HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 4th September, 2015

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 4th September, 2015, at 10.00 am	Ask for:	**Lizzy Adam**
Council Chamber, Sessions House, County Hall, Maidstone	Telephone:	**03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
UKIP (2):	Mr H Birkby and Mr A D Crowther
Labour (3):	Mrs P Brivio, Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor J Howes, Councillor M Lyons, Councillor M Peters and Councillor M Ring

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UNRESTRICTED ITEMS

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

Item Timings*

1. Substitutes

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

3. Minutes (Pages 5 - 14)

4. Kent and Medway Hyper Acute and Acute Stroke Services Review (Pages 15 - 32) — 10:05

5. Emotional Wellbeing Strategy for Children, Young People and Young Adults (Pages 33 - 48) — 10:45

6. West Kent CCG: Diabetes Care (Pages 49 - 78) — 11:30

7. Healthwatch Kent: Strategic Priorities (Pages 79 - 112) — 12:00

8. Chemotherapy Services in East Kent (Written Briefing) (Pages 113 - 116)

9. Date of next programmed meeting – Friday 9 October 2015 at 10:00

   Proposed items:

   - West Kent: Out of Hours Services Re-procurement
   - South Kent Coast CCG and Thanet CCG: Integrated Care
   - EKHUFT Clinical Strategy
   - Kent and Medway Specialist Vascular Services Review
   - Public Health Transformation

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

**Timings are approximate*

Peter Sass
Head of Democratic Services
03000 416647

26 August 2015

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 17 July 2015.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mr H Birkby, Mrs P Brivio, Mr N J D Chard, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr G Lymer, Mr C R Pearman, Cllr Mrs M Peters, Cllr Mrs M Ring and Cllr J Howes

ALSO PRESENT: Dr J Allingham and Cllr Chris Woodward

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer)

UNRESTRICTED ITEMS

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

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

26. Minutes
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions that had been taken:

Minute Number 21 - Medway NHS Foundation Trust: Update. Medway NHS Foundation Trust provided written clarification to the Committee on the action taken by the CQC in August 2014 which was circulated to the Committee on 16 June.

(2) The Scrutiny Research Officer requested that the number of national vanguards in Minute Number 22 be amended to 29 from 20.

(3) A Member noted that Mr Brazier was a substitute for Mr King instead of Mr Chard.

(4) RESOLVED that, subject to the amendments in paragraphs (2) and (3) above, the Minutes of the Meeting held on 5 June 2015 are correctly recorded and that they be signed by the Chairman.

27. Membership
(Item 4)

(1) Members of the Health Overview and Scrutiny Committee noted that:

(a) Cllr Howes (Canterbury City Council) had replaced Cllr Beresford (Dover District Council) as an East Kent borough representative on the Committee in 2015/16.

(b) Cllr Lyons (Shepway District Council) had been confirmed as an East Kent borough representative on the Committee in 2015/16.

28. NHS Ashford CCG and NHS Canterbury and Coastal CCG: Community Networks
(Item 5)

Lorraine Goodsell (Transformation Programme Director, NHS Ashford CCG and NHS Canterbury & Coastal CCG) was in attendance for this item.

(1) The Chairman welcomed Ms Goodsell to the meeting. Ms Goodsell began by outlining the implementation of Community Networks and the development of a new model of care in line with NHS England's Five Year Forward View. She explained that three Community Networks in Ashford and five Community Networks in Canterbury and Coastal were established in 2014 through local engagement events. Each network was supported by a stakeholder group which had representatives from general practice, health providers, social care, public health, voluntary sector and patients. The role of the networks was to consider the health needs of the local population and develop key priorities to inform CCG business planning.

(2) Ms Goodsell noted that mental health services had been identified as a top priority across the networks. The CCGs had been able to use comments and feedback from the networks to revise the local health counselling service specification. The networks had also developed a directory of voluntary services through a portal on the CCGs' websites. The directories had highlighted the range of voluntary services available to GP and nursing staff. She acknowledged that the networks were a work in progress and part of a three year programme of work.

(3) Ms Goodsell explained that the networks would contribute to the implementation of new care models as part of the Five Year Forward View. In recognition of the need to manage care more effectively in the local community, GP practices in Whitstable, led by Dr Ribchester, had developed a new model of care - Multispecialty Community Provider (MCP) – to provide community, acute, mental health and paramedic practitioner services as a seven day primary care service. The MCP was announced as one of 29 national vanguards sites in April 2015. This followed a selection process in which 269 sites applied to NHS England's New Models of Care Team to become a vanguard in three different categories: Multispecialty Community Provider (MCP), Primary and Acute Care Systems (PACS) and Care Home Models. She noted that the MCP was a pilot, in order for it to be successful it would need to demonstrate that it was scalable, efficient and improve quality.

(4) Members of the Committee then proceeded to ask a number of questions and make a number of comments. A Member enquired about seven day primary care services. Ms Goodsell explained that the MCP was initially being piloted in NHS Canterbury and Coastal CCG but reported that GPs in NHS Ashford CCG were watching very closely. She noted that there were a number of challenges in implementing seven day services including workforce availability. She reported that NHS Canterbury & Coastal CCG were initially focused on extending GP services to Saturday mornings only once transformation funding was released. She reported that a seven day GP service had been piloted in both CCGs, they had found that people were not using the service on a Sunday and were presenting to A&E instead.

(5) In response to a specific question about Education Health and Care (EHC) Plans, Ms Goodsell explained that the CCGs were taking the plans very seriously. She noted that the CCGs' Chief Nurse was recruiting to the positions of Named Nurse and Doctor. She reported that the CCGs' had recently brought the commissioning of children's health services back in house as they had not been happy with the commissioning support provided by the South East Commissioning Support Unit. A Member requested a written briefing from all CCGs on the implementation of Education Health and Care Plans.

(6) A number of comments were made about reducing costs and improving quality, sharing best practice with Kent CCGs and outpatient services in Hearne Bay. Ms Goodsell explained that the CCGs were looking to identify duplication of service provision and process map commissioning in order to improve quality and reduce costs. Ms Goodsell reported that the MCP pilot would initially serve a population of 53,000 but could be expanded to 170,000 if every GP practice in the CCG area wanted to become part of the MCP. She highlighted the bimonthly Kent Pioneer meeting between Kent County Council, CCGs and hospital providers and the monthly meeting between the CCGs' Accountable Officers in which information was shared across the whole health economy. Ms Goodsell stated that the removal of outpatient services from Herne Bay to Faversham was part of a review carried out by East Kent Hospitals University NHS Foundation Trust in which the number of outpatient sites was reduced. She noted that the development of the MCP was part of the new national models of care. The NHS Canterbury & Coastal CCG was looking to develop better community services through the MCP in consultation and engagement with the local community.

(7) RESOLVED that the report be noted and NHS Ashford CCG & NHS Canterbury and Coastal CCG be requested to provide an update to the Committee in six months.

29. Kent and Medway Specialist Vascular Services Review
(Item 6)

Oena Windibank (Programme Director, Kent & Medway Specialist Vascular Services Review, NHS England) and Diana Cargill (Specialised Lead, Specialised

Commissioning, NHS England South (East), NHS England) were in attendance for this item.

(1) The Chairman welcomed the guests to the meeting. Ms Windibank began by outlining the case for change. She explained that the review was only considering specialist vascular services, it would not be looking at heart disease, heart surgery or the management of the common types of stroke. She reported that in 2012 there were very poor clinical outcomes for patients in England and Wales receiving vascular services. In response to this the Vascular Society produced best practice guidance which was developed into a national service specification through the specialised Clinical Reference Group in 2013. She reported that following the introduction of the national service specification there had been improved mortality outcomes.

(2) Ms Windibank explained that a vascular services review was initiated in Kent and Medway to determine compliance with the national service specification and best practice. She noted that vascular services were currently delivered at two sites in Kent and Medway: Kent and Canterbury Hospital and Medway Maritime Hospital. A number of patients in North and West Kent were also transferred to Guy's and St Thomas' NHS Foundation Trust. She reported that non-compliance with the national service specification by the East Kent Hospitals University NHS Foundation Trust and Medway NHS Foundation Trust had been identified. The key issues were that the total Kent and Medway activity was borderline for meeting the minimum requirements for Abdominal Aortic Aneurysm procedures and the Carotid Endarterectomy levels at Medway NHS Foundation Trust were routinely below the minimum requirements. There were also concerns regarding workforce availability, retirement and the sustainability of consultant rotas.

