AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 17th September, 2014, at 6.30 pm Ask for: **Ann Hunter**

Council Chamber, Sessions House, County Hall, Maidstone Telephone **01622 694703**

Refreshments will be available 15 minutes before the start of the meeting

Membership

Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Dr B Bowes (Vice-Chairman), Mr A Bowles, Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Ms P Davies, Mr G K Gibbens, Mr E Howard-Jones, Mr S Inett, Mr A Ireland, Dr M Jones, Dr L Lunt, Dr N Kumta, Dr T Martin, Mr P J Oakford, Mr S Perks, Dr R Stewart and Cllr P Watkins

UNRESTRICTED ITEMS

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

1 Chairman's Welcome

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

3 Declarations of Interest by Members in Items on the Agenda for this Meeting

In accordance with the Members' Code of Conduct, members of the board are requested to declare any interests at the start of the meeting. Members are reminded to specify the agenda item number to which it refers and the nature of the interest being declared

4 Minutes of the Meeting held on 16 July 2014 (Pages 3 - 8)

To consider and approve the minutes as a correct record

5 BCF - Updates (Pages 9 - 16)

To receive a report that asks the Health and Wellbeing Board to agree the BCF Plan and to endorse its submission to NHS England.

To receive a report that asks the Health and Wellbeing Board to agree that the Area Team will lead a group to discuss and agree pooled fund arrangements and provide a standard Section 75 Agreement

6 Quality and the Health and Wellbeing Board (Pages 17 - 32)

To receive a report recommending that the Board requests Healthwatch Kent to coordinate a quality overview report at least twice a year to coincide with the annual commissioning cycle

7 Pharmaceutical Needs Assessment (Pages 33 - 58)

To receive a report on the Pharmaceutical Needs assessment

8 Healthwatch Annual Report 2014 (Pages 59 - 72)

To receive the annual report of Healthwatch Kent for 2014.

9 Date of Next Meeting - 19 November 2014

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

Tuesday, 9 September 2014

KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 16 July 2014.

PRESENT: Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Dr B Bowes (Vice-Chairman), Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Ms P Davies, Mr G K Gibbens, Cllr J Howes (Substitute for Mr A Bowles), Mr S Inett, Mr A Ireland, Dr M Jones, Dr N Kumta, Dr L Lunt, Dr T Martin, Mr P J Oakford, Dr R Stewart and Dr J Thallon

ALSO PRESENT: Mr S Bone-Knell, Ms S Gratton and Mr S Mowla

IN ATTENDANCE: Ms E Hanson (Policy Manager), Mr M Lemon (Strategic Business Adviser), Mrs A Tidmarsh (Director, Older People & Physical Disability), Ms M Varshney (Consultant in Public Health) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

85. Chairman's Welcome
(Item 1)

(1) The Chairman welcomed Katherine Rake, Chief Executive of Healthwatch England to the meeting.

(2) He reminded the Board that the Healthwatch Reference Group would welcome some clinical input into its work overseeing the work of Healthwatch.

(3) He also told the meeting about a visit by Norman Lamb, Minister of State for Care and Support, to Broadmeadow Care Home, Folkestone that had taken last week and of Mr Lamb's positive view of activity to integrate health and social care provision.

(4) Mr Gough said he had agreed to the addition of a report on integrated intelligence to the agenda for the meeting as it could not reasonably be deferred to the next meeting of the Health and Wellbeing Board.

86. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Cllr A Bowles, Mr E Howard-Jones, Mr S Perks and Cllr P Watkins. Cllr J Howes and Dr J Thallon attended as substitutes for Cllr A Bowles and Mr E Howard-Jones respectively.

87. Declarations of Interest by Members in Items on the Agenda for this Meeting
(Item 3)

There were no declarations of interest.

88. Minutes of the Meeting held on 28 May 2014
(Item 4)

Resolved that the minutes of the Kent Health and Wellbeing Board held on 28 May 2014 are correctly recorded and that they be signed by the chairman.

89. Dementia Care and Support in Kent
(Item 5)

(1) Anne Tidmarsh (Director of Older People and Physical Disability and chairman of the Kent Dementia Action Alliance) said progress had been made in improving services for people with dementia and their carers and encouraged board members to visit the information stand in the meeting room. She also introduced Sue Grattan (KMCS) and Emma Hanson (Head of Strategic Commissioning) who gave a presentation introducing the report. Dr Liz Lunt followed this with a presentation from the GP's perspective.

(2) The report gave an overview of initiatives across Kent to improve access to a timely diagnosis of dementia and of improvements to services for patients and carers affected by dementia to ensure they are supported to live well with dementia and avoid unnecessary crisis events.

(3) During the discussion it was said that: residents were not clear about the crisis support available; the availability of cognitive stimulation therapies varied across Kent; the single offer was welcome; and the hospital interface was important especially to avoid unnecessary discharge into permanent residential care;

(4) The Board identified a need to: develop indicators that measured the outcome of the strategy and the impact of associated activity; address staff training to ensure staff in the independent and community sector were appropriately skilled to prevent unnecessary admissions to and longer stays than necessary in acute hospitals; campaign for an appropriate level of funding from central government for residential care services in Kent; and ensure the Accommodation Strategy reflected and built on the issues raised in the report.

(5) Resolved that:
(a) The report and presentations be noted;

(b) Dementia be viewed as a long term condition with primary care taking an active role to promote timely diagnosis and the coordination of integrated care;

(c) Progress be noted and the continuation of work to reduce the stigma of a diagnosis of dementia and continuing to increase support available to people affected by dementia be endorsed, so people feel able to come forward to seek a diagnosis and when doing so can be well supported through the process;

(d) The Dementia Call to Action be endorsed and that CCGs and local authorities, working with their partners and local communities, fulfil the

ambition that 67% of people with dementia have a diagnosis and access to appropriate post-diagnosis support by 2015;

(e) Kent's carers' organisations together with KCC and the CCGs be tasked to review their plans in the light of the recently published Call to Action for Carers of People with Dementia to understand where further improvements can be made;

(f) A full review of the acute pathway be conducted and the development of different models of care with increased skills and breadth of services in the private and voluntary sector in order to avoid unnecessary admission and support timely discharges be supported;

(g) A formal link between the Kent Health and Well Being Board and the Kent Dementia Action Alliance (DAA) be recognised and that this be replicated by local HWWBs and their local DAAs, so that the contribution of the wider partnership to improve support to people with dementia and their carers could be acknowledged.

90. Kent Fire and Rescue Service - Presentation
(Item 6)

(1) Sean Bone-Knell (Director Operations – Kent Fire and Rescue Services (KFRS)) gave a presentation on the role of the KFRS and how the service could contribute to the achievement of the outcomes and targets in the Joint Health and Wellbeing Strategy.

(2) There was general agreement that the KFRS had a valuable role to play and, in particular, in relation to falls prevention and the identification of dementia. It was considered that the best way to progress closer working was at the local health and wellbeing board level.

(3) Resolved that:
(a) The presentation be noted;

(b) The Chairman writes to local health and wellbeing boards encouraging them to consider how they might engage with the KFRS and in particular in relation to falls prevention and the identification of dementia.

91. Kent Health and Wellbeing Strategy - 2014-2017
(Item 7)

(1) Malti Varshney (Consultant in Public Health) and Mark Lemon (Strategic Business Adviser) introduced the report which included the final draft version of the Kent Joint Health and Wellbeing Strategy for approval. Changes to the text had been incorporated where appropriate following public comment. In particular Outcome 4 – People with mental health issues are supported to "live well" had been revised and changes had been made to some of the proposed metrics and measurements of performance.

(2) Ms Varshney also said that the draft strategy had been considered by the Children's Social Care and Health Cabinet Committee and Adults' Social Care and Heath Cabinet Committee.

(3) During discussion it was confirmed that every effort would be made to refine targets and indicators over the next three months rather than six months suggested in the report. It was suggested that: the reference to "urgent" on page 64 be deleted; consideration be given to making the measures for Outcome 4 more specific and reference to transition as required by the Care Act 2014 be included. It was also agreed that dementia-friendly communities be promoted more explicitly and an indicator to measure this be considered.

(4) The need for a single message and co-ordination of messages was also identified and agreed.

(5) Resolved that:

(a) The revised Joint Health and Wellbeing Strategy for Kent be approved;

(b) The revised engagement and communication programme be agreed;

(c) Local health and wellbeing boards be tasked to report in November 2014 on how local populations are being engaged in discussions concerning the implementation of the strategy in their local areas;

(d) Local health and wellbeing boards be required to ensure local plans demonstrate how the priorities, approaches and outcomes of the Kent Joint Health and Wellbeing Strategy will be implemented at local levels and report this assurance to the Kent Health and Wellbeing Board in November 2014;

(e) The Chairman writes to all local health and wellbeing boards reminding them of the importance of the role they, and their constituent members, can play in communicating key messages to residents.

92. Better Care Fund: National Review
(Item 8)

(1) Mark Lemon (Strategic Business Adviser) introduced the report which presented a summary of the recent Government announcement about the Better Care Fund. The changes outlined in the announcement related to the financial management of the risks associated with failure to reduce emergency admissions and, in particular, that up to £1 billion of the Better Care Fund would be allocated to local areas to spend on out-of-hospital services and the actual portion of this available to spend on Better Care Fund initiatives would depend on its level of performance in reducing emergency admissions.

(2) Consideration was given to writing to the Department of Health but it was agreed not to pursue this course of action.

(3) Resolved that the report be noted.

93. Potential Merger of Ashford Clinical Commissioning Group and Canterbury & Coastal Clinical Commissioning Group
(Item 9)

(1) Dr Mark Jones and Dr N Kumta introduced the report which said that In July 2014 Ashford and Canterbury and Coastal CCGs intended to take a vote on merging and sought a view from the Health and Wellbeing Board on the structure of the local health and wellbeing boards in the event of a vote in favour of the merger.

(2) The value of the working relationships that had been established within the local health and wellbeing boards was recognised and it was considered that dismantling such relationships and establishing new ones would be costly.

(3) Resolved that:
(a) The report be noted;

(b) Should the merger take place the continuation of two separate local health and wellbeing boards be supported in principle and that further discussion take place outside the meeting.

94. Assurance Framework
(Item 10)

(1) Malti Varshney (Consultant in Public Health) introduced the report which outlined changes to indicators since the last report and highlighted indicators that showed increasing good performance and those raising concerns.

(2) It was suggested that future reports should include national benchmarks alongside the data relating to Kent. In response to a question Ms Varshney undertook to circulate a timescales for the production data for local health and wellbeing boards.

(3) Resolved that:
(a) Areas of variance in the metrics between CCGs or districts be discussed further at local health and wellbeing boards;

(b) Assurances be sought that plans were in place to address the reduction in successful treatment exits and non-representations in substance misuse services;

(c) The development of local assurance framework reports for presentation to the local health and wellbeing boards over the next quarter be noted.

95. First HWBB Report of the JSNA/JHWS Steering Group for Kent
(Item 11)

(1) Abraham George introduced the report by which was the first in a series of progress reports on the development of the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS). The report described how the JSNA/JHWS steering group had been set up including its

terms of reference and membership as well as some of the topics that had been discussed.

(2) It was confirmed that Education and Young People's services are members of the steering group.

(3) Resolved that the report be noted and JSNA/JHWS Steering Group's work plan for the next six months be endorsed.

96. Proposal for Establishing an Intelligence-Enabled Integrated Commissioning Support Capability
(Item 13)

(1) Shakeel Mowla introduced the report with a short presentation that outlined the current situation and challenges being faced by health and social care commissioners and proposed a means of designing and assessing the whole systems impact of strategic programmes.

(2) A number of concerns were raised that led the Board to conclude that further consideration was needed.

(3) Resolved that the proposal be referred to the Integrated Pioneer Group for review as part of a process for understanding the options for integrated intelligence before any further consideration by the Health and Wellbeing Board.

97. Date of Next Meeting - 17 September 2014
(Item 12)

By: Roger Gough, Chair Kent Health and Wellbeing Board and Dr Robert Stewart, Chair Integration Pioneer Steering Group

To: Kent Health and Wellbeing Board, 17 September 2014

Subject: **The Better Care Fund**

Classification: Unrestricted

Summary: This paper presents the revised submission of the Kent Better Care Fund Plan and outlines the steps taken following the assurance process.

The Kent Health and Wellbeing Board is asked to:

(1) **Agree** the BCF plan and **endorse** submission to NHS England with a 3.5% target for emergency admissions across Kent.

(2) Consider the paper presented by the Area Team on risks and governance and **agree** the additional recommendation that the CFO Finance group work on behalf of the Kent HWB to monitor the ongoing finance and performance requirements of the Better Care Fund.

(3) Consider the underlying principles to support the pay for performance element of the fund.

(4) **Endorse** the clear commitment to closer integration across health and social care through the Kent Pioneer Programme and **agree** how they wish to be assured of progress and ongoing reporting on Pioneer.

For Decision

1. Introduction

1.1 The Better Care Fund was announced in June as part of the 2013 Spending Round. Its aim is to act as the enabler to take the integration agenda forward at scale and pace. The development of a Better Care Fund plan is also an integral part of developing the CCG 5-year strategic plans – although must be able to be seen as a stand-alone plan.

