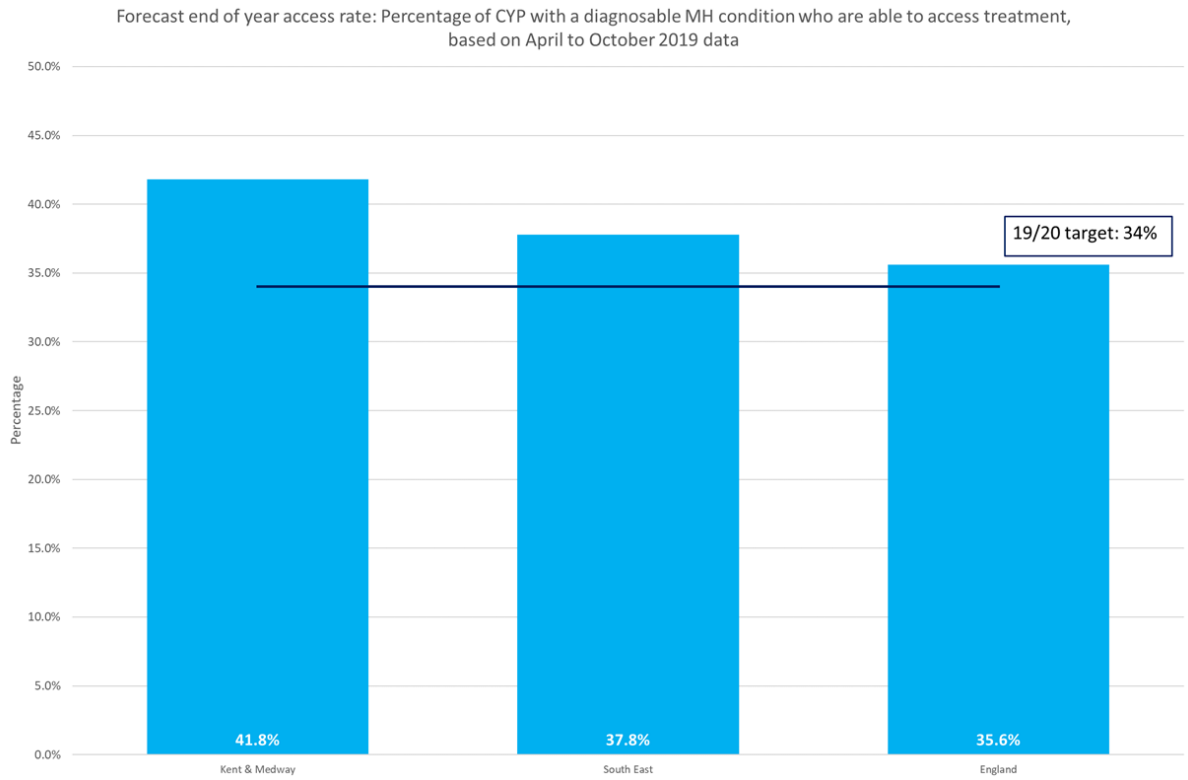
Mobilisation of this service is progressing well with weekly meetings and development of a detailed plan for service handover on 1 April 2020.

National Targets/Ambitions for Children and young people's mental health services in Kent and Medway

Local Transformation Plan Access Target

The Local Transformation Plan is part of a Five Year Forward View (5YFV) national programme which requires CCGs to deliver an improved emotional wellbeing and mental health system for children and young people. The Kent Local Transformation Plan is coordinated collaboratively with partners, providers and families. The success of the programme is measured through the *Access Target*. In 2014/15 the national access rate of children with a diagnosable mental health condition accessing two or more sessions of treatment was at 17 per cent. Each year since 2014/15, NHS England has increased the target in line with the requirement outlined in 5YFV. This year, 2019/20 the national target is 34 per cent.

Based on data from April to October 2019, Kent is predicted to exceed the national children and young people mental health access target (34 per cent), enabling 41.8 per cent of children young people to access evidence based treatment.



Recommendations

Members of the Kent Health and Overview Committee are asked to

(i) NOTE the contents of this report.

Contact:

Dave Holman
Associate Director
Children's . maternity and mental health
NHS West Kent CCG
Dave.holman@nhs.net

Appendix 1

The table below shows the 2018/19 access rate, the number of CYP accessing services and the estimated number of CYP with a diagnosable MH condition by CCG area.

CCG	CYP accessing services in 2018/19	CYP with a diagnosable MH condition	Access rate (%)
Ashford CCG	1700	2583	65.8
Canterbury and Coastal CCG	1725	3492	49.4
Dartford, Gravesham and Swanley CCG	2730	5397	50.6
Medway CCG	2020	6067	33.3
South Kent Coast CCG	2055	3887	52.9
Swale CCG	1425	2530	56.3
Thanet CCG	1890	2964	63.8
West Kent CCG	3555	8936	39.8
Kent	15070	29789	50.6
Kent and Medway	17090	35856	47.7
South East	66505	152411	43.6
England	377866	1046246	36.1

Source: NHS Digital, NHS England

Item 5: South East Coast Ambulance Service NHS Foundation Trust: Update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 5 March 2020

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.

It provides background information which may prove useful to Members.

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1. Introduction

(a) South East Coast Ambulance Service NHS Foundation Trust (SECAmb) 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).

(b) The Care Quality Commission (CQC) published an inspection report on 15 August 2019 which rated the Trust "Good" in all areas. Prior to this inspection, the Trust had been in Special Measures.

2. Previous reports to HOSC

(a) Following the Trust receiving an "inadequate" rating from CQC, it has been requested to attend HOSC on a number of occasions in order to provide updates on its performance.

(b) During its last attendance at HOSC on 23 July 2019, the following issues were raised as continued areas of concern:

- Response times in the early to late evenings;
- Delays faced under Category 3 calls;
- The health and wellbeing of staff (in relation to the Staff Survey results);
- Waiting times in rural areas (not just a Kent issue);
- Handover delays (an issue to be improved in collaboration with the acute trusts).

(c) At the conclusion of the above meeting, the Committee made the following recommendation:

RESOLVED that the Committee note the report and that SECAmb provide an update at an appropriate time.

(d) The Trust has provided the attached report and will attend today's meeting in order to answer questions from Members.

3. Recommendation

RECOMMENDED that the Committee note the report.

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 (23/11/18)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7923&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (23/07/19)',* https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8282&Ver=4

Care Quality Commission, 15 August 2019, https://www.cqc.org.uk/provider/RYD

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

HEALTH
OVERVIEW AND SCRUTINY COMMITTEE
5TH MARCH 2020

SOUTH EAST COAST AMBULANCE SERVICE UPDATE

Report from: Tracy Stocker, Associate Director of Operations, SECAmb

Author: Ray Savage, Strategy & Partnerships Manager, SECAmb

Summary

This report updates the committee on the South East Coast Ambulance Service FT, with a focus on key developments since the committee was last updated in July 2019. These key areas include: CQC reporting, award of the NHS 111 CAS contract, performance and performance recovery, and key senior appointments.

1. Background

1.1. The Trust (SECAmb) during the past few years has been inspected by the Care Quality Commission (CQC). Initially in 2017 the published report recommended that the Trust be placed into 'special measures'. Subsequent inspections (2018 & 2019) acknowledged the progress made in addressing the concerns noted resulting the recommendation that the Trust can come out of 'special measures' and a rating of 'good' overall was recorded.

1.2. The Trust has appointed a substantive Chief Executive Officer and Director of Human Resources & Organisational Development. A restructure within the Operational Directorate saw a number of senior appointments, adding strength and resilience to this directorate.

1.3. Following a competitive tendering process the Trust was awarded the NHS 111 Clinical Assessment Service contract for Kent and Sussex, commencing April 2020. While the contract has been awarded to SECAmb, the Trust will be working in partnership with IC24 in the delivery of the new service from April for the next 5 years.

1.4. Following the Demand and Capacity review during 2017 -19, the identification of a funding gap resulted in additional investment into the Trust and a programme of delivery involving the recruitment of additional front-line staff and the procurement of additional ambulances.

1.5. Improvements have been made in both 999 and 111 performance with a gradual reduction in 111 to 999 calls and improvements made for both in call

answering. The Trust has one of the better C2 performance achievements when compared with other ambulance services in England.

2. CQC

2.1. In 2017, the Trust was placed into special measures resulting in an improvement trajectory being designed. The following year, 2018, the CQC revisited the Trust and in their November's published report they acknowledged that significant improvements had been made which the HOSC was updated on in July 2019.

2.2. It was following the CQC visits of 2019 and the published report in August that the Trust was formally rated as 'Good' overall and it's Urgent and Emergency Care service rated as 'Outstanding' overall, including 'Outstanding for Caring. This also saw the Trust exit special measures. Appendix 1.

2.3. Acting Chief Executive Dr Fionna Moore said: "This positive report is testament to the huge amount of work that has been ongoing at SECAmb for the past couple of years. I am delighted, but not surprised, that staff have been recognised for the fantastic care they provide to patients and pleased that the big improvements we have made as a Trust during the past couple of years have been acknowledged."

2.4. Each of the CQC domain areas – safe, effective, caring, responsive and well-led, were rated as 'Good' individually. The Trust's 111 service was also rated as 'Good'. It was equally heartening to see many areas of good and outstanding practice within the Trust, recognised by the CQC in their report.

2.5. Throughout the report the CQC spoke positively about aspects of the service provided by the Trust, including:

2.5.1. Staff treating patients with compassion and kindness, respecting their privacy and dignity and taking account of individual needs

2.5.2. A strong visible person-centred culture and that staff were highly motivated

2.5.3. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff

2.5.4. There were clear systems and processes to safely prescribe, administer, record and store medicines. Inspectors observed outstanding practice in the management of controlled drugs

2.5.5. Staff were supported following traumatic experiences and events

2.5.6. Trust leaders, new to the organisation at the last inspection, had now embedded into their roles. The changes had had a positive impact on the organisation

2.5.7. Staff told inspectors they felt respected, supported and valued. They were focused on the needs of patients receiving care

2.5.8. The service promoted equality and diversity in daily work and provided opportunities for career development

2.5.9. Whilst the Trust recognises that there are areas where more work needs to be it welcomed the recognition of the significant amount of work that had been undertaken since 2017 and is committed to focusing on improvements going forward.

3. Executive Leadership Development

3.1. On 1st September 2019, Philip Astle joined the Trust as Chief Executive Officer (CEO), replacing Dr Fionna Moore who acted into the CEO role following the departure of Darren Mochrie in April 2019. Fionna returned to her substantive role as the Trust's medical Director.

3.2. Prior to joining South Central Ambulance Service in 2016 as Chief Operating Officer, Philip enjoyed a successful career in the British Army including a lead role as a strategist and planner for operations in Afghanistan and his final role as Chief Operating Officer of the Army Training and Recruiting Agency.

3.3. Ali Mohammed has recently been appointed (January 2020) as the Trust's substantive Director of HR & Organisational Development. Ali is a successful NHS HR leader and has worked previously at a number of large Trusts, including Barts and Great Ormond Street. He replaces interim Director Paul Renshaw.

4. Operational Restructure

4.1. As a part of the ongoing Operational Leadership review, the following appointments have recently been made:

4.1.1. Emma Williams joined the Trust in September 2019 as the Deputy Director of Operations, reporting directly to Joe Garcia – Executive Director of Operations.

4.1.2. Mark Eley and Tracy Stocker have both been appointed as Associate Directors of Operations covering the East and West, Operational areas (Tracy covering East and Mark covering the West) reporting into Emma Williams.

4.1.3. Ian Shaw appointed as the Associate Director of Resilience and John O' Sullivan appointed as the Associate Director for Contact Centres and Integrated Care reporting into Joe Garcia.

5. 111 Clinical Assessment Service

5.1. It was announced in August 2019 by NHS Commissioners in Kent, Medway and Sussex that the Trust had been awarded a contract to provide the new NHS 111 Clinical Assessment Service (CAS) for 5 years from April 2020.

5.2. Work had already been progressing within the Trust to provide clinical support for patients in both the 999 and 111 operations centres.

5.3. A key part of the new 111 service contract is the development of the Clinical Assessment Service which will enable patients to have access to a wider range of health care professionals, such as GP's, Paramedics, Nurses and Pharmacists.

5.4. Access to a broader range of clinical support will be provided either through clinicians based in the contact/operational centres as well as virtually.

5.5. Whilst the contact has been awarded to SECAmb, the Trust will be working in partnership with Integrated Care 24 (IC24) to deliver the new 111 CAS across Kent & Medway as well as Sussex.

5.6. A significant benefit of the Trust being awarded the 111 CAS contract is the continued relationship between the 999 and 111 service and the opportunity, working with IC24 to further develop a seamless service provision of urgent and emergency care across Kent, Medway, and Sussex, to patients through the continued development of the workforce as well as an integrated telephony system.

6. Workforce

6.1. The Trust has continued to make progress in the recruitment of staff and is on track to deliver the targeted increase of those working in frontline roles by 605 WTE from 1808 to 2413 by March 2021.

6.2. Whilst this is good progress, the Trust faces a challenge to its continuous recruitment of the paramedic workforce in light of the developing Primary Care Networks (PCN) which has already started to impact on SECAmb.

6.3. Shift Patterns – a review of all front-line staffing rotas was carried out, with new rotas introduced during 2019 to align staffing levels to demand profiles.

6.4. During 2019, the Trust also took delivery of 117 new ambulances to support the increasing front-line staffing numbers.

6.5. SECAmb utilise approved Private Ambulance Providers across the Trust, to ensure resilience and meet demand profiles.

7. Performance Overview

7.1. The continued recruitment programme in the Emergency Operations Centres has resulted in an overall improvement in call answer time for 999 calls with the Trust performing at a mean response to call answering of ‘2’ seconds (January 20202) and a 99th percentile of ‘17’ seconds. Appendix 2

7.2. Performance for the Trust continues to remain challenged particularly in achieving its C1 mean response time of seven minutes and thirty-six seconds, and 90th percentile of thirteen minutes and fifty-nine seconds (January 2020). The Ambulance Response Programme (ARP) target is seven minutes for ‘mean’ and 15 minutes for the 90th percentile. Appendix 3

7.3. C2 performance has improved throughout the year with the Trust achieving a mean response time of eighteen minutes and six seconds along with a 90th percentile of thirty-four minutes and ten seconds. The ‘mean’ and 90th percentile targets are ‘eighteen’ and ‘forty’ minutes respectively. Appendix 4

7.4. For C3 and C4, the Trust remains challenged and is performing below the national ARP targets. Appendix 4 & 5

7.5. Out of total activity (999 calls and ambulance responses), 37.1% were either telephone triaged or treated at scene, with 62.9% being conveyed either to a hospital ED or an alternative destination.