(3) Ms Windibank stated that the national service specification had been reviewed nationally including in Surrey and Sussex to determine the work needed to ensure local vascular providers comply with best practice outlined in the specification. She noted that the Kent review was at an early stage and was building on learning from the other reviews. The aim of the review was to ensure the delivery of high quality, sustainable vascular outcomes for all Kent and Medway patients which complied with the national service specification. She also noted that the review was looking to develop centres of excellence in Kent and Medway in the future.

(4) The Chairman enquired about the timescale of the review. Ms Windibank advised that NHS England were looking to develop options over the summer with the preferred option being approved in November 2015. She noted that a number of public listening events had already been held. She stated it was difficult to capture the views of service users as they were only 900 total procedures in 2013/14 for Kent and Medway residents.

(5) In response to a direct question about the affordability of clinical best practice, Ms Windibank explained that affordability would be one of the factors looked at during the option appraisal in Phase 2. She stated that the focus of the review was safe and sustainable clinical care and quality. Ms Cargill explained that there were 591 procedures in Kent and Medway in 2013/14 and these were paid on a case by case basis. She noted that money was available to NHS

England South to pay for all these procedures. Further questions were asked about a larger Market Forces Factor in London and patient choice. Ms Cargill explained that any procedure undertaken in London on a Kent and Medway resident was paid for by NHS England London. Ms Windibank acknowledged patient choice and committed to making this clearer in the decision making report.

(6) A number of comments were made about Abdominal Aortic Aneurysm (AAA) screening, consultant rotas and other NHS England reviews. Ms Windibank explained that there was a national screening programme which was delivered by East Kent Hospitals University NHS Foundation Trust for all Kent and Medway residents. Any man registered with a GP would receive a letter inviting him to screening in the year he turns 65. The AAA Screening Programme was provided by EKHUFT has been audited as good. Ms Windibank confirmed that consultant rotas were part of the review. Ms Windibank stated that she was not aware of any other reviews by NHS England in addition to the stroke review. She highlighted the alignment of stroke and vascular services.

(7) RESOLVED that the report be noted and NHS England be invited to submit an update to the Committee at its September meeting.

30. Kent and Medway Hyper Acute and Acute Stroke Services Review
(Item 7)

Oena Windibank (Programme Director, Kent & Medway Specialist Vascular Services Review, NHS England), Ian Ayres (Accountable Officer, NHS West Kent CCG) and Dr David Hargroves (Clinical Lead - Stroke, South East Strategic Clinical Network) were in attendance for the item.

(1) The Chairman welcomed the guests to the meeting. Mr Ayres began by stating that the CCGs were committed to improve current performance and outcomes for Kent and Medway stroke patients. The CCGs were looking to develop a Kent and Medway solution to the hyper acute and acute pathway. He stated that the hyper acute pathway related to the first 72 hours and the package of critical interventions and monitoring particularly within the first four hours. He highlighted the centralisation and consolidation of stroke services in London where patients were admitted to one of eight units for the first 72 hours. He stated that the Kent and Medway CCGs had identified very few county wide service configurations with the exception of stroke and vascular services. He noted that major trauma, paediatric surgery and cancer had already been configured.

(2) Dr Hargroves explained that he was the Clinical Lead for Stroke in the South East Strategic Clinical Network. The Clinical Network had worked alongside the CCGs throughout the process. He noted that the stroke workforce in Kent and Medway was passionate about and fully supportive of the review. He stressed the importance of access to a specialist unit within four hours and clot busting drugs to improve patients' outcomes. He acknowledged that it was very difficult to deliver stroke services across all seven admitting units in Kent and Medway; performance was variable across the county. He noted that only

one site had a seven day unit and workforce levels were low. He stated the CCGs and providers were committed to improving outcomes for Kent and Medway stroke patients.

(3) A number of comments were made about ambulance transfers and travel times. Ms Windibank advised that South East Coast Ambulance Service NHS Foundation Trust (SECAmb) were part of the Clinical Reference Group. Travel times to each unit had been mapped and key issues such as Operation Stack and city centre traffic had been identified. Dr Hargroves stated that brain imaging was an absolute requirement for effective treatment but at present could not be delivered from an ambulance. He highlighted a pilot in East Kent where stroke consultants had a telelink with the ambulance to monitor the patient. The ambulance transfer was also used to take a history which saved time on admission to hospital. Dr Hargroves reported that access to a specialist unit had the most benefit within 4 – 5 hours; all patients in Kent and Medway were transferred by ambulance within this time scale.

(4) In response to a specific question about stroke prevention and rehabilitation services, Dr Hargroves explained that prevention was key. He stated that the risk of a stroke was increased by genetic and lifestyle factors including diet and nutrition; physical activity; smoking and alcohol. Mr Ayres stated that rehabilitation services were not part of the review and that the CCGs would be happy for the Committee to scrutinise these services separately. He noted that finance and workforce would be central to the next part of the review. He acknowledged that the stroke review may be subject to a Joint Health Overview and Scrutiny Committee with Medway Council.

(5) RESOLVED that the report be noted and Kent and Medway CCGs be invited to submit an update to the Committee at its September meeting.

31. NHS England South (South East): General Practice

(Item 8)

Stephen Ingram (Head of Primary Care, NHS England South (South East)) and Dr John Allingham (Medical Secretary, Kent LMC) were in attendance for this item.

(1) The Chairman welcomed the guests to the meeting. Mr Ingram began by highlighting recent national strategy and policy developments. He stated that general practice remained seriously challenged and the level of change had continued to accelerate.

(2) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about practice mergers. Mr Ingram explained that practices submitted merger proposals to NHS England for consideration and processing. NHS England discussed the merger in consultation with the Kent LMC and relevant CCG to ensure that the merger was sustainable, resilient and achieved a greater critical mass. He noted that whilst it was possible to merge existing contracts under the General Medical Services (GMS) and Personal Medical Services (PMS) agreements, it was not possible to merge under the AMS contract. He explained that whilst the decision ultimately lay with the contract holder, NHS England were able to

make suggestions to practices about potential mergers. Dr Allingham stated that the Kent LMC supported practices during mergers and the surrendering of contracts to other providers. He noted that there were still a number of single GP practises in Kent. The Kent LMC encouraged practices to collaborate in order to work at scale and improve resilience. He reported that the CQC could place a practice in special measures and recommend that another provider takes over the service.

(3) In response to a specific question about housing growth, Mr Ingram explained that NHS England was involved in the housing developments at Ebbsfleet and Chilmington Green Ashford. He stated it was important for a practice to be established early, in order for new patients to register. The practices, including the patient list and workforce, should expand as the community grows. He noted that in Broadstairs, a practice's patient list recently increased from 2000 to 5000 following the closure of an existing practice.

(4) Members enquired about the recruitment and retention of GPs. Mr Ingram highlighted the publication of The New Deal for General Practice – GP Workforce 10 Point Plan which set out initiatives to recruit newly trained doctors into general practice, retain GPs and encourage doctors to return to general practice. Dr Allingham stated that general practice was struggling with recruitment and retention. He highlighted barriers to retention included a loss of seniority pay, changes to the pension scheme and GPs reaching their pension lifetime limit early. He reminded the Committee of a case study he had previously bought to their attention regarding a GP who had faced difficulties returning to general practice after a period of absence. He stated that he was currently helping a European GP to retrain in order to practice in the UK. He noted that since April funding had become available to pay the practice providing the training and the European doctor during their training.

(5) A number of comments were made about workforce in coastal areas, sole practitioners in urban areas and prescription and referral powers. Dr Allingham explained that it was difficult to attract the workforce to coastal areas. Many young doctors who trained in Kent had aspirations to return to London. He noted that 36% of GPs in Kent were over the age of 50. Mr Ingram explained that other coastal areas in Essex, Norfolk and West Sussex had similar recruitment problems. Mr Ingram reported that there were a number of sole practitioners in Medway, Dartford and Gravesham. He stated that NHS England's role was to ensure those practices were not left behind in delivering services to the required standard. NHS England's levellers were to encourage and support small practices to reconfigure themselves and become more resilient. Mr Ingram noted that in certain circumstances nurse practitioners were able to prescribe and refer patients. He stated that in the future nurse consultants would be able to independently prescribe allowing GPs to spend more time on complex consultations.

(6) RESOLVED that the report be noted and that NHS England be invited to attend the June 2016 meeting of the Committee.

32. East Kent CCGs: Talking Therapy Services (Written Update)
(Item 9)

(1) The Committee received a report from NHS Ashford CCG, NHS Canterbury & Coastal CCG, NHS South Kent Coast CCG and NHS Thanet CCG which provided details of the procurement and service specification for talking therapy services in East Kent.