1.2 The draft submission was presented to the HWB on 26 March 2014 prior to first submission, it was noted that there were gaps within the Kent plans, particularly around finance and metrics and agreed that a revised version would be presented to the September HWB.

2. National Assurance and Revised Better Care Fund

2.1 The Better Care Fund plans were submitted on 1 April 2014. Following a review there has been a change to the policy framework underpinning BCF and a requirement to submit revised plans. In addition a BCF Programme Team has been established led by Andrew Ridley. Updated plans based on the revised guidance are to be submitted to NHS England on 19 September.

2.2 The BCF guidance states that “Ministers are clear that plans will need to be revisited to demonstrate clearly how they will reduce total emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people’s health and independence in the community.”

2.3 This shift in focus has led to the re-introduction of pay for performance. Pay for performance is only on £1bn portion of the £1.9bn additional NHS contribution and Health and Wellbeing Boards are asked to agree a target for reduction in total emergency admissions (this replaces previous avoidable emergency admissions target).

2.4 There are significant changes required to the templates, but in summary the plans must clearly set out:

- The case for change: a clear analytically driven and risk stratified understanding of where care can be improved by integration
- A plan of action: A coherent and credible evidence-based articulation of the delivery chain that underpins the shift of activity away from emergency admissions developed with all local stakeholders and aligned with other initiatives and wider planning
- Strong governance: clear local management and accountability arrangements, and a credible way of tracking the impact of interventions and taking remedial action as necessary, as well as robust contingency plans and risk sharing arrangements across providers and commissioners locally
- Protection of social care: How and to what level social care is being protected, including confirmation that the local share of the £135m of revenue funding resulting from new duties within the Care Act is protected, and the level of resource dedicated for carers is spelled out.
- Alignment with acute sector and wider planning: including NHS two-year operational plans, five-year strategic

2.5 Following submission to NHS England updated BCF plans will be considered by the national team and by the end of October will receive an approval based on three levels - ‘approved’, ‘approved with support’ or ‘approved with conditions’. They state “We would not expect that any plans would be ‘not approved’ unless they have decided not to submit, or have failed to comply with something fundamental.” There will be a programme of support and/or conditions after the initial BCF planning process, with different timetables depending on Kent’s status to ensure sites can implement their plans from 1 April 2015.

3. The Kent Plan

3.1 Kent has revised its Better Care Fund planning templates in line with the national guidance. This has not led to significant changes to the ambition and detail of the schemes agreed by the HWB in March. However in line with national expectation there has been a revision in the emergency admissions target to 3.5%. This is seen as a step change to reaching higher targets by 2018 as part of Kent’s Pioneer Programme.

3.2 CCGs have undertaken work to discuss plans with local providers. This has been supported across Kent by a series of workshops and summits to present local delivery plans and engage with the local health and social care economy on implementation. Further work has also taken place within CCG areas to engage the public on design and implementation of plans and is evidenced within local area plans.

3.3 Kent has been supported by the national BCF team to finalise the performance, analytics and finance elements of the Kent plan. The national expectation is for Kent's Better Care Fund plan to be monitored at a HWB level; therefore extensive work has taken place to aggregate the CCG area plans to a Kent picture.

4. Risks and Issues

4.1 The NHS England Area Team have been leading discussions regarding risk management and governance arrangements for the Better Care Fund. Agreement is required on who will oversee delivery, how this is reported back to partners and the relationship between local governance arrangements and the Kent Health and Wellbeing Board.

4.2 The Area Team has agreed to convene a group representing all CCG Chief Finance Officers and KCC Finance to establish the pooled fund and associated Section 75 agreements. It is recommended that this group works on behalf of the Kent HWB to monitor the ongoing finance and performance requirements of the Better Care Fund.

4.3 As part of establishing the pooled fund agreement on the pay for performance elements of the plan will be required, as this is implemented at a Kent level. It is recommended that the HWB consider some underlying principles to support this which may include that providers are not penalised for failure to deliver the BCF and partners will not cross-subsidise poor performance.

5. Kent's Pioneer Programme

5.1 It is recognised that the revisions to the BCF have made it less of a vehicle to support the ambition of health and social care integration as set out in Kent's Pioneer Programme. The vision within Kent's Pioneer Programme is to ensure:

- Better access – co-designed integrated teams working 24/7 around GP practices.
- Increased independence – supported by agencies working together.
- More control – empowerment for citizens to self-manage.
- Improved care at home – a reduction for acute admissions and long term care placements, rapid community response particularly for people with dementia.
- To live and die safely at home – supported by anticipatory care plans.
- No information about me without me – the citizen in control of electronic information sharing.

5.2 The Integration Pioneer Steering Group was established in November 2013 and is now made up of "Pioneer Organisations" representing all

stakeholders. They are working to deliver local objectives, with a view to ensuring lessons learned and best practice is shared across Kent. To help facilitate this members of the IPSG are now acting as SROs on key workstreams such as workforce, IT, personalisation, voluntary sector, contracting and commissioning.

5.3 The IPSG is also now being supported by the Leadership Centre to further consider how it can best ensure it functions to achieve the aims and objectives of Kent as a Pioneer and is used more effectively to spread lessons learned, best practice, and barrier bust in a way that is real and practical to local areas.

5.3 Significant progress is being made across Kent as has been demonstrated through CCG area summit meetings. However it is recognised there may be a gap in terms of assurance by the HWB that progress is being made in line with the identified building blocks for 2018 of CCG plans, social care plans, the HWB strategy and the Better Care Fund. It is recommended the HWB consider further how they wish to be assured of progress and ongoing reporting on Pioneer.

6. Recommendations

The Kent Health and Wellbeing Board is asked to:

(1) **Agree** the BCF plan and **endorse** submission to NHS England with a 3.5% target for emergency admissions across Kent.

(2) Consider the paper presented by the Area Team on risks and governance and **agree** the additional recommendation that the CFO Finance group work on behalf of the Kent HWB to monitor the ongoing finance and performance requirements of the Better Care Fund.

(3) Consider the underlying principles to support the pay for performance element of the fund.

(4) **Endorse** the clear commitment to closer integration across health and social care through the Kent Pioneer Programme and **agree** how they wish to be assured of progress and ongoing reporting on Pioneer.

6. Contact details

Report author:

Jo Frazer, Programme Manager Health and Social Care Integration, Social Care Health and Wellbeing, Kent County Council
Email: Jo.Frazer@kent.gov.uk
Tel: 0300 333 5490

By: Elliot Howard-Jones
Interim Area Director (Kent and Medway)
NHS England

To: Kent Health and Wellbeing Board
17th September 2014

Subject: Better Care Fund – Financial risk and governance

Classification: Unrestricted

Summary

The Better Care Fund requires sophisticated pooled budget financial arrangements to be put in place to enable the financial resources to be accessed by CCGs and KCC. In a complex area such as Kent the governance of the pooled funds requires detailed consideration. In addition there are various risks associated with these arrangements which need to be understood and addressed. This paper outlines the issues involved.

Recommendations

The Kent Health and Wellbeing Board is asked to agree that:

The Area Team will lead a group with CCG CFOs and senior leads for KCC identified by KCC Corporate Director of Finance and Procurement to discuss and agree pooled fund arrangements and provide a standard Section 75, with local CCG annexes. This group to be supported by relevant experts in Local Government and the National Support resources available. This group will produce a s75 pooled budget agreement to support and deliver the Kent BCF plan.

1. Process

Routed through NHS England, the better care fund will be created via the CCG and local authority allocations for 2015/16. Unlike the resources supporting integration in 2013/14 and 2014/15, these funds will be transferred to the pooled budget by the CCG and local authority and can then be held by either.

The Care Act 2013 will provide 'a mechanism that will allow the sharing of NHS funding with local authorities to be made mandatory'. A new duty will be introduced requiring NHS England to operate the fund in the joint interests of health and social care. It will also enable NHS England's mandate for 2015/16 to include requirements to allocate resources specifically for the fund, assure local plans for how the fund is to be spent and monitor the performance of CCGs in delivering what was planned. The objectives of the fund will be reflected in the mandate for 2015/16.

The fund will be the subject of a S75 agreement and this paper highlights a number of points for discussion and proposes that a group be formed to take account of both

the board's view and the detailed discussions which need to take place in order to arrive at an agreed and signed S75 document. The group will also need to take account of national guidance still emerging.

2. **S75 Agreement**

Issues to be decided include:

Does the Pooled Budget have to be signed sealed and delivered before the BCF plans can be legally implemented? What are the timetable issues this gives rise to?

The proposal would be that the group tasked with agreeing the S75 also agree a timetable by reference to the governance and sign off requirements of both CCGs and KCC as statutory bodies. It is clear that reaching agreement on the S75 will be complicated, and will require the input and commitment of all parties.

Given multiple CCGs is any configuration of pooled budgets permissible – e.g. a single budget across the County, three budgets based on Health economy geography or seven, for each CCG?

Current likelihood is single s75 to accompany single plan but with CCG specific annexes.

Who holds the pooled budget/is there an option for various 'budgets' within overarching S75/Is that desirable?

Emergency Admissions Target – single target for Kent but how does S75 reflect performance by CCG geography - if single target how will variances between different trusts within the area be dealt with? Only CCGs with a 'successful' Trust are likely to wish to pay performance monies into pool.

3. **Governance**

The fund will operate as a single budget to deliver specific outcomes at a local level. It is a formal arrangement, governed by legislation and, as such, is subject to formal agreement and processes. This influences the services supported, the way in which the fund is used, how use of the fund is reported and accounted for, and the arrangements that must be in place to ensure that taxpayers' money is used wisely and for its intended purpose.

4. **Governance and accountability arrangements**

A signed joint agreement for the fund must be in place by 1 April 2015. This forms the basis of the arrangement and should set out clearly and precisely what the overall aims are, who is responsible for what, and the associated accountability and reporting arrangements. The agreement should be reviewed regularly to ensure that the arrangement remains relevant to local circumstances and that all those involved are working towards the same goals.

5. **Issues to be decided include:**

Is there is a common understanding of the fund's aims?

Are statutory responsibilities understood and will they be met?

Is there is clarity over what is and is not covered by the arrangement?

Are decision-making responsibilities clear?

Do we need to establish a separate forum of the relevant governing bodies, with delegated powers to take decisions about the fund or agree that the governing bodies of each partnering organisation retain all decision rights? (It is important to bear in mind that each partner remains accountable for their share of the pooled funding.)

If we decide to use a forum, what is its membership?

Is it well balanced and sufficiently broadly based to cover all key interests with clear rules governing its operation – for example, to ensure objectivity in its proceedings and to record and manage any conflicts of interest?

Is there clarity around which organisation manages the budget(s) and who has the power to commit expenditure (including details of approval levels)?

How will we ensure accurate and timely reporting of financial and non-financial information?

How do we ensure we comply with still emerging guidance?

6. **Accounting for pooled budgets**

The accounting treatment will be determined by the substance of the arrangements in place. In order to establish the right treatment we need to agree:

Who is commissioning the service(s)?

Which organisations are providing resources?

Who is providing the services?

Who are parties to the contract?

7. **Over/Underspends**

Which organisations bear the risk of overspends and in what proportion?

Which organisations benefit from any cost savings and in what proportion?

8. Conclusions

These issues will need to be addressed between now and the submission of the final plan. It is therefore proposed that the Area Team leads a group with CCG CFOs and senior leads for KCC identified by KCC Corporate Director of Finance and Procurement to discuss and agree pooled fund arrangements and provide a standard Section 75, with local CCG annexes. This will require support from subject matter experts in Local Government and the National Support resources available. Outputs will be signed S75 to support and deliver BCF plan.

9. Recommendation(s)

The Kent Health and Wellbeing Board is asked to agree that:

The Area Team will lead a group with CCG CFOs and senior leads for KCC identified by KCC Corporate Director of Finance and Procurement to discuss and agree pooled fund arrangements and provide a standard Section 75, with local CCG annexes. This group to be supported by relevant experts in Local Government and the National Support resources available. This group will produce a S75 pooled budget agreement to support and deliver the Kent BCF plan.

9. Background Documents

None

10. Contact Details

Paul Hyde
Finance Director Kent and Medway
NHS England
Wharf House
Medway Wharf Road
Tonbridge
TN9 1RE
T: 0113 824 8544

By: Roger Gough, Cabinet Member for Education and Health Reform
Steve Inett, Chief Executive Healthwatch Kent

To: Health and Wellbeing Board, 17 September 2014

Subject: **Quality and the Health and Wellbeing Board**

Classification: Unrestricted

Summary:

Although quality has always been a major area of interest for the health and care system, the publication of the Francis report, the Berwick report into patient safety the Keogh mortality review and others have ensured that it has remained a high priority for health and care organisations.

The Health and Wellbeing Board has a responsibility to ensure that the commissioning plans of its constituent organisations reflect the needs of the population it serves. Service quality and patient/public experience should be part of this overview. This report is designed to provide an opportunity for the Board to discuss how it can best discharge this responsibility.

