HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th September, 2012

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th September, 2012, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Peter Sass**
Telephone: **01622 694002**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr M V Snelling (Chairman), Mr C P Smith (Vice-Chairman), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr K A Ferrin, MBE, Mr L B Ridings, MBE, Mr K Smith, Mr R Tolputt and Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor A Allen, Councillor A Blackmore, Councillor G Lymer and Councillor Mr M Lyons
LINk Representatives (2):	Dr M Eddy and Mr M J Fittock

Webcasting Notice

Please note: this meeting may be filmed for live or subsequent broadcast via the Council's internet site – at the start of the meeting the Chairman will confirm if all or part of the meeting is being filmed.

By entering the meeting room you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If you do not wish to have your image captured then you should make the Clerk of the meeting aware.

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

Item	Timings
1. Introduction/Webcasting	
2. Substitutes	

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

4. Minutes (Pages 1 - 16)

5.	Kent Community Health NHS Trust: FT Application (Pages 17 - 48)	10:00 – 10:30
6.	Vascular Services (Pages 49 - 56)	10:30 – 11:00
7.	Older People's Mental Health Services in East Kent (Pages 57 - 72)	11:00 – 11:35
8.	Joint Health and Wellbeing Strategy (Pages 73 - 108)	11:35 – 12:10
9.	Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Relationship - Written Update (Pages 109 - 114)	12:10 – 12:15

10. Date of next programmed meeting – Friday 12 October 2012 @ 10:00am

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)

Peter Sass
Head of Democratic Services
(01622) 694002

30 August 2012

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 20 July 2012.

PRESENT: Mr M V Snelling (Chairman), Mr C P Smith (Vice-Chairman), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mrs E Green, Mr R Tolputt, Mr A T Willicombe, Cllr Mrs A Blackmore, Cllr M Lyons, Cllr G Lymer, Mr M J Fittock and Cllr R Davison (Substitute for Cllr A Allen)

ALSO PRESENT: Cllr J Cunningham

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting

(Item 1)

2. Declarations of Interest

(1) *Mr Adrian Crowther declared a personal interest in the Agenda as a Governor of Medway NHS Foundation Trust.*

(2) *Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.*

3. Minutes

(Item 4)

(1) It was indicated that the Minutes of 1 June 2012 needed amending on Page 1 so that under those present it read 'Cllr Ann Allen'.

(2) RESOLVED that, with this change being made, the Minutes of the meeting of 1 June 2012 are correctly recorded and that they be signed by the Chairman.

4. Dermatology Services

(Item 5)

Dr Stephanie Munn (Dermatology Lead, South London Healthcare NHS Trust), Alison Poole (Service Manager, South London Healthcare NHS Trust), Diane Hedges (Project Director – Strategic Commissioning, Bromley CCG), Gail Arnold (Locality Commissioning Director for West Kent and Weald CCG), Sue Luff (Lead Commissioner Ashford Locality), and Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway) were in attendance for this item.

(a) The Chairman introduced the item and explained that in April the Committee discussed information sent in to it from NHS Bromley about the Orpington Health Services Project. This information indicated a large number of patients from West Kent accessing dermatology services at Orpington Hospital. More recently, as had been reported in the media, a Trust Special Administrator (TSA) had been appointed for South London Healthcare NHS Trust and the Committee was reminded that the focus was on dermatology services, so detailed answers on the implications of this recent event would not be expected.

(b) NHS representatives were invited to provide a overview of the subject. Beginning with the situation in West Kent, it was explained that a recent review had led to a service shift. There was a lot of independent sector provision in West Kent as well as two key NHS providers in the area. Teledermatology was now available for non-urgent cases, with results of pictures returned from consultants within 48-hours. There were a number of GPs with a Special Interest in dermatology (GPwSI) who were able to provide additional services. Light therapy was available locally and Darent Valley Hospital provided outreach services at Sevenoaks and Borough Green. No services were actually commissioned in South East London, and any patients accessing services there chose to. It was clarified that the 3,223 patients from West Kent accessing services in Orpington referred to attendances, not patient numbers. As each patient may make a number of visits in a year, the actual number of patients was lower.

(c) In East Kent, a complete dermatology service review was carried out in 2010 as the secondary sector was not able to cope with the volume of activity and there was a fragmented service. Following engagement with patients and GPs, all of which supported moves towards community dermatology, a tendering process was carried out to start the community dermatology service from a fresh base. More resources were put into GP training and turnaround for tests went down from 13 weeks to 2 with more cancers being picked up earlier. For chronic dermatology, such as psoriasis, patients were educated to manage their conditions and 7 new providers have entered the arena. Services are also provided by Medway Foundation Trust and East Kent Hospitals. Self-referral was also possible in some circumstances, avoiding the need for a GP referral. Members of the Committee had experienced the East Kent service, including self-referral, and praised it. On the other hand, it was commented that the waiting room facilities at Medway Foundation Trust were inadequate for the dermatology service and NHS representatives undertook to feed this back.

(d) The changes for dermatology services in South London Healthcare NHS Trust (SLHT) were connected with the broader consultation around health services in Orpington which had just been launched that week; the summary document had been placed on Members desks and a supplementary map of services was circulated during the meeting (see Appendices 1 and 2). However, as the dermatology service model had changed, there would have been a need to review services anyway. The facilities at Orpington were not fit for purpose. Dermatology was more nurse-led than in the past and involved expensive equipment. The nature of the consultant workforce had also changed, with more part time female consultants. As more dermatology cases could be

handled in the community, the case mix of those seen in hospitals was more serious and required multi-disciplinary teams, including paediatrics where appropriate. For this reason, the proposals were to consolidate the two centres into one high class centre, with spokes at Sevenoaks and Beckenham. This would enable treatment of skin cancers to be repatriated and so less tertiary referrals to central London and East Grinstead.

(e) On behalf of the commissioners in Bromley, it was explained that the Orpington consultation was discussed prior to the TSA being named for South London Healthcare NHS Trust and legal advice had been sought. There was a high level of support in the Trust and with commissioners for the movement of more services to the community. However, additional time had been allowed for the TSA to report back to take the consultation process into account, and the time also allowed any conflicts between the TSA report and outcomes of the consultation to be considered.

(f) More generally on the impact of the SLHT TSA, Helen Buckingham explained that NHS Kent and Medway currently spent £20 million each year on services provided by SLHT and reported she was producing a report on the impact on Kent for the Health and Wellbeing Board and would undertake to share the report with the Committee.

(g) There was a strand of discussion in the meeting about the extent to which the services given as available in West Kent were so and there was a concern that it was not as well served as East Kent. It was explained that the perception could have come about in part by confusion over the providers of services and the location of them. Maidstone and Tunbridge Wells NHS Trust ceased providing a dermatology service around three years ago, but Medway Foundation Trust provided the service at Maidstone Hospital. Similarly, Queen Victoria Hospital, located in East Grinstead, provided plastic surgery services at Maidstone and Darent Valley. One Member raised a particular concern about the availability of services at Tonbridge Cottage Hospital where the indicated availability of services did not match up with the experiences of some constituents based on what GPs had told them. Representatives from NHS Kent and Medway undertook to speak to the Member after the meeting and follow the matter up. More broadly it was felt there was a need to ensure GPs and patients had up to date and accurate information about what services were available and at what location.

(h) A LINk representative reported that no particular concerns about dermatology services had been received by this organisation but, in common with a number of Members, there was concern about the changes to location of services in South London for those patients who currently accessed them there historically. While the argument was presented by NHS representatives that establishing one dermatology service at Queen Mary's Sidcup may be geographically further away than Orpington, the road links were often better and the new facilities meant a younger and more stable consultant workforce could be recruited, the counter argument was given that going into London, Kings in particularly, would still be easier for the elderly and infirm due to the rail connections. It was felt that accessibility for these patients needed to be considered carefully. It was also felt that the reasons patients chose particular hospitals was often historical and sometimes habit more than active choice. It

was hoped that any changes to the location and nature of services would be properly communicated to all service users.

(i) In response to specific questions about the pattern of dermatological illnesses, it was confirmed that the figure of 24% of visits to primary care professionals involving skin problems was about right, but that this might not always be the reason why the patient initially went to the GP or nurse. Much dermatology could be delivered locally, rather than at hospital, but not all GPs were trained to the same level which is why training was being provided. The four-fold increase in skin cancers was also discussed and it was explained that skin cancer was different to many other cancers. There were three types and 1 type could be treated at the GP level. The other types, in line with other cancers, would be fast tracked to get a consultant appointment within 2 weeks and treatment begun within 31 days. Queen Victoria hospital was part of the Kent and Medway Cancer Network.

(j) Members and guests discussed the rise in skin cancers and the different factors involved. Use of sun beds was highlighted and it was explained that although local dermatologists were not involved in local authority licensing of sun bed premises, the British Association of Dermatologists was. The view was expressed that licensing needed to be more stringent, especially around use by the under-18s.

(k) The issue of research into skin cancer was also raised and it was confirmed that St. Johns was still operational and carrying out research. It was explained that patients were not categorised by skin type. The areas of highest incidence for skin cancer were given as South Coast of England, Scotland and South London. The reasons differed, and in the case of South London it was partly to do with the numbers of service personnel and other who had lived and worked in Africa and the Middle East.

(l) Given the concerns raised by Members, the Chairman suggested the following recommendation:

- That the Committee thank its guests for their informative contributions and agrees to submit the approved Minutes of today's meeting as its response to the Orpington health services consultation.

(m) AGREED that the Committee thank its guests for their informative contributions and agrees to submit the approved Minutes of today's meeting as its response to the Orpington health services consultation.

5. NHS Transition: Update
(Item 6)

Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway) and Chris Greener, (Associate Director Commissioning Development, NHS Kent and Medway) were in attendance for this item.

(a) The Chairman introduced the item and explained that this was a subject the Committee had considered in the past, and will return to in the future as the

preparations for April 2013 continue. NHS representatives were then invited to provide an overview of the situation regarding transition locally and respond to questions.

(b) A clear theme through the comments, questions and concerns of Members was the perceived complexity of the new system being established and the sense that this current reorganisation would not change anything and not be substantially different to the current arrangements.

(c) The initial area of discussion was around the role of GPs in commissioning, which was stated as a goal of change. Reference to media reports around the secondary role of clinicians in Clinical Commissioning Groups (CCGs) was made. It was explained that increasing clinical leadership in the NHS was wider than just involving GPs. Kent and Medway was reported and having very good GP involvement. The Boards of CCGs appointed the Accountable Officer and the Chair and though the specifics varied, one of these top positions in each of the 8 CCGs in Kent and Medway was filled by a clinician. It was also explained that the CCG Boards were only in their interim iteration and were developing organisations and so the balance on the Boards would change. The Local Medical Committee was supporting the development process. It was recognised that there was a need to be transparent and publish details of the Board composition. In answer to a specific question, the proportion of Non-Executive Directors to Executive was a matter of local decision. There was a lengthy national assessment process for CCGs before they could be approved, led by the National Commissioning Board (NCB). Out of area independent assessors were used, with Ann Sutton, the Chief Executive of NHS Kent and Medway, carrying out this role outside the area and other Chief Executives doing so within Kent and Medway.

(d) Commissioning Support Services (CSSs) were being established to provide back office functions such as finance. There was a capped budget of £25/head of population for CCGs to use on management which was a change from the past. Running costs locally were already at this level.

(e) There was discussion about how far CCGs would differ from current Primary Care Trusts (PCTs). It was explained that CCGs would receive about 80% of the budget (proportionally) that PCTs currently received but that overall the PCT budget and responsibilities were being divided into four. Along with the CCGs, responsibilities would transfer to local authorities, Public Health England and the National Commissioning Board. On the subject of the latter, it was explained that the work of the NCB would be carried out by 27 Local Area Teams. Although the first wave of directors of these teams had been named, the one for the Kent and Medway Local Area Team had not. It was acknowledged this led to a measure of uncertainty and appointments to the national structures were a concern locally. However, other senior appointments had been made and in the interim, NHS Kent and Medway would continue to exist until April 2013.

(f) Also at the national level, it was explained that the newly formed NHS Trust Development Authority (TDA) would take responsibility for working with NHS Trusts who were not Foundation Trusts to either ensure they achieved Foundation Trust status, or found an alternative solution. A local example of

an alternative solution was the proposed merger between Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust. Contracting and commissioning services at all Trusts would rest with the NCB and CCGs. Monitor was currently the FT regulator but would become the economic regulator for the whole health sector. The NCB, Care Quality Commission and Monitor were under a duty to work together.

(g) It was stressed that in order to make the system work differently and in an improved manner, there was a need for everyone in the Kent and Medway health economy to make it work. A simulation event had been run to test out different situations. The key role of the Health and Wellbeing Board was highlighted with the CCGs and local authority producing a Joint Health and Wellbeing Strategy to help ensure commissioning plans did not work against each other. Work looking at how things could be done differently and jointly had been undertaken in Dover. There was also joint working more widely with 20 CCGs coming together to commission ambulance services.

(h) A number of Members asked about the process in the NHS about rehiring people who had been made redundant, and whether this involved redundancy payments being returned. NHS representatives undertook to provide this information later.

(i) In answer to a specific question, it was accepted that there was nothing new with the concept of patient choice but that it was taking in other areas beyond choice of hospital.

(j) On patient and public engagement, the same duties around public and voluntary organisation engagement remained, but concerns were raised about communicating with the voluntary sector and NHS representatives undertook to take this back. The local authority and NHS were looking at patient Advisory and Liaison Services (PALS) at the moment as some aspects of the service may sit elsewhere in the future.

(k) The Chairman reiterated that due to the comments and concerns raised by Members, the Committee would certainly return to the subject and proposed the following recommendation:

- That the Committee consider and note the report along with the answers given to the numerous concerns raised by Members.

(l) AGREED that the Committee consider and note the report along with the answers given to the numerous concerns raised by Members.

6. Not the Default Option: Responses
(Item 7)

Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway) was in attendance for this item.

(a) The Chairman introduced the item and explained that, although two formal responses had been received to the HOSC report *Not the Default Option*, a full

evaluation of the responses would need to wait until such time as others had been received.

(b) On behalf of the local health economy, Helen Buckingham undertook to coordinate a collective response before the winter and the Chairman asked for discussion of this response to be added to the Forward Work Programme.

(c) RESOLVED that the Committee note the report.

7. Forward Work Programme: Update
(Item 8)

(a) The Chairman introduced the item and drew attention to the changes made subsequent to the previous Forward Work Programme. In addition, the Chairman suggested that ambulance services may be something the Committee would wish to look at in the future.

(b) On behalf of the Kent LINk, diabetic services and patient choice were put forward as possible suggestions and the Chairman undertook to give the ideas consideration.

(c) Referring to discussions which had taken place earlier in the year, it was suggested that an update on the progress of the new Pembury Hospital be received by the Committee once the new hospital had been operational for a full year. The Chairman agreed and requested Officers to explore the possibility of bringing this item to the October meeting.

(d) AGREED that the Committee approve the amended Forward Work Programme.

8. Date of next programmed meeting – Friday 7 September 2012 @ 10:00 am
(Item 9)

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NHS Bromley

improving health services in Orpington

A consultation on changes to how health services are delivered in the Orpington area

This is a consultation by the board of Bromley Primary Care Trust, known as NHS Bromley and supported by South London Healthcare NHS Trust, Bromley Healthcare, Community Links Bromley, and Oxleas NHS Foundation Trust

Better Healthcare for Orpington

Your local NHS, led by GPs, is planning some changes to health services in the Orpington area, and we want to hear your thoughts on them. This summary has been produced to give you an overview of our proposals. Information on how to get a copy of the full consultation document and how to respond is included later.

"Enactment of the unsustainable provider regime at South London Healthcare NHS Trust is not currently anticipated to impact directly on this consultation. However any Special Trust Administrator recommendations developed that affect this review will need to be taken into account in planning for future services in Orpington and Bromley."
NHS London

Orpington residents will be most affected by our proposals. Other residents in Bromley are also regular users of services in Orpington.

We have developed a set of proposals that will put **services in the most appropriate places**, keeping frequently used services close to where people live, and moving specialist services to local hospitals where the best treatment can be given. We will also improve the quality of GP services and **support people to live healthier lives** through advice services and access to health tests.

This will move some non-urgent care away from hospitals, and for the most complex of healthcare needs bring these together, ensuring that as much money as possible is directed to patient care and away from maintaining buildings.

These changes complement the many improvements that have already taken place.

Our proposals

Our proposals focus on offering the kind of health service that we know local people need. We are already increasing support for wellbeing across the whole of Bromley borough. In Orpington, our proposals enhance this approach and focus on the specific needs of local people.

Some of the main causes of death in Bromley are circulatory disease, cancer and respiratory disease. Some of these conditions are linked to diabetes and high-blood pressure – both of which are increasing. We also have a need for more mental health and dementia services. We need to address these growing concerns.

Our consultation asks for your views on two different approaches to this challenge – the creation of a new **Community Health & Wellbeing Centre** with a wider range of services (our preference), or the creation of a smaller **Local Health Centre** that will keep the most essential services locally and move others to clinics, GP surgeries and local hospitals across a wider area.

Both proposals offer local people all of the essential health services needed in the area and provide new premises for three GP practices.*

The **Health and Wellbeing Centre** is our preference as it aims to bring many more out-of-hospital services together under one roof. We think this one-stop approach is good because it enables people to get health tests, advice and other services all at the same time.

We want the centre to be a place where people drop into, pick up advice and perhaps join in a healthy living session. These kinds of services can't be offered in busy hospitals or small GP clinics.

The proposed **Local Health Centre** would ensure that people still have access to the essential health services, but wouldn't offer any of the extras.

Where would these new buildings be?

As part of our conversations with local people we have been exploring a number of possibilities, for this centre, which include an accessible high street location in a new or existing building, or rebuilding a suitable sized facility on the Orpington Hospital site or elsewhere in Orpington.

*The three practices are Tubbenden Lane, Knoll Rise Surgery and Sevenoaks Road Surgery. As of 1st July 2012 Knoll Rise Practice and Sevenoaks Practice became Knoll Medical Practice.