(2) RESOLVED that:

(a) the Committee does not deem the new service specification for Talking Therapy Services in East Kent to be a substantial variation of service.

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

33. Faversham MIU (Written Update)
(Item 10)

(1) The Committee received a report from NHS Canterbury & Coastal CCG which provided an update on the Faversham Minor Injuries Unit.

(2) A number of comments were made about the Committee's involvement and the positive outcome it had achieved. A Member suggested that the Chairman write to the CCG to express the Committee's satisfaction with the cooperation and response from NHS Canterbury & Coastal CCG.

(3) RESOLVED that the report be noted, the NHS Canterbury and Coastal CCG be requested to keep the Committee informed with progress and the Chairman write to the CCG to express the Committee' satisfaction with the outcome.

34. SECAmb: Future of Emergency Operation Centres (Written Update)
(Item 11)

(1) The Committee received a report from the South East Coast Ambulance Service NHS Foundation Trust which provided an update on the Emergency Operation Centres.

(2) RESOLVED that the report be noted and SECAmb be requested to provide a written update to the Committee in six months.

35. Date of next programmed meeting – Friday 4 September 2015 at 10.00
(Item 12)

(1) The Scrutiny Research Officer updated the Committee on two of the items listed for the September meeting. She stated that the West Kent CCG Diabetes Care item was to be confirmed. She explained that the Patient Transport Services item was unable to return as the procurement process was still running. NHS West Kent CCG was looking to award a contract by 1 February which would prevent it from returning to the Committee before this date.

(2) A Member requested a written briefing on stroke rehabilitation services commissioned by the CCGs in Kent.

(3) A Member requested a written briefing from all CCGs on the implementation of Education Health and Care Plans.

(4) A Member requested that the latest Sussex Partnership NHS Foundation Trust performance data by district. The Scrutiny Research Officer advised that West Kent CCG had committed to provide this to the Committee at the September meeting when the Emotional Wellbeing Strategy returned to the Committee.

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Item 4: Kent and Medway Hyper Acute and Acute Stroke Services Review

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 September 2015

Subject: Kent and Medway Hyper Acute and Acute Stroke Services Review

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

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

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1. Introduction

(a) On 17 July 2015 the Committee considered the case for change for the Kent and Medway Hyper Acute and Acute Stroke Services Review. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that the report be noted and Kent and Medway CCGs be invited to submit an update to the Committee at its September meeting.*

2. Potential Substantial Variation of Service

(a) If the Committee believes it has been provided with sufficient information, it may choose to make a determination as to whether the proposal changes constitutes a substantial variation of service, please refer to the recommendations below.

(b) The Committee may defer making a determination if it feels additional information is required and may request further briefings and attendance at future meetings of the Committee.

(b) Medway Health and Adult Social Care Overview and Scrutiny Committee considered the item on 11 August 2015. They determined that this item constituted a substantial variation of service. If the HOSC determines the proposed service change to be substantial, a Joint HOSC will need to be established.

(c) If the HOSC deems this service change as <u>not being substantial</u>, this does not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the Kent CCGs.

(d) If the HOSC determines this proposed change of service <u>to be substantial</u>, a timetable for consideration of the change will need to be agreed between the Joint HOSC and Kent and Medway CCGs. The timetable will include the proposed date that Kent and Medway CCGs intends to make a decision as to whether to proceed with the proposal

and the date by which the HOSC will provide any comments on the proposal.

(e) If a Joint HOSC is established, the power to refer to the Secretary of State will not be delegated to the joint committee, the power to refer will remain with the individual committees (Kent HOSC and Medway HASC) which appointed the joint committee.

3. Stroke Rehabilitation

(a) In response to a specific question about stroke rehabilitation on 17 July, it was explained that rehabilitation services were not part of the review and that the CCGs would be happy for the Committee to scrutinise these services separately. However Kent CCGs have provided the attached appendices on stroke rehabilitation services as background information for this item:

NHS Ashford and NHS Canterbury & Coastal CCG	pages 23 - 24
NHS South Kent Coast CCG	pages 25 - 26
NHS Thanet CCG	pages 27 - 28
NHS West Kent CCG	pages 29 - 32

4. Recommendation

If the proposals are *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the proposals to be a substantial variation of service.

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

If the proposals are *substantial*:

RECOMMENDED that:

(a) the Committee deems the proposals to be a substantial variation of service.

(b) a Joint HOSC be established with Medway Council, with the Kent HOSC receiving updates on the work of the Joint Committee.

Background Documents

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (17/07/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5841&Ver=4

Contact Details

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Paper presented to:	Kent Health Overview and Scrutiny Committee
Paper subject:	Kent and Medway Hyper acute/Acute Stroke services Review.
Date:	4 September 2015
Presented by:	Oena Windibank; Programme Director, K&M Stroke Review. Ian Ayres; Chief Officer/Accountable Officer West Kent CCG.
Senior Responsible Officer:	Patricia Davies; Accountable Officer DGS and Swale CCGs
Purpose of Paper:	To update the HOSC on the progress of the Kent and Medway Hyper acute/acute review and to ask for consideration of the establishment of a Kent and Medway joint Overview and Scrutiny Committee.

Kent Health Overview and Scrutiny Committee briefing.

September 2015.

Kent and Medway Stroke Services Review.

Introduction:

Kent and Medway Stroke Review commenced December 2014 following concerns of performance and sustainability across the current seven hospitals currently treating stroke patients.

The aim of the review is;
To ensure the delivery of clinically sustainable, high quality, hyper-acute and acute stroke services for the next ten to fifteen years, that are accessible to Kent and Medway residents 24 hours a day, seven days a week.

The review is overseen by a Review Programme Board (RPB) with membership form all eight Kent and Medway CCG's, NHS England(south) , public health, SE Cardio vascular network, the Clinical reference group, SECAmb, NHS communications teams, Healthwatch Kent and Medway , the Stroke association and a patient representative.
A clinical reference group supports and advises the RPB, providing clinical advice, expertise and assessment of the case for change and the options appraisal process. The group is currently leading on detailed modeling to understand some of the challenges, which will inform the options development process. The options appraisal will have input forma range of stakeholders.

The review is also supported by a Communications and Engagement sub group, responsible for ensuring effective engagement and communications through the process.

The review is proactively working alongside the acute and community providers for stroke care to ensure consideration of all aspects of stroke care..

Progress to date:

The Case for Change has been approved by the eight CCG's and agreement made on the direction of travel; to develop options for resolving the current performance and sustainability issues.

Ten 'Listening Events' have been held across Kent and Medway to share the case for change and raise awareness with the public. Just over 100 members of the public attended the events although in some areas there were low numbers. Further work is underway to increase the numbers of the public involved including targeting specific communities of interest, patient groups and an on line survey.

Phase two of the engagement process will include involving a wider stakeholder group, public panels and scenario testing. This will ensure public and stakeholder involvement in options development and appraisal.

The Case for Change has been shared with the Kent HOSC and the Medway HASC.

A number of clinically led modeling groups have commenced work to inform the options development and scenarios based on the clinical best practice/guidance.
These include :

- **Travel/Access;** considering ambulance travel times across Kent and Medway based on 30 and 45 minute isochrones. Qualitative review of travel pressure points/times. Reviewing public transport facilities/times.
- **Patient Profiles/Capacity;** assessing the numbers of patients requiring specialist stroke care, the number of patients suffering from Transichaemic Attacks, and the numbers of patients attending Accident and Emergency departments. The requirements for transferring patients between hospitals.

- **Workforce;** confirming the workforce requirements for specialist stroke care. Assessing the current gaps and options for delivering 7 day services. Reviewing workforce training and supply and possible workforce options. Assessing competencies across the stroke pathway.
- **Public health;** assessing population growth and demand, incidence of Stroke and Atrial fibrillation. Identifying key demographic influences and impacts on service configuration.
- **Financial planning;** confirming current financial envelope across Kent andMedway. Identifying cost implications of options including increased transfers, additional facilities, workforce implications, implementation costs.

Public Listening Events;

Overall, the participants we spoke to reported a **positive experience of stroke services in Kent and Medway** and they were broadly **supportive of the case for change**.