7.6. Performance across Kent and Medway for C1 is marginally better than the Trust’s ‘mean’ at seven minutes and thirty-two seconds, however C2 performance is slightly worse at eighteen minutes and twenty one seconds. Appendix 6

7.7. The recent BBC investigation into C2 ambulance service response times highlighted the challenge that services in England are facing with increasing demand. SECAmb were reported as having one of the best C2 response times. Appendix 7

7.8. Performance in the Trust’s 111 service continues at a sustained level of 77% - 81% August 2019 to December 2019 (calls answered within sixty seconds).

7.9. For the same period improvements have been made in the call abandonment rate resulting in 3% for December 2019. Previous months had reached 3.8% (October 2019).

7.10. December 2019 saw the anticipated seasonal increase of calls (92,173) compared to November 2019 (78,017).

7.11. Work continues in validating non-emergency (C3 and C4) interim dispositions resulting in 92% of these calls being validated of which over two-thirds received a downgraded disposition.

7.12. Ambulance referrals continues to fall with 15.1% recorded for December 2019, a reduction from 16.9% in October 2019.

7.13. Referrals to an emergency department also continued to fall to 9.5% (December 2019) from 10.2% (October 2019).

7.14. Work continues in the development of the CAS and it support to the wider system with 36.3% 'Consult and Complete' for December (calls transferred to a clinician with no further action required).

8. Hospital Handover Delays

8.1. A programme of work began in 2017 with the overall aim of reducing hours lost due to handover delays. A dedicated Programme Director is leading this system wide programme.

8.2. The programme covers 18 sites (12 acute hospitals) across Kent & Medway, Surrey and Sussex.

8.3. An Ambulance Handover Task and Finish Steering Group is in place and is chaired by an Acute Trust Chief Executive. Membership also includes representatives from NHSE and NHSI, lead commissioners, CCG's, two acute hospital Chief Operating Officers, SECAmb and an Emergency Care Intensive Support Team (ECIST) advisor.

8.4. Some of the key developments have been:

8.4.1. Direct access for ambulance crews to non-emergency department areas e.g. Same Day Emergency Care (SDEC) and Ambulatory Care (AMU), as well as Surgical Assessment Units.

8.4.2. Dedicated handover nursing staff

8.4.3. Front door streaming

8.4.4. Automated daily reports on the previous day's handover delay performance

8.4.5. Detailed monthly reports are provided to all acute Trusts and SECAmb Operating Units, giving granular detail on handover and crew to clear performance for individual hospitals.

8.4.6. Access to SECAmb's live Power BI dashboard, to inform key hospital staff of ambulances on route, ambulances waiting to handover, as well as live performance information and activity trends and predicted numbers of conveyance

8.5. Comparing January 2020 with the same period for 2019 for ambulance conveyances, Sussex hospitals showed a 2.9% increase (12,478 to 12,835),

Surrey hospitals a 3.6% increase (10,533 to 10,916), and Kent hospitals a 3.3% increase (16,050 to 16,579).

8.6. The Trust showed a 7% decrease in hours lost due to ambulance turnaround across the three counties.

8.7. While Kent hospitals had a collective decrease of 10% hours lost (2,482 to 2224) both Maidstone and Medway hospitals showed an increase of 34% and 8% respectively.

8.8. SECAmb, have monthly liaison meetings with all the Kent and Medway hospitals to review the hours lost, procedures pertaining to handover, as well as agreeing key actions to reduce ambulance handover delays, review community pathways, and ambulance crew turnaround. Appendix 8

8.9. A 'joint live conveyance review' programme is being carried out at all hospitals where a team consisting of SECAmb, community and ED staff as well as primary care representation, interview ambulance crews after their handover of a patient, following an agreed set of questions, to identify if an opportunity to have left the patient in the community existed, or existed but access was restrictive, or whether support was sought from other services e.g. patients GP etc.

9. Clinical Education

9.1. On 31 July and 1 August 2019, the Trust underwent a two-day Ofsted Monitoring Visit, looking specifically at our apprenticeship training provision. This report was published by Ofsted on their website on 29 August 2019.

9.2. The results of this visit unfortunately showed that the Trust had made 'insufficient progress' in two of the three areas inspected, specifically:

9.2.1. How much progress have leaders made in ensuring that the provider is meeting all the requirements of a successful apprenticeship provision?

9.2.2. What progress have leaders and managers made in ensuring that apprentices benefit from high quality training that leads to positive outcomes for apprentices?

9.3. These findings, together with the results of a subsequent Peer Review commissioned by the Trust, have clearly shown that we need to take immediate action to address the issues identified. It is important to emphasise, however that the quality of the teaching provided to our students, as well as the commitment of the teaching staff has never been in doubt and was recognised as being of a very high standard, both by the Ofsted team and by our students.

9.4. The Trust agreed to undertake a planned, 6-week closure of our Clinical Education Department. During the closure, which began on 11 September 2019, the Executive Management Board (EMB) initiated a series of internal and

external reviews in order to fully understand the issues and the rectification plans required. The temporary closure period was due to be for six weeks but unfortunately, there is still a great deal of work to be done.

9.5. In response, the Trust Board have implemented a Clinical Education Transformation Project. This Project is led by two executive directors, Dr Fionna Moore, Medical Director and David Hammond, Finance Director. The project consists of two phases.

9.5.1. The initial phase (phase 1) addresses a number of immediate issues, including clearing a backlog of marking, ensuring all students are able to progress to the roles that they have been trained for in a seamless and timely way, and aligning the Trust's Clinical Education function to the needs of the whole organisation.

9.5.2. Phase 2 will look at the longer term and will ensure that we are structured, resourced and funded appropriately to deliver the needs of the organisation.

9.6. Progress updates have been shared with our Lead Commissioner for dissemination across the system.

10. Electronic Patient Clinical Report (ePCR) and Service Finder

10.1. During 2019 the Trust rolled out the electronic version of the patient clinical record (ePCR). Previously crews were required to complete an A3 form that captured relevant patients details from which a copy was given to the hospital at the point of patient handover.

10.2. ePCR is accessed via an iPad.

10.3. The version of ePCR that the Trust is using has been developed by the Trust's Computer Aided Dispatch (CAD) supplier, Cleric, enabling ePCR to fully integrate with the CAD.

10.4. With the introduction of the 'Service Finder' app, ambulance crews can now search when on scene with a patient, for available supportive community services that can respond to the patients' needs e.g. community falls teams; instances where a conveyance to Emergency Department is not required

11. Make Ready Centre

11.1. The concept of the Make Ready Centres (MRC) was initially identified in the Carter Review as the most efficient system for vehicle processing and SECAmb opened its first MRC in 2012 at Paddock Wood.

11.2. Across Kent and Medway, SECAmb operates from 3 main Make Ready Centres: Paddock Wood, Ashford and Thanet. As well as a several ambulance stations and a number of ambulance community response posts (ACRP). The

ACRP's give the Emergency Operations Centre the opportunity to strategically place ambulances in locations to enable quicker response times.

12. Finance

12.1. The Trust recorded a deficit in September of £0.5m. This was as planned.

12.2. Cost improvements of £0.5m were delivered in the month, £0.5m lower than planned. The full year target is £8.6m.

12.3. The Trust's Use of Resources Risk Rating (UoRR) for August is 3, in line with plan.

12.4. The Trust faces significant financial risks in 2019/20, the main ones being:

12.4.1. Achievement of contractual income if activity demand and performance trajectories are not met.

12.4.2. Ability to meet the demanding resourcing plans for both 999 and 111, with potential premium costs to ensure delivery of performance trajectories.

12.4.3. Delivery of cost improvements that are essential to ensure financial balance.

12.5. The Finance Team continues to work with budget holders and service leads to mitigate risks as far as possible.

12.6. Provider Sustainability Funding (PSF) of £1.8m is planned to be received this financial year, which is contingent on the Trust achieving its control total. The first and second quarter (£0.6m) has been achieved.

12.7. The financial position is closely monitored through the Finance & Investment Committee, a subcommittee of the Board.

13. Recommendations

13.1. The Committee is asked to note and comment on the update provided.

Lead officer contact

Ray Savage, Strategy and Partnerships Manager, SECAmb

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Item 6: Review of the Frank Lloyd Unit, Sittingbourne

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 5 March 2020

Subject: Review of the Frank Lloyd Unit, Sittingbourne

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

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

The proposed changes around the Frank Lloyd Unit have been deemed a **substantial variation of service**.

---

1) Introduction

a) The Frank Lloyd Unit is an inpatient unit for individuals with complex dementia needs and challenging behaviour.[1] It is accessed by patients across Kent and Medway.

b) The service is provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

c) Due to the falling number of patients receiving care at the Unit, the Trust has deemed its operation as unviable. In April 2019, the CCG's served notice on the Frank Lloyd Unit with a proposal to close on 31 March 2020.

2) Previous monitoring by the Kent HOSC

a) HOSC received notification at their meeting on 21 September 2018 that the Frank Lloyd Unit was under review.

b) HOSC received further written updates at its June and July 2019 meetings, when the CCG acknowledged that work had progressed slower than anticipated.

c) At its 19 September 2019 meeting, HOSC resolved the following:

i. the Committee deem the proposed changes to the Frank Lloyd Unit to be a substantial variation of service;

ii. an informal briefing be arranged to go into more detail concerning the Unit; and

iii. the NHS be invited to attend a future meeting when there was more information available on the new model of care being developed.

[1] KMPT (2019) Frank Lloyd Unit, https://www.kmpt.nhs.uk/our-services/frank-lloyd-unit/

d) In response to point ii) above, an informal briefing was held on 29 January 2020.

e) West Kent CCG have been invited to today's meeting to provide more information on the new model of care and provide final clarity on the closure of the Frank Lloyd Unit.

3. The Next Steps

a) The Committee has deemed the closure of the Frank Lloyd Unit to be a substantial variation of service. The Unit is due to close on 31 March 2020. Therefore, this meeting is the last practical opportunity for HOSC to consider whether they are minded to refer the closure to the Secretary of State for Health and Social Care.

b) As set out in the Protocol for the Health Overview and Scrutiny Committee in the KCC Constitution, a substantial variation of service may only be referred to the Secretary of State for Health and Social Care where one of the following applies:

i. The consultation with the HOSC on the proposal is deemed to have been inadequate in relation to content or time allowed;

ii. The reasons given for not consulting with the HOSC on a proposal are inadequate; or

iii. The proposal is not considered to be in the interests of the health service of the area.

c) If the HOSC does not feel that any of the above apply to the matter under discussion, it will not be able to make a legitimate referral. It will still be able to monitor the implementation of the service and make comments and recommendations directly to the relevant health provider or commissioner.

d) If the HOSC believes that one of the reasons above applies, it cannot make a final determination at this meeting. It must agree which of the above grounds provisionally apply and communicate this to the NHS in writing as soon as possible along with the date it will meet to make its final determination. The NHS must be given time to consider and respond to the Committee's decision.

e) The Committee will meet to consider the NHS response and any other discussions that have taken place, prior to making its final determination.

f) Any referral to the Secretary of State must contain the following:

i. Full evidence of the case for referral;

ii. Evidence that all other options for resolution have been explored, along with all additional requirements for the submission of a referral required by legislation and statutory guidance.

iii. Where the referral is on the grounds that the Committee believes the proposal is not in the interests of the health service of the area, a summary of the evidence considered must be provided, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service of the area.

g) A decision to support the CCG Governing Body decision, or support with qualifications and/or comments could be made at this meeting.

h) The Committee has not yet made a decision around the continuing model of care being a substantial variation, because there was not adequate information available to them at the last meeting to make that decision. Therefore, Members can continue to request updates around the new model of care, but this will be separate to the Frank Lloyd Unit item.

4) Recommendation

The Committee is asked to consider the decision of the Kent and Medway CCGs to close the Frank Lloyd Unit and take one of the following actions:

a) Support the decision of the Kent and Medway CCGs and make any additional comments the Committee deems appropriate; or

b) Specify concerns that the Committee has with the decision of the Kent and Medway CCGs and invite the NHS to a future meeting of the Committee where their response to these concerns will be considered ahead of a final determination by the Committee as to whether or not to refer the decision to the Secretary of State for one of the reasons set out in 3c above.

Background Documents

Kent County Council (2018) *'Health Overview and Scrutiny Committee (21/09/18)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7921&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (06/06/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8281&Ver=4

Kent County Council (2019) *'Health Overview and Scrutiny Committee (23/07/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8282&Ver=4

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

Health Overview and Scrutiny Committee (HOSC)

5 March 2020

Update report of the service for patients with dementia and complex needs currently provided within the Frank Lloyd Unit, Sittingbourne

1. Introduction

This paper has been provided to update HOSC on the proposals for the service provided at the Frank Lloyd unit, since the last update provided in October 2019

The Frank Lloyd Unit (FLU) is a Continuing Health Care (CHC) unit located on the Sittingbourne Memorial Hospital site. Kent and Medway Partnership Trust (KMPT) are commissioned by Kent & Medway Clinical Commissioning Groups (CCG's) to provide this service. The unit provides highly specialist care and treatment for patients at a very advanced stage of their dementia, who have a range of complex needs including behaviours that challenge. All these persons meet and are paid for through the CHC funding. The unit provides a person centred approach, using dementia care mapping to respond appropriately and flexibly to specific, individual needs. The unit is accessed by all CCGs in Kent and Medway within the NHS Standard Contract. The unit was originally made up of two wards of 20 beds, 30 of which were commissioned on a block basis at a cost of circa £3.029m per annum. The remaining 10 beds were purchased on a cost per case basis at £405 per day; however the unit ceased taking cost per case patients in 2016.