Outpatient services, dermatology, hydrotherapy and intermediate care

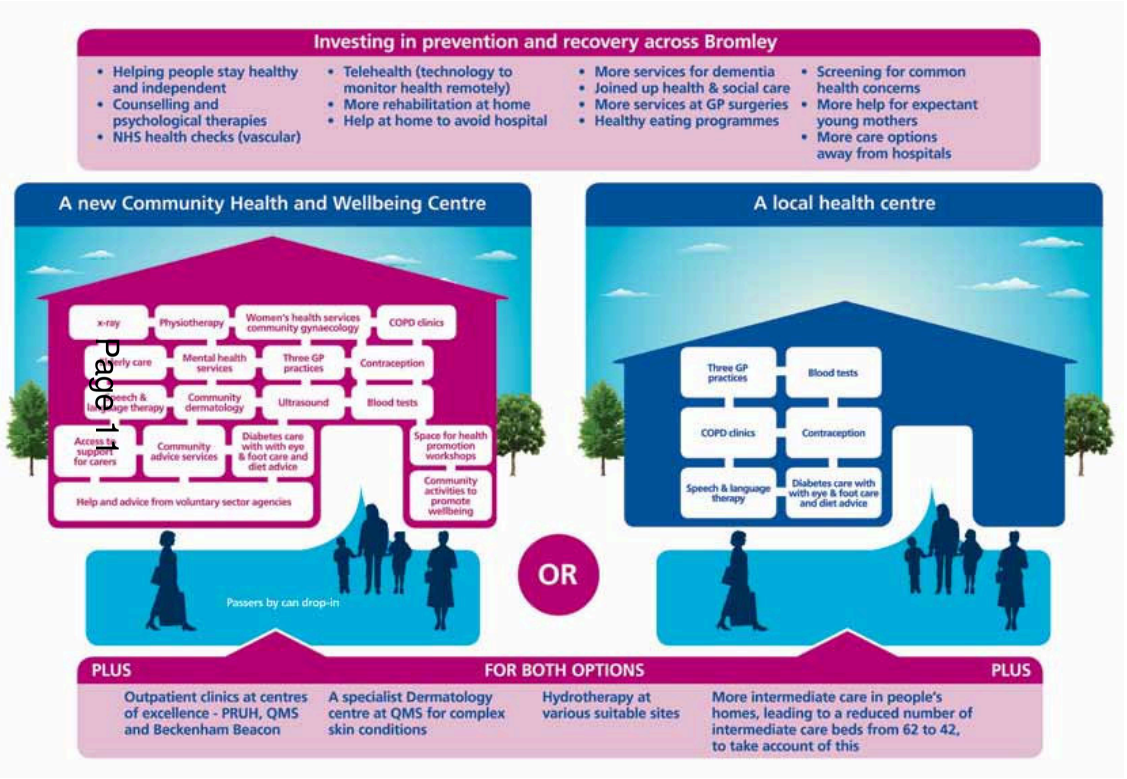
Other services currently delivered at Orpington Hospital will be moved to nearby hospitals to deliver services more effectively. Outpatient services (hospital appointments that people don't need a hospital stay for) will move to Princess Royal University Hospital (PRUH), or in a few cases, Queen Mary's Hospital, Sidcup (QMS) so that the specialist teams who deliver them can work together and are able to liaise directly with other departments that provide tests and treatment. A list of these services is available in the full consultation document.

For dermatology (skin) services, patients with less complex skin conditions will go to either our proposed new centre in Orpington or choose other community clinics in the area. More complex dermatology services will move to a new specialist centre at Queen Mary's Hospital, Sidcup, which will also serve patients across south east London.

Intermediate care (a range of services which helps faster recovery from illness or avoids unnecessary admission to hospital) would continue to bring a greater focus on home-based care, with less use of residential hospital beds – a recent survey of previous patients of this service told us that 84.8% preferred care at home. We are proposing to buy less beds (about 42 instead of 62) to offer more care at home.

Hydrotherapy will be available at alternative sites (e.g. QMS, Phoenix Centre) to support NHS patients. People with a learning disability who currently use the pool at Orpington will be offered individual solutions to ensure their needs continue to be met.

The **quality of South London Healthcare NHS Trust (SLHT)** services has been independently shown as good; with low infection and mortality rates. we are continuing to commission services from the Trust.



What's the difference between the two proposals and services currently offered at Orpington Hospital?

Service	A Health & Wellbeing Centre	A local health centre	Current services Orpington Hospital
Diabetes Services - Podiatry - Dietetics - Obstetrics - Eye care (retinopathy)	✓	✓	✓
COPD	✓	✓	✓
Blood tests (phlebotomy)	✓	✓	✓
Physiotherapy (MSK and acute)	✓	✗	✓
X-ray (radiology) and ultrasound	✓	✗	✓
Health promoting activities	✓	✗	✗
Voluntary sector advice	✓	✗	✗
Contraception and colposcopy (less complex)	✓	✓	✓
Elderly care outpatients	✓	✗	✓
Community clinics (group)	✓	✗	✗
GP practices requiring improved clinical space	✓	✓	✗
Hydrotherapy	Various sites	Various sites	✓
Specialist outpatients	PRUH, QMS and Beckenham Beacon	PRUH, QMS and Beckenham Beacon	✓
Intermediate care	Community setting in Bromley	Community setting in Bromley	✓

The benefits of our proposals

- A new style of local health with a focus on the kinds of services that help to prevent ill health developing
- Support for local GPs and community health services to do work that makes the greatest difference
- Improved buildings for three local GP practices that lack space and are not accessible to people with disabilities, have steep staircases or do not offer privacy
- Care for patients with complex conditions, in centres of excellence, building on recent improvements in cardiology (heart), rheumatology (joint) and stroke, with all of the experts working together, alongside equipment needed to do tests
- More local sites for common tests like blood testing and vascular risk checks
- Better use of the money available for healthcare in Bromley
- Increased rehabilitation services, in the most appropriate settings.

Making the best use of NHS money

Nationally, we need to get better value for money for our NHS. People are living longer, with ongoing health care needs and we need to make sure that as much NHS money as possible is spent directly on patients. Orpington Hospital is unsuitable for modern care and needs upto £3 million to bring it to a suitable standard. Once we make these changes to improve health outcomes over £2 million will be needed by South London Healthcare NHS Trust every year to run the building, before a single patient receives any treatments. For this reason, we cannot recommend continuing to provide services out of Orpington Hospital.

www.selondon.nhs.uk/orpingtonconsultation

How to respond

This leaflet provides a summary of our proposals. You can read the full consultation document by downloading it from our website at:
www.selondon.nhs.uk/orpingtonconsultation

You can also return the freepost postcard to our independent partner, Opinion Leader to receive one in the post, request one by calling **020 7861 3080** or emailing **nblythe@opinionleader.co.uk**

Copies of the full document are also available from local libraries, GP surgeries and other health centres.

The document will also be available in easy read, audio, large print or Braille format, on request, and we can provide support if you need help to respond.

This consultation will run from
16 July – 29 October 2012

All responses go directly to Opinion Leader – an independent company who are receiving your responses on behalf of the NHS and will report back on what you have told them. The local NHS will not see individual responses.

If you have specific concerns about any health service you receive and would like to speak to someone about them, please contact PALS (Patient Liaison Service) on 0800 389 5118

Find out more

If you would like to find out more about our proposals there are a number of opportunities available:

Public meetings

We will be running two public meetings for information and questions.

Thursday 9 August 2012, 7pm
Wednesday 19 September 2012, 2pm
Crofton Halls, York Rise, Orpington

If you have specific questions or concerns that you would like a conversation about, we are also hosting a series of **drop in sessions** around the borough. You can find full details of these on our website.

www.selondon.nhs.uk/orpingtonconsultation

improving health services in Orpington

Please send me a copy of the full consultation document on the future of health services in Orpington.

Mr/Mrs/Ms

First name

Last name

Address

Postcode

improving health services in Orpington

This postcard is free to send to us, however If you choose to use a stamp it will save the NHS money

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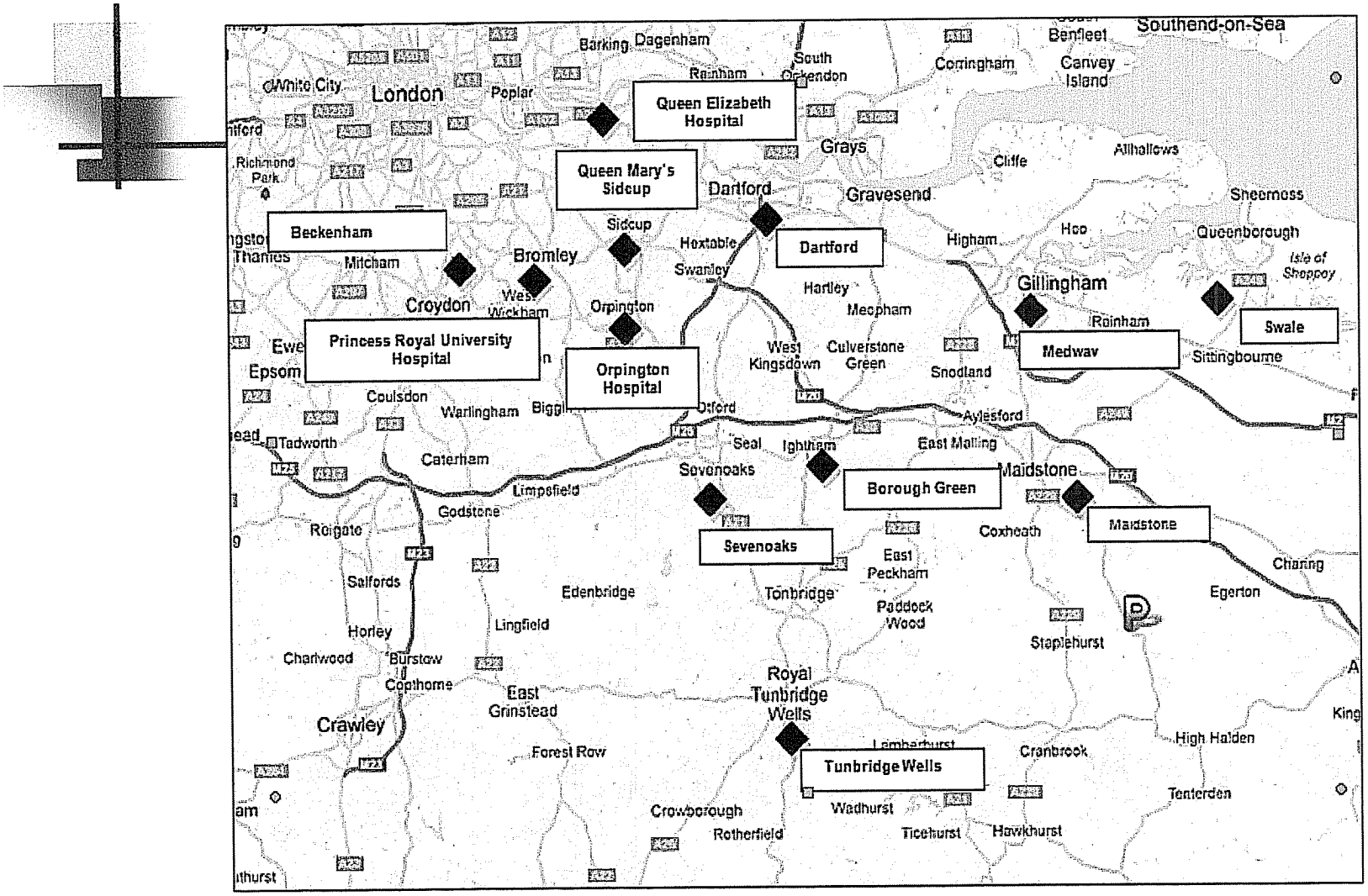
Queen Elizabeth Hospital
Queen Mary's Sidcup
Beckenham
Princess Royal University Hospital
Orpington Hospital
Dartford
Borough Green
Sevenoaks
Medway
Maidstone
Swale
Tunbridge Wells
London
Barking
Dagenham
Southend-on-Sea
Grays
Gravesend
Sidcup
Bromley
Croydon
Orpington
Gillingham
Sittingbourne
Caterham
Tadworth
Epsom
Coulsdon
Warlingham
Sevenoaks
Tonbridge
Edenbridge
Lingfield
Crawley
East Grinstead
Forest Row
Royal Tunbridge Wells
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East Peckham
Chatham
Egerton
Horley
Charlwood
Burstow
Copthorne
Crowborough
Rotherfield
Wadhurst
Ticehurst
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High Halden
Lamberhurst
Benfleet
Canvey Island
Corringham
Cliffe
Allhallows
Snodland
West Kingsdown
Culverstone Green

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Item 5: Kent Community Health NHS Trust – FT Application.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 September 2012

Subject: Kent Community Health NHS Trust: Foundation Trust Application

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1. Background

(a) Kent Community Health NHS Trust has requested the opportunity to bring the subject of the organisation's application for Foundation Trust status to the Committee.

2. Recommendation

That the Committee consider and note the report.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 7 September 2012

Subject: NHS Foundation Trust Status and Monitor

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1. Foundation Trusts (FTs)

(a) Foundation Trusts are independent public benefit organisations but remain part of the NHS. They are accountable to Parliament as well as the local community. They have a duty to engage with their local community and encourage local residents, staff and service users to become members. FT Members can stand for election to the board/council of governors.

(b) The council of governors is drawn from various constituencies, with members either elected or appointed by that constituency. It works with the board of directors, which has the responsibility for day-to-day running of the FT.[1]

(c) As things currently stand, there are a number of differences between NHS Trust and NHS Foundation Trust status. One of the areas of difference is around financial duties:

1. NHS Trusts have a duty to break even, meaning that their expenditure must not exceed their income, taking one financial year with another. Spending on capital and cash held must be within certain limits.

2. FTs are not statutorily required to break even, but must achieve the financial position set out in their financial plan. One main measure of an FT's financial performance is EBITDA (earnings before interest, tax, depreciation and amortisation).[2]

2. The Foundation Trust Pipeline

(a) There are currently 144 FTs across England. The NHS Operating Framework for 2012/13 provides the following summary of the FT Pipeline:

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[1] Monitor, *Current practice in NHS foundation trust member recruitment and engagement,* 2011, http://www.monitor-nhsft.gov.uk/sites/default/files/Current%20practice%20in%20foundatio...ecruitment%20and%20engagement.pdf

[2] Academy of Medical Royal Colleges and Audit Commission, *A Guide to Finance for Hospital Doctors*, July 2009, p.23, http://www.audit-commission.gov.uk/health/audit/financialmgmt/hospitaldoctors/Pages/hospitaldoctors9jul2009.aspx

"Progress on the NHS Foundation Trust (FT) pipeline is not an end in itself but a critical means for creating clinically and financially sustainable organisations across the provider sector. NHS trusts are expected to achieve NHS FT status on their own, as part of an existing NHS FT or in another organisational form by April 2014, with a few concluding beyond this date by exceptional agreement. Plans for all NHS trusts have been agreed under Tripartite Formal Agreements (TFAs), which codify the locally owned issues, actions and processes and set out the journey each organisation must take going forward."[3]

(b) Since October 2010, the Department of Health has been developing new processes to assist aspirant Trusts towards authorisation. The completion of a 'tripartite formal agreement' (TFA) for each Trust has been a core element of this with the TFA summarising the main challenges faced by each organisation along with the actions to be taken by the Trust, SHA and Department of Health.[4] Any issues were put into four categories:[5]

- Financial;
- Quality and Performance;
- Governance and leadership; and
- Strategic issues.

(c) In Kent and Medway, the Foundation Trusts are currently:

- East Kent Hospitals NHS University Foundation Trust;
- Medway NHS Foundation Trust; and
- South East Coast Ambulance Service NHS Foundation Trust

(d) The ***NHS Trust Development Authority (NTDA)*** was established as a Special Health Authority in June 2012 to be able to take on the responsibility for overseeing NHS Trusts (i.e. those which are not FTs) from April 2013 when SHAs will have been abolished.[6]

4. Monitor

(a) Monitor is the independent regulator of NHS Foundation Trusts and is directly accountable to Parliament.

(b) The three main strands to its work are currently:

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[3] Department of Health, *The Operating Framework for the NHS in England 2012/13*, 24 November 2011, p.29, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf

[4] National Audit Office, *Achievement of foundation trust status by NHS hospital trusts*, Full report p.6, 13 October 2011, http://www.nao.org.uk/publications/1012/foundation_trusts.aspx

[5] All TFAs can be accessed here: http://healthandcare.dh.gov.uk/foundation-trusts-tripartite-formal-agreements/

[6] http://www.ntda.nhs.uk/about/

1. Assessing the readiness of Trusts to become FTs;
2. Ensuring FTs comply with their terms of authorisation and that they are well governed and financial robust; and
3. Supporting FT development.[7]

(c) When assessing an NHS Trust applying for Foundation Trust status, the focus is on three key questions:

1. Is the Trust well governed with the leadership in place to drive future strategy and improve patient care?
2. Is the Trust financially viable with a sound business plan?
3. Is the Trust legally constituted, with a membership that is representative of its local community?[8]

(d) Once an FT has been authorised, Monitor looks to ensure it is compliant with its terms of authorisation. These are a set of detailed requirements around how the FT must operate. Some of the areas covered in the terms of authorisation are:

- the general requirement to operate effectively, efficiently and economically;
- requirements to meet healthcare targets and national standards; and
- the requirement to cooperate with other NHS organisations.[9]

(e) Each FT is assigned an annual and quarterly risk rating which indicate the risk of failure to comply with the terms of authorisation. Two risk ratings are published:

1. governance (rated red, amber-red, amber-green or green); and
2. finance (rated 1-5, where 1 represents the highest risk and 5 the lowest).[10]

(f) Where an FT is at risk of breaching its terms of authorisation, Monitor can require an action plan from the organisation. It has a range of formal intervention powers where improvement has not been demonstrated.

(g) FT development is supported through such programmes as service-line management which involves identifying specialist clinical areas and managing them as distinct operational units.[11]

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[7] http://www.monitor-nhsft.gov.uk/home/about-monitor/what-we-do
[8] http://www.monitor-nhsft.gov.uk/about-monitor/what-we-do-0#1
[9] http://www.monitor-nhsft.gov.uk/about-monitor/how-we-do-it/how-monitor-regulates-nhs-foundation-trusts
[10] Ibid.
[11] http://www.monitor-nhsft.gov.uk/SLM

(c) A number of changes to the role of Monitor are being introduced as a result of the health and Social Care Act 2012. It will become the sector regulator for health and carry out functions in the following areas:

1. Licensing providers of NHS care
2. Regulating prices;
3. Enabling integration;
4. Safeguarding choice and competition
5. Assessing NHS providers for FT status;
6. Supporting service continuity.[12]

(d) Monitor and the Department of Health jointly sponsor ***The Co-operation and Competition Panel*** (CCP). The CCP was formally established on 29 January 2009.[13] It provides advice on the application of the Department of Health's *Principles and Rules of Co-operation and Competition*.[14] Cases are undertaken by the CCP in the following four categories:

- Merger cases;
- Conduct cases;
- Procurement dispute appeals; and
- Advertising and misleading information dispute appeals.[15]

[12] Monitor, *Introduction to Monitor's future role*, 20 June 2012, http://www.monitor-nhsft.gov.uk/monitors-new-role/-introduction-monitors-new-role
[13] Co-operation and Competition Panel, *Guide to the Co-operation and Competition Panel*, http://www.ccpanel.org.uk/content/Guide-to-the-CCP.pdf
[14] Co-operation and Competition Panel, *Principles and Rules of Co-operation and Competition*, http://www.ccpanel.org.uk/content/Principles_and_Rules_REVISED5.pdf
[15] Co-operation and Competition Panel, *About the CCP*, http://www.ccpanel.org.uk/about-the-ccp/index.html

Kent Community Health NHS Trust
Our Journey to becoming a Foundation Trust

Report for Kent County Council Health Overview and Scrutiny Committee, 7 September 2012

1. Introduction

1.1 Kent Community Health NHS Trust provides the vast majority of NHS care provided in patients' homes and in the community in Kent. It was formed in April 2011 from the merger of Eastern and Coastal Kent Community Services NHS Trust and West Kent Community Health (part of West Kent PCT) in April 2011.

1.2 The Trust's budget for 2012/13 is £213 million which is approximately 9% of the health care market in Kent. It has 5,400 staff and annually has more than 3 million contacts with patients (representing about 330,000 Kent patients).

1.3 It provides a wide range of services out of GP surgeries, nursing homes, clinics and in community settings, including 7 walk-in centres and 12 community hospitals (with a total of 290 beds), as well as in people's own homes.