Recommendation(s):

The Board is asked to agree:

(a) That the Board request Healthwatch Kent (HWK) to coordinate a quality overview report at least twice a year to coincide with the annual commissioning cycle pulling together the key themes from its own work alongside that of the Quality Surveillance Group and other key sources; and

(b) That a small officers' group is formed to work with Healthwatch Kent to collectively bring together the information required to produce the above mentioned report to be co-ordinated by HWK.

(c) That once the first report has been produced and reported, the Board will discuss how the findings can be best used to inform commissioning decisions.

1. Introduction

(a) Quality of care is a major concern for patients and the public as well as for those responsible for the health and social care system. The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) was a salutary reminder that the quality is not always at the heart of the health and care system.

(b) As the forum where leaders and commissioners of that system come together, the Kent Health and Wellbeing Board has a major interest in the quality of the services offered to the people of Kent. This is especially true at a time of financial stringency that has a potential to impact negatively on issues that can directly affect the quality of care that patients receive.

(c) Subsequent to the publication of the Francis report, the Berwick report into patient safety and the Keogh mortality review along with other related reports, have explored different aspects of quality and together ensured that it has remained as a high priority for health and care organisations.

(d) Some of these reports have been detailed and lengthy, with the Francis report alone containing 290 recommendations. In one form or another, and to different extents, health and care organisations will have considered the implications of these reports for their own way of operating. It would be time consuming to review the responses of the different organisations to all the recommendations contained within all these reports and would not be a profitable enterprise to which to devote finite time and resources. The Health and Wellbeing Board is not a performance management forum and while it need not seek assurances that all individual relevant recommendations are being progressed, quality issues can and do have a direct impact on the broader strategic interests of the Board and its constituent membership.

(e) To this end, this report is intended to support a discussion at the Board as to how it can collectively remain best apprised of these strategic quality issues.

2. Sources of Quality Intelligence

(a) Each commissioning organisation represented on the HWB has access to its own sources of information on quality. While members of the Board are able to draw on these while participating in Board discussions, it may also be useful to be able to draw on 'third party' sources of information on quality in order to provide triangulation and to more fully perceive what common themes are emerging across a health economy or the whole Kent system.

(b) Some of the main sources which could be drawn on are as follows:

i. **Care Quality Commission (CQC)** – The CQC is the national regulator for health and adult social care. In April 2013, the CQC published their strategy for 2013-16, Raising Standards, Putting People First. The strategy proposed changes to the way the CQC regulates health and

social care services, and acted on the recommendations of the Francis report, including the establishment of a Chief Inspector of Hospitals post. Two further Chief Inspector posts, for Adult Social Care and for General Practice, have been introduced (Care Quality Commission 2014). The last year has seen inspection reports published on a number of Trusts and care providers across Kent and Medway.

A summary report of CQC findings on Trusts across Kent and Medway is included as an appendix to this report.

Information provided by other regulators such as Monitor and the Trust Development Authority would also be of value.

ii. **Health Overview and Scrutiny Committee (HOSC)** – The Kent HOSC has a wide remit to review and scrutinise matters relating to health and care across the County. A number of the items considered by the HOSC touch upon, or even concentrate solely upon, quality issues. For example, an item on the Agenda for 18 July 2014 was *CQC Inspection Report and Royal College of Surgeons Report: Maidstone Hospital.*

iii. **Quality Surveillance Group (QSG)** – QSGs came out of the work of the National Quality Board and were given a higher profile as a result of the Francis report and the Government's response to it:

"The Quality Surveillance Groups will focus on the following questions:

- What does the data and the soft intelligence tell us about where there might be concerns about the quality of care?
- Where are we most worried about the quality of services?
- Do we need to do more to address concerns or gather intelligence?
- Once concerns are identified, action can be taken swiftly by the relevant organisation."[1]

While there is an overlap between the membership of the Kent Health and Wellbeing Board and Kent and Medway QSG, there is a need to consider the formal relationship between the QSG and HWB. This was set out in guidance produced by the NQB in March 2014:

"Other than providing assurance on the quality of services, identifying risks and any action required to address these, QSGs also have a role in coordinating actions to drive improvement. Health and Wellbeing Boards – which provide a forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of Healthwatch to discuss how to work together to better the health and wellbeing outcomes of the people in their area -

[1] Department of Health, *Hard Truths. The Journey to Putting the Patient First*, 19 November 2013, Volume 1, p.67, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

are a key vehicle for driving health improvement in local areas and promoting integration and therefore need to be fully involved in discussions on quality of local health and care services. Moreover, the priorities in the joint health and wellbeing strategy will inform local commissioning plans for all health and care services, including concerns on quality."[2]

The guidance also discusses the relationship between the QSG and local Health Overview and Scrutiny Committee (HOSC). The Kent HOSC received a presentation on the QSG on 29 November 2013[3].

Earlier this year, the Chairman of the HWB met with the Chairman of HOSC and representatives of NHS England to discuss how the HWB and HOSC could link effectively with the QSG. With regards actions for the HWB, it was agreed that NHS England would build in, via the HWB, an explicit request to commissioners at the start of the planning process to ensure that issues raised via the QSG (or other quality feedback loops) are reflected in future commissioning plans.

The QSG can often give the commissioner information that can either complement or add to quality concerns. Moreover, it provides reassurance to others that commissioners are taking action as required.

The following are two examples of commissioning concerns which have been raised at the QSG:

- *Patient Transport Services*. Concerns were first raised to QSG in September of 2013 regarding Patient Transport provider NSL. The provider was experiencing problems in meeting Key Performance Indicators for the timeliness of their journeys. A very significant number of journeys were late, resulting in disruption to the operation of hospitals and other providers. West Kent CCG as the lead commissioner for this contract has consistently worked with NSL to improve performance. Quality risks and concerns were shared by members to support the commissioner's approach. In July 2014 CQC published a report following their inspection which outlined a number of concerns. Contractual performance is still under review for this provider, as are future commissioning options.
- *CAMHS*. The commissioning accountability for CAMHS service provision from Tier 1-4 is KCC, West Kent CCG and NHS England. There have been concerns raised within the QSG and wider about the quality of service provision. The commissioners are collaborating to develop a co-commissioning model between partners. This would be a good example of how quality risks raised at the QSG can help to inform commissioning decisions.

[2] http://www.england.nhs.uk/wp-content/uploads/2014/03/quality-surv-grp-effective.pdf
[3] https://democracy.kent.gov.uk/mgAi.aspx?ID=26456

iv. **Healthwatch Kent (HWK)** – Healthwatch Kent is an independent organisation set up to champion the views of patients and social care users across Kent as well as raising the public's voice to improve the quality of local health and social care services in Kent.

Healthwatch Kent is in a good position to bring together the different sources of information set out above along with the fruits of its own work and investigations. As well as being a member of the Board and the QSG, Healthwatch Kent has also been involved in the new style 'quality summits' which form part of the CQC inspection process. While not part of the membership of HOSC, representatives of Healthwatch Kent attend as guests and are able to suggest items for discussion and contribute to debate.

HWK also attends board meetings of a number of providers and CCGs, and contribute to quarterly Patient Experience Committees in all the acute and community trusts which evaluate feedback from comments, complaints and serious incidents.

In order to ensure this adds value to the work of the Board, it will also be necessary to consider how this would fit with the work around the assurance framework. Healthwatch Kent has a role in the assurance framework, contributing to themed areas.

3. The Assurance Framework

(a) The Kent Health and Wellbeing Board has already developed an Assurance Framework designed to demonstrate progress against the priorities in the Joint Health and Wellbeing Strategy. The intention is to give an indication of where unsustainable demand within the overall system is manifesting itself in order to alert the Board to the potential need for action to be taken to alleviate this pressure.

(b) Some of the indicators i.e. bed occupancy rates in acute hospitals, waiting times for services, delayed transfers of care, may also be useful indicators of how service equality is progressing but there may be others that the Health and Wellbeing Board could consider on a less frequent basis that would be useful. These may include:

1. Friends and Family Test
2. Staffing ratios
    a. Nurse : patient ratio
    b. Midwife : birth ratio
    c. Care staff : patient ratio
3. CQC findings & implementation of recommendations
4. Patient safety incidents (e.g. number of never events occurred)
5. Waiting times
6. Healthwatch feedback

7. Re-admission rates
8. Mortality indicators (SHMI)
9. Patient and public feedback (including complaints)

(c) The recent consultation on revision of the NHS Outcomes Framework has also invited proposals for how to assess patient experience, quality of care and patient safety.

4. Conclusion

(a) As the Nuffield Trust report "The Francis Report: one year on" concluded:

"Taking safe and high quality care for this group of vulnerable patients *(older people)* to its logical conclusion…..will require political bravery and strong leadership at the level of health economies. The new bodies set up to enable better planning and implementation of service change at the local level – CCGs and health and wellbeing boards, with the input of NHS England's local area teams – are still evolving, and it is too soon to assess whether they will be more effective than the strategic health authorities that came before them in bringing about these changes."

(b) It goes on to say:

"It is unclear how the requirements of the CQC, Monitor, NHS England, The TDA and clinical commissioners are interacting at a local level, and it is equally unclear how the functioning, culture and behaviour of these bodies will be measured."

(c) Bringing together information and analysis from different bodies such as the Quality Surveillance Group, Health Overview and Scrutiny Committee, Healthwatch, CQC, Monitor, TDA and others can allow the Health and Wellbeing Board to take a strategic overview of the quality of care offered to people in Kent. Issues that could impact negatively at a system level and common issues and themes that emerge across different parts of the system can be identified and addressed. Hopefully, this will go some way in Kent to address the challenges issued by the Nuffield Trust report.

(d) The health and social care economy in Kent is complex and complicated. As a pan county and public facing strategic body the Health and Wellbeing Board is uniquely positioned to be able to understand the experience of Kent residents, and its connections with Healthwatch give it a clear mandate to pursue this issue. A twice yearly report, in early autumn and late spring, would enable the Board to relate information concerning service quality to the commissioning plans it considers.

(e) Maintaining a focus on achieving and maintaining quality is something which health and care organisation will justly want to focus on, but it will also be important to be seen to be doing so. Gathering together quality information

would be an academic exercise were it not then used for some practical purpose. The Board may wish to discuss the form that this should take.

Recommendation(s)

The Board is asked to agree:

(a) That the Board request Healthwatch Kent (HWK) to coordinate a quality overview report at least twice a year to coincide with the annual commissioning cycle pulling together the key themes from its own work alongside that of the Quality Surveillance Group and other key sources;

(b) That a small officers' group is formed to work with Healthwatch Kent to collectively bring together the information required to produce the above mentioned report to be co-ordinated by HWK.

(c) That once the first report has been produced and reported, the Board will discuss how the findings can be best used to inform commissioning decision.

Background Documents

The Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, http://www.midstaffspublicinquiry.com/report
A Promise to Learn – A Commitment to Act. Improving the Safety of Patients in England, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
The Keogh Mortality Review, http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/Overview.aspx
The Francis Report: One Year On, Nuffield Trust, http://www.nuffieldtrust.org.uk/publications/francis-inquiry-one-year-on
Refreshing the NHS Outcomes Framework 2015-16 Stakeholder Engagement, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341391/14-07-30_NHS_Outcomes_Framework_Stakeholder_Engagement_Document.pdf

Contact Details

Jo Pannell
Temporary Project Officer Healthwatch Kent
Contact: 07959 091727 / 07702 911146
jo.pannell@kent.gov.uk

Deborah Benton
Staff Officer to the Cabinet Members for Health Reform and Corporate and Democratic Services
Contact: 01622 221902
deborah.benton@kent.gov.uk

Tristan Godfrey
Policy Manager
Contact: 01622 694270
tristan.godfrey@kent.gov.uk

Mark Lemon
Strategic Business Manager
Contact: 01622 696252
mark.lemon@kent.gov.uk

Appendix – Care Quality Commission: Local Findings

Medway NHS Foundation Trust

Inspection of Medway Maritime Hospital – rating inadequate (Trust remains in special measures)

Inspected 23 – 25 April and 1 May 2014 (report published 10 July 2014)

- Rated as good for being caring but improvement required in providing effective care and being well led.
- The safety of the hospital and being responsive to patients needs were rated inadequate
- Critical care and services for children and young people were deemed as good
- End of life care, out patients, medical and maternity services all required improvement
- Accident and Emergency and surgery were rated as inadequate overall

Summary

- A & E and Surgery – inadequate
- Medical Care, maternity and family planning, end of life and outpatients – requires improvement

Actions to be delivered by overarching improvement plan include:

- Action plans developed and being shared locally with divisions and directorates
- Five priorities – basic standards, flow, recruitment, control and leadership
- Revisiting Transforming Medway to simplify, streamline and focus
- Leadership team more settled
- Benefits of partnership working – not least around IT
- Recruitment underway for registered Doctors and nurses
- Emergency Village plans approved – first phase re-design and refurbish for Emergency department
- Build on strengths

Dartford and Gravesham NHS Trust

Inspection of Darent Valley Hospital – rating requires improvement

- Accident and Emergency – not managing beds / capacity and inappropriate attendance at A & E
- Being responsive to people's needs requires improvement
- Surgery – there are too few staff

- Patients dignity and privacy nota always maintained
- Maternity, outpatients, children's services and end of life care all deemed good

Summary

- A & E, Surgery and Acute services at the Trust – requires improvement

Actions
The Dartford, Gravesham and Swanley CCG published a Francis action plan in May 2014 – listing all points from the enquiry noting how they were performing against each action by way of a RAG system.