2. National picture

Dementia currently affects more than 900,000 people nationally and this number is predicted to rise as the UK's population continues to age and grow. 39% of people living with dementia over 65 are living in care homes (either residential care or nursing homes) and 61% are living in the community (Prince, M et al, 2014)[1].

The National Dementia Strategy[2] explains the vision for the future. The ambition is to put local people at the heart of our services, helping people to stay well and independent in their own homes, in care homes or in nursing homes in their communities and avoid being admitted to hospital.

The national profile is to provide services for patients as close to their home as possible, whether that is in a domestic setting, nursing or residential home. The Department of Health published an issues paper for the commissioning of home care as part of the consultation process for the National Dementia Strategy (2009)[3] this sets out the elements of specialist home care that need to be considered by commissioners, particularly in the context of personalisation and self-directed

[1] Dementia UK: Update Second Edition report produced by King's College London and the London School of Economics for the Alzheimer's Society.
[2] https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
[3] Department of Health (2009) *Living Well with Dementia: A national Dementia Strategy.* London: TSO

support. Social care in England is undergoing an immense cultural change in the way specialist support is provided. The National Dementia Strategy sees the implementation of 'Putting People First' transformation agenda, which outlines a personalised system, available to all, focused on prevention, early intervention, enablement, and high quality personally tailored services (HM Government, 2007)[4].

3. Local care

As the population grows, and more people live with long-term conditions and the predicted number of people living with dementia increases, the demands on our services are changing and increasing. Services are not necessarily designed for todays or future needs, and it is becoming more challenging to keep up with rising costs.

There are approximately 1.8 million people living in Kent and Medway, the number of people living here is predicted to rise by almost a quarter by 2031 and is higher than the average across England. This is because local people are living for longer and because people are moving into the area. While it is good news that people are living longer, an ageing population often means increasing demand for services to keep people well or help them when they are not. We need to change what we currently do to better support older people in our area.

Evidence shows that providing care for people living with dementia, who may also need additional care and support, is better provided care in their usual place of residence within a community environment. Co-ordinating their individual health and social care needs, enables patients, their families and carers to cope better with the illness. It is recognised though, that there will continue to be a small number of people who have highly complex needs, meet the NHS Continuing Healthcare criteria and will require specialist placements in residential or nursing homes.

4. Review of services provided for CHC eligible patients with dementia and complex needs:

The service provided at the Frank Lloyd unit was originally commissioned as a short term inpatient unit for people with dementia and complex needs, which aimed to settle patients with the use of behaviour care plans and dementia mapping and then discharge them back to a community home or care/nursing home. However historic data shows that when CHC patients were admitted to FLU they were unlikely to be discharged again, even when they became physically frail and at end of life. This means that the unit was operating out of scope and at significant cost, providing and enhanced service for patients that could have been suitably looked after in the community.

Over the last two years the Frank Lloyd Unit has been the subject of discussion between the continuing healthcare assessors, provider and commissioners to consider the best options for delivering care to patients who meet CHC criteria for dementia and complex needs and it was agreed that the CHC assessors should work on a model that focused on supporting people to be discharged back into a community environment in line with the Dementia Care Strategy.

CHC teams worked with patients and their family or carers to choose homes that best meet the needs of the person with a focus on keeping people in their usual place of residence.

As this model of care evolved CHC assessors were able to support patients to remain in their care homes with an enhanced care package around them with support from community services. This

[4] HM Government (2007). *Putting People First: A shared vision and commitment to the transformation of adult social care*. HM Government. London

has prevented the need for any new admissions to FLU therefore there have been no new admissions to the inpatient service since 2017.

We have now moved from a service where people were admitted and frequently remained there until the end of their life, to one where they were admitted, stabilised and discharged back into the community, to the current model of care where the majority of people are able to remain in the community home with additional support. Please note that this was the original clinical commissioned purpose for FLU, as a short term intervention unit.

Since Jan 2018 there have been eighteen successful discharges from FLU from all CCG's to a range of care homes and nursing homes within Kent & Medway (listed below) that care for individuals with dementia and complex needs*; these homes have a mix of RMNs and RGNs so staff has the skill set and registration to look after patients with dementia and complex needs as well as physical frailty. They provide a homely environment and have activities you would expect to see in a care home. There have been no 'out of area' placements, for clarification and definition purposes out of area placements are defined as homes that geographically sit outside of Kent & Medway

- Darland House, Gillingham
- St Anselms, Deal
- Tunbridge Wells Care Centre
- Abbottsleigh Mews, Sidcup
- Newington Court Care Home, Sittingbourne
- Elvy Court Care Home, Sittingbourne
- Mayflower Care Centre, Gravesend
- Hazelwood Care Home, Longfield
- Applecroft Care Home, Dover
- Betsy Clara Care Home, Maidstone
- Newington Court Care Home, Sittingbourne
- Creedy House Care Home, New Romney
- Larchmere Nursing Home, Cranbrook
- Warren Lodge, Ashford
- Acacia House Nursing home, Tenterden

(*please note this is not an exhaustive list of current homes that would be suitable).

As an enhanced community service model is further developed it is expected that more care homes will be able to look after this client group without the need for an inpatient admission. Data is currently being collated to scope the future demand for this service as part of the development of the new model and will be provided once completed; however the evidence to date provided above indicates that a community model has been very successful. Wider consideration needs to be given to people with dementia that would not meet the CHC criteria as part of the new model development. We also recognise that for a very small cohort of patients, an inpatient unit will be clinically appropriate and the new service model will take this into consideration as part of the project.

5. Update of service provided at Frank Lloyd Unit & next steps

The FLU project group was unfortunately stalled from Oct 2019 – Jan 2020 due to Internal staffing issues, as well as the general election and the sensitive pre-election period until December 2019.

Currently there is one patient remaining in the unit and when appropriate and in collaboration with their family they will be transferred to an identified care home placement. We have been notified that a bed is now available and it is anticipated that this move to the home will take place soon.

After this the inpatient service will be 'mothballed' as these developments have enabled the local NHS to consider better use of the funding that is currently being used for the inpatient service.

The proposal is to develop an enhanced community service to provide support to current and additional care homes in the community which will both support transition into the home as well as responding to incidents where behaviours may require additional support and provide care home staff with the skills to manage individuals with complex dementia.

The new model in outline proposes a small number of acute dementia "hubs" into which the most challenging patients can be admitted. The NHS would provide specialist staff who would be based in these hubs and who would also provide outreach support into care homes where patients with less complex needs patients might be cared for.

Achieving this kind of transformation in a challenging environment is not an easy task but we are working together with the NHS and social services, with other public, private and voluntary sector providers of care and families and carers to ensure best possible outcomes for local people in the future.

The original NHSE Gateway review was postponed as more evidence was needed on developing a new model of care. It is anticipated that pre-engagement with stakeholders on the new model of care will be concluded by April 2020; it will then be presented to NHSE Gateway review with a view to moving to full consultation and engagement in May 2020 to consult on the development of the new enhanced community model.

Local engagement with Swale residents will be undertaken to consider the future use of the Frank Lloyd building.

Item 7: East Kent Transformation

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 5 March 2020

Subject: East Kent Transformation

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

It provides background information which may prove useful to Members.

This is a written update only and no NHS representatives will be present at the meeting.

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1) Introduction

a) The programme of work under consideration for this item has been in development for a number of years. In November 2017 the NHS announced a 'medium list' of two potential options and has been working since then on developing these options.[1] The shortlist of options was announced on 16 January 2020.[2]

2) Substantial Variation of Service

a) Medway Council's Health and Adult Social Care Overview and Scrutiny Committee (HASC) considered the proposals relating to Transforming Health and Care in East Kent on 16 October 2018. They determined that the reconfiguration constituted a substantial variation in the provision of health services in Medway.

b) The Kent Health Overview and Scrutiny Committee (HOSC) most recently considered the item on 21 September 2018. The Committee has also deemed the changes to be a substantial variation in the provision of health services in Kent.

c) In light of the above, and in line with Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, formal scrutiny of the East Kent Transformation lies with the Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC).

d) The JHOSC may consider whether the reconfiguration should be referred to the Secretary of State under regulation 23(9) of the 2013 Regulations. The JHOSC must recommend a course of action to the relevant Overview and Scrutiny Committees. The JHOSC cannot itself refer a decision to the Secretary of State. This responsibility lies with the Kent County Council HOSC

[1] https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/delivering-our-future/

[2] https://kentandmedway.nhs.uk/latest-news/nhs-leaders-in-east-kent-confirm-shortlist-for-hospital-improvements/

and/or the Medway Council HASC separately, once the JHOSC has concluded its work.

e) The Kent and Medway JHOSC received an update from the East Kent CCGs on 6 February 2020.

3) **The role of the Kent HOSC**

a) Due to the significant impact that the proposed changes in East Kent may have on Kent residents, it has been decided that the East Kent CCGs will continue to update HOSC on the transformation programme. Whilst a discussion at today's meeting will be possible, the Kent HOSC can ultimately only "note" the report until such time that the Kent and Medway JHOSC make a recommendation to it.

3. Recommendation

RECOMMENDED that the Committee note the report.

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

Kent County Council (2018) '*Health Overview and Scrutiny Committee (20/07/2018)',* https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7919&Ver=4

Kent County Council (2018) '*Health Overview and Scrutiny Committee (21/09/2018*)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7921&Ver=4

Medway Council (2018) *'Health and Adult Social Care Overview and Scrutiny Committee (16/10/2018),* https://democracy.medway.gov.uk/mgAi.aspx?ID=19800

Kent County Council (2020) *'Kent and Medway NHS Joint Overview and Scrutiny Committee, (16/10/2018),* https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=8624&Ver=4

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

KENT HEALTH
OVERVIEW AND SCRUTINY COMMITTEE
5 MARCH 2020

A SUMMARY OF EVALUATION PROGRESS FOR OPTIONS FOR THE CONFIGURATION OF HOSPITAL SERVICES IN EAST KENT:

Report from:	**East Kent Transformation Programme**
Author:	Lorraine Goodsell, Deputy Managing Director East Kent Clinical Commissioning Groups

Introduction

This is a summary of a paper presented to the Kent and Medway Joint HOSC on 6 February and is for information to the Kent HOSC. The document provides an overview to the Committee on progress with the East Kent Transformation Programme.

Background

The pre-consultation business case (PCBC) sets out proposals for the reconfiguration of acute hospital services in east Kent, underpinned by changes that are already underway to strengthen and expand the delivery of local care and improve prevention of ill-health, to enable people to stay well and live independently. It is based on work undertaken by NHS organisations and partners in east Kent since 2015 to develop proposals for meeting the changing health and care needs of local people in a sustainable way.

Progress to Date

This document details key activities undertaken over the last year.

Evaluation Summary

Two options for the configuration of hospital services in east Kent were selected for evaluation against five criteria as set out below:

1. Clinical Sustainability
2. Accessibility
3. Implementable
4. Strategic Fit
5. Financial Sustainability

Each option was assessed independently of the other, against a “Do Minimum” control option. The evaluation process focussed on the options appraisal of acute hospital reconfigurations.

An evaluation panel consisting of The Sustainable Healthcare in East Kent Joint Committee voting members was called upon to review each of the five criterion and to award scores based on each option’s outcomes, compared to the Do Minimum. As the Do Minimum is the key comparator, it was agreed that it would score zero across all five criteria.

In January 2020 the east Kent clinical commissioning groups confirmed that both options were shortlisted for inclusion in the pre-consultation business case to be reviewed by NHS England and NHS Improvement.

1. Pre Panel and Programme Assessment

1.1 Development and assessment of the standardised templates

Analysis was undertaken by the Trust, STP workforce and estates leads and independent experts, to respond to each of the evaluation questions in the form of a standardised template.

These templates were designed to ensure consistency in the evaluation response approach and were populated with support from the CCG leads.
These templates were reviewed through and signed off by the East Kent Transformation Programme to ensure robust scrutiny, impartiality and transparency of the analysis undertaken.
Once the templates were signed off and endorsed by the East Kent Transformation Programme, the content of the templates became the basis of the evaluation reports, developed by the CCG.

1.2 Development of the evaluation reports

The endorsed contents of the templates were systematically summarised into a series of evaluation reports to enable the Evaluation Panel to review outcomes against the ‘‘Do Minimum’’ and score accordingly.

To aid the Evaluation Panel in its systematic review of each option, separate reports were prepared comparing each option against the ‘‘Do Minimum’’.

The five reports were reviewed and endorsed through the East Kent Transformation Programme governance structure, before being distributed to the Evaluation Panel in advance of the Panel sessions.

The corresponding templates were also included within the appendices section of the reports to ensure that the panel members had all evidence available to them to support their scoring.

2. The evaluation panel and report

The Panel comprised of an independent chair, as well as scoring members. The role of the independent chair was to mediate discussions during the panel sessions and to facilitate consensus on scores awarded. The scoring members were voting members of The Sustainable Healthcare in East Kent Joint Committee

Three separate panel sessions were held in September, the:

- first session took place on 4th September to evaluate accessibility and strategic fit;
- second session took place on 11th September to evaluate financial sustainability and whether proposals were implementable; and
- final session took place on 18th September to evaluate clinical sustainability.

Subject Matter Experts (SME) were available before each scoring session of the panel, to provide expert knowledge and additional guidance to the scoring members. However, the scoring members deliberated scores in isolation with the independent chair to ensure and maintain impartiality. Members of the East Kent Transformation Programme were also present to provide support to scoring members.

3. Draft Pre Consultation Business Case, Clinical Senate Review & NHSE/I assurance

3.1 Draft pre-consultation business case

A mature draft of the PCBC was finalised and endorsed through our programme governance during October as detailed below:

- Transformation Delivery Board: 21st October 2019
- System Board: 29th October 2019
- The Informal seminar of Sustainable Healthcare in East Kent Joint Committee: 30th October 2019
- Mature draft of the PCBC shared with NHSE/I and the Clinical Senate for review: 11th November 2019

3.2 Clinical Senate review

The Clinical Senate has reviewed the draft PCBC in advance of final submission to NHSE and NHSI in accordance with the major service change assurance processes. Inclusive of all clinically related elements, the review included, but is not limited to, the case for change. The Senate also reviewed shortlisted service configuration options, including the proposed clinical models and standards for ED; Urgent and Acute Care (inclusive of critical care); Planned Care; Cancer sub-specialties; and Paediatrics.