Emerging themes include;

- **Workforce** – the need to address staff shortages and attract high quality staff was seen as a key priority.
- **Travel time** – participants recognised the need to balance travel time with the provision of efficient specialist care and good quality outcomes.
- **24/7 working** – concerns were raised in relation to a lack of 24/7 and poor out of hours service. There was a perception that poor outcomes were linked to out of hours presentation.
- **GP Appointments** – participants reported that GP appointments were often hard to make.
- **Communication** – the need to provide tailored, clear and concise information for both patients and their carers was recognised

Options development:

While the detailed modelling work is underway the clinical reference group has given some early consideration as to the difficulties the stroke services are currently facing, the priorities of the patients' care and the feasibility around the long list of potential options.

Early assessment suggests that to 'do nothing' is unlikely to deliver sustainability of services or consistent good performance. It would also suggest that there is a range of potential options from the status quo of seven units to a significantly reduced number.

Initial consideration of a single or two centre specialist hyper acute units would be extremely challenging due to the patientvolumes, geography, the

impact on accident and emergency units, medical beds and the number of stroke beds required. Therefore these configurations are unlikely to be viable.

For instance: in order to deliver a seven day service the workforce implications are a significant factor. The review will consider the possible configurations of the hyper acute and acute pathways. This may result in a reduction in the number of stroke units and /or separate hyper acute/acute units across Kent and Medway.

The Communication and Engagement plan is being further developed to ensure that the process provides a number of ways in which patients and the public and voluntary sector can engage with the process and inform our emerging thinking as we move towards formal consultation

The Review Stroke Programme Board advises that the review recommendations are likely to result in a significant service change for hyper acute/acute stroke care across Kent and Medway.

Since the review is covering both Kent and Medway we understand that a Joint Health Overview and Scrutiny committee would need to be formed to consider the options when developed and advise on the consultation plan to ensure robust and inclusive process.

Next Steps;

The clinical reference group is developing the modeling process and scenario building. The next phase of engagement will inform this process and the development of the options for full appraisal.

NHS

Meeting:	Health Overview and Scrutiny Committee
Date of meeting:	4 September 2015
Subject:	Briefing Paper: Stroke Services Update – NHS Ashford NHS CCG and Canterbury and Coastal CCG
Action required:	This paper is for information
Purpose:	To update the Health Overview and Scrutiny Committee on developments around stroke services for NHS Ashford CCG and NHS Canterbury and Coastal CCG

1.0 Overview

1.1 This paper seeks to update the Health Overview and Scrutiny Committee on developments around the stroke and rehabilitation pathway for NHS Ashford CCG and NHS Canterbury and Coastal CCG.

1.2 35,000 residents (1.7 per cent) in Kent and Medway were recorded as having a stroke in 2014-15. In Canterbury and Coastal CCG, 4,158 (1.9 per cent) were recorded as having a stroke or transient ischemic attack (TIA) and in Ashford CCG, 2,275 (1.8 per cent) were recorded as having a stroke.

2.0 Work completed to date

2.1 Since April 2015, the CCGs have undertaken a local analysis of services across the Ashford and Canterbury and Coastal area. It has analysed outcomes against its 10 nearest neighbours in terms of population, demographics and activity.

2.2 The CCG analysis shows:

2.2.1 A significant number of patients who are re-admitted to Hospital with a diagnosis of stroke or TIA. The CCGs have introduced shared care plans across the health system. This enables GP's, paramedics and A&E Consultants to see a shared record of patients' care plans, enabling patients who suffer a re-lapse to be well managed.

2.2.2 When benchmarked against the average of 10 other CCGs, Canterbury and Coastal CCG found that 40 per cent more patients were treated in less than 24 hours, Ashford CCG found that 30 per cent. Canterbury and Coastal found that 15 per cent more patients spent more time on a dedicated stroke unit (8 per cent for Ashford), 9 per cent more patients in Canterbury and Coastal (8 per cent in Ashford) were able to return to their own home after treatment both

CCGs observed a significantly better mortality rate when compared to other CCGs (20 per cent above mean average).

3.0 Key next steps

3.1 The CCGs have implemented the fragility pathway across primary care to support:

- Identification at patients at risk and therefore early intervention
- Robust care plans to manage potential problems for post stroke patients as alternative to transfer to secondary care
- Support reduction of length of stay (LOS) through community based rehabilitation services as part of the community networks

3.2 Within general practice GP's are expected to monitor their patients who are at risk of stroke via the Quality and Outcomes Framework (QOF). General practice are expected under the QOF requirements, to assess risk in those likely to be at high-risk (for example, people with hypertension (high blood pressure) a validated assessment tool is used that evaluates a range of modifiable and non-modifiable risk factors.

3.3 The CCGs are working with public health and across east Kent to develop a prevention and self-care pathway. Public health commission a number of schemes that will contribute to early identification of stroke risks factors and patients are able to access a number of services that promote good health and wellbeing such as: health checks, stop smoking services, exercise referral schemes, Fresh Start programmes.

4.0 Recommendation

Members of the Health Overview and Scrutiny Committee are asked to note the contents of this briefing paper.

For any questions about the content of this paper, please contact:

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Stroke prevention and rehabilitation services in NHS South Kent Coast (SKC) CCG

Overview and background

A stroke is a life-threatening medical emergency that happens when the blood supply to part of the brain is cut off. The blood supply may be cut off by a blood clot or from a burst blood vessel. A person having a stroke may lose control over their movement, perception and speech. They may also lose consciousness. Prompt hospital treatment is essential for stroke survival.

South Kent Coast CCG (SKC) serves 199,000 people living across Shepway, Dover, Deal and Romney Marsh with 30 GP practices. In relation to the prevalence of stroke the latest data taken from the Stroke and TIA Kent Joint Strategic Needs Analysis 2013/14 indicated that in Kent and Medway, 30,500 people were recorded as having a Stroke or TIA. This is a prevalence of 1.7% across Kent and Medway (same as the national average), the highest prevalence of 2.1% is seen in South Kent Coast CCG area.

Services for prevention and post stroke in SKC

Prevention of stroke

Within general practice GP's are expected to monitor their patients who are at risk of stroke via the Quality and Outcomes Framework (QOF). General practice are expected under the QOF requirements, to assess risk in those likely to be at high-risk (for example, people with hypertension -high blood pressure) a validated assessment tool is used that evaluates a range of modifiable and non-modifiable risk factors.

South Kent Coast CCG recognises the importance of promoting prevention services and so is working with public health and has developed a prevention and self-care pathway with an underpinning work plan that is overseen by the SKC CCG Prevention and Self-Care Work Stream. In addition, public health commission a number of schemes that will contribute to early identification of stroke risks factors and patients are able to access a number of services that promote good health and wellbeing such as: health checks, stop smoking services, exercise referral schemes, Fresh Start programmes. The CCG and public health are working together with some GP practice in Folkestone to pilot targeted work to address health inequalities that will contribute to stroke risk reduction, with the plan to replicate the model across the SKC CCG.

SKC CCG have in place a cardiovascular disease (CVD) working group to focus on stroke prevention, diabetes and cardiology services in our locality. This group feeds into the SKC Prevention and Self Care Work Stream and also wider east Kent cardiology task and finish group and the East Kent Diabetes Pathway Mobilisation Group. A key priority has been working with our GP practices to educate and encourage them to run the Guidance on Risk Assessment and Stroke Prevention (GRASP) AF software tool promoted by NHS Improvement. This identifies patients that have a diagnosis of atrial fibrillation (AF- a heart rhythm that can cause blood clot formation), who are not receiving any anti-coagulation medication, increasing their risk of stroke. The CCG has held two learning events for GPs

and practice nurses on the subject of AF is topic to raise awareness and the importance of identifying and treating this cohort of patients this work continues.

The GRASP software can also be used to identify diabetic patients that require additional interventions to ensure their condition is optimally managed therefor, reducing the risk of stroke, this work is in progress.

Post stroke care and rehabilitation services

The population of SKC has access to three acute hospitals; William Harvey, Kent and Canterbury and the Queen Elizabeth the Queen Mother hospitals. Each site provides a full acute stroke service, that includes provision of thrombolysis for appropriate patients, a treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs, however; a recent case for change paper produced by NHS England together with the Sentinel Stroke National Audit Programme (SSNAP) data indicates there are variances in service across the 3 hospitals.

The Kent and Medway CCGs requested that a stroke service review is carried out as there was concern on the hospitals variable performance. The review has focussed on benchmarking the current services, identifying a case for change to the existing pathways, recommendations to improve current care pathways and to ensure resilience and sustainability going forward. With this in mind, we need to include the possibility of reconfiguring the current admitting hospitals and how this may impact patient care and treatment.

From the SSNAP data, improvements need to be made in the time it takes for a patient to get to a stroke unit (within 4 hours of arrival in hospital), thrombolysis treatment (up to 4 and a half hours after a stroke), patients receiving speech and language therapy, team working i.e. assessed by all the relevant therapists to agree rehabilitation goals.