2. What we are here to do

2.1 The Trust's mission is to provide high quality, value for money community based services to prevent people from becoming unwell, avoid the need for people to go into hospital and when they do to leave earlier, and to provide support closer to home.

2.2 The Trust's strategy aims:

i. To prevent people from becoming unwell and dying prematurely by improving the health of the population through universal targeted services.
ii. To enhance the quality of life for people with long term conditions by providing integrated services to enable them to manage their condition and maintain their health.
iii. To help people recover from periods of ill health or following injury through the provision of responsive community services.
iv. To ensure that people have a positive experience of care and improved health outcomes by delivering excellent healthcare.
v. To ensure people receive safe care through best practice

2.3 The Trust's strategy has been developed in response to the commissioning intentions identified by the commissioners of health and social care in Kent. The Trust is working collaboratively with health and social care partners to shape new services particularly for those with long-term conditions, those in need of urgent care as well as driving improvement in the wider population's health and wellbeing.

3. Reasons for pursuing Foundation Trust Status

3.1 Foundation Trusts are NHS organisations have greater freedom from central government control. They are free to invest any surplus of money into services for the benefit of local people. They are also free to borrow money for capital projects and are free to innovate.

3.2 As a Foundation Trust we will be able to deliver:
Increased autonomy and financial independence to enable us to react faster and more responsively to necessary changes in local needs by:

i. Remodelling our services based on service user and carer views.
ii. Taking up opportunities for innovative commercial relationships and partnerships.
iii. Approving business cases more quickly to achieve progress.
iv. Re-investing surpluses back into improved services for local people.

3.3 Greater opportunities to integrate our health services with social care by developing our relationships with KCC and other partners across the county.

3.4 Better negotiating opportunities and increased ability to build alliances with other local Trusts who already enjoy Foundation Trust status in order to build new community focused pathways for local people's care.

3.5 A greater level of local accountability and closer local engagement through our membership and Council of Governors

4. Benefits to staff, patients and the wider pubic of becoming a Foundation Trust

4.1 Staff will have greater opportunity to influence the Trust's plans as members directly or through their Staff Governors who will represent them on the Council of Governors. Staff will also benefit from greater job stability, increased flexibility and opportunities to increase their skills and will benefit from the Trust's ability to re-invest money into continued training and development.

4.2 Patients will benefit from better health outcomes because a Kent-wide Foundation Trust which focuses exclusively on community-based health services has greater capacity and flexibility to respond to the changing needs of the population. Patients and their relatives will have greater influence over the way we deliver their services though membership and through their Council of Governors who will hold the Foundation Trust Board to account.

4.3 Our large membership will represent all communities in Kent and will provide opportunities for greater engagement with our patients and their families.

4.4 Any person, resident in Kent can become a member of the Foundation Trust within any one of the 12 local authority boundaries. This will enable them to influence the future provision of community services in Kent which will directly benefit their community.

4.5 Any person residing outside of the Kent catchment area can join our "out of areas constituency" and can influence the future of community health services either in their own areas or on behalf of their relatives who reside in Kent.

5. Assessment of the Risks associated with attaining Foundation Trust Status

5.1 The risks associated with not attaining Foundation Trust status are far higher than the risks associated with gaining it.

5.2 All NHS Trusts are expected to become Foundation Trust by April 2014. Trusts that do not succeed in their applications will cease to exist in their current form and their services will be provided by appropriate existing Foundation Trusts or any other Qualified Provider organisation.

5.3 As a Foundation Trust, Kent Community Health NHS Trust will be able to continue to provide high quality, sustainable and flexible community health services across Kent. The Trust believes that it is best placed to support Kent Commissioners to meet the health needs of our local population.

5.4 We are mindful that:

i. Part of the rigorous process of attaining Foundation Trust status is to satisfy the assessors that the Trust's Board is fit to run such an organisation. The Trust will need to demonstrate robust leadership.
ii. The Trust is very aware of the need not to be distracted from is core business during the Foundation Trust application process and will need to ensure high quality, safe and sustainable delivery of services throughout.
iii. Our staff need to be committed to the Trust's vision and values to ensure its continued success.
iv. We need to continue to develop good relationships with the commissioners of health and social care.
v. We need to ensure our systems of performance monitoring and reporting are robust.

6. Impact on the delivery, location and quality of services related to attaining Foundation Trust status

6.1 The rigorous process of attaining Foundation Trust status puts a spotlight on the quality and delivery of the Trust's services. The Trust will need to demonstrate that it can provide high quality, sustainable services that meet the needs of the population and can respond to future demands.

6.2 The ageing population and increased prevalence of chronic diseases among Kent's population requires more emphasis on prevention and supporting people to

manage their own health conditions better. Services will focus on preventing illness, avoiding admission to hospital and earlier return from hospital.

6.3 As a Foundation Trust we will have a greater degree of flexibility to be more innovative about the locations from where we provide our services, making it easier for the Trust to provide care closer to patient's homes.

6.4 Services will be delivered in a range of local community settings, in people's homes and in community hospitals. Services and care will increasingly be provided in locations that are easily accessible for users and respond to the needs of commissioners.

6.5 The Trust is working closely with GPs and Kent County Council to ensure care is provided by multi-disciplinary health and social care teams that work together to improve the quality of care for individual patients, service users and carers. These teams will be based on the populations served by clinical commissioning groups and configured to target specific local health needs.

6.6 The quality of care will also be improved through greater engagement with the public and patients and greater understanding of patients' experiences.

6.7 As a Foundation Trust we will undergo robust monitoring from our regulators.

7. Outline of Engagement and Consultation Process

7.1 The Trust has a robust Consultation Strategy which has been commended by the Strategic Health Authority during the first phase of our assessment process. Engagement with our staff, patient groups and partners has been ongoing since we first began our application process.

7.2 We are now into our public consultation phase which started on 30 July and will run for 12 weeks. All responses much be received by the Trust before 26 October to ensure all views are taken into account.

7.3 The guiding principles of the strategy are:

i. To make it as easy as possible for people to receive information about our Trust and the plans we have for providing excellent Community Health services and to attain Foundation Trust Status
ii. To provide a platform for people to talk to us freely so that they can be involved and help to shape the services provided by a Kent wide Community Health NHS Foundation Trust
iii. To ensure that the people we consult with is as representative as possible of the diverse communities we serve
iv. To enable varying levels and means of participation in the consultation according to the needs and wishes of individual people or groups
v. To ensure mechanisms are in place to seek and obtain the views of people about issues relevant to our application
vi. To ensure that as many people as possible feel well informed and enabled to enjoy effective two way communication
vii. To ensure people truly feel that their input influences our plans
viii. To receive feedback and views that are collated, reported back and used to finely tune our plans for future provision of services

ix. To ensure that we become the kind of organisation that local people truly need and can provide the quality outcomes that they want

7.4 Key activities:

i. 12 public consultation meetings are being held in the 12 local authority areas during September and October. These have been advertised in the local press, online and through direct marketing to patients, patient groups, partner organisations, via our staff, in community settings and to stakeholders.
ii. A radio and social media campaign has been launched to ensure as wide an audience as possible is engaged in the process.
iii. Kent LINk is supporting the consultation along with other partner organisations that are publicising the consultation to their networks.
iv. The FT membership team has been visiting community groups, major public events including the County Show, public venues and meetings throughout the county to engage directly with communities in Kent.

8. Timeline of the process

- We started our Foundation Trust Application in April 2011.
- In July 2012 The Strategic Health Authority declared us in a suitable position to go to public consultation on our plans.
- During August, September and October we are holding a full public consultation with staff, patients, carers, our partners and members of the population in Kent.
- In November we will report on the feedback from the consultation and if necessary adjust our plans accordingly.
- In December 21012 the Strategic Health Authority will make its recommendation to the Department of Health based on its assessment of our fitness to become a Foundation Trust and compete in a competitive market place.
- At the end of February 2013 the Department of Health will make its recommendations on our readiness to become a Foundation Trust, based on its assessment, to the Secretary of State.
- At the end of June 2013, after rigorous assessments and testing, Monitor will decide if we are ready to be authorised as a Foundation Trust.
- We aim to be approved as a Foundation Trust in July 2013.

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Kent Community Health NHS
NHS Trust

Consultation on becoming a Community NHS Foundation Trust

Contents

Letter from Chairman and Chief Executive

David Griffiths
Chairman

Marion Dinwoodie
Chief Executive

Kent Community Health NHS Trust provides NHS health services locally so that you get support and care for you and your family. Care is provided in your own homes and other locations, including Health Clinics, Community Hospitals and Minor Injury Units, Children's Centres and in nursing homes.

We provide services for children and adults to keep you and your family healthy, manage your long-term conditions, and help you to avoid going into hospital. If you do have to go into hospital, we provide care when you have recovered enough to come home so that you don't have to stay in longer than you need to.

We want to become a Foundation Trust because we believe it provides far greater opportunities to involve patients and their carers in decisions about the Trust and the services we provide.

We will have more freedom, for example by being able to invest surplus funds where we believe they can have the greatest impact on improving patient care.

Our application to become an NHS Foundation Trust, and to continue to provide your local NHS services, will only be successful with your support.

As a Foundation Trust we will still be part of the NHS, treating patients according to NHS standards, free of charge, whenever you need us. But we will have a wide membership, made up of local people and Trust staff. We want to talk to you during this summer to see what you think about our future plans and gauge how well you think we currently provide your services.

We want to hear what you think about the plans we have to improve services in the future. We also want to be sure that you agree with the way in which we, as a Foundation Trust, will engage and involve our members and work with our Council of Governors.

We are committed to becoming the best provider of community-based health services for local people. Gaining Foundation Trust status will secure the future for NHS community health services. You can help us to do that by becoming a member and demonstrating your support for our services. As a member you will also be able to help us to perform better in the future by giving us your own ideas. Details about how to do this are in this document.

This document seeks to set out clearly our plans and intentions. However, if you or your organisation or group would like to learn more about us we would be delighted to meet you at one of our public meetings in September and October (dates, venues and times will be published on our website www.kentcht.nhs.uk).

Introduction

The Trust is now one of the largest providers of NHS community health and clinical care in the country. These services are what most people receive in their home or the community and include District Nursing, Health Visitors and a variety of therapists and specialists.

Kent Community Health NHS Trust:

- Provides health services across Kent (except Medway)
- Serves a resident population of 1.4 million
- Provides services from a variety of bases including 12 Community Hospitals, one Walk-in Centre, and people's homes as well as Health Centres and other sites
- Employs approximately 5,400 staff
- Has a current budget of more than £200 million.

We pride ourselves on our values which reflect those of the NHS nationally, and have been agreed with our staff, who constantly strive to uphold them. These are:

- Caring with compassion
- Listening, responding and empowering
- Leading through partnerships
- Learning, sharing and innovating
- Striving for excellence.

"We want to be the provider of choice by delivering excellent care and improving the health of our communities"

Why do we want to become a Foundation Trust?

We believe that being a Foundation Trust will help to ensure that we provide exactly the right services to meet the individual needs of local people.

- Our members will be able to work with us to influence development in future services
- NHS Foundation Trusts have less control from Whitehall and increased local public ownership and accountability
- NHS Foundation Trust status opens the way to significant new freedoms, including access to greater funding options and the ability to invest surplus money in services for the benefit of local people
- Foundation Trust status supports us to achieve our vision to provide excellent care and improve the health of our communities.

As a forward thinking Trust we have always viewed the establishment of a Kent-wide community trust as the stepping stone to achieving Foundation Trust status.

When the Government set out its vision for the NHS it said that all NHS Trusts should be expected to become Foundation Trusts by 2014 or they should become part of an existing Foundation Trust.
We want to be authorised as a Foundation Trust in our own right by July 2013.

"We firmly believe that in order to thrive and provide the best care for our patients, community services in Kent need to be managed, led and provided by a Foundation Trust that focuses exclusively on these services"

Our vision for the future

Our vision is very simple – to be the provider of choice by delivering excellent care and improving the health of our communities…

"***Excellent care, healthy communities***"

Our aim is to provide services for all ages in our local communities which:

- Are local and provided as close to people's homes as possible
- Respect people's privacy and dignity
- Are safe and of a high quality, delivered by skilled staff who uphold our values
- Are provided alongside social services and other health services, in a co-ordinated way
- Maintain people's independence
- Are provided at an early stage to prevent people having to go into hospital unneccesarily.

Working in partnership with our patients, their carers, our members and governors, local GPs, hospital clinicians, local authority colleagues and others we will continue to develop services that achieve the best outcomes for local people. Our teams of staff are located geographically so that services are developed in response to local needs.

We will:

- Deliver services that have safety (including safeguarding vulnerable people) and quality of care as our highest priority
- Tailor services to meet the needs of the individual
- Recruit and retain the very best staff and provide development opportunities which build on their skills and knowledge
- Ensure we build on our successful financial management maximising the amount of money available for direct patient care.

Question 1
Do you agree with our Vision?

Priorities for developing our services

Our top four priorities, decided by working with patients and families, local GPs and others working in health and social care in Kent, are:

One – To provide community-based services to stop people from becoming unwell

Provide services which support and inform local people to help them to improve their wellbeing, take responsibility for their health and increase their life expectancy. These services help people to:

- Stop smoking
- Eat healthily
- Increase activity
- Improve their sexual health
- Support more families and give children the very best start in life.

Two – To avoid the need for people to have to go into hospital and, if they do require hospital care, to provide support so they can leave earlier

- Support people living with long-term conditions to manage their conditions better
- Introduce integrated health and social care services for our community teams to ensure continuous care which is more effective
- Use telehealth/telemedicine that enables remote monitoring to ensure a speedy response to signs of fluctuation in a patient's condition
- Provide excellent palliative care in home settings, and ensure that people have a choice about their treatment towards the end of life and their place of death
- Provide services which allow children with disabilities and serious health conditions to be cared for at home after a period of intensive care in a specialist hospital.

Three – To provide care which is closer to people's homes

Services and care will increasingly be provided in locations that are easily accessible for users and carers:

- Services will be developed to respond to the needs of local people and the requirements of the new commissioners of NHS care
- Support carers and patients so they do not need to travel for much of their healthcare.

Four – To continually improve patients' experiences of our services

- We will develop a single point of access to services, operating 24 hours a day, seven days a week with direct links to interpreting and advocacy
- Involve patients and their carers in decisions about their care and the management of their conditions
- Give patients greater knowledge and confidence to enhance their quality of life
- Continually seek and develop new techniques to improve the quality of care.

Question 2
Do you agree with our top four priorities for service development?

What would be different if we became a Foundation Trust?

By becoming members who elect govenors, local people and our staff would have a greater say in the future of our services, working closely with the Trust's Board. Members will have a real opportunity to increase the way they are involved in developing and delivering services that they feel they need by:

- Joining Focus Groups
- Participating in patient experience/satisfaction surveys
- Attending service redesign groups
- Standing for election as a governor
- Attending public meetings and putting views forward
- Supporting your local governor.

Membership

It is completely up to you how much time you give to being a member. We are proposing two categories of membership – Public and Staff.

Membership is open to anyone aged 14 or over, reflecting the age when individuals are deemed to be competent to give their own consent. Members over 16 may vote in governor elections or stand for election as a governor. We will effectively and appropriately communicate with young people to ensure we get their views and listen to their opinions.

Public constituencies

The public constituencies will be defined by the 12 District Council areas within the Kent County Council Boundaries and a Rest of England constituency, which are:

- Ashford Borough Council
- Canterbury City Council
- Dartford Borough Council
- Dover District Council
- Gravesham Borough Council
- Maidstone Borough Council
- Sevenoaks District Council
- Shepway District Council
- Swale Borough Council
- Thanet District Council
- Tonbridge and Malling Borough Council
- Tunbridge Wells Borough Council
- Out of area "Rest of England".

Members of the public will be eligible for membership of the constituency in which they live. Staff are not eligible for membership of the public constituencies.

You cannot become or remain a member of an NHS Foundation Trust if you have been:

- Involved in the previous five years in an act of assault, violence or harassment against any NHS staff or registered volunteers of the local NHS
- Convicted of offences against children or vulnerable adults.

We aim to recruit as many people as possible from our staff and the public to become members of our organisation by the time we are authorised by Monitor, the regulator, to become a Foundation Trust. We also aim to increase membership year on year once we are an established Foundation Trust.

Members will not receive any payment or receive preferential treatment. Local people who choose not to become a member of the Kent Community Health NHS Trust will have the same access to our services, but may not have the same opportunity to help shape them.

Our aim is to ensure that membership represents the people we serve, promote equality and prevent discrimination. We will have an effective and inclusive strategy ensuring we enable everybody to influence the health and social care we provide. This will be guided by our existing commitment to the Equality Act 2010 and all protected groups.

Staff constituencies

Our staff are our greatest asset and it is essential that they play a major role in shaping our future. There will be four staff constituencies in line with our service directorates:

- Services for children, young people and their families
- Adult services
- Health and Wellbeing services
- Corporate services.

Any individual employed by the Trust under a contract of employment will automatically become a member (unless they say that they do not wish to be) provided that:

- They are employed by the Trust under a permanent contract or a contract with a fixed term of 12 months or longer
- They are not directly employed by the Trust but provide services for the Trust on a contract, and have been doing so for at least 12 months.

Question 3
Do you agree with our proposals for public membership?

Question 4
Do you agree with our proposals for staff membership?

Governors

So that decisions are made in the best interest of the people we serve we will encourage the members to elect a Council of Governors to represent their views and be responsible for feeding back their comments.

The Council of Governors will play an important role for the Trust, so we will provide ongoing training, workshops and support for Governors to ensure they are fully aware of the scope of their role, and are fully equipped to carry out their duties.

In order to establish a Council of Governors, elections will be held as required with members aged 16 or over.

The Council of Governors will:

- represent the interests of all members
- enable local residents, patients, staff and partners to influence decisions about the development of community services
- ensure that members are properly supported
- appoint or remove the Trust's Chairman and approve the appointments of Non-executive Directors
- approve the appointment of the Chief Executive
- be responsible to, and represent, the members by regularly attending Council of Governors meetings
- be supported by the Trust's Membership Office to keep in contact with members within their own constituency.

By having a strong membership and Council of Governors, our patients have greater powers to hold the Trust to account.

Council of Governors

The proposed number of governors is 25. The Council of Governors will be made up of the following people.

Public Governors

Public governors will constitute the majority of the Council. The Trust proposes 13 Public Governors, one Public Governor for each of the 12 District Council areas in Kent, and one for the rest of England.

Staff Governors

It is proposed that there will be four Staff Governors. One governor for each service directorate

- Services for children and young people **1**
- Adult services **1**
- Health and Wellbeing services **1**
- Corporate services **1**.

Appointed Stakeholder Governors

In addition, it is proposed that there should be eight Stakeholder Governors who would be representatives of syndicates of partner organisations with which the Trust has strong relationships. They will be drawn from the following groups:

- Kent County Council Governors (Councillor, representatives from Education, Public Health, Social Services) **4**
- Primary Care Trust Governor **1**
- Partnership Governors (University, Police, Council for Voluntary Services) **3**.

Question 5
Do you think we have the right number of Public Governors?

Question 6
Do you think we have the right number of Staff Governors?

Question 7
Do you think we have the right number of Appointed Partner Governors?

Question 8
Do you think there are other partner organisations that should appoint Governors to join our Council?

We want to hear what you think

We welcome your views on our proposals to become an NHS Foundation Trust. The consultation runs from Monday, 30 July 2012 until Monday, 22 October 2012.