The recommendations from the Senate will be incorporated into the final report that will be submitted to NHSE/I.

4. Finalising the PCBC

4.1 Internal Governance

The steps that will be completed to finalise the PCBC are detailed as follows:

- Completion of additional work identified as required for the final draft of the PCBC including incorporating the recommendations from Clinical Senate and initial review by NHSE/I/E.

- Final draft to be reviewed through internal governance process by end of February 2020.

- Final draft PCBC, endorsed by Provider Boards and Joint Committee, by end of March 2020.

4.2 Key Planning Assumptions/ NHSE/I Assurance Process

NHSE/I will receive a final draft PCBC in April 2020 and consultation will follow conclusion of assurance process

5. Next Steps

The timescale for delivery of the revised PCBC means that a final draft, that addresses actions identified by the Senate, will be completed by 12th February. This will allow for the PCBC to be reviewed and agreed in accordance with CCG and provider governance processes.

The evaluation panel will meet again in February to review:

• the information requested for assurance at the panel meetings in September;

• issues that have been considered through the change control process and may present a material change to the outcomes from evaluation; and

• information that may present a material impact to the PCBC and evaluation of options, this includes responses to Clinical Senate recommendations.

6. Appendix

1. The Evaluation Process
2. Options Summary (including do minimum)
3. Evaluation Criteria

Lead officer contact

Lorraine Goodsell,
Deputy Managing Director
East Kent Clinical Commissioning Groups

Appendix 1 The Evaluation Process

The end to end evaluation process involves three key stages:

Objectives

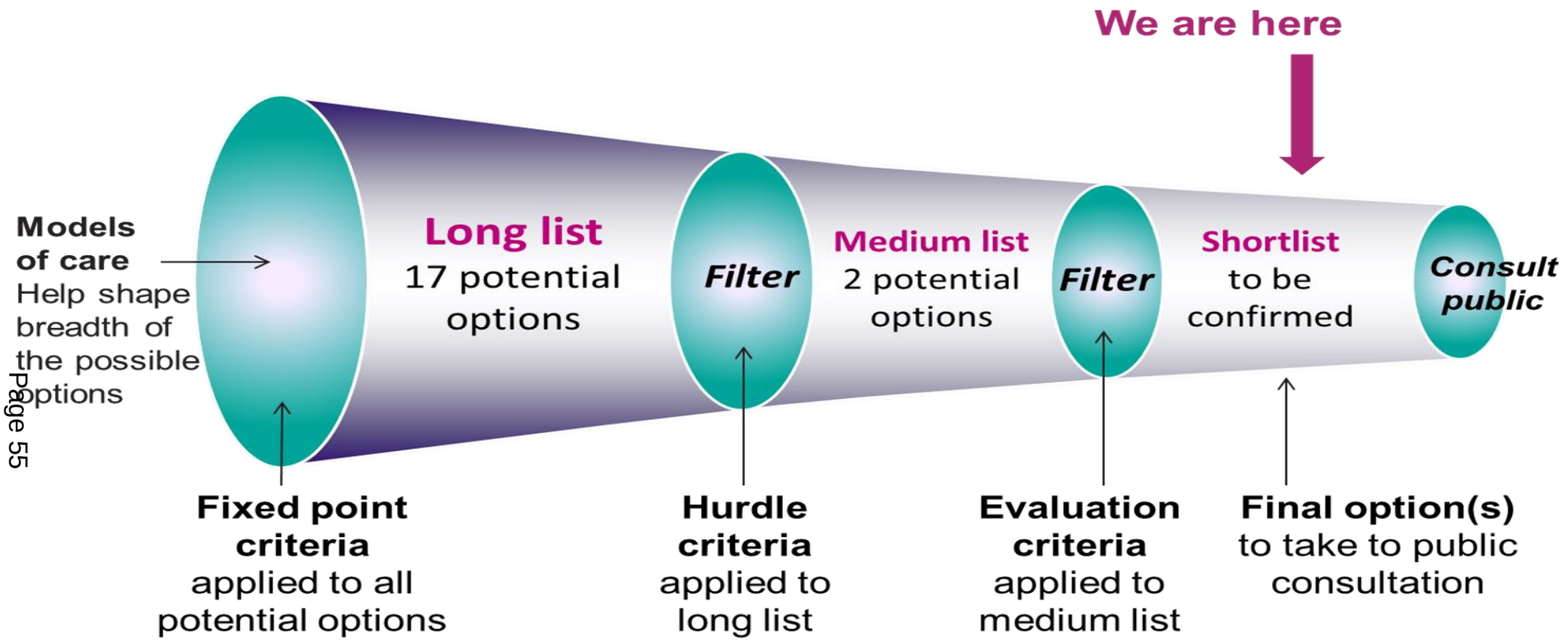
Key objectives of the evaluation process include:

- Provide an objective and transparent framework for the assessment of all possible UEC reconfiguration options
- Derive a manageable shortlist of options from the longlist of options
- Ensure that shortlisted options would enable East Kent local health economy's objectives to be met

The three key stages of the evaluation process

- **Stage 1: Hurdle Criteria (completed):** Application of agreed hurdle criteria with a clear threshold which the options either pass or fail
- **Stage 2: Ranking Criteria (completed):** Where multiple permutations of the same reconfiguration model (e.g. "one UEC site" or "two UEC site") are qualified, the options are ranked to select the best option of that type
- **Stage 3: Full Evaluation (current) :** This will form the final detailed evaluation stage

Options development and assessment



Application of hurdle criteria

- Following the completion of the previous first stage of evaluation, a proposal from Quinn Estates (land developer) to provide a “hospital shell” on/adjacent to the Kent and Canterbury Hospital site for a single Major Emergency Centre was received

- This inferred a substantial and material capital benefit to the East Kent health economy. This option was agreed to be included in the original medium list, announced in November 2017

- Following an assessment from EY, a decision was taken to rerun the first stage evaluation in order to put the newly emerged option through the same degree of scrutiny and rigour as other options to clarify whether this option passed the hurdle stage

- Reapplying the hurdle criteria to the long list of options, included revising the hurdle criteria

The Hurdle Criteria

The table below summarises the hurdle criteria that was applied. Please note, that strategic fit is greyed out to highlight that it was not used as a hurdle criteria, but was taken forward as a criterion in the full evaluation.

#	Criteria	Criteria Description
1	**Is the potential configuration option clinically sustainable?**	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver this and will it assist in addressing the workforce sustainability issues? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective?
2	**Is the potential configuration option accessible?**	• **Urgent Care:** East Kent patients can access a UEC site within 60 minutes • **Trauma:** Trauma Units are on route to the major trauma centre (MTC); i.e. going to the trauma unit for stabilisation does not take the patient away from the MTC) • **Trauma:** the proportion of patients with **45min** access to a trauma unit is maintained or improved relative to the previous site designation (i.e. trauma Unit at WHH) • **Cardiac:** all Kent and Medway patients can reach pPCI centre within 90 minutes • **Stroke:** 95% of the East Kent population can access a stroke unit within 60 minutes (to enable call to needle time within 120 minutes) • **Vascular:** 95% of the East Kent population can access vascular services within 60 minutes
3	**Is the potential configuration option financially sustainable?**	• Will the option generate a cost of capital for the acute provider that is no more than £25m per annum?
4	**Is the potential configuration option implementable?**	• Will the option be implemented within a reasonable timescale i.e. no more than 12 years from completion of the public consultation?
5	**Is the potential configuration option a strategic fit?**	

Medium list of options

- Stage 1 (hurdle criteria) and stage 2 (ranking criteria) took the long list of seventeen options down to two options

- It should also be noted in July 2018 - there was a proposal of an independent review of the capital costs of Option 9 (a single emergency model at William Harvey Hospital). This review was taken forward and confirmed that capital costs did not meet the hurdle criteria for financial viability

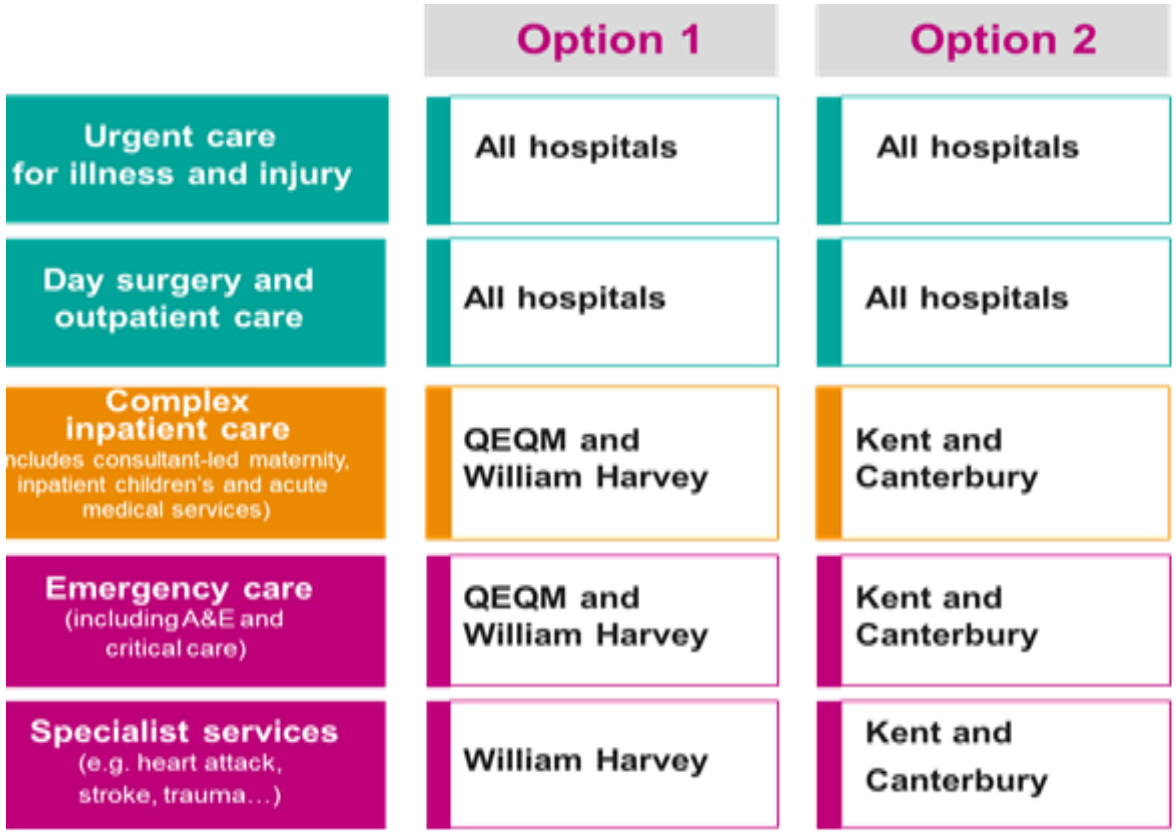
The medium list of options included:

Option 1: Two site ED model with William Harvey Hospital as the Major Emergency Centre

Option 2: One site ED model with Kent & Canterbury Hospital as the Major Emergency Hospital

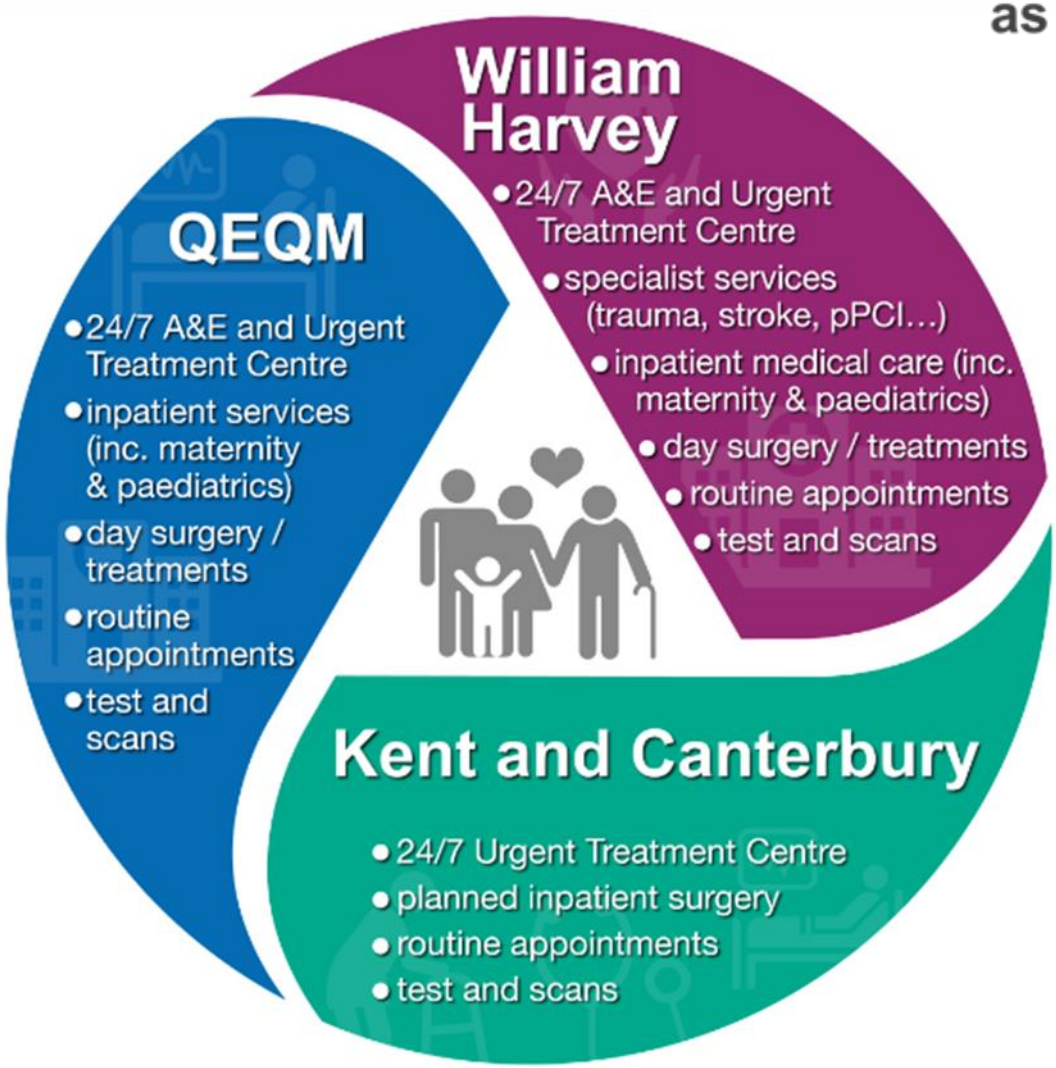
- During the final and detailed stage of the evaluation (stage 3) option 1 and 2 was also reviewed against a do – minimum option