The CCG commissions Intermediate Care Services (ICS) in the community, with specialist therapists and clinical nurse specialists (CNS) in stroke care, to provide an early supported stroke discharge pathway, with follow up post stroke at given points, which expects the hospital and community to work together for seamless transfer to either the patient's own home, or an short term bed placement, if appropriate, for rehabilitation. The provision of the community service is based on need not on time limitation. We will be working with colleagues in across the hospital and community to ensure that the current early discharge pathway, and subsequent follow up by CNS in stroke, is this effective, what can be improved

Summary

The CCG is undertaking a lot of work for address stroke prevention that includes review of existing post stroke services that will continue as per the work plans, with the next steps following the Kent and Medway Stroke Review that clinical discussions will now need to take place at an east Kent level with CCG GP stroke leads and hospital Consultants to prioritise the standards that require improvement across east Kent and agree a work plan for implementation and delivery.

Stoke rehabilitation, NHS Thanet CCG

Overview

NHS Thanet CCG commissions a Stroke Early Supported Discharge programme which facilitates early hospital discharge of patients with a newly diagnosed stroke to their home (or appropriate setting), providing specialist rehabilitation in the community.

Key elements of the service, locally

The service aims to:

- Enable patients to return to their own home, where appropriate, as soon as possible with support from a specialist multi-disciplinary rehabilitation programme and co-ordinated care pathway. This ensures patients receive optimum care and rehabilitation by working across both primary and secondary care.
- Continue to provide the patient with daily rehabilitation on the day after discharge as appropriate with review and adjustment of the rehabilitation programme appropriate to patient need.
- Provide information and knowledge/training to carers and relatives, thereby enabling and supporting them in providing ongoing care to the patient.

How services are accessed

The Stroke Early Supported Discharge programme referral is initiated following a clinical decision made by a consultant and/or following a CT scan result. The programme is available to patients aged 16 years and over whose rehabilitation needs are related to a new stroke episode. Access to the programme is via referral from the acute hospital team which is made to a single point of access within the Integrated Care Team based in the community.

To support management, criteria of entry are in place to support the patient's rehabilitation and care pathway.

The criteria are:

- Medically stable and appropriate diagnostics performed.
- Mild/moderately affected by the new stroke episode, for example, can transfer with one person or less.
- No moderate/severe cognitive impairment or dysphasia that would preclude successful rehabilitation.
- Have all care needs in place.
- Have suitable accommodation or minimal adaptations required.
- Achievable rehabilitation goals are identified and agreed with the patient and hospital staff prior to discharge into the community.
- Environment conditions are safe and suitable for rehabilitation.
- Patient is registered with an NHS GP within the locality or eligible to do so.
- Patient and/or their next of kin (or carer) agree to co-operate with the principles of rehabilitation including working in partnership with team members, carers and where appropriate voluntary services.
- GP is aware of referral to the Community Stroke Rehabilitation Team (CSRT).

Service provision

The care team is multi-agency and multi-speciality working within Thanet and includes stroke specialist nurse, neuro-clinical specialist physiotherapist, occupational therapy, speech and language therapy, dietetics, neuropsychology, rehabilitation support worker and care management.

The referrals will identify whether it is an Early Supported Discharge (ESD) patient, a Community Stroke Pathway (CSRT) patient, a patient for the specialist stroke nurse or a combination of these, and the patients care will be managed along the pathway as indicated as above.

Future developments

Following a review of the recently published stroke standards, work is underway with the East Kent Hospitals University Foundation Trust (EKHUFT) to identify and address gaps in current standards.

Thanet CCG will also be using Sentinel Stroke National Audit Programme data to support any further change management or development programmes.

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Paper presented to:	Kent Health Overview and Scrutiny Committee
Paper Subject:	Commissioned Services for Stroke Rehabilitation: NHS West Kent CCG
Date:	
Presented by:	Ian Ayres, Accountable Officer, NHS West Kent CCG
Purpose of Paper:	To the update the HOSC on current commissioned services

West Kent CCG currently commissions the following rehabilitation services for patients who have suffered from a stroke:

Kent Community Health Foundation Trust
Sapphire Unit – Community Neurological Rehabilitation Services
Gravesham Community Hospital, Bath Street, Gravesend, Kent, DA11 0DG

The Sapphire Unit is a 21-bed nurse-led rehabilitation unit in Gravesham Community Hospital. Sapphire has 15 beds for patients with progressive and non-progressive neurological conditions who need more rehabilitation following discharge from an acute hospital. This may be following a stroke.

The primary purpose of the Sapphire Unit is to provide a seamless, integrated inpatient Community Neurological Rehabilitation service to patients who have had a new neurological event or acute change in the long term Neurological condition. .

Rehabilitation is provided for patients who are medically stable but need support to improve their independence. The service will provide appropriate therapy, education and support enabling patients and their carers to achieve the best possible quality of life. The Sapphire Unit works on improving mobility, strength, independence in personal and domestic care tasks, cognitive ability, communication and language. Patients are given the opportunity to develop their daily skills before they are discharged back to living in their own home.

The rehabilitation team comprises of nurses, physiotherapists, occupational therapists, speech and language therapists, dietitians and neuropsychologists.

The service is a 24 hour service for inpatients.

Kent Community Health Foundation Trust
Tonbridge Cottage Hospital
Vauxhall Lane, Tonbridge, Kent, TN11 0NE

Tonbridge Cottage Hospital is a 14-bed rehabilitation unit. The service provides rehabilitation to patients who are medically stable but need further rehabilitation. The hospital takes patients directly from their own homes to avoid admission to an acute hospital, or following a stay at an acute hospital.

The service aims to help patients regain their independence where appropriate and to teach them coping strategies. Staff work in partnership with the patient, carer and relatives to ensure all aspects

of care, including assessment of needs on admission, joint goal setting, planning, implementation and evaluation of care are effective.

The team consists of a modern matron, junior matron, registered nurses, rehabilitation assistants, health care assistants, physiotherapists, occupational therapists, a care manager, a pharmacist and medical consultants.

The service is a 24 hour service for inpatients.

Kent Community Health Foundation Trust
Community Neurological Rehabilitation Team (CNRT)
Churchill Centre, Preston Hall, Aylesford, Kent, ME20 7NJ (Offices only);
Dartford, Gravesham & Swanley (DGS), Joynes House, First Floor, New Road, Gravesend, Kent, DA11 0AT;
Sevenoaks Hospital, Hospital Road, Sevenoaks, Kent, TN13 3PG

The Community Neurological Rehabilitation Team (CNRT) is a specialist service providing rehabilitation to adults with progressive and non-progressive neurological disability. This may include stroke.

The CNRT help to discharge patients from hospital who have had a stroke or brain injury and help to support patients who have a long-term condition such as MS to maintain their levels of function and independence. The team help to rehabilitate in the most appropriate community setting, this may be in the home, day centre or in an out-patient clinic. They also run a range of therapy groups, including balance and exercise, and fatigue management. Intervention is time-limited and goal-directed. The team works with the patient and their family to ensure that rehabilitation is carried over into everyday activities.

The CNRT consists of physiotherapists, occupational therapists, speech and language therapists, dietitians, nurses, rehabilitation assistants and administrators. The team also have close links with the neuro-psychology service and works closely with social services, hospitals and the voluntary sector.

The service runs Monday to Friday, 9am – 5pm.

Kent and Medway Partnership NHS and Social Care Partnership Trust
West Kent Neuro-rehabilitation Unit
The Knole Centre, Darent House, Hospital Road, Sevenoaks, Kent, TN13 3PG

West Kent Neuro-rehabilitation Unit at Sevenoaks is an eight-bed inpatient service for West Kent residents. It is a patient centred neuro-rehabilitation service focusing on complex Acute Brain Injury patients requiring a multidisciplinary team intervention in a specialist setting who have experienced non-progressive neurological illness or accident.

The service helps patients to acquire new skills so they can re-adjust to independent life in the community by identifying and working towards realistic goals within important areas of the patients life. These areas could include mobility, work, study, leisure, personal, social or domestic activities. The team can also, where appropriate, provide emotional support to the patient's carers and relatives.

Stroke Association
Communication Support Service
29 Hollingworth Court, Turkey Mill, Ashford Road, Maidstone, Kent, ME14 5PP

Stroke Association provides a Communication Support Service to stroke survivors who are living with the effects of communication difficulties, to create opportunities to develop communication strategies, help rebuild confidence and get back to life after stroke.