This system noted that as a CCG NHS organisation it had an overall of 27 targets of these 14 were outstanding (amber) and 13 completed (green).
For the CCG as commissioner of service there were 22 targets of these were 13 as outstanding (amber) and 9 completed (green)

East Kent Hospital University NHS Foundation Trust

Inspection of William Harvey Hospital, Ashford, Kent and Canterbury and Queen Elizabeth the Queen Mother Hospital, Margate – rating requires improvement (recommendation to be placed in special measures)

Intelligence Monitoring Report – 13 March 2014 – rating Elevated Risks

- Risks to patients were not always identified, and where they were, were not always acted on by the trust.
- A number of clinical services across the trust were poorly led
- Concerns about staffing levels in a number of areas, especially in A&E, in children's care, and at night.
- Poorly maintained buildings and equipment were identified in a number of areas.
- A worrying disconnect between those running the trust and frontline staff
- Long standing cultural issues, such as bullying and harassment
- Caring was rated as good

William Harvey Hospital, Ashford summary of findings

- Accident and Emergency, surgery and Childrens care –Inadequate
- Medical care, maternity and family planning, end of life care and outpatients – Requires Improvement
- Intensive and critical care – Good

Overall rating – Inadequate

QEQM, Margate summary of findings

- Accident and Emergency – Inadequate
- Medical Care, surgery, maternity and family planning, Childrens care, end of life and outpatients - Requires Improvement
- Critical care - Good

Overall rating – Requires Improvement

Kent and Canterbury summary of findings

- Surgery – Inadequate
- Emergency Care, medical care, Childrens care, end of life car and outpatients – Requires improvement

Overall rating - Inadequate

The Care Quality Commission has requested the following actions must be taken:

William Harvey Hospital, Ashford

- There is always enough suitably skilled staff on duty to meet people's care needs in a timely way, including appropriately trained paediatric staff in all areas of the hospital where children are treated.
- The patient environment is clean, well maintained and fit for purpose and equipment is well maintained and available when needed
- Staff are better informed of end of life care arrangements and provision of this area is reviewed.

Kent and Canterbury Hospital

- There is an identified lead at board level who takes responsibility for services for children and young people
- Adequate administrative support is made available in outpatient services, and the risks to patients using these services due to delays and cancellations is properly assessed
- Arrangements for end of life care are clarified to staff to ensure that the patient is protected against the risk of receiving inappropriate care.

QEQM, Margate

- Safety is made a priority in A&E
- Discharge planning and flow through the hospital is responsive to people's needs.
- Patients are not subject to unnecessary delays for outpatient appointments, either to get an appointment or when waiting in the department.

Actions

East Kent University Hospital Trust published its action plan in response to the Francis enquiry in February 2014.

Updated in June 2014 it noted under the specific headings:

- Business as usual – of the 48 actions – 5 were outstanding
- Francis specific – of the 70 actions – 8 were outstanding and
- We care and staff survey – of the 51 actions all had been completed.

South East Coast Ambulance Service NHS Foundation Trust

Inspected 2 – 8 December 2013 (report published 21 January 2014)

Summary

- Care & welfare of people who use the services – met the standard
- Cleanliness & infection control – met the standard good
- Management of medicines – met the standard good
- Supporting workers – met the standard
- Assessing and monitoring the quality of service provision – requires improvement
- Complaints - met the standard

Actions to be delivered include: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people receiving care.

The action plan should have been with the CQC by 13 February 2014. I have looked on both SECAMbs website and CQC and cannot find the action plan referred to

Kent and Medway NHS and Social Care Partnership Trust

There are no reports specifically about the Trust on the CQC website.

There are a number of the Trust's services that have been inspected and reports made, a sample is given below:

St Martins Hospital, Canterbury

Inspected 14 and 15 February 2014 (report published 26 June 2013)

Met all the following standards

- Treating people with respect and involving them in their care
- Providing care, treatment and support that meets peoples needs

- Caring for people safely and protecting them from harm
- Staffing and
- Quality and suitability of management

The following services provided by Kent and Medway NHS and Social Care Partnership Trust also met the standards above on inspection by the CQC

Littlebrook Hospital, Dartford

Inspected 9 October 2013 (published 16 November 2013)

Priority House, Maidstone

Inspected 16 October 2012 (published 27 November 2013)

Trust Headquarters, Maidstone

Inspected 2 November 2010 (published 8 March 2011)

The Red House, Maidstone

Inspected 12 June 2013 (published 10 July 2013)

Trevor Gibbens Unit, Maidstone

Inspected 30 August 2010

Littlestone Lodge, Dartford

Inspected 7 August 2013

Jasmine Unit, Dartford

Inspected 11 September 2013

Maidstone and Tunbridge Wells NHS Trust

The CQC carried out three inspections within the Trust in 2013/14: Maidstone Hospital in March 2013, Tunbridge Wells Hospital in November 2013 (as part of an 'out of hours' review) and Maidstone Hospital in February 2014.

Maidstone Hospital - inspected by the CQC on the 12 February 2014.

The following standards were inspected and rated:

- Consent to care and treatment – standard met
- Care and welfare of people who use services – standard not met. Action needed
- Staffing – standard not met. Action needed

- Assessing and monitoring the quality of service provision – standard not met. Action needed

Actions to be delivered:

The report for the February visit was as a result of the concerns relating to upper GI surgery following a review by the Royal College of Surgeons.

The findings from the CQC report relate to staffing, medical staff job planning and governance. An action plan to address these concerns has been developed and the CQC have reported that the key issues relating to job planning are already being addressed. Challenges to the frequency of meetings of the Quality and Safety Committee have also been addressed. The committee now meets monthly with a focused topic for 'deep dive' on alternate months. All actions are being monitored by the relevant governance committees.

The Tunbridge Wells Hospital at Pembury – inspected by CQC on 23 November 2013

The following standards were inspected and rated:

- Care of people who use the service – standard met
- Management of medicines – standard not met. Action required
- Staffing – standard not met. Action required
- Supporting workers – standard met
- Assessing and monitoring the quality of provision – standard met

Actions to be delivered:

- Paediatric staffing in A&E
- Safe storage of medicines

The CQC requested that the Trust produces a report by 13 February 2014, setting out the actions they will take to meet the required standards. The CQC has reported that a full action plan is now in place for the safe storage of medicines and the Trust is now compliant.

Paediatric staffing in A&E is subject to a wider review and this is detailed in the Trust's Quality Accounts for 2013/14.

Overall rating – low risk

The CQC developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals in 2013. These indicators relate to the five key questions asked of all services – are they safe, effective, caring, responsive and well led? Trusts are given a risk rating of between 1 and 6, with band 1 being the greatest risk and 6 the lowest. The rating is revised

every quarter and for the last two quarters the Trust has achieved and maintained a score of 5 (low risk).

Kent Community Health NHS Trust

The CQC has recently inspected the Trust and a Quality Summit took place on the 14 August 2014. The outcome of the report has yet to be published.

However, the following services have already been inspected and assessed against the following criteria:

- Treating people with respect and involving them in their care
- Providing care, treatment and support that meets people's needs
- Caring for people safely and protecting them from harm
- Staffing
- Quality and suitability of management

Dental Department HMP Swaleside. Inspected on 28 and 29 April. All standards met except for "People should get safe and appropriate care that meets their needs and supports their rights". This is being appropriately addressed.

Edenbridge and District War Memorial Hospital and Minor Injuries Unit. Inspected on 22 April 2013. All standards met

Hawkhurst Community Hospital. Inspected 7 June 2013. All standards were met.

Sevenoaks Hospital and Minor Injuries Unit. Inspected on 12 January 2012. All standards were met.

Whitstable and Tankerton Hospital. Inspected on 13 September 2012. All standards were met.

This page is intentionally left blank

From: Roger Gough Cabinet member for Education and Health Reform
Graham Gibbens Cabinet member for Adult Social Care and Public Health
Andrew Scott-Clark Interim Director of Public Health.

To: Kent Health and Wellbeing Board – 17 September 2014

Subject: Pharmaceutical Needs Assessment

Classification: Unrestricted

Summary

Health and Wellbeing Boards in England have a statutory responsibility to publish and keep up-to-date, a statement of the need for pharmaceutical services in its area, otherwise referred to as a Pharmaceutical Needs Assessment.

Each Health and Wellbeing Board is required to publish its own revised Pharmaceutical Needs Assessment for its area by 1st April 2015.

Last November the Kent Health and Wellbeing Board agreed for a joint Kent and Medway PNA Steering group to be set up to oversee development of the PNA. That group has met on a number of occasions and we are coming back to the Kent Health and Wellbeing Board to gain approval to begin the formal consultation phase of the PNA.

A draft form of the Kent Pharmaceutical Needs Assessment is now ready for consultation and can be found on the Kent and Medway Public Health Observatory website. http://www.kmpho.nhs.uk/reports-and-strategies/pharmaceutical-needs-assessments/

We have provided this Board an overview and background plus the key recommendations the steering group have agreed. The PNA is separated into the main document for Kent (attached) and an individual assessment for the seven localities matching the Clinical Commissioning Group areas. These documents, appendices, datasets and maps will be loaded on the Kent and Medway Public Health Observatory site for easy access.

These are working documents which will be continually reviewed particularly in the light of formal consultation and as circumstances change (for example where NHS England determines existing applications) and will remain as draft until final publication date at end of March 2015.

The consultation will be for a minimum of 60 days from the first date of publication and those being consulted will be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

We will be seeking formal approval for the PNA in the new year (2015) following consultation.

Recommendations

The Kent Health and Wellbeing Board are asked to:

1) Note the development of a draft Pharmaceutical Needs assessment.

2) Note the key findings and recommendations to be formally consulted on.

    a) Overall there is good pharmaceutical service provision in the majority of Kent.
    b) Where the area is rural, there are enough dispensing practices to provide basic pharmaceutical services to the rural population.
    c) There are proposed major housing developments across Kent, the main ones being Chilmington Green near Ashford and Ebbsfleet Garden City, which will mean that these areas will need to be reviewed on a regular basis to identify any increases in pharmaceutical need.
    d) The proposed Paramount leisure site plans in North Kent should be reviewed regularly to identify whether visitors and staff will have increased health needs including pharmaceutical.
    e) The current provision of “standard 40 hour” pharmacies should be maintained especially in rural villages and areas such as Romney Marsh.
    f) The current provision of “100 hour” pharmacies should be maintained

3) The Health and Wellbeing Board is therefore asked to endorse proceeding to statutory consultation on the Pharmaceutical Needs Assessment with the key stakeholders and any other identified interested parties as per regulation and according to KCC’s policy.

Pharmaceutical Needs Assessment

Kent County

Contents

Executive Summary

The Health and Social Care Act 2012 transferred responsibility for the Pharmaceutical Needs Assessment from the Primary Care Trusts to the Health and Wellbeing Boards on the 1st April 2013.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at:
http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/

Every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up-to-date, a statement of the need for pharmaceutical services in its area, otherwise referred to as a Pharmaceutical Needs Assessment (PNA).

Each HWB is required to publish its own revised PNA for its area by 1st April 2015.

The main aim of the Kent Pharmaceutical Needs Assessment is to describe the current pharmaceutical services in Kent, systematically identify any gaps/unmet needs and in consultation with stakeholders make recommendations on future development.

The Pharmaceutical Needs Assessment is a key document used by the local area Pharmaceutical Services Regulations Committee (PSRC) to make decisions on new applications for pharmacies and change of services or relocations by current pharmacies. It is also used by commissioners reviewing the health needs for services within their particular area, to identify if any of their services can be commissioned through pharmacies.

A draft form of the Kent Pharmaceutical Needs Assessment is now ready for consultation and can be found on the Kent and Medway Public Health Observatory website.
http://www.kmpho.nhs.uk/reports-and-strategies/pharmaceutical-needs-assessments/

The Kent Pharmaceutical Needs Assessment consists of an overarching document (attached) explaining the details about pharmaceutical services and how needs are assessed, accompanied by a separate document for each Clinical Commissioning Group area giving recommendations for that area.

In November 2013, a paper was taken to the Health and Wellbeing Board seeking agreement to set up a Steering Group to oversee the production, consultation and publication of the Pharmaceutical Needs Assessment. This was approved.

The steering group is made up representatives of key stakeholders as well as representatives of each of the Clinical Commissioning Groups.

Each stakeholder and each Clinical Commissioning Group has been consulted on the data available for their area as documented in the supplementary maps etc.

Recommendations for each individual area have been discussed in detail by the steering group and are documented in the CCG PNAs.