Appendix 2 Options summary



Option 1

Two site emergency department model with William Harvey Hospital as the Major Emergency Centre

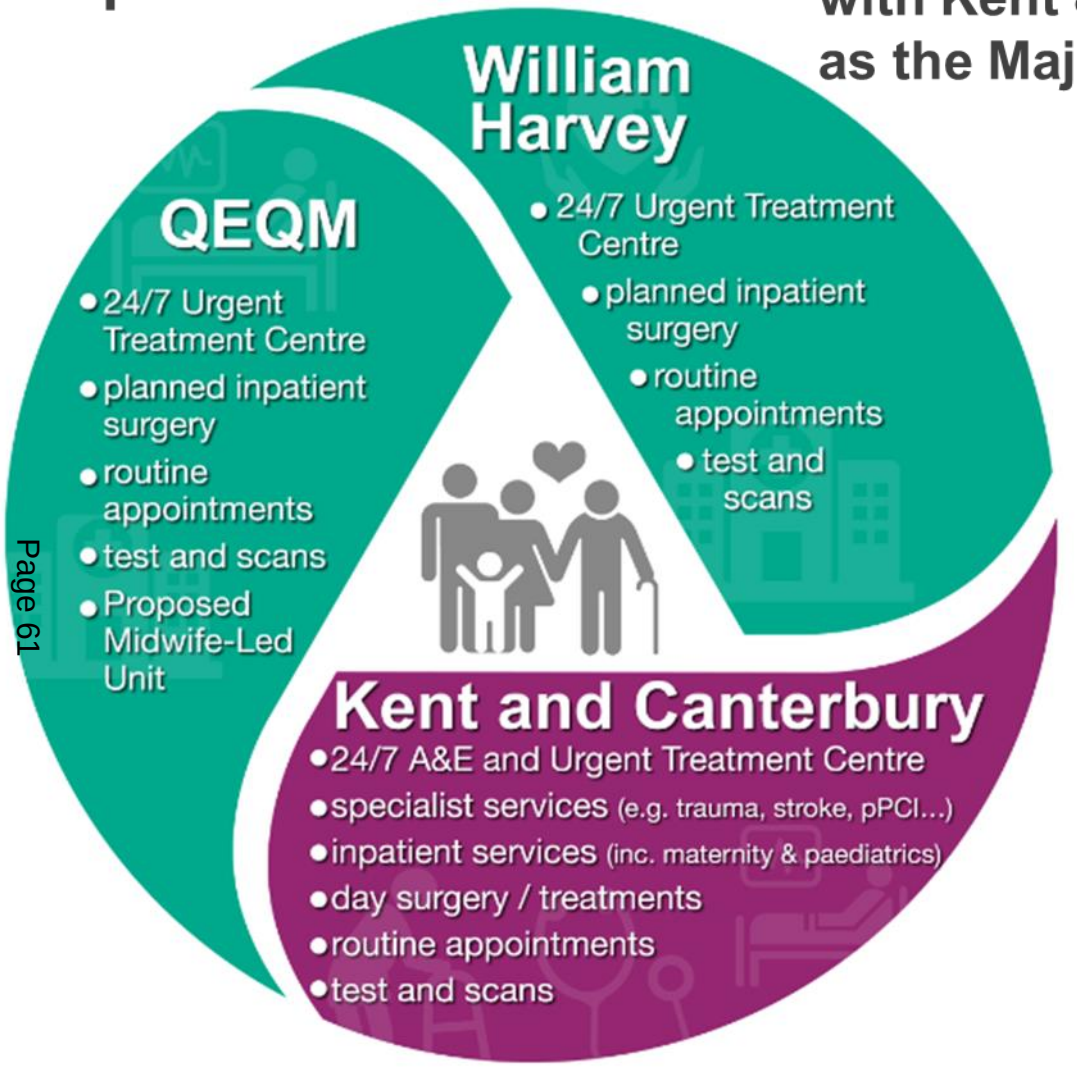


Option 1 has the following key acute changes:

- Permanent 2 site emergency medicine
- 2 critical care units
- 1 site elective surgery (low risk cases)
- 1 site stroke (HASU/ ASU)

Option 2

One site emergency department model with Kent & Canterbury Hospital as the Major Emergency Centre



Option 2 has the following key acute changes:

- Changes to a single site emergency medicine
- 1 critical care unit
- 1 or 2 site elective surgery (low risk cases) - to be confirmed
- 1 site stroke (HASU/ ASU)
- Single site obstetric and paediatric services
- Introduction of 1 standalone Midwife Led Unit at QEQM

Options summary

What is the ‘do-minimum’ option

Deciding whether to shortlist the options involved comparing them to a scenario without significant change. For this programme the do minimum has two elements:

Some planned improvements which would continue regardless of these proposals, including:

- delivery of 7 day working across the three sites
- establishing hyper acute stroke units in Kent & Medway
- do minimum includes changes or developments that are likely to happen within the next 12 years; including a range of agreed capital investment projects.

The modelling for do minimum scenario also needs to assume that some temporary changes made in recent years go back to their original model:

- Kent and Canterbury would return to taking emergency medicine admissions (but would not have a full A&E – the removal of full A&E services was formally consulted on previously)
- emergency medicine and critical care units at all three sites
- piloting of single site elective orthopaedic surgery reverts to two sites.

Options summary

Why compare against a ‘do-minimum’ option

The NHS Capital Investment Manual states:

The ‘Do-minimum’ option should be retained as a baseline in the shortlist since the implications of doing the minimum must be assessed and understood. It may be that a ‘do minimum’ option is not acceptable, or possible. However, the ‘do minimum’ option must then be included as a baseline so that the extra benefit and costs of other options can be measured against it. This will involve understanding the cost of merely maintaining the current level of service, over the full lifetime of the project. The effect of doing minimum might be that the life of the option is limited.

Significant resource input may be required just to maintain the status quo: that is, doing the minimum. Buildings or plant may have to come to the end of their useful life and may require replacement or upgrading. If the throughput of patients is increasing, maintaining service provision may take additional costs in staff, energy and other running expenditures.

Appendix 3
Evaluation criteria used in evaluating the medium list options

The evaluation criteria outlined on the following slides was used to score the medium list options against the 'Do-minimum'. While there is recognition that the 'Do-minimum' is not a sustainable option for the future, it is being used as the 'control' group to assist with objectively scoring both options. More detail on the 'Do-minimum' can be found in the next section.

Criterion	Sub-criteria	Evaluation questions
1. Is the configuration clinically sustainable and are able to deliver required quality standards?	**1.1) Quality: workforce**	In comparison with the 'do minimum' scenario, to what extent do the options: a) Allow each organisation to operate working patterns that are safe and compliant with regulatory standards? b) Impact on delivering a sustainable workforce, improving the recruitment and retention of suitably skilled staff across the East Kent health and social care system?
	1.2) Quality: Clinical recommendations and standards	In comparison with the 'do minimum' scenario, to what extent do the options: a) Allow services to be configured in alignment with the Clinical Senate's recommended co-dependencies? b) Improve adherence to NHS policy (e.g. seven-day working and FYFV) and Royal College standards of care and conveyance standards?
	1.3) Quality: patient experience and performance	In comparison with the 'do minimum' scenario, to what extent do the options: a) Provide a better experience for patients as determined by nationally recognised and validated tools (i.e. Patient Reported Outcome Measures)? b) Improves overall performance (i.e. RTT, A&E, and cancer) ? c) Deliver hospital sites that best meet the quality standards for buildings?

The evaluation criteria used in evaluating the medium list options

Criterion	Sub-criteria	Evaluation questions
2. Is the potential configuration option accessible?	**2.1) Emergency Travel Times**	In comparison with the 'do minimum' scenario, to what extent do the options: Enable emergency ambulance travel times to be in line with the following national / locally agreed standards. • 95% of the east Kent population can access an A&E department within 60 minutes. • The east Kent population can access a trauma unit for stabilisation within 60 minutes. • 95% of the Kent & Medway population can access the pPCI centre within 100 minutes (to enable a call-to-balloon time within 150 minutes). • 95% of the east Kent population can access a stroke unit within 60 minutes (to enable a call-to-needle time within 120 minutes). • 95% of the east Kent population can access vascular services within 60 minutes.
	2.2) Distance to hospitals	In comparison with the 'do minimum' scenario, to what extent do the options: (a) Enable the greatest number of people to receive appropriate hospital care at the site closest to home (b) Enable the greatest number of people from deprived communities to receive appropriate hospital care at the site closest to home
	2.3) Car/public transport travel times	In comparison with the 'do minimum' scenario, to what extent do the options: Enable patients requiring an inpatient stay and visitors (i.e. carers and relatives) to have the shortest travel times (a) By car (b) By public transport

The evaluation criteria used in evaluating the medium list options

Criterion	Sub-criteria	Evaluation questions
3. **Is the potential configuration option implementable?**	**3.1) Time to implement**	Which option can be successfully delivered in the shortest times scale?
	3.2) Delivery risks	In comparison with the 'do minimum' scenario, to what extent do the options present any risks of delays or failure to deliver owing to: a) Council planning or resource consent requirements? b) Number of delivery partners? c) Operational complexity and decant arrangements? d) Funding from external source to the NHS?
	3.3) Transition period	In comparison with the 'do minimum' scenario, to what extent do the options: a) Maximise value from investments made during the transition period to support the sustainability of vulnerable services (minimises sunk costs) b) Enable the capital investment required to be phased over the transition period?

The evaluation criteria used in evaluating the medium list options

Criterion	Sub-criteria	Evaluation questions
4. Does the potential configuration option align strategically?	**4.1) long-term sustainability**	In comparison with the 'do minimum' scenario, to what extent do the options: a) Enable longer-term sustainability for the system (e.g. to avoid the need to reconfigure in the next 5-7 years following implementation)
	4.2) Impact on neighbouring systems	In comparison with the 'do minimum' scenario, to what extent do the options: a) Impact on neighbouring systems and other providers through outward flow
	4.3) Research, innovation and education	In comparison with the 'do minimum' scenario, to what extent do the options: (a) Support research, education and innovation current and developing research and education? (b) Provide opportunities to develop innovative practice that improves patient outcomes?
5. Is the potential configuration option financially and economically sustainable?	**5.1) System affordability and I&E performance**	In comparison with the 'do minimum' scenario, to what extent do the options: a) Support a financially viable system across East Kent? b) Which option gives the best steady state I&E performance after year 10
	5.2) Net present value	In line with the STP evaluation methodology, which option gives the best 30/64 year net present value? (whole of system lens, including capital costs)
	5.3) Economic Impact	In comparison with the 'do minimum' scenario, to what extent do the options: a) Impact on employment opportunities within local communities

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KENT HEALTH
OVERVIEW AND SCRUTINY COMMITTEE

5 MARCH 2020

A SUMMARY OF THE CONSULTATION ACTIVITY PLAN FOR THE NHS EAST KENT TRANSFORMATION PROGRAMME

Report from:	**East Kent Transformation Programme**
Author:	Tom Stevenson, Acting Director of Communications and Engagement, Kent and Medway Sustainability and Transformation Partnership

Summary

This document is a summary of the consultation activity plan for when the transformation proposals go to full public consultation. A version of this report has been presented to the Joint HOSC on 6 February and is for information to the Kent County Council HOSC. It provides an overview to the Committee on planning for public consultation.

The full consultation plan and a version of the near final consultation document will be brought back to a JHOSC meeting for a further review and endorsement ahead of launching a formal consultation.

Progress to Date

The consultation activity plan and consultation document structure have been developed with feedback from the Kent and Medway Sustainability and Transformation Partnership Patient and Public Advisory Group and Kent Healthwatch.

1. Introduction

The following is a summary of our draft consultation plan for the East Kent transformation proposals. The full plan will be finalised as part of completing the Pre-Consultation Business Case for submission to NHS England/NHS Improvement.

Consultation with JHOSC

As part of the process of consulting with JHOSC on our proposals and how we intend to run a formal public consultation we presented to the 6 Feb 2020 JHOSC to seek feedback on the consultation activity plan and a draft of the consultation document structure).

The full consultation plan and a version of the near final consultation document will be brought back to JHOSC for a further review and endorsement ahead of launching a formal consultation.

Consultation length and timings
The consultation will be a minimum of 12 weeks and if necessary will be extended if there are overlaps with significant holiday periods. We cannot confirm timings for the consultation until we have further feedback from NHS England/NHS Improvement through their assurance processes.

2. Consultation scope

The consultation will focus on:

- Two options for reconfiguring acute hospital services in east Kent, including:
    - emergency departments (A&E)
    - specialist inpatient services;
    - services that are interdependent with the above
    - elective surgery

- Related plans to improve local cares services (e.g. general practice and community based services) to provide more care away from acute hospitals

A full list of services affected will be part of the consultation materials.

We know that people want to hear and comment on how improvements to care provided outside of hospitals such as ambulance services, general practice, NHS community services and social care services would be delivered to support the hospital based changes. Information on this will be provided during the consultation and comments sought.

Geographical scope

In geographical terms, the consultation will cover the four CCG areas in east Kent (Ashford; Canterbury and Coastal; South Kent Coast; and Thanet), although all eight CCGs in Kent and Medway are merging into a single organisation from April 2020.