The service provides high quality information, emotional support and practical advice in the aftermath of a stroke. The Stroke Association will work with the survivor and their family immediately following a stroke and will continue for as long as needed (in hospital, care homes, their own home and in the community).

Support is provided on a one to one basis or within a group setting with the service co-ordinator and trained volunteers providing the survivor with an opportunity to practice communication and gain confidence in dealing with everyday situations. Support groups are run on a regular basis for survivors and carers to attend.

This service runs Monday to Friday, 9am – 5pm.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 September 2015

Subject: Emotional Wellbeing Strategy for Children, Young People and Young Adults

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the Emotional Wellbeing Strategy for Children, Young People and Young Adults.

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

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1. Introduction

(a) The Health Overview and Scrutiny Committee considered reports on emotional wellbeing and mental health services for children and young people in Kent on 31 January 2014, 11 April 2014, 6 June 2014, 10 October 2014 and 6 June 2015.

(b) On 6 June 2015, the Committee agreed the following recommendation:

- *RESOLVED that the report be noted and NHS West Kent CCG and Kent County Council be invited to submit the final version of the strategy and provide answers to questions raised at today's meeting to the Committee in September.*

2. Potential Substantial Variation of Service

(a) It is for the Committee to determine if the NHS commissioned aspect of the new model of care constitutes a substantial variation of service.

(b) Where the HOSC deems the new service specification as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to NHS West Kent CCG.

(c) Where the HOSC determines the new service specification to be substantial, a timetable for consideration of the change will need to be agreed between the HOSC and NHS West Kent CCG after the meeting. The timetable shall include the proposed date that NHS West Kent CCG intends to make a decision as to whether to proceed with the proposal and the date by which the HOSC will provide any comments on the proposal.

3. Recommendation

If the NHS commissioned aspect of the new model of care is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the new model of care in relation to CAMHS to be a substantial variation of service.

(b) NHS West Kent CCG be invited to submit a report to the Committee in six months.

If the NHS commissioned aspect of the new model of care is *substantial*:

RECOMMENDED that:

(a) the Committee deems the new model of care in relation to CAMHS to be a substantial variation of service.

(b) NHS West Kent CCG be invited to attend a meeting of the Committee in three months.

Background Documents

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (31/01/2014)'*,
https://democracy.kent.gov.uk/mgAi.aspx?ID=27048

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (11/04/2014)'*,
https://democracy.kent.gov.uk/mgAi.aspx?ID=27877

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (06/06/2014)'*,
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5397&Ver=4

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (10/10/2014)'*,
https://democracy.kent.gov.uk/mgAi.aspx?ID=29245

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (05/06/2015)'*,
https://democracy.kent.gov.uk/mgAi.aspx?ID=31953

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NHS
West Kent
Clinical Commissioning Group

Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years) (CAMHS)

Health Overview and Scrutiny Committee

4th September 2015

Patient focused,
providing quality,
improving outcomes

Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years)

Summary

This paper provides a progress report on the development of the Emotional Wellbeing and Mental Health Service for Children, Young People and Young Adults in Kent.

Historically, children and young people's services have been fragmented, disjointed and confusing to navigate with services working in silos. This has often resulted in the child or young person having to 'start over' with each new service they come into contact with and a 'revolving door' culture in which the health and wellbeing needs of the child or young person are not being adequately met.

The new Model, which draws together all the current service provisions throughout Local Authority and Healthcare, outlines a whole system approach to emotional wellbeing and mental health in which there is a Single Point of Access, clear seamless pathways to support ranging from Universal 'Early Help' through to Highly Specialist care with better transition between services. Work is already taking place to implement the associated Delivery Plan; short term actions are in progress and longer term work on future commissioning plans has started.

Work is continuing with partners to look at how existing resources can be aligned to support this work. Following the final agreement of the Service Model, the contract procurement process will commence in autumn 2015.

Recommendation

Members of the Kent Health Overview Scrutiny Committee are asked to note the contents of this report.

Due to legal obligations relating to the extension of the current contract, a procurement process is necessary in order to identify a new provider.

1.0 Introduction and Background:

1.1 In January 2014, Kent HOSC raised concerns regarding the performance of child and adolescent mental health services across Kent. This prompted a review of the services which found disparity between how schools support CYP and staff approach to building resilience, numerous contact points and disjointed services, too much focus on Tiers of service rather than the needs of the CYP, lengthy waiting times from assessment to treatment, high numbers of cases not meeting the referral threshold and inconsistent support to young people around transition. A whole system agreement was reached that a new approach to children's mental health in Kent was urgently needed.

1.2 This issue is clearly of national concern. A national task group set up by Norman Lamb, the then Minister for Care and Support, reported similar concerns to those in Kent. This important work stream for Kent strategically fits with work across the country in improving children's emotional wellbeing provision. It strategically aligns with the NHS 5 year forward View, the 49 recommendations of Future in Mind, the mental crisis care concordat and KCC transformation programme for 0-25 years old.

1.3 Emotional wellbeing underpins a range of positive outcomes for children and young people and is a key multi-agency agenda. Nationally and locally, demand is rising for specialist mental health services: 3 children in every class have a diagnosable mental health condition (10%) and there is recognition of the need for a whole-system approach to promote wellbeing, identify need appropriately, and intervene earlier.

1.4 Over the last year a huge amount of work and negotiation has taken place to transform children's emotional wellbeing services in Kent. The emotional and wellbeing strategy has been developed and consulted on widely with children, young people and families.

1.5 In light of the complexity of the challenge agreement was reached across the system to extend two major children and young people's contracts to allow the time for organisations to develop a major transformation programme for children's and young peoples emotional wellbeing services across Kent.

1.6 This work has been developed though a range of partnership structures and governance arrangements to ensure whole system commitment and agreement. This has included regular reporting to both the Childrens and Kent Health and Wellbeing Board, bespoke strategic summit events, Clinical Commissioning Group governance structures and KCC 0-25 Portfolio Board.

This report summarises the:

- Final version of the Strategic Framework
- A multi-agency Delivery Plan
- The Model
- The Procurement Process
- Financial and Activity Mapping

2.0 What's Different in the New Model?

- A Single Point of Access (SPA) to ensure swifter referral and appropriate sign posting
- Anti-stigma campaign associated with poor mental health
- Whole school approach to improving CYP resilience
- Upskilling children's workforce
- Support to families through universal and accessible services
- Making the most of technology
- Focussed on the needs of the child and young person
- A whole system approach to reduce transfer between services
- Partnership working between Heath and LA for efficient use of resources
- Improved Specialist support for long term mental health problems and during crisis
- Smooth transition between children's and adult mental health services for the 14-25's

3.0 Overview of Activity

3.1 Development of the Emotional Wellbeing Strategy and supporting Delivery Plan (presented to the committee on 5 June 2015) has been driven by a real desire to engage with and listen to the views of children, young people, families and professionals of all backgrounds. In total, around 650 contributions have been received since June 2014 via a range of online surveys, workshops, and engagement events. The amount of interest and quality of responses given by such a wide cross-section of the local population and workforce underline the importance of this agenda, both at a strategic level and in the everyday experience of families in Kent.

3.2 The aim of such extensive engagement was to piece together a variety of perspectives in order to understand how best to design a 'whole system' approach: one not only focussed on the quality of commissioned services (crucial though these are), but also on strengthening partnership working at every stage, improving the visibility and accessibility of support, and underlining the role of all partners to promote and protect emotional wellbeing.

3.3 In addition to engagement activity, the content of both the Strategy and Delivery Plan has been directed by the findings of a refreshed Emotional Wellbeing Needs Assessment, and from a range of national and local reviews and best practice guidelines.

3.4 A draft Service Specification has been written and circulated to all CCG commissioners and Clinical Leads and KCC colleagues and the feedback is currently being collated and incorporated into the document and will be finalised by September 2015 ready for the initiation of the procurement process.

3.5 This issue is everybody's business. Families, schools and universal services play the key role in promoting children's emotional wellbeing. In addition to universal provision KCC commissions and manages contracts that deliver a range of services in relation to emotional wellbeing and is responsible for 2 key contracts relating to emotional wellbeing - the Young Healthy Minds Service and the Children in Care element of the CAMHS contract. The NHS Clinical Commissioning Groups are responsible for commissioning targeted Child and Adolescent Mental Health service. The specialist services are commissioned by NHS England.

4.0 Strategic Framework

4.1 The Strategy was developed following initial surveys and facilitated discussion groups with children, young people and families and from service providers.