The key findings and recommendations of the PNA steering group are

1) **Overall there is good pharmaceutical service provision in the majority of Kent.**
2) **Where the area is rural, there are enough dispensing practices to provide basic pharmaceutical services to the rural population.**
3) **There are proposed major housing developments across Kent, the main ones being Chilmington Green near Ashford and Ebbsfleet Garden City, which will mean that these areas will need to be reviewed on a regular basis to identify any increases in pharmaceutical need.**
4) **The proposed Paramount leisure site plans in North Kent should be reviewed regularly to identify whether visitors and staff will have increased health needs including pharmaceutical.**
5) **The current provision of "standard 40 hour" pharmacies should be maintained especially in rural villages and areas such as Romney Marsh.**
6) **The current provision of "100 hour" pharmacies should be maintained and a "long opening" pharmacy service should be identified for the Isle of Sheppey.**

Introduction

In April 2013 responsibility for the Kent Pharmaceutical Needs Assessment (PNA) passed from the Kent Primary Care Trusts (PCTs) to the Kent Health and Wellbeing Board (HWB), a committee of Kent County Council (KCC). The PCTs had published their last PNAs in February 2011.

Pharmaceutical Needs Assessments are intended to be refreshed every three years or earlier if necessary and therefore were due to be reviewed by February 2014. However because of the complications around the transition of health services from PCTs to Clinical Commissioning Groups (CCGs), NHS England and local government in April 2013, the Department of Health (DH) decided to delay the necessary review of PNAs until 2014-15 with a publishing date of 31st March 2015 or before.

A paper was taken to the November 2013 meeting of the Kent HWB, identifying the need to publish a PNA by 31st March 2015. The Board agreed to the setting up of a PNA steering group in partnership with Medway Council chaired jointly by the Directors of Public Health for both councils.

The PNA is an information document used by the local area Pharmaceutical Services Regulations Committee (PSRC) to make decisions on new applications for pharmacies and change of services or relocations by current pharmacies. The PSRC is a committee of NHS England. It can also be used by commissioners reviewing the health needs for services within their particular area to identify if any of their services can be commissioned through pharmacies.

Background

If a person (a pharmacist, a dispenser of appliances, or in some circumstances and normally in rural areas, GPs) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by the NHS Commissioning Board, now known as NHS England. This is commonly known as the NHS “market entry” system. The regulations for “market entry” have changed since the publication of the previous Pharmaceutical Needs Assessments (PNA) and this has been reflected in the reviewing of current pharmaceutical services.

Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services Regulations[1] (“the 2013 Regulations”), a person who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a relevant list. An explanation of the application process is covered on page 17

[1] http://www.legislation.gov.uk/uksi/2013/349/contents/made

The original PNAs were published by NHS primary care trusts (PCTs) and every PCT was required to have published their PNA by February 2011. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013 and PNAs are key reference documents when reviewing the development and improvement of pharmaceutical services.

Health and Wellbeing Boards

The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWB) within the local authority.

The NHS Act (the "2006" Act), amended by the Health and Social Care Act 2012, sets out the requirements for HWBs to develop and update PNAs well as giving the Department of Health (DH) powers to make Regulations.

Every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up-to-date, a statement of the need for pharmaceutical services in its area, otherwise referred to as a Pharmaceutical Needs Assessment (PNA).

Each HWB is required to publish its own revised PNA for its area by 1st April 2015.

The Pharmaceutical Needs Assessment Steering Group

Meetings were held with NHS England area team in January 2014 to decide how the process of reviewing, preparing, developing and publishing the new PNA were to be carried out and the resources need to do this. The funding to cover project and admin support time has been met by Kent Public Health and Kent and Medway Public Health Observatory

The PNA steering group met for the first time in late January 2014 and has met roughly every 2 months since then. It comprises of representatives from Kent Public Health, KCC, Kent and Medway Public Health observatory (KMPHO), Local Pharmaceutical Committee (LPC) (representing community pharmacy), Local Medical Committee (LMC) (representing dispensing doctors), Healthwatch (representing the general public), Medway Public Health and Council, NHS England area team and representatives from the Clinical Commissioning Groups (CCGs). Terms of reference were agreed.

It was decided by the PNA steering Group that data should be presented at CCG level and then by specific localities within the CCGs.
A diagram of the CCGs and localities involved is in Appendix A

Information has been provided by NHS England, Kent Public Health and KMPHO.

KMPHO have collated this information and produced a supplementary data set per CCG which informs the development of the assessment. The dataset for Kent can be found in Appendix B of this document. Each CCG has a separate PNA which includes its own dataset.

All members of the steering group were shown the first and second draft of these datasets. Each CCG was consulted in June 2014, as to the correctness and appropriateness of their dataset and for any first comments that they may have to help develop the PNA.

Discussion was had as to what services should be included as part of the Pharmaceutical Needs Assessment. This varied from the representatives from NHS England only needing the national pharmaceutical services to be included, to the Local Pharmaceutical Committee requiring all services that pharmacies partake in to be looked at including non NHS ones. Guidance was sought from the DH and it was eventually agreed that all services commissioned by NHS England should be in the assessment and other NHS and Public Health services should be listed separately for completeness.
There was also discussions as to whether Healthy Living Pharmacies (see page 14) should be included and it was agreed that these would be identified in the datasets

Structure of the Pharmaceutical Needs Assessment

The document is structured into an analysis of pharmaceutical need based on Clinical Commissioning Group (CCG) boundaries and local health and wellbeing boards. Individual CCGs are divided into localities, which reflect district local authority boundaries
The CCGs are

NHS Ashford CCG
NHS Canterbury and Coastal CCG (C4G)
NHS South Kent Coast CCG
NHS Thanet CCG
NHS Swale CCG
NHS Dartford, Gravesham and Swanley (DGS) CCG
NHS West Kent CCG

The CCGs have been chosen as they are the level at which public health information is available and are currently used as the basis for determining health and social care need.
Please see diagram of CCGs and localities Appendix A

Information included in the Health and Social Care maps was reviewed to ascertain pharmaceutical need. Health and Social Care Maps give an overview of healthcare needs and service gaps for the locality, such as population mix, deprivation and health performance data.
They pull together information from a range of sources across both health and social care
Further information on Health and Social care maps can be found on the Kent and Medway Public Health Observatory website:
http://www.kmpho.nhs.uk/health-and-social-care-maps//

Information published in the Joint Strategic Needs Assessment (JSNA) and the CCG profiles within the JSNA, where available, were used to determine pharmaceutical need.

An overall assessment has been carried out for Kent and relevant data and maps have been produced to accompany this document. Each CCG has also been looked at individually and an individual assessment has been carried out for each CCG area which are also accompanied by the relevant data and maps for that CCG.

Pharmaceutical Need

Basic pharmaceutical need within the context of this document can be described as the requirement for the dispensing of medicines when the decision has been made by a clinician that the most appropriate treatment is indeed a drug or medicine or appliance. The clinicians that are able to prescribe include NHS general practitioners, NHS dentists, supplementary and independent prescribers (e.g. Nurses, pharmacists & other allied health professionals with prescribing qualifications) and hospital doctors.
Research has shown that in general, and during a lifetime, children and older people consume more medicines and that generally women, over their lifetime, consume more medicines than men. Therefore areas where there are a higher number than average of children 0-9 and elderly people over 65 living alone, especially female, will have need to access pharmaceutical services more often. However this need does not necessarily equate to needing more pharmacy premises as pharmacies are not restricted by list size and can readjust both staffing levels and premises size to manage the increased volume.

It is widely thought that people being cared for in care (residential or nursing) homes access NHS services more frequently but that is not always the case in the access of pharmaceutical services. The nature of the care given in care homes means that medicines are ordered and supplied by the care home and patients rarely need to access a pharmacy individually. Most care homes now have external contracts with

medicines suppliers which are not necessarily local and therefore there is no relationship in the amount of care homes and the need for local services.

Data shows out of a practice population of 1,523,370 that there are 180,064 children aged 0-9 living in Kent (11.8%), 293,148 people who are over 65 in Kent (19.2%), 30.2% of whom are living alone and 3.3% of whom are living in Care homes.

Access

The 2008 White Paper '*Pharmacy in England: Building on strengths –delivering the future*' [2] states that it is a strength of the current system that community pharmacies are easily accessible, and that 99% of the population –even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport. Moreover recent research carried out by Durham University (published in BMJ Open online on 12th August 2014 http://bmjopen.bmj.com/content/4/8/e005764.full) suggests that 99.8% of the people in deprived areas can walk to a pharmacy within 20 minutes (1 mile/1.6km).
A map showing the 1 mile (1.6km) radius around community pharmacies is available in the supplementary datasets

Number of service providers.

Ratio of number of service providers per 100,000 population (excluding appliance contractors)			
Locality	Number of service providers	Practice Population	Ratio/100,000 population
NHS Ashford CCG	26	126,697	21
NHS Canterbury and Coastal CCG	48	215,736	22
NHS Dartford, Gravesham and Swanley CCG	59	254,973	23
NHS South Kent Coast CCG	47	202,039	23
NHS Swale CCG	29	108,169	27
NHS Thanet CCG	32	142,987	22
NHS West Kent CCG	95	472,769	20
Kent	336	1.523,370	22
England	-	-	23

[2] Department of Health (2008). 'Pharmacy in England: Building on strengths – delivering the future.' Available at: http://www.official-documents.gov.uk/document/cm73/7341/7341.pdf

The England average is 23 and although this is not necessarily a good marker as it does not take the size of the pharmacy into account, most of our CCGs are near to the England average except NHS West Kent CCG which is predominantly rural and has the largest number of dispensing practices.

Pharmaceutical services

Pharmaceutical services in relation to PNAs include:

"essential services" which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service[1] –

*"**advanced services**"* - services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary –

"locally commissioned services" commissioned by **NHS England.**

Essential Services.
These are provided by all community pharmacies, appliance contractors and distance-selling pharmacies and include the following:
Dispensing of medicines
Repeat dispensing
Waste management
Public health
Signposting
Support for self-care
Clinical governance
Additional essential service requirements linked to the supply of appliances

Advanced Services
These can be provided by all contractors once accreditation requirements have been met. There are four Advanced Services within the NHS community pharmacy contract. Contractors can opt to provide any of these services as long as they meet the requirements set out in the Secretary of State Directions.

The four Advanced Services are:
For Community Pharmacies
Medicines Use Review (MUR) and Prescription Intervention Service
New Medicines Service (NMS)
For all contractors
Appliance Use Review (AUR) Service
Stoma Appliance Customisation (SAC) Service

Local services commissioned by NHS England
Various enhanced services which were commissioned by the original PCTs are currently being managed and reviewed by NHS England. These services include rota services and various bespoke services such as warfarin monitoring and access to palliative care drugs. These are not currently being assessed as part of the PNA until the review has been completed.

Public Health services provided through pharmacies.
Many community pharmacies are also commissioned by Public Health on a 'needs' basis to provide services, which are not necessarily classed as pharmaceutical services as they are provided by other healthcare providers as well.
Examples of these are smoking cessation, NHS Healthchecks and sexual health.
For completeness we have included maps showing where these services are available and published them alongside the PNA.

CCG services provided through community pharmacies.
These are also not necessarily pharmaceutical services and therefore not considered as part of the PNA. However for completeness we are including maps of such services where the information is available.

Non NHS and private services
The needs assessment is related to the provision of NHS pharmaceutical services. Pharmacies also provide many other services to the public which are not part of NHS pharmaceutical services and therefore not paid for from the NHS or Public Health budget. These can include delivery services, provision of medicines in multi-compartment aids, blood pressure checks and travel medicines. All of these services may attract an additional charge. Community Pharmacy also provides over the counter medicines including those on the 'general sales list' and 'pharmacy only medicines'. The provision of retail sales in community pharmacy is not part of this needs assessment since it is not contracted for by the NHS.
These services will not be included as part of the PNA.

Providers of Pharmaceutical services

The current providers of pharmaceutical services are community pharmacy, dispensing practices and appliance contractors.

Community Pharmacy
There are 276 pharmacy contractors who are registered on the Kent NHS pharmaceutical list as providing the full range of NHS pharmaceutical services across the Kent area.

Kent - Community Pharmacies	
Total number of Pharmacy contractors providing NHS pharmaceutical services	276
Number of standard 40 hour pharmacies	239
Number of 100 hour pharmacies	33
Number of mail order/internet pharmacies	4
Number of pharmacies offering electronic prescription service (EPS)	270

A list of the relevant pharmacies along with those that provide MURs and NMS can be found in the CCG PNAs.

Standard 40 hour community pharmacies.
These are pharmacies which are registered as providing at least 40 'core' pharmacy hours per week. These hours are usually 8 hours daily, Mon – Fri but are agreed at the time of application to join the register.
Pharmacies cannot change their 'core' hours without prior agreement with NHS England.
Many of these pharmacies also provide supplementary opening hours, often opening slightly later in the evening and on Saturdays.
Pharmacies can change their supplementary hours if they so desire, as long as NHS England receives the statutory 3 months' notice.

100 hour pharmacies
These are pharmacies which opened using the "Control of Entry" exemption clause in the original regulations. They did not have to prove that their service was "needed" according to the PNA. This exemption was removed in the 2013 regulations and there have not been any applications for 100 hour pharmacies since. However those granted before 2013 still have to be open for a minimum of 100 hours per week with the hours being agreed with NHS England. Many subsequent healthcare services have been commissioned on the assumption that these pharmacies will be available for 100 hours a week and it was the recommendation of the previous PNAs that they would not be allowed to reduce their hours to the standard 40 hours.

Mail order/internet pharmacies
These are pharmacies which provide pharmaceutical services via mail order or the internet. They are not accessible to the general public.