You can share your views in a number of ways:
You can complete and return this form to our freepost address:

Membership Manager
Kent Community Health NHS Trust
Freepost RSYZ-CKAR-BGAA
The Oast
Unit D, Hermitage Court
Hermitage Lane
Barming
Maidstone
Kent, ME16 9NT

You can contact us via email at kcht.membership@nhs.net or visit our website at www.kcht.nhs.net where the feedback form can be completed online and submitted electronically.

Want to know more?

Come along and join one of our public events in various locations across Kent during September and October. Dates and venues will be advertised soon. Please see our website www.kentcht.nhs.uk for more information.

Or you can invite us along to one of your own group or community events.
To arrange a meeting contact our Membership Office by emailing kcht.membership@nhs.net or by calling us on 01622 211970.

What happens next?

Once the consultation period has finished we will review all the feedback we have received and this will inform our application to the Secretary of State. Your feedback will need to be received by us by Friday, October 26 to ensure we can consider your comments before we make our final application.

If the Secretary of State supports our application our Trust will then be assessed by Monitor, our regulatory body, to assure themselves we are fit to provide high quality, services that are fit for your needs and will provide you with the very best outcomes.

Notes

Question 1
Do you agree with our Vision?

Question 2
Do you agree with our top four priorities for service development?

Question 3
Do you agree with our proposals for public membership?

Question 4
Do you agree with our proposals for staff membership?

Tear along perforation

When you have completed the form please send to: Foundation Trust Membership Office, Kent Community Health NHS Trust, The Oast, Unit D, Hermitage Court, Hermitage Lane, Barming Maidstone, Kent ME16 9NT or email kcht.membership@nhs.net

Question 5
Do you think we have the right number of Public Governors?

Question 6
Do you think we have the right number of Staff Governors?

Question 7
Do you think we have the right number of Appointed Partner Governors?

Question 8
Do you think there are other partner organisations that should appoint Governors to join our Council?

Tear along perforation

Kent Community Health NHS Trust
Membership Form

Your contact details (PLEASE PRINT)

Title First name

Surname

Address

Postcode

Home phone number

Mobile phone number

Email address

How would you prefer us to contact you?

(Contacting you by email saves us money)

Email ☐ Post ☐ SMS ☐ Telephone ☐
Textphone/minicom ☐

Your involvement as a member

Please tell us more about how you would like to be involved.

I'd like to... (please tick all that apply)

- ☐ receive information, e.g. members' newsletter
- ☐ respond to surveys and questionnaires from time to time
- ☐ be involved in/comment on public information leaflets
- ☐ come to events
- ☐ be part of a panel or working group (relevant to your interests)
- ☐ find out more about becoming a governor
- ☐ be sent membership forms to recruit family, colleagues, etc, as members - please tell us how many forms you would like ☐

Everyone can become a member, but please also tell us if you are one of the following: (please tick any that apply)

Carer ☐ Patient ☐
Kent Community Health NHS Trust volunteer ☐

Form continued overleaf

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When you have completed the form please send to: Foundation Trust Membership Office, Kent Community Health NHS Trust, The Oast, Unit D, Hermitage Court, Hermitage Lane, Barming Maidstone, Kent ME16 9NT or email kcht.membership@nhs.net

More about you

We ask for this information so that we can be sure we have a good balance of members from all of the communities we serve. We would be grateful if you would complete this section.

Date of birth:* ☐☐ / ☐☐ / ☐☐☐☐

Gender: Male ☐ Female ☐ Transgender ☐

Do you consider yourself to have a disability?

Yes ☐ No ☐ Prefer not to say ☐

Your ethnicity:

White British ☐	White Irish ☐	Other White ☐
Black African ☐	White & Black African ☐	White & Black Caribbean ☐
Black Caribbean ☐	Other Black ☐	Chinese ☐
Indian ☐	Pakistani ☐	Bangladeshi ☐
White & Asian ☐	Other Asian ☐	Other Mixed Background ☐
Gypsy/Romany ☐	Roma ☐	Traveller of Irish origin ☐
Prefer not to say ☐		

Your sexual orientation:

Bisexual ☐	Gay man ☐	Gay woman/Lesbian ☐
Hetrosexual/Straight ☐	Other ☐	Prefer not to say ☐

Thank you for your support.

If you **do not** wish to be listed on the public register of members please tick here: ☐

* If you are under 16 you can still get involved but you will not be able to vote for, or stand as, a governor. Please ask your parent or guardian to sign here to allow you to be involved:

Relationship to you: ☐☐☐☐☐☐☐☐ Name: ☐☐☐☐☐☐☐☐☐☐

Signature: .....

Tear along perforation

Talk to us

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01622 211970
or mobile 07880 500018

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 September 2012

Subject: Vascular Services

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1. Background

(a) NHS Kent and Medway have requested the opportunity to bring the current item to the Committee. The same subject was also considered at the 21 August meeting of Medway Council's Health and Adult Social Care Overview and Scrutiny Committee.

(b) If both this Committee and Medway Council's Health and Adult Social Care Overview and Scrutiny Committee consider the changes to be a substantial variation, then its consideration by a Joint Health Overview and Scrutiny Committee would need to be arranged. The Kent and Medway NHS Joint Overview and Scrutiny Committee are currently considering the Adult Mental Health Inpatient Services Review.

(c) At it's meeting of 21 August, Medway Council's Health and Adult Social Care Overview and Scrutiny Committee made the following decision on vascular services:

"The South of England Specialised Commissioning Group were asked to report back on their findings from the gap analysis and action plan in September to the Chairman and opposition spokespersons on the basis that a report would come back to the Committee should those Members consider the proposal to constitute a substantial service change at that point."

(d) The next formal meeting of Medway Council's Health and Adult Social Care Overview and Scrutiny Committee is 9 October 2012.

2. Recommendation

That the Committee determines whether the proposals constitute a substantial variation of service.

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By: Tristan Godfrey, Research officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 7 September 2012

Subject: Vascular Services

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1. Introduction[1]

(a) Vascular services involve the care of patients with diseases of blood vessels outside the heart, lungs and brain.

(b) Types of vascular disease

- Arterial disease:
  1. Narrowing or blockages of the arteries, arteries becoming hard and inflexible (atherosclerosis).
  2. Weakened section of artery stretches/balloons (aneurysm)
  3. Tear in the wall of the aorta (aortic dissection).
- Venous disease – the most common kind is varicose veins.
- Lymphatic disease - Problems in the lymphatic system where fluid cannot leave the limb (or other affected area) causing it to swell (oedema).

2. The Provision of Vascular Services

(a) The Vascular Society of Great Britain and Ireland published *The Provision of Services for Patient with Vascular Disease* in February 2012 setting out 'the principles by which a 24/7 high quality, consultant led vascular service might deliver optimal patient care.'[2]

(b) This following are some of the key points in this document under the heading 'current problems and pressures for change':[3]

- The proportion of patients with vascular disease presenting urgently or in an emergency can be up to 50%. Vascular emergencies should be treated by a vascular specialist rather than a general surgeon.
- Vascular surgery was a subspecialty of general surgery but has emerged as a separate speciality.

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[1] Information in this section: NHS Commissioning Support for London, *Cardiovascular project The case for change*, August 2010, pp.11-12, http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cardiovascular-case-for-change.pdf

[2] The Vascular Society of Great Britain and Ireland, *The Provision of Services for Patients with Vascular Disease*, 2 February 2012, p.11, http://www.vascularsociety.org.uk/library/vascular-society-publications.html

[3] Ibid. pp.11-14.

- Training vascular surgeons to provide the full range of emergency general surgery and vascular on call is no longer possible.
- The demands of the European Working Time Regulations.
- There should be coordination between elective and emergency vascular surgical and interventional radiology services.
- Commissioning vascular services is currently the responsibility of PCTs/CCGs, but the Department of Health is currently considering it for inclusion in the Specialised Services National Definitions Set which will mean it could come under specialised commissioning. There are currently some elements of specialised commissioning.[4]
- The requirements of vascular services need to be considered along with the development of cardiac, renal, diabetes, stroke and trauma services.
- Providing an effective vascular service is relatively expensive so replication is not cost effective.
- This section ends with the following summary:

  "The front door of the vascular service will remain the patient's local hospital and it is important to maintain local vascular services which are as good, if not better than, before. Vascular specialists will be on site to perform clinics and see referrals in the local hospitals. It is only patients requiring intervention or emergency treatment who will be transferred, but may still be repatriated to their local hospital for rehabilitation."[5]

[4] See: National Specialised Commissioning Group, *Specialised Services for Vascular Disease (adult) – Definition No. 30*, http://www.specialisedservices.nhs.uk/library/26/Specialised_Vascular_Services_adult.pdf

[5] The Vascular Society of Great Britain and Ireland, *The Provision of Services for Patients with Vascular Disease*, 2 February 2012, p.14, http://www.vascularsociety.org.uk/library/vascular-society-publications.html

Vascular Review

A brief outline of the proposal with reasons for the change and timescales

The current model of care for vascular surgery across Kent and Medway needs to be changed which will involve the potential centralisation of specialised vascular surgical procedures at the East Kent Hospitals University NHS Foundation Trust (EKHUFT) Kent and Canterbury Hospital site whilst retaining Medway Maritime Hospital as a 'spoke' site where the majority of care for Medway and Swale residents will take place.

These changes are required in order to ensure that the two current vascular surgical centres, Medway NHS Foundation Trust and East Kent Hospitals NHS University Foundation Trust are compliant with the recently published Vascular Society of Great Britain and Ireland document 'The Provision of Services for Patients with Vascular Disease 2012'). All services across the South of England are currently under review.

Implementation of any changes will take place in 2013/14.

Extent of consultation

Currently commissioners are undertaking a gap analysis and developing an action plan as part of a South of England SHA review. Patient and public engagement has been undertaken via the patient representatives on the Kent and Medway Vascular and Interventional Radiology Network.

There has been no formal consultation at this point as the proposals are still being developed and the impact is not yet fully quantified. However, the impact is expected to be minimal as the majority of patients will continue to receive care locally and only a small number of patients will need to access specialised surgery at a different provider.

Effect on access to services

The number of patients affected is currently being quantified as part of the review work. However, only those patients requiring specialised surgery will be treated at an alternative site under the proposal.

The main impact will be on Medway/Swale patients who currently have specialised vascular surgery requiring an in-patient stay at the Medway Maritime hospital. The current proposal being discussed by the two Trusts is for a proportion of these patients to be treated at the Kent and Canterbury hospital.

The majority of services will continue to be provided at the Medway Maritime site with enhanced local services to support the new model where required.

A small number of patients will need to travel to Canterbury for their surgical procedure instead of Medway under the proposed potential model.

Demographic assumptions

During 2011/12, there were a total of 1,278 vascular attendances at Medway Maritime hospital for Kent and Medway vascular patients.

Of these attendances, approximately 200 Kent and Medway residents received *specialised* vascular surgery at the Medway Maritime hospital. Table one below shows the proportion of vascular patients, by locality, that may have to travel to Canterbury for specialised vascular surgery under the potential model being discussed:

CCG/Locality	**Total number of vascular attendances at MFT**	**No of *Specialised* Vascular Surgical procedures at MFT**	**% of vascular patients that may be treated at K&C instead of MFT**
NHS Dartford, Gravesham & Swanley CCG	25	1	8%
NHS Swale CCG	250	49	26%
NHS West Kent CCG	305	61	27%
NHS Medway	698	86	17%
NHS Kent and Medway Total	**1,278**	**197**	**21%**

Table 1

The main impact will be on Medway and Swale patients who currently flow into the Medway service. However, the majority of patients will continue to receive their care locally, with enhanced local services to support the proposed changes.

Patients currently referred to Kings College, London (predominantly DGS and West Kent patients) will continue to be offered the option to be treated in London.

Impact of proposals on specific groups

The impact on affected groups of patients is currently being quantified as part of the review work. However, the total number of patients that will be affected by the proposed change is small. A full EIA will be undertaken as part of the South of England review.

Choice and commissioning

There should be no change to demand as a result of the potential change. The Trusts involved are currently assessing the financial implications of any changes.

The proposal is consistent with World Class Commissioning and is being driven by a requirement to ensure safe, sustainable and robust services for the future. The review is in line with the national commissioning requirements of the NHS Commissioning Board Authority.

Clinical evidence

The review is in response to the recently published Vascular Society of Great Britain and Ireland document "The Provision of Services for Patients with Vascular Disease 2012" which sets out clinical standards and outcomes for vascular surgery.

The proposals will also strengthen vascular surgical services for all patients across Kent and Medway. The proposals will contribute to the achievement of national priorities.

Joint Working

The proposed changes will be based on a network of care which will encompass joint working between the two main acute providers – EKHUFT and Medway FT. In addition, the pathways for pre and post care for vascular patients will be strengthened as a result of the review, with an additional focus on non-acute health services.

Health inequalities

This proposal is intended to improve health outcomes by ensuring high quality services in line with national clinical outcome standards. Centralisation of specialised surgical services will enable robust clinical infrastructure and sustainable expertise into the future.

All patients within Kent and Medway will be able to access the same quality of care. The options for service delivery are being developed in line with the Vascular Society standards of care.

Wider Infrastructure

The proposed service will make more efficient and effective use of the expertise currently available within Kent and Medway. Both EKHUFT and Medway FT have existing infrastructures that when brought together, will result in economies of scale which will enable the Kent-wide service to be fully compliant with the necessary infrastructure to deliver the required standards. Local infrastructure requirements will be put in place to support the model, ensuring local access for the majority of patients.

The specialised surgical elements of the service will be commissioned by an expert team within the new National Commissioning Board for April 2013.

The number of patients requiring treatment at a different site in the future is small. Transport arrangements are already in place to ensure that patients can access vascular services across both providers and will be clarified as part of the detailed work over the next 6 weeks. Clinicians from Medway FT undertook surgery at the Canterbury site as part of the development of the Medway service, and therefore such transport arrangements have been proven to work in the past.

The majority of vascular services will continue to be delivered locally, with a small number of patients receiving surgery in the future at an alternative site. The changes will deliver improved outcomes and a service that will be robust and sustainable into the future.

Following the current NHS restructure, the commissioning of vascular surgery will be led by the National Commissioning Board, through a team serving the Kent & Medway, Surrey and Sussex areas. The NCB team will liaise with local Clinical Commissioning Groups to ensure that services commissioned by them meet local needs as appropriate.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 September 2012

Subject: Older People's Mental Health Services in East Kent.

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1. Background

(a) NHS Kent and Medway presented a preliminary paper on this subject on 25 November 2011 with a view to returning to it at the appropriate time in 2012.

(b) Members were also invited to an Options Appraisal Workshop on *Remodelling the Acute Care Pathway for East Kent Older Adult Services* which took place on 22 December 2011.

(c) This item was considered and discussed as a substantive item by the Committee at it's meeting of 9 March 2012 with the understanding a further update would be received later in the year.

2. Recommendation

That the Committee consider and note the report.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee: 7 September 2012

Subject: Older People's Mental Health Services: Recent National Policy Developments.

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1. Select Committee Report on Dementia

(a) On 15 December 2011, County Council endorsed the work of the Select Committee report, *Dementia – a new stage in life.*[1]

2. Recent National Policy Developments

(a) In the NHS Operating Framework for 2012/13, published on 24 November, one of the areas highlighted for particular attention during 2012/13 is dementia and care of older people, with reference being made to the recent Care Quality Commission report, *Dignity and Nutrition for Older People.*[2] A number of systemic things which need to be done were included in the Framework, including:

- "commissioners should ensure that providers are compliant with relevant NICE quality standards and ensure information is published in providers' quality accounts;
- commissioners should work with GP practices to secure ongoing improvements in the quality of general practice and community services so that patients only go into hospital if that will secure the best clinical outcome;
- ensuring participation in and publication of national clinical audits that relate to services for older people;
- initiatives to reduce inappropriate antipsychotic prescribing for people with dementia to improve quality of life with a view to achieving overall a two-thirds reduction in the use of antipsychotic medicines;
- improving diagnosis rates, particularly in the areas with the lowest current performance;
- the continued drive to eliminate mixed-sex accommodation;
- the use of inappropriate emergency admission rates as a performance measure for national reporting; and
- non-payment for emergency readmissions within 30 days of discharge following an elective admission.

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[1] County Council, 15 December 2011, http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=113&MId=3486&Ver=4 Full Select Committee Report and Executive Summary available at:: http://www.kent.gov.uk/your_council/how_the_council_works/decisions/overview_and_scrutiny/select_committee_reports/dementia_select_committee.aspx

[2] Care Quality Commission, October 2011, http://www.cqc.org.uk/node/1785

- PCT clusters should ensure that all providers have a systematic approach to improving dignity in care for patients."[3]

(b) On 7 December, the NHS Outcomes Framework for 2012/13 was published. This is structured around five domains that set out the high level outcomes which the NHS should be aiming at nationally.

(c) These five domains are: [4]

1. Preventing people from dying prematurely;
2. Enhancing the quality of life for people with long-term conditions;
3. Helping people to recover from episodes of ill health or following injury;
4. Ensuring people have a positive experience of care; and
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

(d) There are a number of indicators under each domain by which these outcomes will be measured. Under Domain 2, "A placeholder has been included for the development of a suitable indicator for dementia. (A placeholder represents a commitment to develop an indicator in this area, recognising that this may take time)."[5]

(e) On 6 February 2012, the Joint Commissioning Panel for Mental Health published *Guidance for commissioners of dementia services*.[6] This report set out six key principles underpinning dementia commissioning:

1. Seamless services across health, social care, housing and other providers;
2. Commissioning on the basis of need, not chronological age;
3. The availability of different services at different times;
4. Dementia to be seen as 'everybody's business' and mainstream health and social care services to have a basic awareness of dementia;
5. Delivery of care by organisations and individuals in partnership; and

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[3] Department of Health, *The Operating Framework for the NHS in England 2012/13*, 24 November 2011, pp.12-13, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf

[4] Department of Health, *The NHS Outcomes Framework 2012/13*, 7 December 2011, p.16, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

[5] Ibid., p.12, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

[6] Joint Commissioning Panel for Mental Health, *Guidance for commissioners of dementia services*, 6 February 2012, http://www.rcpsych.ac.uk/pdf/JCP-MH%20dementia%20(Feb%202012).pdf

6. Care should be personalised.[7]

(f) To put these into practice, the report recommended the commissioning of a wide range of services, including:

1. Preventive public health interventions;
2. Dementia assessment, diagnosis and intervention services;
3. Home care and care home support;
4. Specialist mental health care;
5. Acute hospital liaison services; and
6; Support for carers.[8]

(g) On 26 March 2012, the Prime Minister's challenge on dementia was set out and included the following 14 commitments:[9]

1. Increased diagnosis rates through regular checks for over-65s.
2. Financial rewards for hospitals offering quality dementia care.
3. An Innovation Challenge Prize of £1m.
4. A Dementia Care and Support Compact signed by leading care home and home care providers.
5. Promoting local information on dementia services.
6. Dementia-friendly communities across the country.
7. Support from leading businesses for the PM's Challenge on Dementia.
8. Awareness-raising campaign.
9. A major event over the summer, bringing together UK leaders from industry, academia and the public sector.
10. More than doubling overall funding for dementia research to over £66m by 2015.
11. Major investment in brain scanning.
12. £13m funding for social science research on dementia (National Institute for Health Research (NIHR) and Economic and Social Research Council (ESRC).
13. £36m funding over 5 years for a new NIHR dementia translational research collaboration to pull discoveries into real benefits for patients.
14. Participation in high-quality research.