EKHUFT provides some regional specialist services, with residents from other parts of Kent, Medway, Surrey and Sussex either travelling to the hospitals in east Kent or receiving care at satellite centres run by EKHUFT services affected by the proposals. We are planning direct engagement activities with patients of these services during the consultation period. These regional services include:

- Haemophilia outpatient services
- Renal services
- Primary Percutaneous Coronary Intervention (PPCI)

We have also analysed patient flows from areas outside of east Kent to non-regional services affected by the proposals and discussed these with neighbouring CCGs and trusts. There are no significant flows of patients from outside of east Kent to these non-regional services, however, we will ensure neighbouring areas are informed about the proposals and residents in border areas who may use EKHUFT services will be invited to respond to the consultation.

3. Consultation approach

Statutory duties and legislation

This consultation plan has been designed to ensure we deliver effective patient and public engagement as part of our obligations and legal duties under:

- The five tests for service change laid down by the Secretary of State for Health and Social Care
- The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)
- The Equality Act 2010

Consultation principles

Our consultation plan has been shaped to meet the following principles:

- Consulting with people who may be impacted by our proposals
- Consulting in an accessible way
- Consulting well through a robust process
- Consulting collaboratively
- Consulting cost-effectively
- Independent evaluation of feedback

Consultation objectives

We will deliver a formal public consultation in line with best practice that complies with our legal requirements and duties. Our specific objectives for the consultation are to:

- Raise awareness of the public consultation across all the geographies affected

- Explain how the proposals have been developed and what they could mean in practice, so people can give informed responses.

- Collect views from the full spectrum of people that may be affected, gathering feedback from individuals and representatives of those affected.

- Ensure we use a range of methods to reach different audiences including activities that target specific groups with protected characteristics and seldom heard communities.

- Meet or exceed our reach target within the timeframe and budget allocated.

- Consider the responses and take them into account in decision-making, with sufficient time allocated to give them thorough consideration.

Accessible and inclusive consultation materials

We will endeavour to prepare all our public facing consultation materials in simple jargon free language. We will continue to use our Patient and Public Advisory Group as part of our drafting and testing process to make sure materials are clear and easy to read.

An exception to note will be the technical content of the detailed pre-consultation business case. This will be publically available but may not be easily digestible for the general public. If people raise questions about the content of the PCBC we will endeavour to explain specific points in simple terms as part of responding to correspondence during the consultation.

Specific accessible format materials will include:

- An 'Easy Read' summary consultation document and response form.
- A plain text, large print version of the consultation document and summary leaflet. Plain text documents will meet the requirements for text readers to support people with more significant visual impairments.
- Braille and audio version of the main consultation materials will be available on request.
- A British Sign Language video to summarise the proposals and explain how deaf people can get full details and respond to the consultation.
- A foreign language translation/interpreting service will be provided on request. This will be noted on the back of key documents in the 10 top languages across the area.

4. Consultation reach

The consultation activities will ensure that we consult with a representative sample of the population potentially affected by the proposals and we will have dedicated activity planned to collect views from representatives of all nine protected characteristics. We will deliver targeted engagement activities to reach individuals and groups which represent people with these characteristics.

We will measure two key elements of the consultation reach; one for informing people about the proposals/consultation and one for actual responses. The activities are being planned to balance informing people and collecting responses with delivering a cost effective consultation.

The quality of feedback and ensuring it comes from a representative group of the population is as important as the overall quantity of responses. Provided we reach a representative group we can be reassured that we will capture a full range of significant issues/concerns.

5. Stakeholder mapping

Through our pre-consultation engagement work we have identified and worked with a wide range of stakeholders. We have grouped our stakeholders into 8 categories with detailed sub-groups within each category:

Patients and public	Staff
• East Kent residents • EKHUFT patients/service users and carers • Patient and Public Advisory Group • Patient and carer support groups • Voluntary, community and local business groups • Seldom heard • Protected characteristics groups • Campaigners (groups and individuals) • EKHUFT governors and membership • Other NHS Foundation Trust governors and membership • CCG local health/engagement networks • GP Patient Participation Groups	• EKHUFT (inc. trade unions) • General Practice in East Kent • East Kent focussed CCG teams • Ambulance Trust • Community Trust • Mental Health Trust • Social care
Elected representatives (East Kent and bordering areas)	**Regulators**
• East Kent MPs • JHOSC • County councillors • District/City councillors • Parish/Town councillors	• NHS England/NHS Improvement & NHS Improvement • Healthwatch Kent • Healthwatch Medway
System leaders	**Clinical experts and professional bodies**
• EKHUFT Board • CCG Governing Body • Provider Trust Boards (community, mental health, ambulance) • Kent and Medway ICS leadership • Kent County Council executive team • District council executive teams	• South East Clinical Senate • Kent Local Medical/Dental/Pharmacy Committees • Royal colleges • Academic Health Science Network • Kent Medical School/universities

Media	**Out of area stakeholders**
• Local and regional newspapers, radio, TV and online • Trade press • National press • Social media	• EKHUFT patients living outside east Kent • Residents of neighbouring areas • MPs and councillors in neighbouring areas • Boards of providers in areas neighbouring east Kent

In addition, to the patient and public stakeholder groupings identified above, an Integrated Impact Assessment carried out as part of the pre-consultation phase will be used to identify groups that may have a disproportionate need for the services affected by the proposals. There will be targeted engagement activity during the consultation to get feedback from these groups.

6. The consultation questions and document

There will be a formal questionnaire as part of the consultation, although letters and other open comments will be welcome. The questions will be developed to capture feedback covering:

- How strongly people agree or disagree with the model of centralising specialist services
- The potential impact (positive or negative) on patients, relatives, carers and staff
- The potential impact (positive or negative) on wider services outside of hospitals
- Whether there is further evidence, insight and ideas that have not been considered.

The specific questions to be asked in the consultation will be developed in partnership with our Patient and Public Advisory Group and an independent research/engagement organisation to ensure we design clear and non-leading questions. There will be a mixture of ranking style questions, asking people how strongly they agree or disagree with specific points plus open questions with a free text response.

It will be clearly stated that we are **not asking people to choose their preferred option**, but we will record if people do so. Public consultation is not a referendum /vote so the total number of responses for or against a specific option captured during the consultation is not the deciding factor when the CCG makes a final decision.

The draft structure of the main consultation document is attached at the end of this paper and we would welcome comments from JHOSC members.

7. Consultation activities and materials

Our consultation activities are being designed to reach, and collect feedback from a broad range of audiences through a mixture of channels. How people want to participate in public consultations varies widely, and we must offer different ways for people to participate.

Our plans take account of people having varying levels of interest and prior involvement in the proposals. Some will have been actively involved in the proposals through work to develop the original east Kent case for change and developing and assessing the options. Others will find out about the plans for the first time through the formal public consultation.

Engagement activities

Engagement activities	Frequency, numbers, format
Public listening events	**12 events** - up to 100 audience per event, mix of presentation, open questions and table discussion. Open invitation with details published through media and other channels.
Street surveys	**300 target -** Commissioned from an independent agency with a specific remit to collect feedback from seldom heard and protected characteristic groups. Rural and deprived area focus. Structured discussion to capture responses.
Focus groups	**12 events -** Dedicated events with up to 10 attendees per event. Structured presentation and discussion with specific remit to collect feedback from seldom heard and protected characteristic. Commission from independent agency.
Telephone surveys	**500 target** - Structured discussions to capture responses - commission from independent agency and targeting specific groups identified in the integrated impact assessment.
Patient / community group visits	Attending existing meetings of established patient / community groups. Structured presentation and discussion. Delivery split across internal consultation team and independent research agency.
Online webinars / chats	We will explore options for live online discussions with key clinical / executive leaders of the programme.
Hospital site roadshow / display stands	A display to rotate around main sites/services during the consultation period to engage patients and hospital staff.
EKHUFT staff events	Internal communications teams to co-ordinate staff events for affected services/sites.
CCG staff events	CCG communications to co-ordinate internal events.
South East Coast Ambulance staff events	Internal communications to co-ordinate internal events.

Other NHS providers staff events	Internal communications to co-ordinate internal events.
County and district council staff	Internal communications to co-ordinate internal events.
Councillor and MP briefings	Presentations to existing meetings, JHOSC, JHWBB, Offer of briefings to council meetings at county and district/city level (in addition to formal updates to JHOSC). Parish/town council presentations on request. 1-2-1 and/or group briefings for MPs.

Staff engagement

All staff across health and social care will be asked to feedback into the consultation through the main survey and contact points; rather than having a staff specific survey or contact point. Following the launch of the consultation, our staff engagement approach will include the following activities:

- **Events/briefings** - for health and social care staff, including: hospital teams, GPs and their practice staff, ambulance, community, primary care and social care.

- **Line manager support materials** - so they can speak with confidence about the proposals during team and 1-2-1 meetings.

- **Existing internal communications channels** - intranets, newsletters, staff briefings and existing meetings and fora will all be used to engage with staff.

We will contact and distribute materials to GP practices, via practice forums and promote the consultation via existing bulletins to GPs and their practice staff.
We will also seek to work through existing networks to reach independent contractors such as dentists, pharmacies and opticians.

Consultation materials

Materials	**Frequency, numbers, format**
Core documents	
Main consultation document	Content and format is being developed with input from the STP Patient and Public Advisory Group, Healthwatch, and NHS England/NHS Improvement.
Summary leaflet	Short A5 document explaining core points of proposals, providing links to further materials and events, and encouraging responses.
Fliers	For circulation to main sites and use at events. We will cost the option of a direct door to door distribution

	across the whole of east Kent as part of our planning. However, previous experience with the stroke consultation showed door distribution is high cost but has limited impact in raising awareness / response rates.
Questionnaire	Questions to be developed in discussion with Patient and Public Advisory Group and with support from expert external advisors. There will be online, printed and easy read options of the core response questionnaire.
Alternative formats	**Easy read** version of summary leaflet published online and links cascaded to stakeholders. **Large print** copy of consultation document and leaflet published online and links cascaded to stakeholders. **Translations** of specific documents on request **Other alternative formats** developed on request.
Material for online / public events	
Consultation webpages	Dedicated section of KMCCG website, NHS Trust and partner websites. Providing all relevant documents, details of public meetings, feedback options, news updates, questions and answers etc.
Videos	Selection of videos covering overall proposals and service specific impacts. Interviews with key spokespeople, patients and carers to help engage our target audiences, disseminate key information, share understanding and encourage responses to the consultation.
Animation	Short animation with summary of overall proposals and encouraging people to find out more and respond.
Digital display screens	Slides for display on digital screens in waiting areas at hospital and GP surgeries. Potential use of videos/animation depending on format.
Presentations	Range of presentations for delivery at public events, focus groups, council meetings etc.
Frequently Asked Questions	Initial list for consultation launch. Additions added to website during course of consultation. Service specific FAQs in additional to overall plans.
Service specific factsheets/infographics	Individual factsheets / infographics to explain impact on specific services e.g. maternity, A&E, planned operations.
Printed display material	
Pop-up banners	For display at hospital sites and use at events

Posters	For display at hospital sites, GP surgeries, libraries, town halls, job centres etc. Full list of distribution to be confirmed following further review of opportunities with private organisations such as supermarkets.
Drinks mats	Targeted use of paid advertising in pubs using printed beermats to highlight the consultation dates and where to find details – seeking to reach younger audiences and seldom heard communities in areas of deprivation.
Pharmacy bag advertising/inserts	Targeted use of paid advertising in pharmacies using printing on prescription bags or fliers to insert. Selective use to reach people from seldom heard communities in areas of deprivation.
Staff pay slips	Flyers to attach/inserted messages in EKHUFT payslips and / or printed message inside payslips.
Social media	
Free	Regular promotion through social media accounts of the STP, CCGs, hospital trust and other partners to promote key messages and encourage responses to the consultation.
Paid for adverts and post boosting	We will develop a costed plan for regular adverts and post boosting through Twitter / Facebook over the course of consultation. Targeting audiences by geography and demographics.
Partner/stakeholder publications	
Articles for editorial in local publications	Series of articles to send to existing publications including: council (county, district, town/parish), CCG health networks, NHS trusts, GP Patient Participation Groups, Healthwatch, voluntary sector etc
Adverts in local publications	If free editorial is not possible in key publications we will consider paid averts based on cost vs audience reach.
Paid media advertising	
Newspapers	Series of quarter page adverts across East Kent titles through consultation period. Highlight key proposals and ways to find out more and respond.
Radio	Adverts on East Kent stations repeated at times throughout the consultation. Highlight key proposals and ways to find out more and respond.
Pubs and pharmacies	See information in “printed display material” section.

Media releases / interviews	
Print, online and broadcast media	Series of proactive releases and broadcast interviews during the consultation to raising awareness and encouraging feedback. Reactive responses to media queries throughout the consultation.

Media approach

Our media approach will be proactive during the consultation period. In the consultation catchment area the local media continues to be important in influencing public perception and reaction to all aspects of health and care changes and we will work with them and communicate key messages for the consultation through the channels they provide.

We will issue regular media releases throughout the consultation period to local newspapers, local radio and community magazines (including newsletters produced by residents' associations, parish, borough and district councils, community, faith and voluntary groups etc).

The media audiences we will target with information about the consultation include:

- All local newspapers
- Professional journals such as Health Service Journal, Pulse, Nursing Times, Nursing Standard and GP magazine

During the consultation period, we expect extensive reactive media work. We will also seek to ensure that messaging on the wider aspects of improving local care are covered alongside responding to issues focused on the hospital service options – so that we are telling the 'whole story' for patients, carers and the public.

8. Distribution channels

We will distribute a range of consultation materials using online and physical channels to meet the varying preferences of our stakeholders; balancing the need to make hard-copy materials available widely with delivering a cost effective consultation.

Virtual distribution

Channels	Materials
Websites	A new website for the Kent and Medway CCG will be our online consultation hub. Current information on the development of the proposals on the STP website (www.kentandmedway.nhs.uk/eastkent) will be transferred to the new site as background to the consultation. The website will host all consultation information in one place including an events diary and document store with the more technical PCBC documents. The hospital trust and other NHS and social care partners will be asked to publish links to the consultation site.
Email bulletins	We will build on our existing e-bulletin for the east Kent transformation programme and issue regular updates through the consultation period. This directly reaches an audience of 850 [at Jan 2020] key stakeholders and individuals including: all district, town and county councillors, parish council central contacts, MPs, and a wide range of patient and public representatives and voluntary/community groups. Contacts in provider trusts and partners including Healthwatch Kent will be asked to cascade the bulletins on to their wider distribution lists.
Social media	Twitter and Facebook will be used to keep online stakeholders informed, and to signpost and facilitate discussion, during and after the consultation period. A central KMCCG account will be the main channel though links will be made with accounts run by the hospital trust and other partners.
Online video	We will produce a series of short videos to support the consultation and these will be available through our YouTube channel and links promoted through our social media account and e-bulletins.