Opening times of all pharmacies along with the additional services that they offer can be found on NHS Choices
http://www.nhs.uk/Service-Search/Pharmacy/LocationSearch/10

Dispensing practices.

A lot of Kent is still considered to be “rural” and therefore there are a considerable number of dispensing practices

Kent – Dispensing practices	
Total number of GP surgeries providing pharmaceutical services to their patients	54
Total number of sites providing pharmaceutical services to their patients	60
Total no of population registered as a dispensing patients	136,160

A list of dispensing practices can be found in the relevant CCG PNAs

Dispensing doctors are only able to provide pharmaceutical services where registered patients reside in a controlled locality, live more than 1.6 km from a community pharmacy and a pharmaceutical services contract has been awarded. The norm in England is for the separation of prescribing and dispensing functions except for rural populations, when community pharmacies are not viable. These patients can access dispensing services through authorised GP practices. Dispensing practices do not have to provide all the ‘essential’ services. They mainly provide dispensing services and Dispensing review of the Use of Medicines (Drums).

Appliance Contractors

Appliance contractors provide appliances only, which are defined in Part IX of the Drug Tariff (e.g. ostomy, colostomy appliances) and these often require tailoring to meet the need of individual patients. There are 2 appliance contractors in Kent.

Essential Small Pharmacy Local Pharmaceutical Services (ESP LPS) scheme.

The ESP LPS scheme provided financial assistance to pharmacies which are deemed to be essential for the provision of pharmaceutical services to a local population, but would otherwise be unviable.

This scheme finished in 2011 but has been extended by the Department of Health for current ESPLPS contracts although our understanding is that it is due to finish completely on 31st March 2014. There are 3 ESPLPS pharmacies in Kent. NHS England will be reviewing the need for these ‘essential small pharmacies’ within the next few months.

Pharmaceutical services out of hours

There are 33 '100' hour pharmacies across Kent. These provide access to pharmacy services from early in the morning until late at night Monday to Saturday and for 6 hours on Sunday

Access to medicines via 100 hour pharmacies is considered to be especially important in areas which are deprived, especially if there is a high number of children aged 0-9 and/or elderly people over 65 who are living alone with no family/carer support.

Our expectation is that those pharmacies granted 100 hour contracts will continue to provide the 100 hour provision in the future thus securing access to pharmaceutical services for longer periods than the 40 hour normal requirement.

Access to medicines outside these times, is commissioned from the local out-of-hours medical services provider, who has available essential and urgently needed medicines, as agreed in the *National Out of Hours Formulary* and are supplied where the need for them cannot wait until the 100 hour pharmacy opens.

Other providers of pharmaceutical services

Acute trusts (hospitals), community health trusts (community hospitals and district nursing), hospices, private hospitals, mental health trusts and prison services are all providers of pharmaceutical services to specific patients. Most of these organisations either have their own pharmacy team which provide support and supply or they contract from an external provider for the whole service. These services are not available to the general public outside of the service so have not been included in list of providers for the purposes of the PNA.

The monitoring of providers of pharmaceutical services

Currently all providers of pharmaceutical services are monitored by NHS England with the local area team, based at Tonbridge, managing Kent and Medway. Community Pharmacies have to provide services according to the Community Pharmacy Contractual Framework (CPCF). The essential services are mandatory with the advanced services being voluntary. Pharmacies are monitored on a yearly basis and those that cannot meet their essential services are not expected to be allowed to go on to provide advanced and locally commissioned services. Pharmacy premises are now inspected by the General Pharmaceutical Council (GPhC) and all pharmacists and pharmacies have to be registered with the GPhC. This is an equivalent to a CQC inspection.

Dispensing practices are invited to take part in the Dispensing Services Quality Scheme (DSQS) which is part of the GMS contract and equivalent to the monitoring under the CPCF. This is however voluntary and not all practices take part. GP dispensary premises are inspected as part of the CQC inspection of practices.

Kent Healthy Living Pharmacy Scheme

The Healthy Living Pharmacy is a voluntary national programme aimed at improving the quality of commissioned pharmacy services. The concept derived from the 2008 White Paper, Pharmacy in England**:** *Building on strengths – delivering the future,* setting the scene for pharmacies to become health promoting centres "promoting health literacy and NHS LifeCheck services, offering opportunistic and prescription-linked healthy lifestyle approach".[2] The first Healthy Living Pharmacy programme was piloted in Portsmouth in 2009 and its success launched the national pathfinder programme in 2011.

The Healthy Living Pharmacy service model aims are:

- To recognise the significant role pharmacies have in the community and encourage proactive pharmacy leadership and multi-disciplinary working
- To deliver consistent and high quality health and wellbeing services linked to outcomes
- To reduce health inequalities
- To provide proactive health advice and interventions – 'make every contact count'
- To create healthy living 'hubs' and engage with the local community
- To meet commissioners' needs

Kent participated in the national pathfinder work and saw 46 pharmacies accredited. Evaluation has shown the results are cost-effective and have high levels of public approval. The Kent programme was revised in early 2014 with new conditions and support measures to help pharmacies develop sustainable business models and has been adapted for pharmacies to gain a Kent bespoke 'quality kitemark'. Of the 276 pharmacies in Kent, 146 are now participating in the HLP programme. Funding has been secured to train two 'champions' per pharmacy on the RSPH Level 2 Understanding Health Improvement programme which will commence in Autumn 2014. A HLP e-learning programme is also being offered for a limited period for Pharmacists, Pharmacy Managers and Pharmacy Technicians to support leadership skills. These training programmes form part of the HLP accreditation.

The HLP programme will ensure a consistent 'quality platform' across pharmacies and will form the basis to expand the types of services which may be commissioned in the future. It will also increase and improve the access of the public to Health and Wellbeing services across Kent.

Requirements for accreditation include the following:

1. Agree to meet eligibility criteria
2. Satisfactory pharmacy site assessment visit
3. Successfully complete training:
   i) The Kent Healthy Living Pharmacy e-learning course / leadership:
   ii) Evidence prior learning of leadership and / or undertake the e-learning programme. Should be a pharmacist or manager;
   iii) Champion training (x2) per pharmacy. Presently, two champion places are being funded per pharmacy.

HLP is a well-recognised, successful national programme which continues to evolve. The work being done in Kent has a high profile and is being integrated into existing and proposed commissioned services. It has the potential to substantially increase the capacity and access to Health and Wellbeing services, not only in pharmacies but has the potential to include dentistry and optical outlets also.

Current Principles of Pharmaceutical Contract applications – 'Market Entry'

The opening of new community pharmacies is currently controlled by legislation and regulations. These can be found at
http://www.legislation.gov.uk/uksi/2013/349/contents/made
The most recent Department of Health guidance can be found at
https://www.gov.uk/government/publications/nhs-pharmaceutical-services-assessing-applications
The NHS England Kent and Medway Area Team Pharmaceutical Services Regulation Committee (PSRC), supported by the Kent Primary Care Agency, currently assesses all applications for new pharmacies and any changes to the current provision.

Applications mainly now have to be submitted on the basis of

1) meeting a "current or future need" identified in the PNA or
2) offering "current or future improvements or better access" as identified in the PNA or
3) providing unforeseen benefits which has not been identified in the PNA.
4) Providing a distance selling (mail order or internet) pharmacy

Guidance for applications for providers of pharmaceutical services can be read in full at http://www.england.nhs.uk/wp-content/uploads/2013/07/pol-1.pdf

Controlled and Non-Controlled Localities ("Rural" & "Urban")

The area that NHS England is responsible for is designated for the purposes of the NHS (Pharmaceutical Services) Regulations 2013 as being either Controlled or Non-Controlled Localities. In Controlled Localities, as an exception to the general rule, it is possible for NHS patients to have their medicines both prescribed and dispensed by their GP practice. In Non-Controlled Localities all NHS GP prescribing, with a few limited exceptions such as "Serious Difficulty" cases, has to be dispensed by Community Pharmacies.
GP practices serving patients resident in a Controlled Locality are required to either have been dispensing to their patients prior to 1982 ("Historic Rights") or to have obtained the consent of NHS England to dispense to their patients ("Outline Consent").
Pharmacies that wish to open and obtain a NHS contract to dispense prescribed medicines have to satisfy the "Market Entry" rules within these Regulations and these rules differ between Controlled and Non-Controlled Localities.

Definition of a Controlled Locality
The Regulations define a Controlled Locality as an area, or part of an area, which is "rural in character" The local area team of NHS England is required to determine, within the area it is responsible for, which parts are "rural in character", delineate precisely the boundaries of such areas and publish a map of such areas. They are also required to determine or re-determine any area for which they are responsible if requested to do so by either the Local Medical Committee (LMC), or the Local Pharmaceutical Committee (LPC), the local representative bodies of their respective professions. Such determination processes are often referred to as Rurality Reviews.
These Regulations first came into force in April 1983 and wherever an existing medical practice already dispensed to its patients within the area served by the practice (i.e. its Practice Area) then that practice area was deemed to be a Controlled Locality and the practice continued (unless and until the area was re determined as a Non-Controlled Locality) to be able to dispense to those of its patients who resided within the practice area more than one mile (now 1.6 km) from a pharmacy. Such Dispensing Medical practices are referred to as having "Historic Rights" to dispense.
Medical practices that wished to commence dispensing to their patients after the 1st April 1983, or existing "Historic Rights" practices who added additional areas to their Practice Areas after 1st April 1983, have had to obtain permission to dispense to their patients (i.e. Obtain "Outline Consent" for the areas they wished to provide dispensing services to). Where necessary an application for "Outline Consent" will have been, and will often continue to be, preceded by a "Rurality Review"
However once an area has been determined by a Rurality Review no part of this area can be the subject of a further Rurality Review for 5 years unless NHS England is satisfied that there has been a substantial change in the circumstances of the area since the previous Rurality Review was determined.

The definition “rural in character” is augmented in the Guidance issued by the Department of Health. The relevant sections of this guidance read as follows:-

What makes an area rural?

The factors that might be considered include, for example:

• environmental – the balance between different types of land use;

• employment patterns (bearing in mind that those who live in rural areas may not work there);

• the size of the community and distance between settlements;

• the overall population density;

• transportation – the availability or otherwise of public transport and the frequency of such provision including access to services such as shopping facilities;

• the provision of other facilities, such as recreational and entertainment facilities. A rural area is normally characterised by a limited range of local services.

None of the above will automatically determine the matter. For example, the expansion of housing provision may also be an indication that the status of the area should be reconsidered, but of itself will not necessarily change that status. That will remain a question of judgement.

Therefore, rurality is not something which can be subject to rules such as density or distribution of population or the number of trees – it is essentially a matter of common sense. However, experience has shown that photographs and documents are an unreliable basis for determining rural questions. Judgement will need to depend on local knowledge of the area. A rural area need not have a high level of agricultural employment; many residents may commute to jobs in local towns.

Implications of a Determination of Rurality

A. *An area is determined to be insufficiently “rural” in character and therefore a Non-Controlled Locality*

No NHS patients’ resident within this area may be dispensed for by their GP unless the patient has applied for and satisfied NHS England that they “would have serious difficulty in obtaining any necessary drugs or appliances from a pharmacy by reason of distance or inadequacy of communication”.

Where an area had previously been designated as a Controlled Locality but has now been re-determined following a Rurality Review as Non-Controlled any existing patients being dispensed for by their GP will have (other than those with approved serious difficulty status) to be transferred to their GP’s “prescribing list”. They will then be issued with FP 10 prescription forms in future by their GP, and they will need to present these prescriptions for dispensing to a pharmacy of their choice. This change will normally be phased in over a number of months (occasionally years), a practice known as “Gradualisation”. This gradualisation period is determined by NHS England.

B. *An area is determined to be sufficiently "rural" in character and therefore a Controlled Locality*

NHS patients resident within this area and registered with a GP Practice that has the necessary approvals (i.e. Outline Consent or Historic Rights) to dispense to its patients will have the choice of being dispensed for by their GP or requesting and obtaining FP 10 prescription forms from their GP for presentation to a pharmacy of their choice.

The major exception to this is that no patient resident within 1.6 kilometres (as the "crow flies") of a pharmacy may be dispensed for by their GP, unless the patient has obtained serious difficulty status or the Pharmacy is located in a "Reserved Location".

In areas within a Controlled Locality determined by NHS England as being Reserved Locations there can be both a dispensing Medical practice and a pharmacy serving patients within this location. In such cases each patient can choose each time they are prescribed medication by their dispensing doctor, whether to have the prescription dispensed by the doctor's dispensing service or by the pharmacy, even if the patient resides within the 1.6 km of the pharmacy. Reserved Locations can only exist within Controlled Localities and are defined by the Regulations as locations where there are fewer than 2750 registered NHS patients residing within 1.6 km of the pharmacy's site.

This document does not purport to give a full and authoritative account of the Regulations and of all their possible implications and effects.

It is intended solely as a summary document to assist those interested parties (such as Parish Councils) who are requested by NHS England to make representations on applications and rurality issues under the consultation procedures laid down in these Regulations.