(h) The Prime Minister's challenge on dementia is complementary to the implementation framework[10] for the Government's 2011 mental health strategy *No Health Without Mental Health.*[11]

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[7] Ibid., p.8.
[8] Ibid., p.8-13.
[9] Department of Health, *Prime Minister's challenge on dementia*, 26 March 2012, pp.6-7, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133176.pdf

[10] Department of Health et al., *No Health Without Mental Health Implementation Framework*, 24 July 2012, p.6, http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

[11] HM Government, *No Health Without Mental Health*, 2 February 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

Report to the Kent Health Overview and Scrutiny Committee on the recommendations for improving outcomes for older people with mental health needs and people with dementia in east Kent and Swale

1. Introduction and Background

Proposals for the redesign of older people's mental health services were presented to Clinical Commissioning Group (CCG) Boards, the NHS Kent and Medway Board, Kent and Medway Partnership Board, (KMPT) and the Kent Health Overview and Scrutiny Committee (HOSC) in February and March 2012. The proposals were focussed on improving community support for older people with mental health needs and people with dementia and therefore reducing the reliance on acute psychiatric inpatient beds. The proposals were also scrutinised by the Strategic Health Authority (SHA) and National Clinical Advisory Team (NCAT).

The outcomes of the formal consultation will be presented to the NHS Kent and Medway Board in September 2012

Dementia Strategy

The recommendations in this paper also need to be considered alongside the dementia integrated plan which has a number of key themes, i.e.

- Raising awareness and reduction of stigma.
- Improving diagnosis.
- Enabling people to remain independent for as long as possible.
- Avoiding the need for hospital admission and improving hospital care.
- Improving end of life care.
- Ensuring good support to carers.

It also needs to be considered in conjunction with other workstreams which are currently in progress, e.g.

- **Care Homes Project** which seeks to work intensively with care homes to help avoid hospital admissions and attendances.
- **Intermediate Care Review.** A review of all intermediate care services is currently in progress and has identified a lack of intermediate care services for people with dementia.
- **Project Invicta.** This is a project for end of life care which seeks to improve services for anyone at the end of their life, which includes people with dementia.
- **Improving Support to Carers.** It is proposed to commission jointly a range of services for carers with Kent County Council (KCC) which will include support and advice and carers breaks.

1.1 The case for change

The clinical case for changing the way services are delivered to older people with mental health needs and people with dementia is well documented. There is strong evidence that greater investment in community services leads to better outcomes and reduces the need for hospital admission. This is documented in such documents as Healthcare at Home – Dementia Care Report 2011 and The Alzheimer's Report Support, Stay, Save.

When considering the redesign proposal Dr Sudbury from NCAT commented as follows:

"The clinical case for change is sound. In particular, the move away from in-patient provision to crisis and home treatment services is a general direction of travel across the country"..

Dr Sudbury also said that the impact of the new services *"might well be greater than anticipated."*

1.2 The proposed redesign of services

The proposals which were consulted upon consisted of the following elements:

- Enhancement of the Home Treatment Service for dementia to enable a more responsive service to people in their own homes and improve the support to care homes. Additional staff have now been recruited to this service.

- Introduction of a 24 hour a day crisis service. This will provide prompt support in the event of a care crisis in the home. It was agreed that this would be commissioned by KCC, but the process has been delayed by the proposed re-let of Kent County Council's (KCC) domiciliary care contract. However, an interim solution has now been agreed and this will be in place by September 2012.

- Reconfiguration and refurbishment of current inpatient provision. Three options were developed which were included in the consultation process. These are:

  Option 1 - One ward in Canterbury, one ward in Ashford and one ward in Thanet.

  Option 2 - One ward in Canterbury and two wards in Thanet. It is to be noted under this option that the current out-patient activity that takes place in the Arundel Unit will be relocated to community facilities in line with bringing these services closer to the patients and primary care.

Option 3 - Three wards in Thanet.

The Ashford unit would be on the site of the William Harvey Hospital, the Thanet unit would be on the site of the Queen Elizabeth, the Queen Mother hospital (QEQM) site and the Canterbury site would be at St Martins.

1.3 The Four Tests

The redesign of the mental health services for older people in east Kent was required to meet the following tests:

- Support from GP Commissioners
- Strengthened public and patient engagement
- Clarity on clinical evidence base
- Consistency with current and prospective patient choice

This paper will demonstrate how these tests have been met in the development and consultation on the proposed pattern of services.

2. Public Consultation

Formal public consultation commenced on 26 March and concluded on 25 June 2012. A range of communication methods were employed to raise awareness of the review and encourage people to contribute, and the commissioners and citizen engagement team have been widely available to discuss the issues and listen to people's views. The following communication methods were used:

- News items in local newspapers across east Kent,
- News items on local radio stations.
- News items appeared in local papers
- Promotion the Kent LINk AGM, at the KCC 'Remember the Person Event' during dementia awareness week and again during national carers week
- 700 emails and 1,300 postal copies of the consultation document were sent to a range of local organisations from GP practices through to the voluntary sector and the PCTs virtual panel,
- 500 Posters, 2,500 full consultation documents and 10,000 summary documents were in GP surgeries, libraries, council buildings, community centres, hospital waiting rooms, KMPT buildings, Age UK and other voluntary sector centres, and shopping centres
  Online information has been available at: http://www.easternandcoastalkent.nhs.uk/get-involved/consultations-and-surveys/dementia-and-older-peoples-mental-health/with suitable links to the KMPT website and the dementia helpline, Dementia web and information

about KCC select committee reports and other evidence which has informed the review

- Your Health magazine has featured dementia and OPMH in the last two issues featuring the review and consultation, 30,000 copies distributed across east Kent.
- Presentation and discussion with a range of local groups such as dementia cafes and pensioner forums.
- Three public meetings were held in Canterbury, Deal and Ashford The audiences at the these meetings were relatively small but well informed with a broad range of service users, carers, commercial care organisations, councilors, and third sector support organisations attending. An independent research team conducted 13 in depth interviews with care home staff, and the voluntary sector organisations who support people with dementia and with carers.
- Consultation with various staff groups.

The consultation documents were available in various formats including: easy read, large print, and audio.

It was acknowledged from the outset that it would be difficult to reach this vulnerable group of service users and carers, but we have worked closely with those organisations and services with whom there is already an established trust to enable discussion of the issues and record their views.

2.1 Key Themes from Consultation

An independent analysis of the outputs from the consultation was undertaken and are summarised below.

- Widespread support for the expansion and improvement of community based services, underpinned by an endorsement of the benefits of keeping dementia patients within a safe, secure and settled environment wherever possible.

- A need for the personnel who are delivering community-based care to be trained and skilled in the handling and treatment of dementia patients. Similarly within the hospital wards the key need was for trained, quality nursing staff who understood dementia patients and who were, therefore, able to deliver the critical emotional support required.

- A desire for effective collaboration and communication between all parties involved in the delivery of care to dementia patients and support to their carers.

- Regarding hospital services the main comments were regarding the ease of access to hospital wards, for carers and also for staff, particularly if facilities are centralised in one location only.

- For this reason the majority of respondents supported Option 1 – three wards across three locations

3. Economic Analysis

An economic analysis of all options has also been undertaken. The economic case is divided into three sections:

- Non-financial options appraisal which identified the three options to be included in the consultation process.
- Financial appraisal of the capital and revenue implications of each of the options.
- Risk assessment of the options

Following a full review of the above option 2 is the preferred economic option. The reasons for this are summarised below.

Option 2 would provide:

- Two centres of excellence giving a critical mass of staff at inpatient units, therefore enabling more therapeutic interventions to be made across extended hours.
- Care will be provided from a high quality environment that is known to deliver improved outcomes and meets best practice guidance.
- Best care arrangements for people with organic and functional illnesses.
- A 15% revenue saving from the current position.
- The lowest risk profile of all options as identified in the risk assessment.
- The best available balance of the three options that offers two locations for access and the clinical and safety advantages of a reduced number of sites.

4. Summary analysis

The analysis of the outputs from the consultation demonstrated that the majority of those people who responded supported the three site option (option 1). This result was mainly due to the fact that this option delivers the greatest level of access to inpatient provision.

However, this option does not offer the same clinical or safety advantages that a reduction in sites would offer, by offering best practice care in a high quality

environment, and giving a critical mass of staff at inpatient units, therefore enabling more therapeutic interventions to be made across extended hours.

Option 1 also generates the smallest financial saving.

The concern of patients and their carers of access to inpatient services have been taken into account and will be mitigated by the introduction of a volunteer car scheme. Volunteer drivers will be recruited and carers will be able to book a journey through the scheme to take them from their home to the hospital unit.

The main priority from respondents was improving community care and support for patients and carers.

In order to improve the overall quality of care KMPT needs to make efficiencies in the acute services line to make the most effective use of current resources, and provide scope for sustaining the investment in community care.

Maintaining inpatient provision on all three sites presents significant operational; risks for KMPT namely in providing an out of hours medical rota due to the problems of recruiting junior doctors, which has implications for patient care. Reducing the number of sites to two makes this more manageable and significantly reduces the risks.

Both the St Martin's and Thanet Mental Health Unit are owned by KMPT. This means the redesign can be delivered with relative ease. The Ashford site is leased from EKHUFT. Continuation of the unit on the Ashford site is unlikely to be compatible with EKUHFT long term estate and clinical strategy. There are also likely to be considerable restrictions on refurbishment and potential increase in revenue costs.

Option 3 generates the greatest level of saving, although it requires the most capital investment. It is also the least accessible of all the options and was the least supported option in the consultation.

It is therefore recommended that option 2 is taken forward for implementation. This option does not have the patient safety issues associated with option 1 and whilst concerns do remain about accessibility for some families and carers, option 2 presents less of an issue that option 3. As indicated previously, one of the mitigating actions will be to consider the establishment of a volunteer car scheme based on a similar scheme in west Kent. In addition it should be noted that the vast majority of patients will, through the investment in community support, be treated much closer to home than is currently the case and will only be admitted to hospital when it is clinically necessary.

Reducing the number of inpatient sites also reduces management and administrative costs as well as consolidating clinical staff and expertise.

Clinical support for this option has been provided byDr Karen White, Medical Director of KMPT, and Dr David Kanagasooriam

5. Meeting the case for change tests

The following tests have been met through the process of developing and consulting on the options and in reaching the recommended option 2:

5.1 Support from GP Commissioners

CCG GP representatives have been involved in the development of the options and recognise the case for change. There has been strong support for the investment in local community services and acknowledgement that this will lead to reduced hospital admissions. There is broad recognition that the two site option of Option 2 will bring improvements in both environmental and clinical quality for the care of the patients when needing an in-patient service.

All CCGs have now confirmed their support for option 2.

5.2 Strengthened public and patient engagement

The extensive public consultation process has achieved good public and patient engagement and this will be continued through continuing contact with a variety of local forums.

5.3 Clarity on clinical evidence base

There is good clinical evidence that delivery of care to older people nearer to home and avoidance of inappropriate hospital admissions produces better clinical outcomes. The proposals will increase the support available in the community and provide a quick response in the event of a crisis without the need to resort to hospital admission. Hospital admission to an acute psychiatric bed will be reserved for when it is clinically appropriate.

5.4 Consistency with current and prospective patient choice

The increased provision of enhanced local community support is consistent with patient choice. Although option 1 would be the preferred option of patients due to accessibility, the increased community support will increase the level of access for the majority of patients. In addition the reconfiguration will reduce the need for acute psychiatric hospital admission for the minority of patients that require this level of care.

In conclusion, option 2 is likely to be the most sustainable of all the options and whilst it does not generate the same level of savings as option 3, it is more economically

advantageous than option 1. Most importantly option 2 will deliver the improved outcomes for all older people with acute mental health needs across east Kent.

6. Timetable for implementation of inpatient redesign

It is proposed that the capital developments to support the redesigned inpatient service take place between 2012 and 2014. It is intended to begin the refurbishment programme on the Thanet site as there is already empty space and will provide options to decant wards as necessary. Work has already been started to plan in advance of the conclusion of the consultation process as all options include Thanet. The order in which the remaining two wards are developed is still to be determined.

However, exact timeframes will be dependent on a number of factors, including the receipt of planning permission and the capital development procurement route selected.

A communication plan has been developed to support the implementation of the proposed changes.

7. Risks to Implementation.

Potential risks to implementation are detailed in table 1 below.

Risk	Mitigating Action
Failure or delay in obtaining planning permission.	Engagement with local council at an early stage of planning.
Inability to recruit sufficient staffing.	KMPT undertaking stakeholder and consultation with staff.
Savings not realised or not realised in full.	Good project management.
Demand greater than anticipated and community services unable to cope.	On-going monitoring of community services to identify issues at an early stage.
Exact location of St Martins option still to be determined.	Complete the site assessment as a matter of priority.

Table 1

There were concerns that the one ward at Canterbury would not provide sufficient beds for admissions from Ashford and that there would be a risk that people from Ashford would have to travel to the wards at Thanet. The new bed capacity has been modelled against the admission pattern for the 12 months up to July 2012 and although a guarantee cannot be given that this would never happen, it is unlikely that Ashford patients would have to go to Thanet.

Additionally there were concerns raised through the consultation that the increasing incidence of dementia would mean there would be a risk that the new pattern of beds

would not be sufficient. Modelling of the increased incidence has been undertaken and 45 beds will be sufficient to accommodate increased demand in line with the increased incidence.

8. Timetable for Approval and Implementation

The timetable for approval of recommendations and implementation of inpatient redesign is given below in table 2.

Presentation and approval by CCGs	July – August 2012
Presentation to KMPT Board	20 July 2012
Presentation to HOSC	7 September 2012
Presentation to the NHS Kent and Medway Board	26 September 2012
Begin implementation of inpatient proposals	October 2012

Table 2

9. Recommendations

The Health Overview and Scrutiny Committee (HOSC) are asked to support the recommendation to proceed with the inpatient reconfiguration based on option 2.

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By:	Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform
	Meradin Peachey, Director of Public Health
To:	Kent Health Overview and Scrutiny Committee
Subject:	Developing Kent Joint Health and Wellbeing Strategy – The process for engaging Public and Stakeholders
Classification:	Unrestricted

1 Introduction

1.1 This paper outlines the process for developing and undertaking patient and stakeholder engagement in developing Kent's Joint Health and Wellbeing Strategy.

2 Developing the Draft Joint Health and Wellbeing Strategy

2.1 The Health and Social Care Act 2012 introduced duties and powers for Health and Wellbeing Boards in relation to the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategies (JHWS). Upper Tier Local Authorities and Clinical Commissioning Groups have an equal and joint duty to prepare JSNAs and JHWS through the Health and Wellbeing Board. JSNAs are local assessments of current and future health and social care needs. The current JSNA for Kent can be found at http://www.kmpho.nhs.uk/jsna/. The JHWS is the strategy for meeting the needs identified in the JSNA.

2.2 Initial development of Kent's JHWS (the current Draft version is at Appendix A) took into account the key themes from the JSNA, a range of national and local related information (see Appendix B) as well as discussions at Kent Health and Wellbeing Board meetings and other forums where strategic discussions, particularly on health services, are being held - for example the NHS Chairs and Chief Executive forum.

2.3 The current Draft Joint Health and Wellbeing Strategy focuses on five overarching outcomes identified as the most important for the population of Kent:

- Every child has the best start in life

- People are taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental ill health are supported to live well
- People with dementia are assessed and treated earlier.

2.4 These outcomes are supported by a number of key principles including:

- Engaging with the community via Healthwatch and other engagement mechanisms
- Halting the widening of health inequality gaps both within and between communities and improving healthy life expectancy.
- Focus on prevention and the individual taking more responsibility for own health and care.
- Providing good quality joined up support and care to people with long term conditions and dementia, preventing unnecessary hospital admissions. By care we mean both health and social care.
- Reducing premature deaths by the key killers including: Cancers and respiratory diseases
- Integrating commissioning of health and social care services as well as integrating how those services are provided.
- Ensure cost effectiveness and efficiency are not achieved at the cost of quality.

An Equalities Impact Assessment has also been produced to accompany the draft strategy.

3 Engaging patients and stakeholders in developing the JHWS

3.1 There is a statutory duty to involve certain groups and organisations in the development of a JSNA and the resultant JHWS[1]. These include people who live or work in the area, local Healthwatch and if applicable district councils. There should also be wider engagement, for instance with other agencies, the voluntary sector and health and social care providers. This involvement should be continuous, from early development onwards.

3.2 The following engagement timeline was agreed by the Kent Health and Wellbeing Board on the 18th July:

- 18th July – discussion and agreement by the Kent SHWB on the stated outcomes and overall steer of the draft strategy.
- End July to end August – engagement with key stakeholders (CCGs, KCC, district councils) to build on the draft strategy
- 19th September – Feedback from this first stage of engagement to Kent Shadow Health and Wellbeing Board (SHWB).
- September to November – wider public engagement on the revised draft strategy

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[1] DH January 2012 Draft guidance on Joint Strategic Needs Assessments and joint health and wellbeing strategies

- Mid November – sign off by the SHWB of the final version of the Strategy.
- End 2012 – Publication of the JHWS.

(Key milestones diagram is at Appendix C)

3.3 Engagement with key stakeholders started mid-August and responses to a survey designed for this have been asked for by 12th September, so that these can be fed into the next iteration of the draft JHWS (Survey and cover letter are at Appendix D and E).

3.4 The wider public engagement on the draft strategy will tie into parallel work taking place in the CCGs on the development of the 2013 – 2014 Annual Operating Plans.

3.5. A range of engagement methods will be used in phase 2 – the wider engagement stage - that are deemed 'fit for purpose'. These will include:

- Draft JHWS and questionnaire published both in paper form and online on KCC, PCT and LINk websites
- Paper documents placed in public places, such as libraries, leisure facilities, town halls
- Attendance at existing forums with particular interest/focus groups on one or more of the four outcomes
- Discussions with GP Patient Participation Groups, LINk/Local Healthwatch and other service user/participation groups, ensuring inclusion of diverse groups.

4. Conclusion

4.1. Information from the wider engagement phase will be used to inform and develop the final version of the JHWS. This will be published at the end of 2012 and will demonstrate how public and stakeholder engagement has influenced its final development.

Recommendation

The Health Overview and Scrutiny Committee is asked to note the approach being taken. We are also seeking the views of the HOSC as part of the engagement process.

Appendices:
Appendix A – Draft Health and Wellbeing Strategy
Appendix B – Supporting Information
Appendix C - Key milestones diagram
Appendix D – Copy of Survey
Appendix E – Covering email to partners from Roger Gough

Contact details Julie Van Ruyckevelt, Interim Head of Citizen Engagement for Health, KCC 07799472930

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Kent Health and Wellbeing Board

DRAFT

Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

DRAFT Engagement Document

If you have any queries or require this strategy in another format, please contact…..name.surname@kent.gov.uk

Foreword

This consultation document is part of the development process for the first Joint Health and Wellbeing Strategy for Kent, and aims to address the health and wellbeing needs of the people of Kent at every stage of their lives. In general, the health of Kent's residents is better than elsewhere in the country; however there are significant differences in people's health across Kent, and there are actions that we can take to continue the improvements of people's health and wellbeing in Kent. The ideas outlined in this document were taken from the needs identified in the Joint Strategic Needs Assessment. Taken together, the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy aim to improve the health and wellbeing of the people of Kent, they are not an end in themselves but a continuous process of strategic assessment and planning.