4.2 The draft Strategy has been shared widely and a12-week period of engagement ran from 20 October 2014 to 5 January 2015 through the following channels:

- **Online consultation survey**, hosted on kent.gov.uk and CCG platforms, with links through the Live it Well website and KELSI. The survey was further promoted through the Schools e-Bulletin, GP bulletins, Members' bulletins, District Council and Voluntary and Community Sector (VCS) networks, Health Watch Kent and Kent Public Health Observatory.

- **Presentation of the draft Strategy and engagement discussions** held at a wide range of strategic and local multi-agency forums, including Kent Health and Wellbeing Board, Health and Social Care Cabinet Committee, Clinical Commissioning Groups, Mental Health Action Group Chairs, local Health and Wellbeing Boards, patient involvement forums, and Children's Operational Groups.

4.3 In addition to the discussions held, a range of individuals and organisations responded to the engagement. Overall findings indicated:

- 100% of respondents identified parents and carers as the primary group needing additional information and support around emotional wellbeing issues.

- Schools were identified as the second key group needing additional information and support around responding to emotional wellbeing.

- The structure of the strategy is around four themes; Early Help, Access, Whole Family Approaches, Recovery and Transition, however importantly the underpinning action to promote emotional wellbeing at every opportunity was unanimously welcomed.

4.4 Following the engagement, a number of amendments have been made to the original Strategy to incorporate feedback received (including the addition of content relating to children affected by Child Sexual Exploitation and to target health inequalities). (Please refer to the Strategy document provided to the committee on 5 June 2015).

5.0 Development and Engagement Activity for The Delivery Plan

5.1 In addition to the online survey, a number of engagement events were held during November and December 2014 to inform development of the supporting Delivery Plan. These included:

- Practitioner workshops,

- Further engagement with young people, including the development of a second film sharing young people's views about the most valuable methods of delivering support.

- A second Emotional Wellbeing Summit (18 December 2014). A number of KCC members attended the summit events.

5.2 The draft Delivery Plan summarises findings from the Kent Emotional Wellbeing Needs Assessment, engagement activity, and best practice reviews and outlines a series of recommended actions that together will lay the foundation for a whole-system approach to emotional wellbeing.

5.3 The recommended actions will be achieved through a combination of improved partnership working, particularly in relation to much more and more effective

communication, training for universal services staff, and also access to consultation with specialist professionals, as well as key procurement activity.

5.4 This means that some of the actions can be implemented in the short-term, which began in March 2015, while others will need to be included within procurement exercises for new services beginning in October 2016 (when existing contracts with providers will expire). Suggested timescales are included within the Delivery Plan, alongside recommended lead agencies.

5.5 This is clearly a multi-agency action plan; founded on the vision agreed by key strategic stakeholders and partners at the Emotional Wellbeing Summit in July 2014 that emotional wellbeing is 'everybody's business'. The recommended actions will therefore only be achievable with involvement and commitment from a wider range of partners than before – for example, in supporting relevant workforce development or embedding it within planned programmes of training.

5.6 Work is therefore continuing with partners to identify how existing resources can be realigned to support the 'whole system' approach, recognising that this is intrinsically connected to the success of specialist commissioned services in meeting need. The emotional wellbeing and mental health needs of children in care will be considered as part of this work. A technical group has been drawn together to lead on this element, led by the Clinical Commissioning Groups (CCGs).

6.0 The Model

6.1 The detail required to deliver the model will be contained within the national specification guidance and the service specification will inform the future contracts and the contractual framework required. A contract technical group has been established which has developed the Service Model in partnership with commissioners and clinicians (see Appendix 1).

6.2 Key points of the model include the following:

- Promoting emotional wellbeing – how to embed this in all the work that we do this will include a multi-agency communications strategy.

- A single point of access/triage pathway model across emotional wellbeing early intervention and mental health services.

- Enabling children and young people to receive timely access to support; development of drop-ins or safe spaces in schools.

- Increased availability of consultation from specialist services.

- A ‘whole family’ protocol, defining how parents and carers will be involved and identifying and responding to the wider needs of the family within assessments of the child’s emotional wellbeing.

- Effective implementation of multi-agency tools and protocols to identify children and young people who have been affected by Child Sexual Exploitation (CSE), and rapid access to specialist post-abuse support.

- Emphasis in the model for continued improvement of performance to agreed contract requirements across the system

- Smoother transition between services, particularly from children’s to Adult’s mental health services and additional support for those aged 14-25 and leaving care.

7.0 Procurement Process and Contracting

7.1 The service will be procured by NHS West Kent CCG acting as a lead commissioner on behalf of other CCGs across Kent and Medway and Kent County Council. The structure of this arrangement will be defined using the standard model NHS collaborative commissioning agreement.

7.2 As this is a healthcare service commissioned by the NHS it will be procured in accordance with the relevant statutory regulations – the Procurement Patient Choice and Competition Regulations 2013. These place extensive obligations on the commissioner to act in a transparent and proportionate way, to treat providers equally and in non-discriminatory way, and to procure the service from providers that are most capable and best value, while ensuring proper management of conflicts of interest.

7.3 The procurement aspects of the commissioning project will be led by NHS Commercial Solutions, the procurement partner of NHS South East Commissioning Support Unit (SECSU) which supports NHS West Kent CCG.

7.4 The service will be contracted using the standard NHS healthcare services contract. In accordance with NHS recommended practice, the contract will have an initial term of 3 years and an optional extension of 2 years. The contract management for the service will be based on the provisions of the standard NHS contract, supported by the pricing model and key performance indicators defined in the service specification referred to above.

7.5 Initial assessment of the provider market indicates there is already an established wide pool of potential providers for the service. Accordingly, there is no requirement to conduct market development activity prior to the formal procurement process.

7.6 The procurement approach will be structured to mirror the provisions of a fully-regulated procurement procedure, taking account of the requirement to execute an assured and robust process within a challenging timetable. Subject to detailed planning (currently in progress) the approach will use either (a) the restricted procedure (a two-stage approach comprising an initial shortlisting stage (pre-qualification) and a tender stage) or the competitive dialogue procedure (a three-stage approach comprising an initial shortlisting stage (pre-qualification), a dialogue stage, and a final tender stage).

7.7 The procurement will be executed within the overall governance structure of the collaborative commissioning programme, resourced by a multi-disciplinary team combining subject matter experts for commissioning, clinical quality and patient safety, financial management, patient experience, workforce, information governance systems and technology, and other resources as appropriate. The team will include representatives of patient groups.

7.8 When the project team has completed the evaluation stage and its recommendation of preferred bidder have been approved, it will initiate two parallel streams of work to
   (a) conclude the contract with the preferred bidder, and
   (b) work with the preferred bidder on mobilisation and transition to the new service.

8.0 Financial Envelope:

8.1 The current dedicated financial envelope to deliver the new model is over £22m. This includes over £16m Health and Local Authority funding for the specialist services for children with significant mental health problems including those who are in Local Authority care and those who have been victims of child sexual exploitation.

8.2 In addition, there will be over £5m invested in support services which intervene earlier, through provision which provides additional support to children, young people and their families.

8.3 There will also be enhanced support, information and guidance offered to those services which work universally with children's - for example children's centres, health visiting, schools and services for adolescents. This will be delivered through information about technology available, workforce development including training and regular information provided to services.

8.4 Kent is part of a national bid for Big lottery funding for the Headstart programme. This programme of work is already investing in research and pilot programmes both in Kent and nationally. This will see new resource for Kent for supporting schools in promoting resilience and wellbeing, in reducing the stigma attached to ill mental health and providing guidance in how the curriculum can incorporate teaching about good mental health.

9.0 Next steps:

9.1 During Autumn 2015, the following activity will take place:

- Continued implementation of short-term improvement actions identified in Delivery Plan
- Continued scoping of the interdependencies of current pathway developments e.g. neuro development, learning disabilities, Early help, health visiting, eating disorders pathways.
- Finalise the new NHS Child and Adolescent Mental Health specification, including the Child in Care element of the contract and the early intervention contract and agreeing contract procurement frameworks.
- Present the Model and Specification to each CCG for approval.
- Seek KCC and CCG governance approval for the proposed model and financial envelope (see Appendix 2) to deliver the new service.
- Technical group to complete activity, capacity mapping and recommend resource allocation.

- Consider consultation route for new procurement and contract framework
- Market engagement to inform development and costing of the model

9.2 It is anticipated that formal procurement processes will begin in the autumn 2015, subject to approval of specifications.

10.0 Recommendations

Members of the Kent Health and Overview Committee are asked to

(i) NOTE the contents of this report.