Maps showing the controlled areas and the 1.6km boundaries around pharmacies in the relevant CCG area are included in the CCG. There is also some areas which have not yet been determined. Part of the recommendations from the previous PNAs were to ensure the rurality reviews were carried out on these areas as soon as possible and this is ongoing.

The impact of new housing and the construction of retail and industrial sites on pharmaceutical needs

Housing

Kent is recognised as an area of where the housing stock is likely to increase considerably in the next 20 years. Consultation with Kent County Council planners and the local district planning offices have highlighted some areas where large increases in both new housing and leisure facilities will affect the pharmaceutical needs of the population. Planned large housing developments in areas such as Chilmington Green, near Ashford and Ebbsfleet Garden City may result in the PNA for those areas needing to be reassessed. Areas where we know that there is a large proposed development have been marked on the accompanying maps. Currently they are not expected to be in place in the next 3 years (the life of this PNA) but these areas will be reviewed regularly. Most of the district areas have produced their long term plans and planners will inform the HWB of any long term projects which could have an effect on the health needs of a district. The district maps also show many areas where infilling is proposed which could affect the health needs of an area. These will be reviewed regularly.

Retail, leisure and industrial

Although increases in housing are markers to increased health needs, the development of large retail parks such as Westwood Cross and Bluewater are also markers for increased health needs, both from staff and visitors.

Specifically the proposal to build a large leisure complex on the North Kent coast near Swanscombe, will result in increased need for health provision for the many tourists expected to visit such a complex. These proposals will be reviewed regularly and the PNA in that area reassessed if necessary.

The closure of such major industrial sites such as Pfizer and Sheerness Steel can often mean a transfer of the population away from that area, resulting in a decreased health need. Although currently NHS England cannot close pharmacies (unless they do not meet certain standards) reduction in pharmaceutical need will be taken into account when pharmacies wish to relocate or change services.

Consultation

Each Health and Wellbeing Board has a duty to consult with key stakeholders as defined in Regulation 8 of the above regulations. These include

(a) any Local Pharmaceutical Committee for its area (including any Local Pharmaceutical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(b) any Local Medical Committee for its area (including any Local Medical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);

(c) any persons on the pharmaceutical lists and any dispensing doctors list for its area;

(d) any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services;

(e) any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB1 has an interest in the provision of pharmaceutical services in its area; and

(f) any NHS trust or NHS foundation trust in its area;

(g) the NHSCB; and

(h) any neighbouring HWB.

The Health and Wellbeing Board is therefore asked to endorse proceeding onto statutory consultation on the Pharmaceutical Needs Assessment with the key stakeholders and any other identified interested parties.

The consultation will be for a minimum of 60 days from the first date of publication.

Those being consulted will be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

Key Findings and Recommendations

The key findings and recommendations of the PNA steering group are

1) **Overall there is good pharmaceutical service provision in the majority of Kent.**
2) **Where the area is rural, there are enough dispensing practices to provide basic pharmaceutical services to the rural population.**
3) **There are proposed major housing developments across Kent, the main ones being Chilmington Green near Ashford and Ebbsfleet Garden City, which will mean that these areas will need to be reviewed on a regular basis to identify any increases in pharmaceutical need.**
4) **The proposed Paramount leisure site plans in North Kent should be reviewed regularly to identify whether visitors and staff will have increased health needs including pharmaceutical.**
5) **The current provision of "standard 40 hour" pharmacies should be maintained especially in rural villages and areas such as Romney Marsh.**
6) **The current provision of "100 hour" pharmacies should be maintained**

These are subject to consultation and any resultant changes to the Pharmaceutical Needs assessment

List of Abbreviations and Acronyms

AUR	Appliance Use Review
C4G	Canterbury and Coastal CCG
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DH	Department of Health
DRUM	Dispensing review of the Use of Medicines
DSQS	Dispensary services Quality Scheme
EPS	Electronic Prescription Service
GP	General Practitioner
GPhC	General Pharmaceutical Council
HLP	Healthy Living Pharmacy
HWB	Health and Wellbeing Board
JSNA	Joint Strategic Needs Assessment
KCC	Kent County Council
KMPHO	Kent and Medway Public Health Observatory
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
MUR	Medicines Use Review
NHS	National Health Service
NMS	New Medicines Service
PCT	Primary Care Trust
PNA	Pharmaceutical Needs Assessment
PSRC	Pharmaceutical Services Regulation Committee
RSPH	Royal Society for Public Health
SAC	Stoma Appliance Customisation

This page is intentionally left blank

From: **Steve Inett, Chief Executive Healthwatch**

To: **Health and Wellbeing Board – 17 September 2014**

Subject: **Healthwatch Kent – Annual Report 2014**

Classification: **Unrestricted**

Summary
This report contains the Healthwatch Annual Report for 2014. It outlines Healthwatch's vision, mission and values, its activities over the last year and its plans and projects for the future.

Recommendation
The Health and Wellbeing Board is asked to note the report.

1. Introduction

1.1 Healthwatch Kent was established as a community interest company to fulfil the role of consumer champion for health and social care. Over the last year, Healthwatch Kent has established its infrastructure to fulfil its role and deliver its statutory functions which are set out in the Health and Social Care Act 2012.

1.2 The legal requirement to publish an annual report provides an opportunity to demonstrate to local people, stakeholders and the Kent Health and Wellbeing Board the progress that has been made in 2014 and to look forward to the coming year.

2. Recommendations

The Health and Wellbeing Board is asked to note the annual report which is at Appendix 1.

3. Background Documents

3.1 There are no background documents.

3.2 The annual report is at Appendix 1

4. Contact details

Steve Inett
Chief Executive Officer, Healthwatch
Tel: 07702911143
Email: steve@healthwatchkent.co.uk

This page is intentionally left blank

healthwatch
Kent

Healthwatch Kent
Annual Report 2014

What is healthwatch? Kent

Welcome

We are the **CONSUMER CHAMPION** for **HEALTH & SOCIAL CARE**

our **STATUTORY POWERS**

Our aim to **IMPROVE SERVICES** by ensuring **LOCAL PEOPLE'S VIEWS** are **HEARD**

PLANNING AND REVIEWING OF SERVICES

"We provide signposting information"

ENTER & VIEW VISITS

HEALTH & WELLBEING BOARDS

AS AN ORGANIZATION WE WANT TO BE...

- Transparent
- Open to feedback
- In partnership
- Volunteer-Led
- Objective & balanced

our **VOLUNTEERS** are **CHAMPIONS**

we are volunteer-led & we're RECRUITING

We **REPRESENT RESIDENTS OF KENT**

PUBLIC ENGAGEMENT

LISTENING

CONSULTATIONS
Targeted surveys, listen event.

INTERVIEWS

INFORMATION — SIGNPOSTING

Support this way

Freephone number

Health or socialcare

Complaints

ADDRESS PRIORITY ISSUES

PROJECTS

Funds available → Grants

GP HUB

The **FUTURE**

- Dementia services
- Children or adolescent mental health services
- Kent-wide public services

Health & Social Services **INTEGRATION** = **LOTS OF CHANGE HAPPENING**

A good time for us to be **INVOLVED**

A move to community services

Our vision, mission and values

Our vision

You, the public, are listened to, and involved in, improving our health and social care services in Kent.

Our mission

To raise the public's voice to improve the quality of local health and social care services in Kent.

We achieve this by

Listening to you about your experiences of health and social care services and taking those experiences to the people who commission health and social care services in Kent.

Our values

- **Open and transparent**
- **Volunteer led**
- **Objective and balanced**
- **Working in partnership with organisations – no surprises**
- **Critical friend**
- **Balancing positive and negative, loud and quiet, many and few, critical and accumulative**
- **Truly represent residents of Kent**

Kent in focus

Health and social care is changing for everyone. In Kent that means 1.5 million people will be affected in the coming years. As the independent consumer champion, Healthwatch Kent's Chief Exec, Steve Inett, has the task of representing us all.

If we want our health and social care services to improve, then we need to shout about our experiences, good and bad. How else will those that deliver, and ultimately pay for, the health and social care services in Kent know what needs to be kept and what needs to changed?

During our first year, Healthwatch Kent has been helping people to do just that. You've told us about your experiences and we've taken that information directly to the people who commission our health and social care services in Kent. Together we are already making a difference.

As a new organisation we've also focused our efforts this year on building relationships with the organisations that deliver and commission our services. We believe that we can bring about more change in partnership with others than we could on our own. We've signed seven partnership agreements so far and have more in the pipeline.

We've also spent a lot of energy recruiting and training our volunteers. Volunteers are vital to everything we do at Healthwatch and without them we wouldn't achieve our mission so it's important that we have the right people on board who share our passion for improving services across Kent. I am delighted to say that we have a truly excellent group of volunteers from members of our Deliberations & Directions Group who help us to determine our priorities and projects through to our trained Enter & View visitors who conduct visit health and social care services on our behalf.

Now that our volunteers and partnerships are in place we are all set for a busy and exciting year ahead. We've got a number of projects underway and more in development. We are also looking forward to getting the Healthwatch Kent name out and about. We've got an action packed agenda to meet more members of the public and hearing about their views and experiences. We're also organising a series of events to explain to GPs and Patient Participation Groups about how we can work together. We've got plans to work closer with the voluntary sector too. For example, we're commissioning a group to help us with a project around Eastern European Communities. Not stopping there, we're organising an event to help organisations deliver better public consultations. Our aim is to ensure the public are truly listened to and understood when changes to services are made.

So watch this space and do get in touch with us if you want to know more.

The Team

The Healthwatch Kent team, which includes all our staff and volunteers, is important to us.

We currently have nearly 50 volunteers working on a range of different roles and activities. Volunteers are involved in every aspect of our work from agreeing our priorities, representing us at meetings, analysing information and visiting health and social care services. We are always looking for more volunteers to join us. If you are interested in more information visit our website.

All our volunteers receive a detailed induction programme and ongoing training relevant to their role. We also organise a Monthly Learning Programme to keep informed and up-to-date about topical issues. For example, last month we had a session on the Kent Health & Well Being Strategy and this month we are welcoming a speaker to talk about Integration of health & social care services in Kent.

Public Voice

Talking and listening to you, the public, is extremely important to us. We want to know what you value about the services you receive and what you feel needs to be improved. We will collate all the information you provide and present our evidence to the people who commission and develop our health and social care services. We can ensure that they take account of, and listen to, public opinion. BUT that's only going to work if you talk to us and tell us what you think.

For example, many of you told us about issues you had experienced with mental health services. We've listened to you and we're actively working on several projects around mental health.

We've been out and about this year talking to people at Gateways, Forums and Voluntary groups. We've also been talking to people via our free Information & Signposting telephone service and information email service as well as capturing feedback through our Speak Out forms which allows people to share their experience in writing from home or via our website. A Speak Out form has been included in every copy of the annual report but if yours is missing, let us know and we can send you one. Email us at info@healthwatchkent.co.uk

This year will see Healthwatch Kent out and about much more. Each month, we will focus on a different area and visit as many places and people as possible. For example, July will see Swanley awash with Healthwatch activity. We will be visiting the library, hospital and voluntary groups as well as handing leaflets out on the streets. August will see us doing the same in Thanet. If you are a member of an organisation, voluntary group or forum and you would like us to visit you, then do please get in touch at info@heathwatchkent.co.uk

Of course, you don't need to wait until we're in your area. You can contact us anytime on 0808 801 0102, email info@healthwatchkent.co.uk. We also have a partnership with the Citizens Advice Bureau across Kent. You can pop into any CAB office and talk to someone face to face.

An important way for people to hear about us is through their local GPs and we will be mailing copies of our annual report and our leaflets to every GP, Dentist, Optician and Pharmacy in Kent and encourage them to tell you, the patient, about Healthwatch and how we can support you. You can help by asking your GP to display our posters in their waiting rooms.

Information & signposting service

With all the changes to health and care services it's not always clear where you should go to report an urgent issue, to make a complaint, or for further information.

Healthwatch Kent can help you find the right services to suit your needs through our FREE Information & Signposting Service.

Although we can't give you advice or make specific recommendations, we can help you make an informed decision in finding the right health and social care service whether it is provided by the NHS, the Council, a voluntary or community organisation.

We've been helping hundreds of people over the past year

A caller had been struggling to find a local dentist with a hoist to lift him from his wheelchair. Our team tracked one down for him and provided all the information he needed to make an appointment.