This document is seeking your views on whether we are focussing on the right key health and wellbeing issues for Kent and that we are taking the right approach to tackling those issues. This document builds on many years of joint working between local government and health, which has delivered improvements in services leading to improvements in people's health.

Over the coming weeks we will seek the views of our key partners in health, local government and beyond; these will then be reflected in a second draft document which we will take out to wider consultation with patients and the public to ensure that we have chosen the right things to focus on.

This document has been produced by the Kent Health and Wellbeing Board, which is a partnership between local government and health; whose members include GPs, County Council and District Council Councillors; LINks (patient and public representation) and senior officers for Families and Social Care and Public Health. This new partnership was established as a result of the Health and Social Care Act 2012, and gives partners in Kent the opportunity to look at the health and care system as a whole; identify what we should be addressing to improve people's health and ensuring that this is undertaken through GP and local government commissioning plans and through integrated working. Our aim is to improve the quality of life, health and wellbeing, including mental well being, for the residents of Kent. This strategy is the starting point for this approach.

Signed by Roger Gough
Chair of the Kent Health and Wellbeing Board.

Summary

This is the first Joint Health and Wellbeing Strategy for Kent. Good health and wellbeing is fundamental to living a full and productive life. Overall Kent has a good standard of health and wellbeing, but this hides some significant areas of poor health and a wide gap in life expectancy (15 years between the healthiest and least healthy wards in Kent). This overarching strategy aims to identify the health and social care outcomes that we want to achieve for the people of Kent. This Consultation document will set out the challenges we face, what we are going to do to address them and what we hope to see as a result. However, we need to ensure that we are focussing on the right things for the people of Kent. Please take some time to respond to this consultation document by completing the questionnaire which can be accessed via the web link in the covering email.

Our Vision:

Our vision in Kent is to deliver better quality care, improve health outcomes, improve the public's experience of health and social care services and ensure that the individual is at the heart of everything we do.

The Health of the People of Kent

This document is based on data and evidence in the Kent Joint Strategic Needs Assessment, the Kent Health Profile 2012, the Kent Health Inequalities Plan and guidance from the Department of Health. These documents can be found at:

Joint Strategic Needs Assessment http://www.kmpho.nhs.uk/jsna/
Kent Health Profile 2012 http://www.healthprofiles.info
Kent Health Inequalities Plan http://www.kmpho.nhs.uk/health-inequalities/?assetdet1118452=228636

Kent is a large county, covering 1.46 million people. The health of the people of Kent is mixed. Deprivation levels are lower than the England average, but there remain areas of deprivation and over 50,000 children live in poverty. Life expectancy is higher than the England average for both men and women, with men living for 79.1 years and women living for 82.7 years. Kent also performs above the England average in terms of child development at age 5, childhood obesity (is lower than England average), infant deaths and early deaths from cancer and heart disease are all better than the England average. However, life expectancy is significantly lower in deprived areas, with a man in a deprived area living on average 8.2 years less, giving him a life expectancy of 70.9 years and a woman living on average 4.5 years less, with a life expectancy of 78.2 years.

To be inserted here: Graphic depicting differences in life expectancy for males and females (Kent average, England Average and lowest Kent life expectancy) and key killers to go in here.

The Challenges that we face:

Demographic Pressures

Kent ranks 102 out of 152 county and unitary authorities in the English Indices of Deprivation 2010 (ID2010). This places Kent within England's least deprived third of authorities as a rank of one indicates the most deprived area. However, there are areas within Kent that do fall within the 20% most deprived in England. Overall, Kent suffers the most from barriers to housing and services deprivation and suffers the least from health deprivation and disabilitie[6].

With a resident population of just over 1.46 million, Kent has the largest population of all of the English counties. Just over half of the total population of Kent is female 51.1% and 48.9% are male. People living in urban areas make up 71% of the Kent population, the remaining 29% of the population live in rural areas. Over the past 10 years Kent's population has grown faster than the national average. The population of Kent has grown by 7.8% between 2000 and 2010, above the average both for the South East (6.7%) and for England (6.1%). Kent's population is forecast to increase by a further 10.9% between 2010 and 2026.

Overall the age profile of Kent residents is similar to that of England. However, Kent does have a greater proportion of young people aged 5-19 years and of people aged 45+ years than the England average. Just under a fifth of Kent's population is of retirement age (65+). Kent has an aging population. Forecasts show that the number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026, yet the population aged under 65 is only forecast to increase by 3.8%. 70% of Kent residents describe themselves as being in good health and 16.5% of Kent's population live with a limiting long term illness. Kent's ageing population will place significant pressures on health and social care services.

Where Kent is performing below the national average:

Kent's performance on smoking in pregnancy, breast feeding initiation, healthy eating among adults and obesity in adults is worse than the national average. Continued poor performance in these areas will have a significant impact on the health of the population over the coming years with poor diet being a contributory factor in cancer and heart disease and obesity in adults in contributing to the increase in type 2 diabetes.

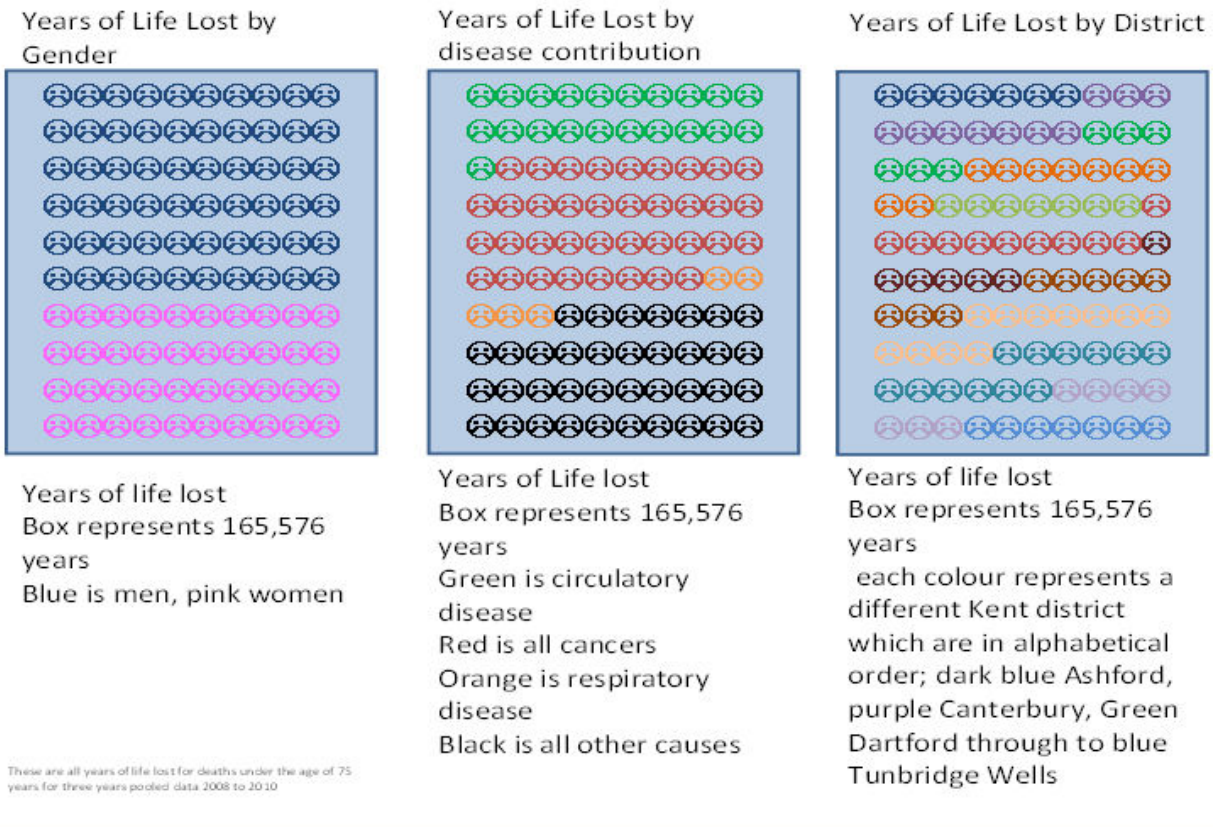
To improve people's long term health we will have to reduce unhealthy lifestyles, encourage healthy eating in adults, address the challenges of an ageing population, give every child the best start in life and enhancing the quality of life for people with long term conditions and dementia. We will need a real focus on differences in outcomes both within and between communities. In addition to this, we will need to look at how we improve people's knowledge of both the symptoms of various diseases such as cancer, and what they can do prevent them e.g. encouraging physical activity.

We will also need to address the wider determinants of ill health e.g. lifestyle, access to services, employment status and housing conditions. If these are tackled successfully they will have a significant long term impact on people's health.

To be inserted: Vignettes about wider determinants of ill health here

Years of life lost by people dying early.

A simple way to identify the impact of poor health and lifestyle choices on life expectancy is by looking at how many years of life are lost by people dying prematurely. In Kent, the number of years of life lost by people dying of preventable causes before the age of 75, is **165,576**. The key diseases that have led to the years of life lost are circulatory disease, cancer and respiratory disease; all of which can be reduced by taking a more proactive approach to health and care. The graphic below depicts the breakdown of years of life lost by men and women; the types of disease contributing to this and the years of life lost by district.



Many factors affect our health and wellbeing; our environment, living and working conditions, genetic factors, economic circumstances, how we interact with our local community and choices we make in our lifestyles.

We know these are difficult economic times for everybody. Public sector organisations are facing tough decisions, about how to deliver the best, most efficient services within reduced budgets. This is made more challenging by an increase in demand on services such as social care and rising expectations of residents for higher quality services.

This strategy takes into account the health and wellbeing challenges facing Kent and the difficult financial situation for public services. It is important we look across organisations in Kent and consider how we may change the way we work together so that we can improve the health and wellbeing of every person in Kent. The Health and Wellbeing Board will champion and work hard on behalf of the residents of Kent to ensure we make these improvements.

We also believe it is important that local communities have a greater role in shaping and influencing services and improving health and well being in communities. This will be supported by the role of democratically elected members and our local HealthWatch (patient representation is an integral part of the Health and Wellbeing Board). Not only do we think this will help us tailor services to meet the needs of local people we also understand the value of community in improving the health and well being of residents.

What difference will this strategy make?

Partnership working on health and wellbeing issues is not new in Kent. We have a long history of doing so; the recent establishment of the Kent Health and Wellbeing Board which includes a HealthWatch representative, Council representatives and Health representatives will enable even closer working.

This joint health and wellbeing strategy is a new opportunity for the health and wellbeing board members to explore together the local issues that we have not managed to tackle on our own. It sets out collectively what the greatest issues are for the local community, based on evidence in our Joint Strategic Needs Assessment, how we will work together to deliver the agreed priorities and what outcomes we intend to be achieved.

The Health and Wellbeing Strategy will inform commissioning decisions made by local partners especially GP Commissioning Groups (CCGs) so that they focus on the needs of service users and communities, tackle factors that impact on health and wellbeing across service boundaries and influence local services beyond health and care to make a real impact on the wider determinants of health (e.g. employment, housing and environment).

Guidance for the Joint Strategic Needs Assessment and Health and Wellbeing Strategy is very clear in that we should prioritise what needs most attention so we do not try and take on everything at once. By focusing on key issues we can make the biggest difference. This strategy sets out what we propose to focus on, how we purpose to deliver improvements to health and wellbeing in Kent and what outcomes we want to achieve. It has not been developed in isolation and so reflects the evidence base of our Joint Strategic Needs Assessments and other key partner documents and data sources. This is also a high level strategy, all of the partners have detailed plans on how they plan to deliver improved services in Kent including improving people's health and wellbeing. This strategy will not repeat those documents, it will instead focus on issues we need to tackle together.

We will focus on an "outcomes based approach", in other words, what will be the tangible difference if we deliver everything we plan to deliver.

We will:

- Help ensure services are tailored to local needs and utilise local assets within communities
- Encourage people to make better lifestyle choices and support them to consider their own future health needs
- Use our influence to ensure key organisations work more efficiently and differently together so that we can improve the health and wellbeing of residents within available resources. This will include the development of integrated services so that patients receive joined up care.
- Ensure that the patient is at the centre of everything that we do.

We intend to test out the priorities and outcomes outlined in this document to ensure we have chosen correctly. Please follow the link to the website, where you can feedback your comments.
http://www.kent.gov.uk/health_and_wellbeing/joint_health_and_wellbeing_str.aspx

What are we aiming to do?

To promote healthier lives for everyone in Kent our priorities are to:

- Tackle the key health issues where Kent is not performing as well as the England average. For example tackling the levels of adult obesity.
- Tackle Health Inequalities across and within Kent. For example delivering the Kent Health Inequalities Action Plan
- Tackle the gaps in provision and quality of care and support that the people of Kent receive. For example ensuring improved rates of diagnosis for mental health problems and get people into the right services when they need them.
- Transform services to improve health and care outcomes, patient experience and value for money.

With limited resources we need to focus on the key health issues that have been identified through the Joint Strategic Needs Assessment, this includes moving our focus from treatment to prevention; by adopting healthier lifestyles our health will improve reducing the risk of getting ill.

We also need to focus on doing the right things well, in other words, commissioning the right services that improve health as well as delivering value for money. The priorities outlined above will be delivered through three key Approaches:

- Integrated Commissioning, leading to
- Integrated Provision (delivering seamless services to the public), which will be
- Person Centred, we will get better at treating the whole person and not just the condition.

Patients and the public should experience seamless services; and a way in which this can be achieved is through integrating the way we commission services and how those services are provided. By health and local government commissioning services together, we will ensure that patients get the right services at the right time and in the right place. We know that patients can spend longer in hospital because they cannot go home as a result of their home not having the right adaptations. If we commission services together, we can work towards this sort of thing no longer happening.

We also want to see a move from treating the condition to treating the patient. Quite often patients will experience more that one health problem, these needed to be treated together, rather than separate treatment and appointments for each health problem; saving both patient time and improving clinical outcomes.

From these **Priorities** and **Approaches** come 5 key **Outcomes** against which we will measure our success in improving the health of the people of Kent. These key outcomes are:

1. Every Child has the best start in life
2. People are taking greater responsibility for their health and wellbeing
3. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
4. People with mental ill health are supported to live well.
5. People with dementia are assessed and treated earlier.

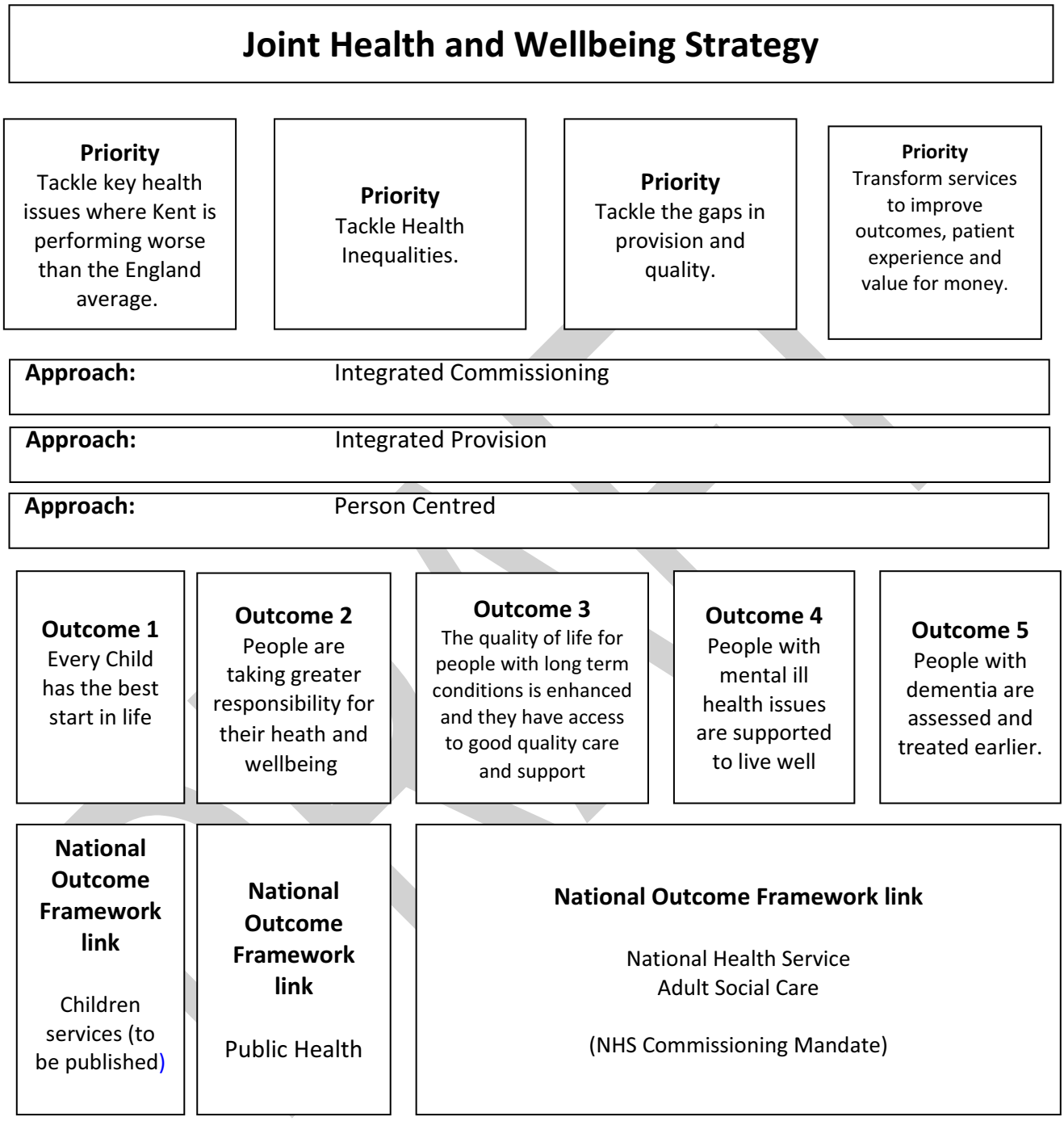
We will achieve our outcomes by:

- Engaging with the community via HealthWatch and other engagement mechanisms
- Halting the widening of health inequality gaps both within and between communities and improving healthy life expectancy.
- Focus on prevention and the individual taking more responsibility for own health and care.
- Providing good quality joined up support and care to people with long term conditions and dementia, preventing unnecessary hospital admissions. By care we mean both health and social care.
- Reducing premature deaths by the key killers including: Cancers and respiratory diseases
- Integrating commissioning of health and social care services as well as integrating how those services are provided.
- Ensure cost effectiveness and efficiency are not achieved at the cost of quality.

There is already a lot of good work going on across Kent in these areas and this strategy is not intending to duplicate the work already taking place but we do want to ensure we are aware of these areas and make sure we are performing well.

All of this activity will deliver the priorities and targets identified in the National Outcome Frameworks for Public Health, National Health Service and Social Care (Children's Services is due). This is important as these Outcome frameworks set the national and local priorities

for service delivery and outcomes. By identifying what is important for Kent, the Joint Health and Wellbeing Strategy is also the Health and Care Outcomes Framework for Kent.



Proposed Kent Health and Care Outcomes

We believe that the Kent Health and Wellbeing Board should focus on the key health and care outcomes over the next 3 years:

- Every child has the best start in life
- People are taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
- People with mental ill health issues are supported to live well
- People with dementia are assessed and treated earlier.