Physical distribution
The physical distribution of our consultation materials will focus on the locations below. With all distributions we will include details of how to request further copies as required.

Location type (sites in EK)	Proposed materials (per site)
Acute hospitals (3)	Main consultation doc. (no. tbc) Summary leaflet (no. tbc) Posters (no. tbc) Pop-up banners (2)
Community hospitals/health centres (12 KCHFT, 6 EKHUFT)	Main consultation doc. (10) Summary leaflet (100) Posters (4) Pop-up banners (1)
General practice (68)	Main consultation doc. (5) Summary leaflet (50) Posters (2)
Pharmacies (tbc)	Summary leaflet (25) Posters (1) Pharmacy bag advertising
Libraries (tbc)	Main consultation doc. (10) Summary leaflet (50) Posters (1)
Town halls (6 = KCC and 5 district/city)	Main consultation doc. (10) Summary leaflet (50) Posters (2) Pop-up banners (1)
Leisure/sports centres (tbc)	Summary leaflet (20) Posters (2)
Job centres (tbc)	Summary leaflet (20) Posters (2)
Children's centres (tbc)	Summary leaflet (20) Posters (1)
Clinical Commissioning Group local offices (4)	Main consultation doc. (10) Summary leaflet (25) Posters (1)
Healthwatch offices (tbc)	Main consultation doc. (10) Summary leaflet (25) Posters (1)
Public consultation events	Main consultation doc. Summary leaflet Pop-up banners

9. Collecting responses

We will provide the following mechanisms for people to respond to the consultation:

- A questionnaire with specific questions about the proposals (print, online and easy read)
- Freepost address
- Email address
- Free phone line/voicemail
- Face to face through the range of meetings identified in the consultation plan

All feedback will be collected, logged and considered. Respondents will be encouraged, but not required, to use the main questionnaire.

10. Analysis of consultation responses

Mid-consultation
Throughout the consultation period we will monitor responses to identify any demographic or other trends which may indicate a need to adapt our approach regarding consultation activity, or refocus efforts to engage a particular group/locality.

Post-consultation
In line with best practice for a consultation of this nature we will commission an independent research/engagement organisation to analysis the responses and produce a non-biased objective report summarising all feedback. The independent report will identify trends and themes from the consultation responses. The commissioners will consider the consultation feedback in full and decide what actions need to be taken in response.

11. Measure of a successful consultation

The success of our consultation will be measured against:

- the aim and objectives set out in this plan
- the depth and breadth of responses/feedback on the proposals
- feedback from respondents on the process of the consultation
- feedback from JHOSC, Healthwatch and NHS England/NHS Improvement post consultation
- whether we meet our statutory and legal duties during the consultation

12. Resourcing

A dedicated consultation team

This team will consist of in-house communications and engagement staff and additional capacity and expertise commissioned from external suppliers. Planning and delivery of the consultation activities/materials will be led by the communications and engagement workstream, however, the consultation team will consist of a wider group, including:

- Clinical leaders from CCG and EKHUFT
- Executive leaders from CCG and EKHUFT
- Project management and administrative support

Non-pay resources

Identifying the costs for non-pay materials and resources, ranging from printing documents, bulk mail distribution, and advertising to venue hire and catering costs is a work in progress. The budget to cover all non-pay costs of communications and engagement activity for the consultation will be finalised following feedback on our planned activity from JHOSC and NHS England/NHS Improvement.

13. Conclusion

The full consultation plan in its final version will set out how we will be assured that the public consultation will gather effective feedback to help inform the final decision making process and meet statutory/legal requirements.

Once consultation is underway we will maintain a flexible approach to assessing the effectiveness of the activities identified in this plan; and will amend our approach as appropriate. Significant changes to the approach would be discussed and approved through the East Kent Transformation Delivery Board and briefings provided to the Joint Health Overview and Scrutiny Committee and NHS England/NHS Improvement.

REPORT ENDS

Lead officer contact

Tom Stevenson,
Acting Director Communications and Engagement
Kent and Medway Sustainability and Transformation Partnership

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Item 8: EKHUFT general update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 5 March 2020

Subject: East Kent Hospitals University NHS Foundation Trust - update

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

It provides background information which may prove useful to Members.

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1) Introduction

a) East Kent Hospitals University NHS Foundation Trust (EKHUFT) has five hospitals serving a local population of around 695,000 people across Dover, Canterbury, Thanet, Shepway and Ashford.[1]

b) The latest CQC inspection, published 5 September 2018, rated the Trust as "Requires Improvement". It received a "good" rating under the section "are services caring".

c) NHSI placed the Trust in financial special measures in March 2017.

d) The Trust has asked for the attached reports to be presented to the Committee:

i) General update
ii) Orthopaedic pilot update
iii) Care Quality Commission Inspection of Children's and Young People's Hospital Services

2. Recommendation

RECOMMENDED that the Committee consider and note the report and that the Trust be requested to provide an update at the appropriate time.

[1] Care Quality Commission (2018) East Kent Hospitals University NHS Foundation Trust - Inspection report

Background Documents

Kent County Council (2019) *'Health Overview and Scrutiny Committee (1/03/19)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=7926&Ver=4

Care Quality Commission (2018) East Kent Hospitals University NHS Foundation Trust - Inspection report, https://www.cqc.org.uk/sites/default/files/new_reports/AAAH5843.pdf

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

East Kent Hospitals Update for Health Overview and Scrutiny Committee

General Update

1 Winter planning and improvements to 4 hour performance

1.1 The Trust has maintained a stable position in the number of patients we assessed, treated, discharged or admitted within the national standard of four hours. This was 74% in January 2020, the same as in January 2019, compared to 69% in January 2018. This is against a backdrop nationally of more frail, elderly patients who are particularly susceptible during the winter, needing emergency hospital care.

1.2 Between April 2019 and January 2020, the Trust saw 13,317 more attendances by patients to its emergency departments, an increase of 7 per cent than over the same period the previous year. In total we treated 197,854 people over that period, or 647 people a day.

1.3 The Trust has invested in its emergency departments, creating space for new assessment units in addition to the observation wards put in last winter, has increased staffing and made more beds available for emergency patients.

1.4 The Trust is also working with GPs in east Kent to deliver 24/7 Urgent Treatment Centres which replace Minor Injury Units at Kent & Canterbury Hospital, Queen Elizabeth the Queen Mother Hospital, William Harvey Hospital and Buckland Hospital.

2. Other key access targets

2.1 Staff have worked extremely hard to improve access to Cancer care. The percentage of patients receiving an appointment within 2 weeks of an urgent GP referral is now 97.97% in January 2020. Patients starting first treatment within 31 days from decision to treat, regardless of route of referral, has been met for the last seven consecutive months.

2.2 In the third quarter of the year, the Trust achieved the national standard of 85% for the percentage of cancer patients starting their treatment within 62 days, for the first time since 2014. The Trust is now ranked 59th out of 150 trusts in the country.

2.3 Waiting times for planned care are also improving, with 81.18% of patients in January 2020, compared with 76.1% in January 2019, starting their treatment within 18 weeks. Despite increased demand we are working hard so that no patient waits more than 52 weeks, at the time of writing four patients were waiting more than 52 weeks, compared to 222 in April 2018. Improvement is due in part to improved efficiency in theatres and patient pathways and extra capacity as a result of the orthopaedic pilot.

3. Staffing

3.1 The 12 month vacancy rate decreased to 9.5% for the average of the last 12 months, an improvement on the previous year. There are currently approximately 715 WTE vacancies across the Trust. More work is being undertaken to target hard to fill vacancies, particularly within nursing and medical specialties. There are around 480 people in the pipeline (going through clearance processes) to join the trust covering a range of roles and job types. Turnover has remained stable with minor fluctuations normal for this time of year.

3.2 The percentage of substantive staff versus agency workers has improved and this continues to reflect the increase in use of bank workers rather than agency workers. Bank workers are mostly drawn from our substantive workforce thereby providing a better standard of patient care and continuity of provision. Statutory training completion remains high and above target showing a high level of compliance.

3.3 Sickness absence remains high and we are supporting staff in order to reduce this through return to work interviews, support from occupational health and through increased focus on mental health and wellbeing, this is important for NHS staff who work in a challenging environment with high demand.

4. Financial performance

4.1 The Trust continues to work hard to improve its financial position. For the third year running the Trust has an annual £30m savings target to make. To date this year we had delivered £20.7m in savings against this target and are on target to achieve the total by the end of the year.

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

4.3 The year to date position is a deficit of £26.4m, £0.4m better than plan. With recovery plans in place and a robust internal operating framework, the Trust remains on target against the planned position of £36.5m deficit agreed at year end.

February 2020

East Kent Hospitals Update for Health Overview and Scrutiny Committee

Orthopaedic Pilot

1. Background

1.1 East Kent Hospitals is taking part in a national GIRFT (Getting it Right First Time) pilot to improve the experience and outcomes for patients undergoing planned orthopaedic inpatient operations and those suffering a trauma as a result of a fall or accident.

1.2 National standards are moving to physically separating emergency and planned operations into different hospitals to protect planned operations from cancellations when there are surges in emergency admissions. Where these changes have already taken place in other parts of the country, waiting times have reduced, fewer patients have had their operations cancelled and recovery times are quicker.

2 Stage 1: Treating more patients sooner

2.1 Participating in this pilot has enabled the Trust to improve services for patients by carrying out more planned orthopaedic inpatient operations, continue operating throughout the winter and improve capacity to treat trauma patients.

2.2 Since November 2018, patients previously treated at William Harvey Hospital (WHH) have had their planned hip and knee operations in dedicated facilities at Kent and Canterbury Hospital (K&C). As a result:

- Over 2000 patients have their planned lower limb operations sooner
- The number of patients waiting for these operations has reduced by more than a third.
- Waiting times have reduced by nearly nine weeks for knee replacements and three weeks for hip replacements.

2.3 The pilot has also benefited patients at WHH by freeing up operating theatres and beds to treat other patients more quickly. As a result:

- almost 2,000 more patients had their trauma, gynaecology and general surgical operations sooner
- an extra ward has been released for patients with medical emergencies.

3. Stage 2: New operating theatres at Kent and Canterbury Hospital

3.1 The Trust has successfully secured almost £15 million new capital investment from the NHS nationally to build four new operating theatres and 24 more dedicated beds at K&C to extend these benefits to more patients.

3.2 Building work starts in July 2020 so that by Spring 2021 all patients needing planned orthopaedic inpatient operations in east Kent will be treated in new and improved facilities at the hospital.

3.3 The new investment will extend improvements to more orthopaedic patients and bring significant benefits for patients at QEQM Hospital by freeing up operating theatres and beds to treat more patients needing cancer surgery and trauma operations sooner.

3.4 It will also help the Trust develop plans to improve care for frail patients and treat patients with medical emergencies sooner at both QEQM and WHH hospitals.

3.5 Patients will continue to have day operations and care before and after their inpatient orthopaedic operation at their local hospital, including tests and scans, pre-op and follow up appointments. Emergency (trauma) patients will continue to be treated at William Harvey and QEQM hospitals as now, for example, for fractures sustained in a fall.

February 2020

East Kent Hospitals Update for Health Overview and Scrutiny Committee

Care Quality Commission inspection of children's services

1 Background

1.1 The Care Quality Commission (CQC) undertook an inspection in October 2018 of children's and young people's hospital services at William Harvey Hospital (WHH), Ashford, and Queen Elizabeth Queen Mother Hospital (QEQM), Margate. The CQC inspected the:

- Children's ward at each hospital
- Emergency departments
- Operating theatres
- Neonatal Intensive Care Unit at WHH
- Special care baby units at both hospitals

1.2 On 13 February 2019 the CQC published its reports which rated children's services 'good' for caring with the overall rating for children's services in the two hospitals as 'inadequate'. The CQC confirmed that since October 2018 the Trust has made significant improvements in all of the areas that they highlighted and the Trust has met the conditions required by the CQC following the inspection.

1.3 In September 2019 the Trust undertook a Routine Quality Review to children's services at WHH and QEQM to review progress, and noted significant improvements had been made. Action plans were updated after the visit to reflect findings and those areas that required further improvement.

1.4 To date 112 of 116 actions on the Trust's paediatric improvement plan have been met with work underway to complete the remaining four. Monthly CQC Paediatric Taskforce meetings, chaired by the Chief Nurse, continue to ensure oversight and progression of the improvement plan.

2. Padua Ward improvements

2.1 Padua Ward – the children's ward at WHH – has been extensively redesigned and renovated, providing a much more conducive environment for children and young people. New cots and children's beds were purchased and air conditioning installed.

2.2 The Children's Assessment Unit has been relocated onto the ward to improve safety and provide more space. The outpatient children's area has also been enlarged, to provide an extra clinic room and a larger waiting area.

2.3 A larger locked drug room for safe storage and preparation of medicines has been provided, along with fob access to the ward for improved safety.

3. Increased staffing levels

3.1 Since the inspection staffing levels in our emergency departments for children's services at both hospitals have increased to ensure services are safe and children and young people are well-cared for.

3.2 We have also successfully appointed a Head of Nursing for Child Health in May 2019 and a Quality Improvement Matron, work within the senior nursing team, to support and embed the improvements underway for children and young people.

3.3 Our emergency departments provide a 24/7 service for children and young people, with specialist children's nurses and Health Care Assistants, supported by specialist A&E and paediatric doctors. This means children and young people attending our emergency departments are cared for by clinicians who are expert in these patients' needs.

3.4 The paediatric nursing team at WHH emergency department is fully staffed and we are actively recruiting to fill the remaining paediatric nursing vacancies at QEQM's emergency department. These are currently filled by a consistent group of agency paediatric nurses.