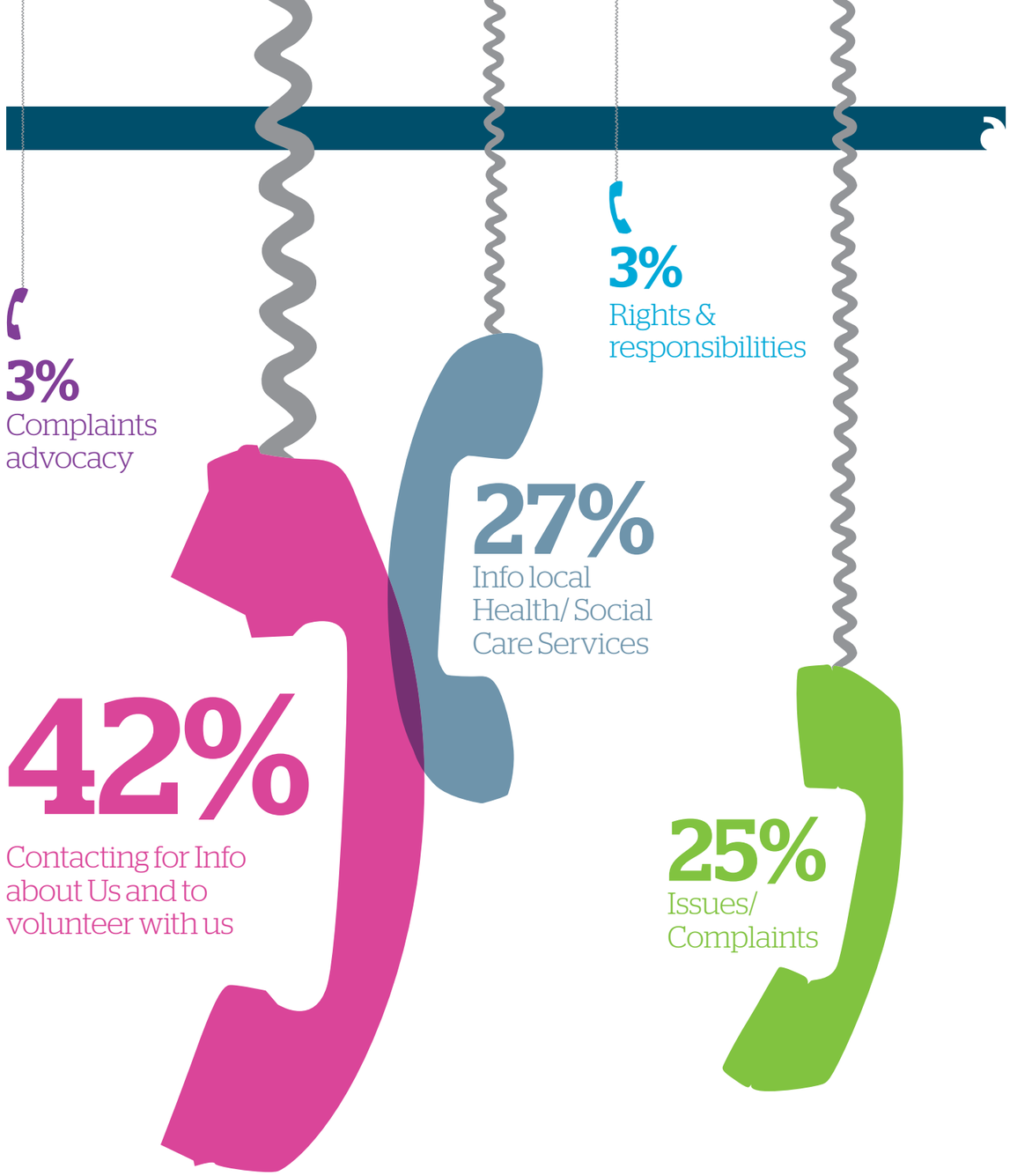
A lady had been told by her GP surgery that she could no longer be a registered patient as she didn't have a permanent address. The caller was very distressed as she urgently needed to see a doctor. We did some research and called her back with details of the legislation that every patient has the right to see a doctor and gave her confidence to meet with the Practice Manager and talk face to face.

Call us for FREE on
0808 801 0102

Calls answered from
10am - 4pm every weekday

Messages welcome anytime and responded to next working day
Email us at **info@healthwatchkent.co.uk**
or pop into any Citizen Advice Bureau to speak to someone face to face

We know how complicated it can be to find your way around the health and social care system. Our team of trained staff can take the worry away and find the answers for you. Call us!



What are people ringing us for?
Here is a breakdown of the calls this year

Our Information & Signposting service is provided in partnership with Citizens Advice Bureau

Projects

We are currently working on a number of projects. Each of these have been informed by talking to people about their concerns.

We have a group of volunteers who work together to make decisions about our priorities and projects. This group is called the Deliberations and Directions Group or DaDs. They have a Priority Setting Tool to help them make balanced decisions.

Children and Adolescent Mental Health service – We've heard concerns about this service from members of the public as well as organisations and groups. We are currently gathering insights into this service from members of the public, carers, stakeholders and patients. We will be publishing our report and recommendations very soon.

Mental Health – People using mental health services and their carers have raised concerns with us regarding the impact of the recent move of mental health acute beds from Medway. We are reviewing the situation to identify the concerns of, and implications for, people using mental health services, their friends, family and carers. We are visiting services in Dartford, Maidstone and Canterbury. As part of this, we are also working with the county network of Mental Health Action Groups to help them raise their voice and be heard by the people who commission and deliver mental health services. We're also looking at how Carers can be more involved in both the care of their loved ones and decisions about changes to mental health services.

Dementia – we are gathering insights from members of the public, service users, carers and stakeholders on the current services provided for people with Dementia and what the patient experience is like. In particular we are focusing on the issues around diagnosis, the parity of provision and access to services across the county.

Access to services for the Eastern European population in East Kent - We have become concerned about how the Eastern European community is accessing health and social care services, particularly in East Kent. To explore this concern further and to identify the issues, Healthwatch is seeking to commission a project to investigate and report on the issues.

Quality of Care in Residential and Nursing Homes – we are undertaking an assessment of care homes to gain an overview of quality and health and well being for residents. This overview will help inform our future work priorities. As part of this project, we will be conducting Enter & View visits to a number of homes across Kent.

For more information about these and other projects please visit our website.

Influencing

We're often asked what teeth do we have? It's an interesting question!

Working in partnership with organisations and individuals is important to us. We strongly believe that we can achieve more by working together than we could on our own. With this in mind, we have been building our relationships with the organisations that deliver and commission health and social care services. To date we have signed seven formal partnership agreements and we are benefiting from a close working relationship with them all. More agreements are in the pipeline.

However, if we wanted to, we do have the option to invoke our statutory powers and ask the Care Quality Commission to undertake reviews and investigations, and we can make recommendations to Healthwatch England. We haven't yet had the need to use either of these statutory powers but we do have an excellent relationship with both organisations should the need arise.

We have a voting seat at the Kent Health & Well Being Board and a seat at the Health Overview and Scrutiny Committee (HOSC). Through both forums we actively work hard to ensure the public opinion is heard loud and clear. We also have representatives at the majority of key health and social care meetings and forums across Kent including the local Health & Well Being Boards to ensure we stay abreast of the issues and can represent the public.

Other 'teeth' as some people call it, is to visit any health or social care service and talk to patients, families and staff about the experience provided by the service in question. This is called Enter & View and we can do unannounced or announced visits. Enter & View visits are an important way for us to get an in-depth understanding about a service but it is also a real privilege to be able to talk to patients and their families, often during what can be an emotional or difficult time.

We have invested a lot of time this year recruiting the right volunteers to undertake this service for us and training them to ensure they are able to deal with any situation. For example, we have developed in-depth training around mental health before we undertake a visit to mental health wards and rehabilitation centres. That training is now complete and we will be visiting centres in Dartford in June. Similarly we are currently organising training around Learning Disabilities so our volunteers are trained on what to look for when visiting services for people with Learning Disabilities.

We have Enter & View visits booked to Faversham Minor Injuries Unit, Darent Valley Accident & Emergency Unit and some Care Homes. All are planned to take place in June. The reports from all of these visits will be on our website.

What does all this mean?

It's all very well talking about relationships and statutory powers, but what does all this actually mean?! A real life example is Faversham Minor Injuries Unit.

When it was announced that Faversham Minor Injuries Unit was to close, we received several calls from concerned members of the public. That decision had been made by Canterbury & Coastal Clinical Commissioning Group so we immediately picked up the phone and talked to them about how they had come to that decision and questioned if they had listened to local people. We also discussed the announcement at the Health Overview & Scrutiny Committee. We agreed with them that the Unit would remain open while a full public consultation process was undertaken to ensure that everyone had a chance to share their views and experience. As part of that, Healthwatch Kent joined the Faversham Minor Injuries Review Group. That group has involved members of the Public plus the Friends of Faversham and discussed several options for the future of the Unit. Healthwatch Kent is planning an Enter & View visit to the Unit in June to talk to patients and staff and get a better understanding of how the public use the service. Our report will feed into the discussions around Faversham. Whatever the outcome, our role is to ensure the public have been truly listened to and consulted with.

Sign Off from Engaging Kent

The Healthwatch Kent contract was awarded by Kent County Council to an organisation called Engaging Kent.

Engaging Kent is a Community Interest Company which means that they are a non profit making organisation and any money they do make is invested back into the community. Engaging Kent is made up of three Board Directors and their role is to ensure that we are meeting the requirements of the Healthwatch contract. They are not involved in determining Healthwatch's projects or priorities. That role is undertaken by our Directions and Deliberations Group which is staffed by volunteers.

The role of Engaging Kent is to support the development of Healthwatch Kent and ensure our Governance structures are robust and fair.

Talking on behalf of Engaging Kent, Sue Alder says,

"It's been an incredibly challenging year but ultimately a successful and uplifting experience. As anyone will know who has created a new company, it's never an easy process and things always take longer than you anticipate despite every best intention. However when I look now at how far we have come since those early days, I feel great pride.

At the last Healthwatch Kent Public meeting, we asked you what you liked and didn't like. You told us that you were happy with our Governance structure and our staff team, but you wanted to see us get out and about more and talk to more people in Kent. You also asked us to shout more about what we've doing. We've listened to you and we're going to do a lot more talking and listening on the streets of Kent this year. We've also revised our website and we're sharing more detail about what we're up to and our achievements. I hope you will agree this annual report is a good example of what we've achieved so far.

Healthwatch has already come a long way in representing the public to improve services and I know they will continue to do so in the year ahead."

Tell us and together we can make a difference

Post your comments to us at:
FREEPOST RTHK-YCBA-RXRY
Healthwatch Kent
2 Bower Terrace
Tonbridge Rd
Maidstone
Kent ME16 8RY

Call us on our Freephone number:
0808 801 0102

Visit our website :
www.healthwatchkent.co.uk

Email us:
info@healthwatchkent.co.uk

hwkent
@healthwatchkent

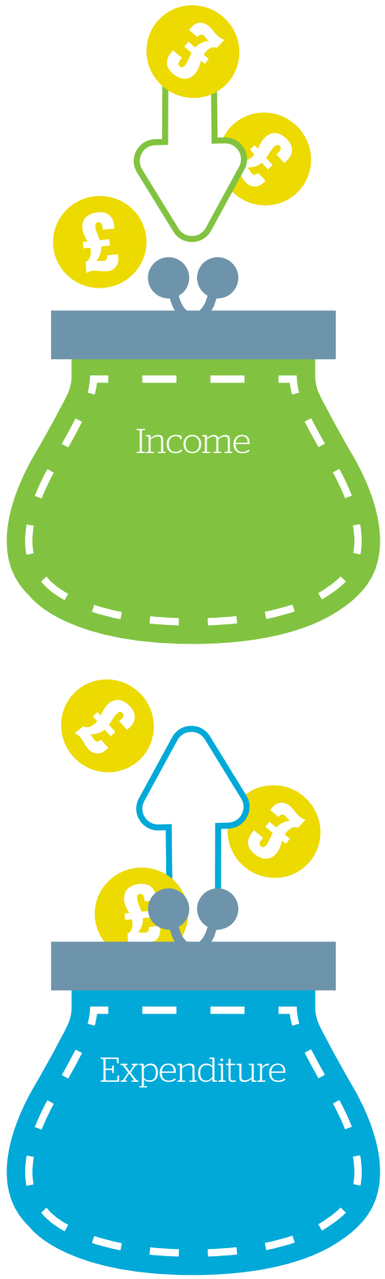
Finances

Table heading showing statement of activities for the year ending 31 March 2014

Income	Total
Contract Income	£529,307
Interest received	£32
Total Income	£529,339

Expenditure	Total
Grants payable	£181,871
Non Salaried Directors fees	£70,295
Salaried Director fees	£11,039
Staff salaries	£70,907
Employers National insurance	£7,878
Training and development	£9,796
Recruitment and expenses	£14,690
Volunteer and consultancy	£118,466
Professional fees	£9,637
Office, computer and telephone	£13,304
Insurance	£2,915
Promotion and communication	£18,096
Sundry and depreciation	£445

Total resources	**£529,339**



Balance sheet as at 31st March 2014

Fixed Assets	
Tangible assets	£3,592

Current Assets	
Debtors	£1,333
Cash at bank and in hand	£218,022
Total current assets	**£219,355**
Creditors (amounts falling due within one year)	**(£222,947)**
Net current liabilities	**(£3,592)**
Net assets	-
Unrestricted funds	-
General income funds	-
Designated income funds	-
Total charity funds	-

Notes
Tangible assets – based on ICT equipment purchases minus a deprecation charge for the period

Cash at Bank and in hand – funds allocated to current projects

Creditors – Trade creditors, taxation and social security, deferred income and accruals.

Healthwatch Kent
Seabrooke House, Church St. Ashford, TN23 1RD
Tel 0808 801 0102
Twitter @HealthwatchKent
Facebook hwkent
info@healthwatchkent.co.uk
www.healthwatchkent.co.uk

This page is intentionally left blank