The following pages outline why we want to focus on these areas and what we plan to do to tackle them. We welcome your views on these outcomes (please see online survey).

Outcome 1: Every child has the best start in life

We know that improving health and wellbeing in early life contributes considerably to better outcomes in later life and helps reduce inequalities.

If we do this in Kent the following will happen: Over the next 3 years we would hope to see an increase in breast feeding take up. We would also like to see targeted support on healthy eating in families leading to an increase in healthy weight levels. There will also be an increase in MMR take up, particularly in east Kent. Kent will see an additional 450 Health Visitors by 2015 who will support families with young children.

We will focus on:

1. Increasing breast-feeding initiation rates and prevalence at 6-8 weeks in all parts of Kent
2. Improving MMR uptake and improve access to the vaccination particularly for the most vulnerable groups
3. Promoting healthy weight for children particularly those in deprived areas
4. Ensuring women have access to good information and health and wellbeing in pregnancy and book their maternity care early
5. Roll out the increase in Health Visitors and ensure they are engaged with GPs and Children's Centres.
6. Better use of Community Assets such as children centres to deliver integrated health and social care to high risk vulnerable families
7. Rolling out Total Child Pilot to schools to help schools identify health and wellbeing problems for pupils
8. Working with families to promote healthy eating and increased physical activity
9. Reduce the numbers of pregnant women who smoke through their pregnancies
10. Delivering the intensive family worker intervention programme and Family advice workers in each District.
11. Improving child and adolescent mental health services (CAMHS).
12. Implement the Adolescent support workers programme, to deliver brief interventions as part of a wider team supporting young people and their families.

13. Ensure there is adequate health provision in Special Needs schools and for children with Special Needs in mainstream schools.
14. Safeguarding target?
15. Reduce risk taking behaviour in children and adolescents e.g. smoking, sexual health, teenage conception, drugs and alcohol.

Outcome 2: People are taking greater responsibility for their health and wellbeing

We all make decisions which affect our health and wellbeing. We want to ensure we have provided the right environment in Kent for people to make better choices.
We have already got some good examples of where we are working with communities to promote healthy living, diet and exercise such as the Change 4 Life. Kent is performing below average on obese adults and healthy eating and we are average on physically active adults. We will work towards ensuring that patients and the public are better informed about symptoms of major diseases such as cancer.

If we do this in Kent the following will happen: A continued increase in people accessing treatment for drug and alcohol problems; fewer alcohol related admissions to hospital; an increase in people quitting smoking and staying smoke free; more people supported to manage their own conditions.

We will focus on:

1. Working with young people, in school settings, particularly those who are vulnerable to tackle substance misuse and underage drinking and other risk taking behaviour
2. Reducing the levels of inequalities for Life Expectancy
3. Reduce homelessness and its negative impact for those living in temporary accommodation
4. Reducing rates of deaths attributable to smoking in all persons targeting those who are vulnerable or most at risk
5. Ensuring there is provision for people with a learning disability living within residential accommodation to engage in physical activity and have a healthy diet
6. Ensure rehabilitation pathways and screening services are in place and systematically applied so all people eligible are offered service.
7. Ensure people are aware of symptoms, particularly cancer and encouraged to access services early.
8. Developing health checks appropriate for local populations
9. Improve the proportion of our adult population that enjoy a healthy weight, a healthy diet and are physically active.
10. Ensuring primary preventative strategies are systematically in place locally to address the lifestyle contributory causes of the big killers, e.g. smoking, obesity
11. Ensure secondary prevention interventions are systematically in place locally and delivered at scale in order to have an impact on life expectancy.eg cardiac rehabilitation

12. Ensure the critical care pathways are in place across the Kent population to manage acute events according to nationally advised guidance (e.g. NICE) e.g. heart attacks and strokes.
13. Ensure that all providers maximise the opportunities to improve people's health e.g. implement the NHS Every Contact Counts initiative.

Outcome 3: The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

We know that our population is ageing and is living longer, we need to focus on not just adding years to life, but life to years. Currently, as we age, we start to experience a number of long term conditions (high blood pressure, COPD, heart problems) and these have a limiting affect on the quality of life and have an impact on resources. We want people with long term conditions to experience well co-ordinated services which prevent them from being admitted to hospital unnecessarily or experiencing a crisis.

If we do this in Kent the following will happen: More patients and their carers will be supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improve access to patient information; reduce number of times patients have to repeat information to professionals (Tell us Once); see a 15% reduction in A&E admissions; a 20% reduction in emergency admissions and a 14% reduction in elective admissions. More importantly this will lead to a 45% reduction in the rates of people dying earlier than expected.

We will focus on:

1. Ensuring risk profiling is carried out consistently across the population of Kent using the same tool and done at scale, using both GP and social care data, which will help to prevent unplanned hospital admissions
2. Ensuring we have multi-professional teams working together not in silos so that people who need support from a variety of organisations do not face duplication of assessment and numerous referrals around the system
3. Ensuring people can be supported to live as independently as possible at home
4. Enabling General Practitioners to act as navigators, rather than gatekeepers, retaining responsibility for patient care and experiences throughout the patient journey
5. Enabling Clinical records to be shared across the multi-professional team, by assessing patient record schemes e.g. Patient Knows Best.
6. Reduce the numbers of hip fractures for people aged 65 and over, where Kent is currently performing significantly worse than the England average.
7. Integration of services so that the patient does not see a gap between health and social care.
8. Palliative and end of life care
9. Ensuring a range of self management approaches are in place including:
    - patient and carer education programmes

- medicines management advice and support
- the provision of telecare and telehealth,
- psychological interventions (e.g. health trainers)
- pain management
- patient access to own records
- systematic training for health providers in consultation skills that help engage patients

Outcome 4: People with mental ill health issues are supported to 'live well'

We have been working hard to ensure we deliver the Kent wide integrated strategy (Live it Well) for mental health and wellbeing of people in Kent. We have been putting into place the action plan to deliver high quality services for people with mental ill health issues. We know this can only be achieved by organisations working together across Kent, particularly in primary and secondary care. In addition we will work with partners to continue to improve mental health service provision and implement "No health without mental health"

If we do this in Kent the following will happen: Early diagnosis of mental ill health will be increased, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support and early intervention services will see an increase in people reporting an improvement in their own mental ill health and wellbeing. The stigma of mental ill health will be reduced.

We will focus on:

1. Improving rates of diagnosis in Kent and get people into the right services when they need them.
2. Promoting independence and ensuring the right care and support is available to prevent crisis
3. Awareness raising and access to good quality information
4. Ensure more people with mental ill health are recovering
5. Ensure more people with mental ill health have good physical health
6. Ensure more people with mental ill health have a positive experience of care and support
7. Ensure more people with mental ill health are supported in employment and/or education
8. Work with the voluntary sector, other provider, carers and families to reduce the social isolation of people with mental health issues
9. Ensure we have robust audit processes around mental health e.g. suicide prevention.

Outcome 5: People with dementia are assessed and treated earlier.

There are currently 9200 people living with dementia in Kent, and this figure is set to more than double over the next 30 years. Dementia is a progressive disease (which means it will only get worse) placing a significant strain on services, families and carers (who are often elderly and frail themselves). We have been working hard to ensure we deliver the National Dementia Strategy in Kent. Following Kent County Council's Dementia Select

Committee we have been putting into place the action plan to deliver high quality services for people with dementia. We know this can only be achieved by organisations working together across Kent. In addition we will work with partners to continue to improve mental health service provision.

If we do this in Kent the following will happen: Early diagnosis of Dementia will become the norm, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support including housing, supported housing options and dementia friendly communities will lead to patients being able to stay within their own communities for longer. GPs and other health and care staff will be able to have the appropriate conversations with patients and their families about end of life care.

We will focus on:

1. Deliver the Integrated Dementia Plan
2. Developing an integrated model of care
3. Improving rates of early diagnosis in Kent and get people into the right services when they need them.
4. Early intervention to reduce care home placements and hospital admission
5. Improve accommodation and hospital care
6. Work with the voluntary sector, other provider, carers and families to reduce the social isolation of people with dementia.
7. Awareness raising and access to good quality information
8. Work with partners to develop dementia friendly facilities and communities in Kent.

What happens next?

This consultation document sets out the key priorities and outcomes that the Kent Health and Wellbeing Board proposes to focus on over the next 3 years. We are asking your views on whether we have identified the right outcomes and if we are taking the right approach to tackle them. We will consult on this document with key partners in late august/early September, taking those views into account before undertaking wider consultation during the autumn of 2012, and will publish the final version of the Kent Joint Health and Wellbeing Strategy in December 2012.

We want to hear your views on our proposals. You can have your say by completing the online survey on
http://www.kent.gov.uk/health_and_wellbeing/joint_health_and_wellbeing_str.aspx.
The consultation with key partners closes on 12th September 2012.

Kent Joint Health and Wellbeing Strategy - Supporting Information

1. National Context

'The ambition is for health and wellbeing boards to go further than analysis of common problems and to develop deep and productive partnerships that develop solutions to those commissioning challenges, rather than just commenting on what those problems and challenges are. Building on enhanced JSNAs, the Bill places an additional duty on the local authority and CCGs to develop a joint health and wellbeing strategy for meeting the needs identified in the relevant local JSNA are to be met. This could potentially consider how commissioning of services related to wider health determinants such as housing, education or lifestyle behaviours can be more closely integrated with commissioning of health and social care services. Once again, this function is to be undertaken through the health and wellbeing board. In line with other local authority committees, the health and wellbeing board is able to request information for the purposes of enabling or assisting its performance of functions from the local authority and certain members and persons who are represented on the health and wellbeing board. In preparing JSNAs and joint health and wellbeing strategies, local authorities and CCGs must have regard to any guidance issued by the Secretary of State and to the Secretary of State's mandate to the NHS Commissioning Board. The NHS Commissioning Board must appoint a representative to participate in preparation of JSNAs and joint health and wellbeing strategies. The joint health and wellbeing strategy may consider services beyond health and social care – how the commissioning of health and social care services, and wider health-related services, could be more closely integrated – enabling the board to look more broadly at factors affecting the health and wellbeing of their populations. Both JSNAs and joint health and wellbeing strategies must be published.'

A key element of the health reforms is the move towards commissioning for **outcomes**; rather than the current situation which is commissioning to achieve targets, that often relate to process, not outcomes.

The national ambition is to deliver outcomes that are amongst the best in the world, supported by three outcomes frameworks:

- The NHS Outcomes Framework,
- The Public Health Outcomes Framework and
- The Adult Social Care Outcomes framework

The three outcomes frameworks will drive future commissioning and thus are critical to the context of our health and Wellbeing strategy for Kent.

NHS Outcomes Framework

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on:

Domain 1	**Preventing people from dying prematurely;**
Domain 2	**Enhancing quality of life for people with long-term conditions;**
Domain 3	**Helping people to recover from episodes of ill health or following injury;**
Domain 4	**Ensuring that people have a positive experience of care; and**
Domain 5	**Treating and caring for people in a safe environment; and protecting them from avoidable harm.**

Overall the NHS Outcomes aspiration is to:

- Reduce years of life lost from conditions amenable to health care intervention and improve under 75yrs of age life expectancy.
- Improve health related quality of life for people with long term conditions.
- Improve experience of people of the care they receive.
- Reduce emergency admissions (for acute conditions that should not usually require hospital admission) and readmissions within 30 days of discharge
- Reduce the number of patient safety incidents including those that result from sever harm or death.

Public Health Outcomes Framework

In January 2012 the Department of Health published 'Improving Outcomes and Supporting Transparency. Part 1 A public health outcomes framework for England, 2012 to 2016'. The framework is geared to refocus around achieving positive health outcomes for the population and reducing health inequalities.

The framework is focused on two high-level outcomes which are:

1. **increased healthy life expectancy**
2. **reduced differences in life expectancy and healthy life expectancy within and between communities**

It is acknowledged that improvements in these outcomes make take years – sometimes even decades- to see marked change. Thus a set of supporting public health indicators have been developed to show how well we are doing year on year. These are as follows:

Domain 1	improving the wider determinants of

	health
Domain 2	health improvement
Domain 3	health protection
Domain 4	healthcare public health and preventing premature mortality.

Social Care Outcomes Framework (ASCOF)

The ASCOF is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care. They are not a performance measurement tool but have been devised nationally to guide local commissioning and provision of service.. The framework will allow benchmarking and comparison with other areas which is critical to local accountability of councils and reporting to their citizens on a consistent basis

Again, the ASCOF is structured into four domains as follows:

Domain 1	Enhancing quality of life for people with care and support needs
Domain 2	Delaying and reducing the need for care and support
Domain 3	Ensuring that people have a positive experience of care and support
Domain 4	Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm

Delivery of these outcomes will require collective effort over all parts of the Kent system and Kent population and provides the opportunity for systematic coherence in order to protect and improve the health of the people of Kent.

2. Local Context

Bold Steps for Kent

Bold Steps for Kent sets out how Kent County Council needs to change the way it works to reflect the changing shape of public services, as the Government has set out plans to

fundamentally reform how key public services, such as education and health, will be provided in the future, underpinned by the clear message that residents should have more influence on how services are provided locally.

There are three clear aims that run throughout Bold Steps for Kent:

- To help the Kent economy grow - We must support and facilitate the new growth in the Kent economy by delivering the priorities in our regeneration framework Unlocking Kent's Potential, by delivering new housing and new infrastructure and by working with key business sectors.
- To put the citizen in control – power and influence must be in the hands of local people so they are able to take responsibility for their own community and service needs.
- To tackle disadvantage – We will make Kent a county of opportunity where aspiration rather than dependency is supported, particularly for those who are disadvantaged or who struggle to help themselves and their family.

More specifically the County set out the following in relation to Health:

Bold Steps for Health

The health reforms proposed by the Government will give greater power to GPs to choose the best services for their patients, with local government having strategic responsibility to ensure the County's health needs are met. We must use this opportunity to improve the quality of the health service in Kent.

- We will help ensure that GP commissioning plans meet the health needs of all residents and communities in Kent. Working at County and District level we want Locality Boards to play a key role in this commissioning process, better connecting KCC and wider public services with health provision at the local level.

- We will work with GP consortia to encourage new healthcare providers to enter the market for health services in Kent. This will drive up standards, provide competition, increase choice and drive greater value for money for GPs and patients.

- We will work to join up and integrate health and social care service provision to reduce costs and demand that could be avoided - for example, by joining up our assessment processes.

- We will focus on a preventative approach to public health, supporting people to make better lifestyle choices and consider their own future health needs – so expensive health services aren't required as frequently as now.

3 Summary

The context within which this Health and Wellbeing Strategy is produced reflects not only the national changes happening in a reorganising NHS and Local Authority environment,

but also in a context of national and local aspiration to improve health outcomes, reduce health inequalities and integrate care in order to improve the health of the population of Kent.

Summary and priorities from the Joint Strategic Needs Assessment

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What are the big issues in Kent and how can we get the biggest health gains for Kent?

National policy emphasises a life course approach towards improving health inequalities and health and wellbeing, where a combination of health, social and economic factors affect people's health outcomes at different periods in their lives. In Kent, a number of priorities have been suggested orientated around five main areas:

1. Early Years

Improving the continuation (and recording) of breastfeeding rates beyond six weeks.

There is no doubt over the benefits of breastfeeding towards health and wellbeing of children. However breastfeeding is not being sustained into the early months of infancy for a large number of children. The rates of breastfeeding in Kent drop from around 70% at birth to 25% at six months of age.

Health and social care organisations need to fully implement key recommendations from the Healthy Child and Baby Friendly Initiative Programmes, in order to improve the uptake and continuation of breastfeeding.

Improving MMR uptake as well as general routine immunisation rates and reduce variation in general practice coverage to ensure herd immunity and prevent future epidemics.

The current MMR vaccination rates by Year 5 are 84% and 87% in east and west Kent respectively, well below the 95% coverage required for herd immunity (the level at which risk of spread of infection is reduced)

This will be achieved through closer working between the immunisation and vaccination coordination service and GP practices, utilizing a targeted approach to those practices and vulnerable population groups where uptake is lowest. Social marketing campaigns and improved monitoring systems.

Using Children Centres more effectively to deliver integrated services to vulnerable high risk families

This includes services such as health visitors delivering messages around health promotion and behaviour change such as reduction of second hand smoke, alcohol and substance abuse, domestic violence and improving healthy weight and emotional wellbeing.

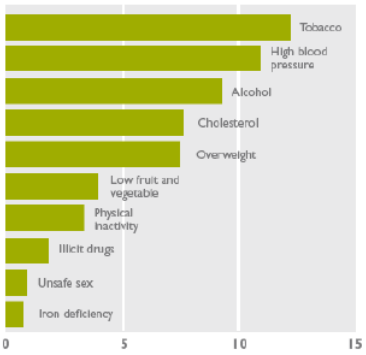
2. Young People and Lifestyle choices

The numbers of young people drinking responsibly has increased in Kent as it has nationally, and fewer children drink. However the small number of young people who do drink at increasing risk or higher risk levels and those who regularly binge drink are likely to be drinking more hazardously. 11% of 11- 16s in the Kent Children's *Smoking Drinking and Drugs* survey (2008) indicated that they did drink alcohol most days or once or twice a week. They are also likely to be from a more vulnerable group of young people. In the same way, although most children will not misuse drugs, and most of those young people who do experiment will not continue to do so, these more vulnerable young people are more likely to continue in dangerous drug use. This small group of young people in Kent are likely to have multiple risk factors such as parental substance misuse, family breakdown, domestic violence, poverty, truancy or school exclusion. They show significant levels of poor physical and mental health as well as poor sexual health and substance misuse issues. They are often disengaged from school as a result of behavioural issues, and are more likely to be 'Looked after Children' or known to the Youth Offending Service. The more vulnerable the young person is, i.e. the more risk factors they have: the more likely it is that the child will misuse drugs, alcohol and tobacco.

Young people benefit from life skills approaches to early intervention. They need to be engaged in learning and in school: and positively engaged in activity to build resilience over time through developing friendships, life skills and positive social peer networks. Positive relationships with adults in specialist services who understand the needs of young people and adolescent behaviours like substance misuse and risking sexual health are also needed. Currently, there are specialist services commissioned to tackle young people's substance misuse needs, and this includes understanding the dangers and consequences of a range of risk-taking behaviours. The DUST screening tool is promoted to identify those who need help, and further work is being developed in 2012 to support those families and young people in greatest need in Kent and help them to tackle their problems.

3. Prevention

Percentage of health years of life lost due to behavioural factors in wealthy nations.



Percentage of healthy years of life lost due to behavioural factors in wealthy nations (World Health Organization, 2002)

Percentage of health years of life lost due to behavioural factors in wealthy nations.
Cabinet Office (2010) Applying behavioural insight to health

Significant variation in the prevalence of unhealthy lifestyles exists across the 12 districts, often linked with deprivation.
80% heart disease, stroke and type 2 diabetes, and 40% cancer could be avoided if common lifestyle risk factors were eliminated. Smoking, high blood pressure and alcohol contribute to the largest proportion of healthy years life lost [Figure 3]. Therefore, people, who are at future risk, need to be identified early enough and their lifestyle and behaviour should be modified accordingly through self management, supported by social marketing campaigns such as Change 4 Life and integrated frontline services such as Stop Smoking, IBA (Alcohol), and Healthy Weight. Therefore, the rollout of the national Health Checks programme across Kent needs to be accelerated across the county and a specific focus on keys areas such as Thanet and Swale.