3.5 Both children's wards have been successful in recruiting additional staff and are currently fully staffed. This is supported by an additional layer of support at both hospitals with a senior paediatric nurse on-call rota to provide additional paediatric expertise out of hours and at weekends. Daily assurance regarding staffing is gained and is escalated to the Chief Nurse or her deputy to ensure safe services.

3.6 We have recruited two additional paediatric speciality middle grade doctors at WHH and now have eight at each WHH and QEQM. We are seeking to recruit four more middle grade doctors, to have ten at each hospital.

3.7 During the winter we have increased the presence of middle grade doctors overnight at both hospitals (currently locums), to ensure that we have two doctors on at night seven days per week. We are putting plans in place to continue this level of night staffing with substantive staff.

3.8 We have appointed an additional Consultant Paediatrician (locum) at QEQM to release a substantive Consultant Paediatrician to provide specialist paediatric expertise within the Emergency Department.

3.9 We have extended the presence of paediatric consultants at QEQM to provide additional support to the emergency care pathway, with additional capacity at the busiest times, four days a week, with plans to extend this to seven days a week at both QEQM and WHH hospitals. We are seeking to recruit two additional consultant paediatricians at both QEQM and WHH.

4. Daily safety checks

4.1 Daily safety checks are carried out across all hospital areas caring for children and young people, including in the emergency departments. This gives full assurance that thorough checks are carried out every day on the fundamentals of care, including medicines storage, cleanliness of equipment and safe medical and nursing staffing.

4.2 These are reported daily to the Chief Nurse and discussed at the daily staff safety huddles led by the senior paediatric nurse on duty with actions progressed. Safety huddles provide daily assurance and ensure safe staffing across the Trust as staff can be deployed where they are needed.

4.3 Each children's ward now has a Quality Board visible in the patient areas containing daily assurance for families/children and staff on a variety of safety issues including staffing levels both nursing and medical, audits including hand hygiene, infection

control, number of complaints/complements/incidents and also learning from them. We also regularly report back on how learning from complaints is being taken forward.

5. Care of the deteriorating child

5.1 Ongoing training in the identification and care of the deteriorating child continues with staff on the children's wards, operating theatres and emergency departments.

A separate "Management of the Child and Young Person Deteriorating Policy" is now in use. This revised guidance and re-training is ensuring every member of staff caring for sick children and young people follows the same Trust procedures and standards.

6. Improved systems

6.1 Children's observations are now electronically monitored via the VITAL PAC system used in other wards in our hospitals, using the paediatric early warning system (PEWS) template. This is in full use on our children's wards and being rolled out within our emergency departments imminently.

Recording observations electronically enables robust and accurate audits to be gathered of both PEWS and Sepsis, and has ensured that clinicians can monitor a child's observations remotely.

7. Workstreams

7.1 The Paediatric Improvement Programme continues to foster a culture of excellence and best practice, with improvement projects being taken forward under six workstreams, led by senior paediatric clinicians. The workstreams are: 1) Every child big voice 2) complex teams working together 3) culture of good effective communication 4) high quality safe service 5) consistent clinical standards and 6) confident decision-making using data and evidence.

8. Paediatric mental health training

8.1 We have recently been successful in receiving funding from NHS England to participate in a project in collaboration with our local mental health Trust. This involves additional funding to improve training for professionals who care for children with mental health needs.

February 2020

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Item 9: Maternity Services at East Kent Hospitals University NHS Foundation Trust

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 5 March 2020

Subject: Maternity Services at East Kent Hospitals University NHS Foundation Trust

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

It provides background information which may prove useful to Members.

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1) Introduction

a) Following a coroner's inquest in January 2020, the Care Quality Commission (CQC) and Healthcare Safety Investigation Branch (HSIB) carried out a two-week investigation into maternity services at East Kent Hospitals University Foundation Trust, with a report presented to Nadine Dorries MP (Parliamentary Under-Secretary of State for Health & Social Care) on 10 February. This was discussed at the House of Commons on 13 February, where Ms Dorries confirmed she had requested HSIB consider a deep dive investigation into historical and existing cases of maternal death at the Trust.

b) NHS England and Improvement have also announced an independent review into East Kent's maternity services.

2) The role of HOSC

a) EKHUFT have been requested to attend today's HOSC meeting in order to update the Committee on their action plan for improving maternity services in East Kent.

b) As per KCC's Constitution (17.138), HOSC cannot consider individual complaints relating to health services. It also cannot consider information where a living individual would be identifiable.

c) HOSC Members can review the Trust's action plan in relation to the operation of maternity services in East Kent and make reports and recommendations as it sees fit.

3. Recommendation

RECOMMENDED that the Committee consider and note the report, and that the Trust be requested to provide an update at the appropriate time.

Background Documents

Care Quality Commission, East Kent Hospitals University NHS Foundation Trust, Overview and CQC inspection ratings, https://www.cqc.org.uk/provider/RVV

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

East Kent Hospitals Update for Health Overview and Scrutiny Committee

Maternity services

1 Introduction

1.1 As a result of concerns about our maternity service, NHS England and NHS Improvement have commissioned an independent review into the service. The review will be led by Dr Bill Kirkup.

1.2 NHS England and NHS Improvement have also provided a package of support from the NHS Maternity Support Programme, which includes a team of national experts working alongside our maternity teams.

1.3 The Trust has also set up an externally-chaired Board sub-committee, chaired by consultant in Obstetrics and Gynaecology Mr Des Holden, to oversee seven key areas of work.

2 Background

2.1 In January this year, the inquest was held into the tragic death of baby Harry Richford. Baby Harry died in November 2017. The Trust wholeheartedly apologises for its failings in Harry's care and fully accepts the Coroner's conclusion and recommendations.

2.2 Since the inquest further families have raised concerns. The Trust is taking these concerns extremely seriously and has apologised to all those families for whom we could have done things differently. While a number of changes have been made to our service over recent years, we recognise that the scale of change needed in our maternity service has not taken place quickly enough.

2.3 In February 2020 the minister for patient safety, Nadine Dorries MP, asked both the CQC and the Healthcare Safety Investigation Branch (the organisation that investigates maternity incidents in all NHS Trusts) to provide a report on the Trust's maternity service.

2.4 Following these reports, Nadine Dorries announced that NHS England and NHS Improvement are commissioning an independent review. This review will provide an independent look-back, in partnership with affected families, of potentially avoidable or preventable deaths of babies in east Kent and will be led by Dr Bill Kirkup.

2.5 England's Chief Midwifery Officer, Jacqueline Dunkley-Bent, and the Regional Chief Nurse, have visited east Kent in recent weeks to provide assurance about the service we are providing now.

2.6 The Trust has already implemented a number of actions to improve safety. It has created and filled several specialist midwife posts. Safety huddles, where safety issues are regularly and frequently discussed, have been embedded across the Trust to anticipate problems before they occur, and multi-disciplinary teams work collaboratively and effectively within these huddles. And a protocol is in place to ensure that fetal heart rate recording is subject to a 'fresh eyes' check by another member of staff.

2.7 The Trust has also developed its approach to working with families in the sad case of a death, to ensure that it always provides a point of contact and that it includes and involves families in its investigations of these incidents, from the moment a serious incident occurs.

3. Timeline

3.1 In 2015, the Trust commissioned the Royal College of Obstetricians and Gynaecologists to review maternity services. In 2016, the Trust received this report, which identified areas of concerns and made a number of recommendations for action. The Trust began a number of changes to improve the safety and experience of women and their families, which included:

- Adding more consultants, auditing senior clinician oversight of births at our hospitals and increasing the hours some consultants worked
- New standards for obstetric care on our labour wards
- Comprehensive training for all maternity staff on identifying and safely supporting difficult births
- Investing in more maternity and neonatal equipment.

3.2 In 2017, the maternity team launched an improvement programme called BESTT (Birthing Excellence Success Through Teamwork), through which staff work with women to continuously improve maternity services. This has led to improvements such as fetal monitoring and obstetrics emergency training and the introduction of bereavement midwives and bereavement suites in both hospital sites.

3.3 The Trust's initial investigation into the death of Harry Richford, and subsequent independent reviews commissioned in 2018 by the new Head of Midwifery, found that further changes needed to be made to the maternity service. Since that time the service has:

- Implemented a more comprehensive way of monitoring babies' heart rate during labour, in line with best practice
- Improved the way we recruit, assess, support and supervise our temporary / locum doctors
- Put a comprehensive training programme in place for staff involved in identifying and safely supporting difficult births, including neonatal resuscitation and complex caesarean sections, including simulation training, plus training to improve communication, team working, recognising when a patient is deteriorating and escalation to senior clinicians

- Fully implemented labour ward safety huddles – whole team conversations focused on patients and care priorities - that take place four times a day, every day of the week
- Strengthened the leadership in midwifery, in addition to the new Head of Midwifery appointed in 2018 supported by two site-based deputies; a new clinical lead for obstetrics was appointed in 2019 supported by new site-based leads.
- Introduction of physiology–based cardiotocographic (CTG) interpretation and improved focus based on the best practice St Georges' Model.

3.4 The Trust also restructured the service in 2018 into a clinically led service to provide more senior clinical support and oversight of the service.

4. What is happening next

4.1 The Trust welcomes the independent review being led by Dr Bill Kirkup, and we continue to work with the Care Quality Commission, the Healthcare Safety Investigation Branch, NHS England and NHS Improvement to improve services for families in East Kent.

4.2 Collaboration with the NHS Maternity Support Programme, which includes support from a Director of Midwifery from a Trust rated 'Outstanding' by the CQC; consultant obstetricians and consultant paediatricians, one specialising in neonatology, is supporting our teams to make rapid and sustainable improvements to our service.

4.3 A new Trust board sub-committee, chaired by Mr Des Holden, is overseeing seven task and finish groups that will:

- Review the Royal College of Obstetricians and Gynaecologists report undertaken in 2015;
- Review the BESTT programme;
- Establish a process to implement, embed and assure the Coroner's recommendations;
- Carry out a review of obstetric and paediatric medical job plans;
- Carry out a review of Serious Incidents and investigations and their actions
- Review data available on our maternity services
- Review Paediatric Emergency Department oversight.

4.4 The practical changes in our maternity service continue. For example we have implemented centralised CTG monitoring, which will allow continuous fetal monitoring to be displayed on monitors in the labour wards' midwifery stations and viewed by consultants elsewhere in the hospital or on call at home. This means staff can immediately be alerted to a potential problem and on call doctors will be able to provide expert opinion straight away, wherever they are.

4.5 We are also recruiting six more consultants to extend and further improve the presence on our labour wards.

4.6 The CQC undertook an unannounced inspection of the maternity service in January 2020. The initial feedback to the Trust has been discussed at the Trust's Board of Directors public meeting and is available on the Trust's website. The full report is expected in the Spring.

5. Conclusion

5.1 East Kent Hospitals University NHS Foundation Trust recognises that in recent years it has let down a number of families and has not always delivered the high-quality maternity care that local residents have a right to expect. We apologise unreservedly for our failings in this respect and we are determined to improve our maternity service in the weeks and months ahead.

5.2 We have already made a number of improvements in our maternity service. However, we absolutely recognise the need to do more and the need to make further improvements as rapidly as possible.

5.3 The Trust has made clear that it welcomes the support it is currently receiving from a number of independent, senior, maternity clinicians from outside of East Kent and it welcomes too the independent review being undertaken by Dr Bill Kirkup.

5.4 The Trust Board is determined that working together with the executive leadership, Trust clinicians and external advisers, it must and will ensure the development of a maternity service that our local residents and our local representatives can all be truly proud of.

February 2020

Item 10: Work Programme 2020

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 5 March 2020

Subject: Work Programme 2020

Summary: This report gives details of the proposed work programme for the Health Overview and Scrutiny Committee (HOSC).

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1. Introduction

a) The proposed Work Programme has been compiled from actions arising from previous meetings and from topics identified by Committee Members and the NHS.

b) The HOSC is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services to bring an item to the HOSC's attention, as well as taking into account the referral of issues by Healthwatch and other third parties.

c) The HOSC will not consider individual complaints relating to health services. All individual complaints about a service provided by the NHS should be directed to the NHS body concerned.

d) The HOSC is requested to consider and note the items within the proposed Work Programme and to suggest any additional topics to be considered for inclusion on the agenda of future meetings.

2. Recommendation

The Health Overview and Scrutiny Committee is asked to **consider** and **note** the report.

Background Documents

None

Contact Details

Kay Goldsmith
Scrutiny Research Officer
kay.goldsmith@kent.gov.uk
03000 416512

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

29 April 2020		
Item	**Item background**	**Substantial Variation?**
Medway NHS Foundation Trust - performance update	To receive a general update on the performance of the Trust	-
East Kent CCGs Financial Recovery Plan	To receive an update on the financial position of the East Kent CCGs	-
Kent and Medway STP – Publication of the Primary Care strategy	For information, following publication of the strategy	-
The Maidstone and Tunbridge Wells Stroke Service	To receive an update following the closure of the Tunbridge Wells stroke unit	-

2. Items yet to be scheduled

Item	Item Background	Substantial Variation?
Urgent Care provision in Swale	To receive greater clarity around the plans for Urgent Care provision in Swale	To be determined
Pathology Services	The changes were not deemed to be substantial, but Members wanted to receive updates on the move toward a single service	No
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	Members requested an update at the “appropriate time” during their meeting on 1 March 2019	-
Publication on the local Workforce Strategy	To discuss the Strategy once published	-
Wheelchair Services	Members requested an update in 9-12 months following their meeting on 29 January 2020	-

3. Items that have been declared a substantial variation of service and are under consideration by a joint committee

Kent and Medway Joint Health Overview and Scrutiny Committee NEXT MEETING: TBC		
Item	**Item Background**	**Substantial Variation?**
Transforming Health and Care in East Kent	Re-configuration of acute services in the East Kent area	Yes
Assistive Reproductive Technologies	Consideration of proposed changes to fertility services	Yes
Specialist vascular services	A new service for East Kent and Medway residents	Yes
Changes to mental health provision (St Martin's Hospital)	KMPT's plans for the St Martin's (west) former hospital site, under their Clinical Care Pathways Programme	Yes