Change4Life three year social marketing strategy
In just three years, Change4Life has become one of the most instantly recognisable brands in health improvement, enjoying high levels of trust and involvement, not only from the public, but from healthcare professionals, staff in schools and early years' settings, local authorities, community leaders, charities and businesses.
The first year of Change4Life in 2009 was successful, awareness of the brand built rapidly and attitudes towards it were (and remain) very positive.
Over 400,000 families joined Change4Life in its first year and over 1 million mothers claimed to have made changes to their children's behaviours as a direct result of Change4Life Tesco club card research analysing the purchases of 10,000 Change4Life families has shown early signs of positive behaviour change in food

purchasing patterns and that the campaign is resonating with and attracting the intended target audience (DH 2010)

Locally NHS West Kent developed – the **Change 4 Life (C4L) – Healthy Passport Club,** a locally designed social marketing campaign to promote the Department of Health 'Change4life' programme since April 2011. The aim of the club is to promote the national C4L messages of healthy living, diet and exercise. The campaign has set out to build a supportive environment, provide tools for people to set goals, record achievements and provide motivational support in a fun way.
To date more than 14,000 people from all walks of life have joined the club, a significant proportion encouraged by GPs. All the activities undertaken by those involved are recorded as steps around the world; currently this stands at 10,562,491 steps or 5,300 miles. As this campaign has been so successful in west Kent it has been agreed that it should be rolled out across Kent.

4. The Shift to Out of Hospital Care

The population of Kent in the older age group (65+ and 85+) is predicted to increase significantly over the next 5 to 10 years. This is a demographic bubble leading to disproportionate numbers of older folk in our population. It is just emerging now and expected to persist for the next 25 years or so. This bubble along with the changing nature of longevity and health deterioration, has led us to consider major changes to the way the health and social care system work.

The system we operate comprises myriad silos of care, with inherently high levels of referral out of one and back to another. There is limited coordination and integration between them. The environment is such that, these transfers from one isolated part of the system to another, almost occur by default for reasons of infrastructure and culture. For example after hours care providers do not usually have access to information from the patient record, other providers who may need to make decisions in isolation e.g. community matrons, may be similarly disconnected from the central primary care information store. As a result, emergency admissions in the elderly for falls and dementia have increased by more than 50% and 85% respectively over the last 5 years.

Risk stratification of the Kent population is urgently required to pro-actively identify complex elderly patients in need of a multi disciplinary integrated approach (across primary care, community, and acute care and social services) towards crisis response and support, and exacerbation management ultimately resulting in hospital admission avoidance.

Risk stratification – key points

Predictive risk models are used for predicting events such as unplanned hospital admissions, which are undesirable, costly and potentially preventable.

Such models have been shown to be superior to other 'case finding' approaches, including threshold models and clinical opinion. Although the Department of Health has previously funded two predictive models for the NHS in England, the current policy is to promote an open market in terms of suppliers of risk tools.

Commissioners should consider a range of factors when choosing whether to 'make or buy' a predictive model, including the outcome to be predicted, the accuracy of the predictions made, the cost of the model and its software, and the availability of the data on which the model is run.

Predictive models should be seen as one component of a wider strategy for managing patients with chronic illness.

In NHS Blackpool, risk profiling was used to target resources more effectively to reduce unplanned care activity, using the combined predictive model. Approximate annual spend is around £26 million per year and makes up 65% of occupied bed days. The model used primary care and hospital data, (inpatient, outpatient and A&E data). The initial results showed that out of the 150,000 population in Blackpool approximately 765 patients were identified as very high risk generating more than 2,639 unplanned admissions in the previous year and the admissions avoided (323) if the necessary clinical intervention was delivered, generating £586,000 in gross savings. Apart from the benefits of identifying very high risk patients the tool enables access to real-time clinical patient data and prioritisation of community matron workload. *Nuffiield Trust (2011)*

5. Information sharing

The successful delivery and evaluation of programmes will depend on developing more robust arrangements for sharing information between health and social care organisations. For example use of an identifier such as NHS number will help to understand how patients access services across the continuum of care.

Care for older people in Torbay

Care for older people in Torbay is delivered through integrated teams of health and social care staff, first established on a pilot basis in 2004 and since extended throughout the area. Each team serves a locality of between 25,000 and 40,000 people and is aligned with the general practices in the locality. Budgets are pooled and used flexibly by teams who are able to arrange and fund services to meet the specific needs of older people. A major priority has been to increase spending on intermediate care services that enable older people to be supported at home and help avoid inappropriate hospital admissions. The work of integrated teams has been taken forward through the work of the Torbay Care Trust, created in 2005. Results include a reduction in the daily average number of occupied beds from 750 in 1998/9 to 502 in 2009/10, emergency bed day use in the population aged 65 and over that is the lowest in the region, and negligible delayed transfers of care. Since 2007/8, Torbay Care Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes, with a corresponding increase in home care services targeted at prevention and low-level support.

Chronic care management in Wales

In Wales, three Chronic Care Management Demonstrators in Carmarthenshire, Cardiff and Gwynedd Local Health Boards pioneered strategies to co-ordinate care for people with multiple chronic illness. By employing a 'shared care' model of working between primary, secondary and social care – and investing in multidisciplinary teams – the three demonstrators report a reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent respectively between 2007 and 2009. This represented an overall cost reduction of £2,224,201.
Nuffield Trust (2012).

In summary the Kent JSNA in totality has pointed to a large number of priorities.

Specifically it highlights the following as priorities for Kent:

- Early Years
    - Improving breast feeding rates
    - Improving coverage of immunisations
    - Improving the use of children and families centres

- Young people and lifestyle choices

- Prevention
    - Reduction in risk from life style behaviours
    - Roll out of Health Checks

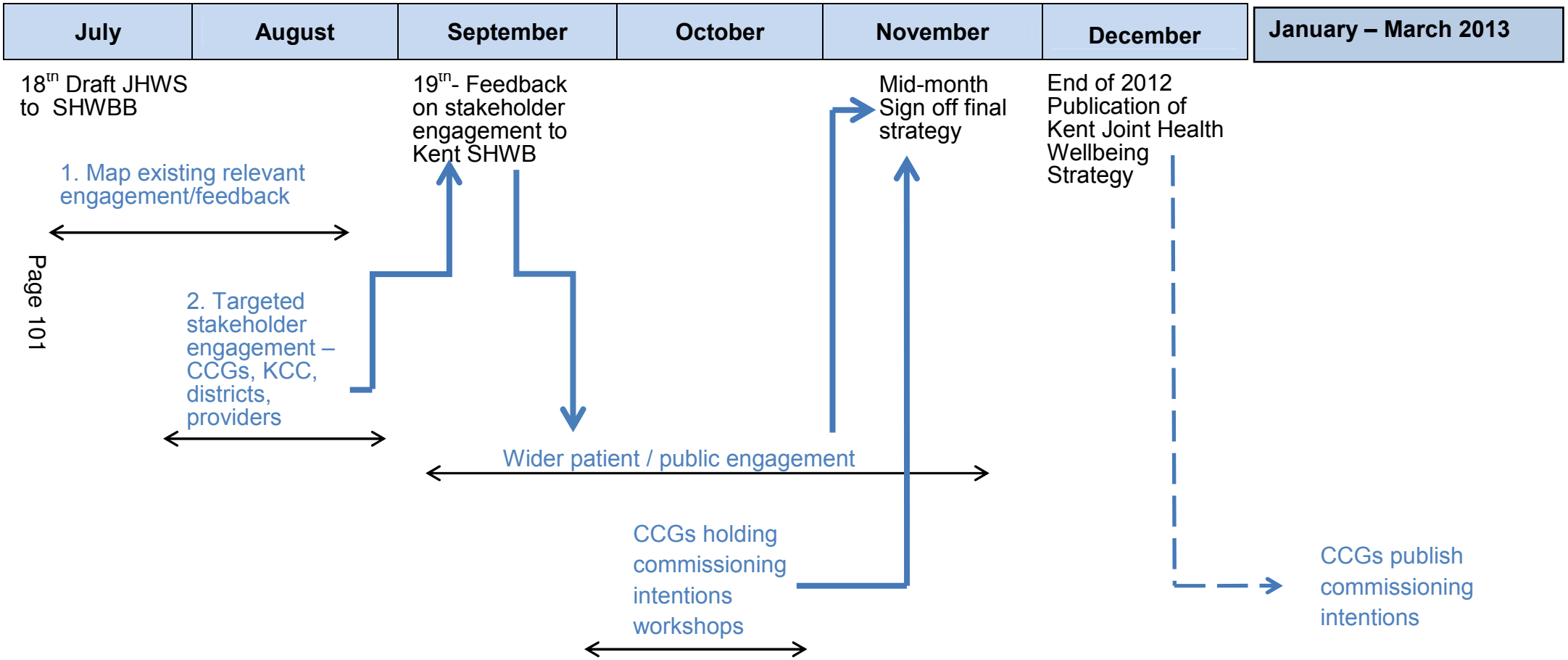
- Shifting care to outside hospitals
    - Risk profiling
    - Provision of integrated care teams
    - Move to self management

- Information sharing between organisations

Appendix C

Kent Joint Health and Wellbeing Strategy

Key Milestones



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Appendix D

Draft Joint Health and Wellbeing Strategy

Survey Questions

1. Our Vision

Our vision in Kent is to deliver better quality care, improve health outcomes, improve the public's experience of health and social care services and ensure that the individual is at the heart of everything we do.

Do you agree with our overall vision? (Please tick one)

☐ Yes
☐ Partly
☐ No
☐ Don't know

What was the reason for your answer?

What else would you like to see added?

2. Health and Wellbeing Strategy Priorities

The following 4 priorities have been identified for Kent; please state how much you agree with the priorities (please tick)

	Priority	**Strongly agree**	**Agree**	**Neither agree or disagree**	**Disagree**	**Strongly disagree**
1	Tackle key health issues where Kent is performing worse than the England average.					
2	Tackle health inequalities					
3	Tackle the gaps in provision and					

	quality.					
4	Transform services to improve outcomes, patient experience and value for money.					

3. Health and Wellbeing Strategy Outcomes

To promote healthier lives for everyone in Kent we have focused on 5 key outcomes.
These are:

1. Every Child has the best start in life
2. People are taking greater responsibility for their health and wellbeing
3. The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
4. People with mental ill health
5. People with dementia are supported to live well.

How much do you agree with each of the 5 outcomes (please tick one in each row)

	Outcome	**Strongly agree**	**Agree**	**Neither agree or disagree**	**Disagree**	**Strongly disagree**
1	Every Child has the best start in life					
2	People are taking greater responsibility for their health and wellbeing					
3	The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.					
4	People with mental ill health issues are supported to live well					
5	People with dementia are assessed and treated earlier.					

How would you rank the 5 in order of priority? (1 being top priority)

	Outcome	**Priority**
1	Every Child has the best start in life	
2	People are taking greater responsibility for their health and wellbeing	
3	The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.	
4	People with mental ill health issues are supported to live well	
5	People with dementia are assessed and treated earlier.	

Please give your reasons below:

Are there any key outcomes you think we've missed? If so, please describe below:

4. Any other comments

Having read the draft Health and Wellbeing Strategy are there any other suggestions or comments you would like to make?

What could your organisation do to help deliver the Health and Wellbeing Strategy?

Did you find the supporting information useful?

☐ Yes
☐ No

Do you have any comments about the supporting information?

5. About you.

1. Are you completing this questionnaire as an individual or on behalf of a group?

☐ Individual ☐Group

2. Which of the following best describes your role:

☐ Member of the public
☐ County Councillor
☐ District Councillor
☐ County Council Officer
☐ District Council Officer
☐ NHS: Commissioner
☐ NHS: GP
☐ NHS: Clinician
☐ NHS: Provider
☐ Other Public Sector Organisation
☐ Business Organisation
☐ Voluntary, Community or Faith Sector
☐ Service Provider
☐ LINk member
☐ Other Please State:

Which Organisation do you represent? *(optional)*

Appendix E

Sent on behalf of Roger Gough, Chair of Kent Shadow Health and Wellbeing Board

Dear Colleague

Draft Kent Joint Health and Wellbeing Strategy

As you are aware, the development of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy (JHWS) are two of the main duties of the Kent Health and Wellbeing Board, as both of these documents will form the basis of commissioning plans in both health and social care.

At the last meeting of the Kent Health and Wellbeing Board, we looked at and discussed an early version of the Kent JHWS. We agreed at that meeting that we would circulate an updated version (reflecting the comments made during the discussions) to the Health and Wellbeing Board and its wider membership, for further comment. I am pleased to share with you for consultation the draft Joint Health and Wellbeing Strategy for Kent. This consultation document sets out the key priorities and outcomes that the Kent Health and Wellbeing Board propose to focus on over the next 3 years. We are now seeking your views on whether we are focussing on the right issues for Kent and if we are taking the right approach to tackle them. Also included is some supporting information and a copy of the survey that we would like you to complete online at, through the following link:
http://www.kent.gov.uk/health_and_wellbeing/joint_health_and_wellbeing_str.aspx

We are consulting on this document with key partners in health, local government and beyond in late August/early September. We will be taking those views into account and feeding back to the Kent Health and Wellbeing Board at its September meeting, before undertaking wider consultation during the autumn of 2012 and the final version of the Strategy will be published in December 2012. The wider consultation on the JHWS will take place alongside the development of the CCG Commissioning plans for 2013/14.

This will not be your only opportunity to comment on the development of the JHWS; you will be able to further comment during the wider engagement phase in the autumn. We will also engage directly with various partners such as clinicians to ensure that we fully capture their views.

We want to hear your views on our proposals and you can have your say by completing the online survey. I would be grateful if you could send in your comments by the consultation deadline of the 12th September 2012.

I shall look forward to receiving your comments.

Roger Gough
Chair of Kent Shadow Health and Wellbeing Board

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Item 9: Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Relationship - Written Update

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 September 2012

Subject: Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust: Developing Relationship - Written Update

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1. Background

(a) The Committee last discussed this item at its meeting of 9 March 2012. It is on the Forward Work Programme for the meeting of 30 November 2012.

2. Recommendation

That the Committee note the report.

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Dartford and Gravesham NHS
NHS Trust

Medway NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S OFFICE
Direct Line 01634 833944
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Mr Michael Snelling
Members Suite
Sessions House
County Hall
Maidstone
KENT
ME141XQ

Ref: HOSCSeptember2012.doc

22 August 2012

Dear Mr Snelling,

Re: Health Overview and Scrutiny Committee Meeting – 7th September 2012

Further to your letter, please find our written update on the integration between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust below.

1. **Timeline and progress update**

1.1. Timeline update
We are on track to integrate and become one trust in spring 2013.

1.2. Co-operation and Competition Panel (CCP) update
The CCP have been considering the impact of integration on patient choice and competition since February 2012. This is part of the normal NHS merger process. In April 2012, they decided to extend their investigation into a second phase. They were due to conclude this phase by 6 August, however, they have 'paused' the process for a short time, with the trusts' agreement. They will use this time to gather further information from the trusts and, should potential loss of choice or competition be identified, work with ourselves, commissioners and possibly other healthcare providers to agree mutually acceptable remedies or measures. We understand that they expect to conclude the phase by the end of August. Monitor and the Department of Health will consider the CCP's final recommendation alongside the trusts' plans during the approval process.

1.3. Public engagement update

An analysis report on the first phase of public engagement has been published on both trusts' websites. It outlines who the trusts engaged with and how, as well as the feedback received and how it is being used to shape plans. Phase two of the engagement process is being planned and will take place following the submission of the business plans to regulators. The trusts continue to meet with community groups, borough councils and individuals, on request.

1.4. Business plan update

Both Trust Boards have considered draft versions of the business plans, which are now being finalised ready for submission. These documents include: Integrated Business Plan, Full Business Case (which will form the basis of the divestment case that the NHS South of England will put forward) and Post-transaction Implementation Plan (outlining the processes in place to enable the trust to operate effectively on day 1 and beyond, as well as the timely achievement of integration benefits). The Full Business Case and Post-transaction Implementation Plan have also been shared with NHS South of England throughout the process, to ensure that they meet their requirements.

2. South London Healthcare NHS Trust

Susan Acott, Chief Executive of Dartford and Gravesham NHS Trust, has met with the Special Trust Administrator appointed to South London Healthcare NHS Trust (SLHT), Matthew Kershaw, to better understand the process they are going through. We understand that a report will be published in October, making recommendations. Dartford and Gravesham NHS Trust have expressed their interest in supporting and being a part of the solution to SLHT's situation, and are participating in a number of working groups set up by the Special Trust Administrator. The Integrated Trust could benefit from providing elective services to South London patients, providing the resources and facilities are carefully planned.

3. Dartford and Gravesham NHS Trust's PFI

Ongoing financial support for Dartford and Gravesham NHS Trust's PFI is still being discussed with NHS South of England (Strategic Health Authority) and the Treasury. Mark Reckless MP (Rochester and Strood) has requested a meeting with the Minister, Simon Burns MP, to gain clarity and reassurance on this matter. This support is an essential part of the integration deal and we are very keen to know the outcome.

With regards to recent media coverage concerning expert teams from the Department of Health assisting trusts with their PFI agreements, Dartford and Gravesham NHS Trust has not been directly communicated with by the Department of Health. We can confirm that two leading accountancy firms have recently reviewed the PFI contract and we are now working on their findings, to ensure that our contract is good value for money and that we are fully realising the benefits from the agreement. However, we welcome any additional help that the Department of Health may offer.

We will be happy to provide any further information in November.

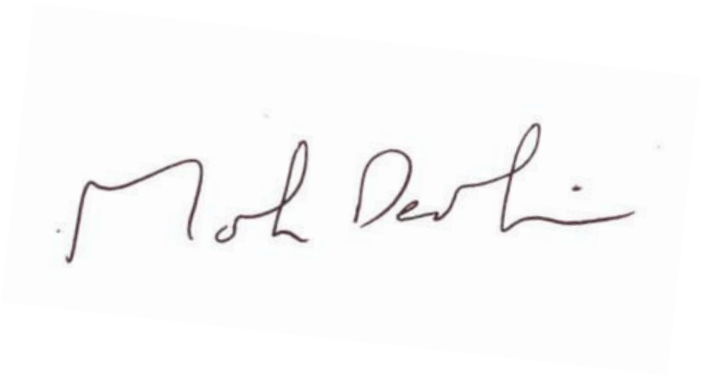
4. **Name for the integrated trust**

   As part of our first phase of engagement, we asked about a new name for the integrated trust, to represent the wider population and geographical area the trust will serve. A number of options were suggested and the two most popular choices were: North Kent NHS Foundation Trust and North Kent Hospitals NHS Foundation Trust. Of these names, we have a preference for North Kent NHS Foundation Trust. This is because we do not solely offer hospital-based services, and would like the opportunity to develop more in the future, therefore including 'Hospitals' would be less accurate.

   We would like to invite Kent Health Overview and Scrutiny Committee to discuss and formally respond to us with the committee's opinion on the name for the integrated trust by 14 September.

Thank you for this opportunity to provide an update to members and we look forward to attending the HOSC meeting in November. Should members have any questions in the meantime, please do not hesitate to contact us.

Yours sincerely



Mark Devlin
Chief Executive
Medway NHS Foundation Trust

Susan Acott
Chief Executive
Dartford and Gravesham NHS Trust

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