11.0 Appendices

Appendix 1 Service Model

Appendix 2 Needs Assessment

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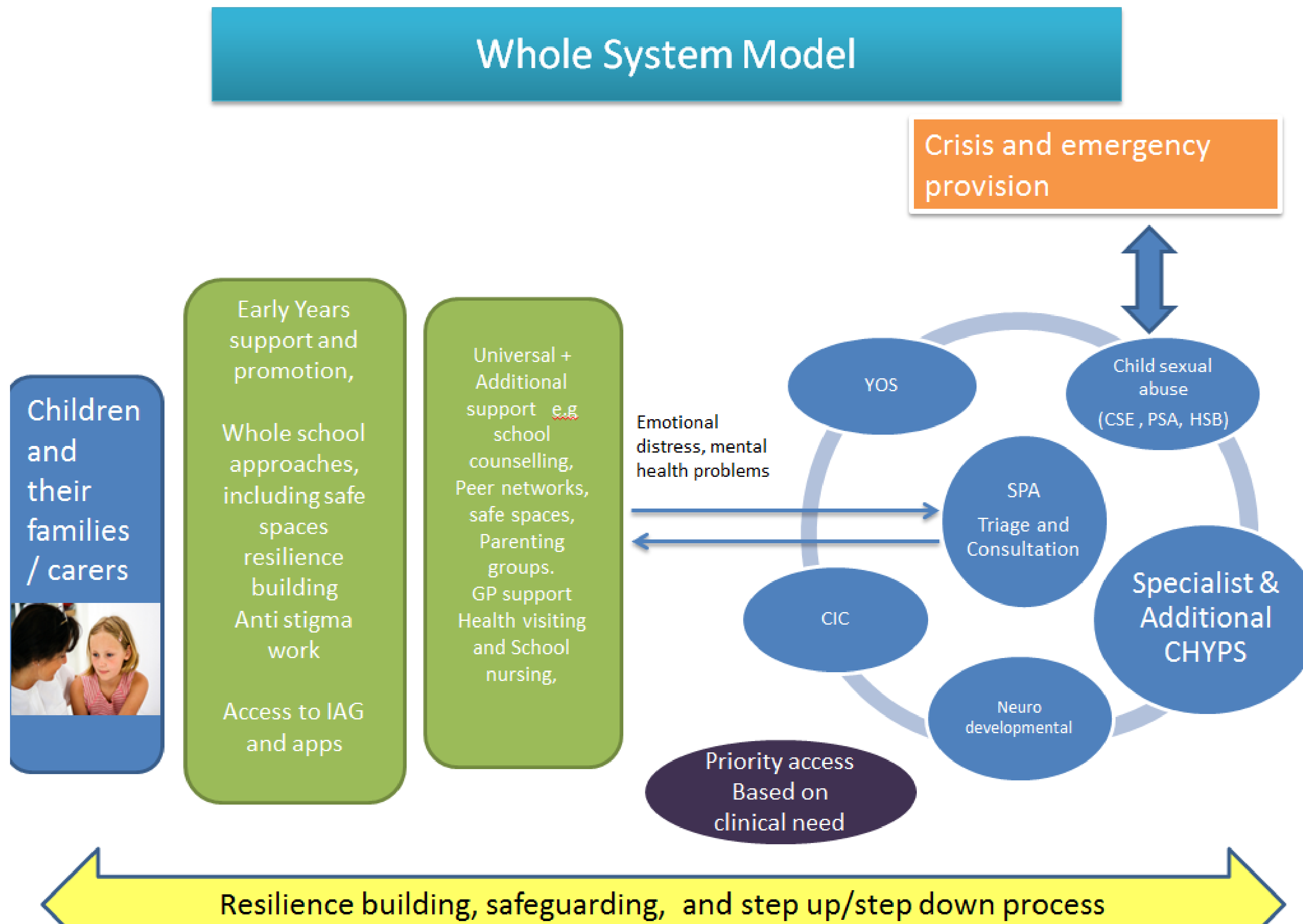
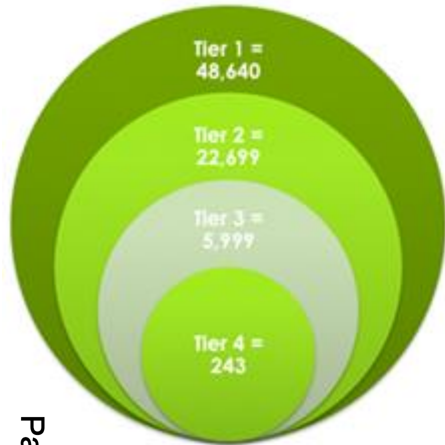
APPENDIX 1 – The Service Model



APPENDIX 2 – Needs Assessment



Specialist

CAMHS

LAC CAMHS

Sexual abuse

Additional

Parenting programmes

Troubled Families

Mental Health Practitioners within EH Units

Universal

Schools

Children Centre's

Troubled Families

Health Visitors

School Public Health services

HeadStart Resilience Programme

Child Sexual Exploitation JSNA

Significant behaviours identified by CYP who are being sexually exploited can include:

- Poor mental health
- Self-harm
- Thoughts of suicide

Prior to abuse CYP can exhibit

- Low self-esteem and lack of confidence.
- Poor mental health
- Living in a chaotic household

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Item 6: NHS West Kent CCG: Diabetes Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 September 2015

Subject: NHS West Kent CCG: Diabetes Services

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

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

---

1. Introduction

(a) NHS West Kent CCG has asked for the attached report to be presented to the Committee:

NHS West Kent CCG Report	pages 51 - 56
Appendix 1 - Patient Engagement Report	pages 57 - 72
Appendix 2 - GP Membership Engagement Report	pages 73 - 76
Appendix 3 - Proposed Model of Care	pages 77 - 78

2. Potential Substantial Variation of Service

(a) It is for the Committee to determine if the proposed model of care constitutes a substantial variation of service.

(b) Where the HOSC deems the proposed model of care as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the CCG.

(c) Where the HOSC determines the proposed model of care to be substantial, a timetable for consideration of the change will need to be agreed between the HOSC and CCG after the meeting. The timetable shall include the proposed date that the CCG intends to make a decision as to whether to proceed with the proposal and the date by which the HOSC will provide any comments on the proposal.

3. Recommendation

If the proposed model of care is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the proposed model of care for Diabetes Services in West Kent to be a substantial variation of service.

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

3. Recommendation

If the proposed model of care is *substantial*:

RECOMMENDED that:

(a) the Committee deems the proposed model of care for Diabetes Services in West Kent to be a substantial variation of service.

(b) West Kent CCG be invited to attend a meeting of the Committee in three months.

Background Documents

None

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NHS

West Kent
Clinical Commissioning Group

Diabetes Service Review 2015/16

Health Overview & Scrutiny Committee
Friday 4 September 2015

Patient focused
Providing quality,
improving outcomes

NHS West Kent CCG Diabetes Service Review 2015/16

Summary

This report advises the Committee of a proposal under consideration by NHS West Kent CCG to reconfigure/recommission diabetes services. As part of the CCG's Commissioning Intentions 2015/16 and 2016/17, diabetes services and care have been identified as a key priority for improvement to meet the future challenges that will come with the predicted rise in prevalence. The current pathway is fragmented, with services delivered by separate organisations (hospital, community, GP practices) with no overarching care planning across the system. There is scope to deliver more holistic care for patients and to develop a more 'joined-up' pathway between hospital, GP practices, community and mental health support. The successful management of patients with diabetes requires a whole system approach, with support for self-care and care in the community as key elements that can have a major impact on outcomes across all care settings. Through delivering more integrated care, NHS West Kent CCG anticipates that it will improve both the quality of care and also make better use of resources.

The proposal is to decommission the current secondary care level 3 diabetes services for NHS West Kent CCG and to recommission the same in the community under an integrated level 2 and 3 service.

During May and June 15, NHS West Kent CCG has led a joint patient and stakeholder engagement programme to seek views on improvements in diabetes care, covering both local health care professionals and patients. The purpose of this paper is to provide a summary on the results and outcomes of the engagement.

Members of the Kent Health Overview & Scrutiny Committee are asked to note the contents of this report.

Introduction and Background

The current diabetes pathway for NHS West Kent CCG follows a tiered approach, as listed below:

Level 0 is Public Health commissioned prevention and lifestyle services for self-care, underpinning all of the other tiers;

Level 1 is NHS England commissioned core primary care services delivered by health care professionals across the 62 GP practices within NHS West Kent CCG;

Level 2 is enhanced primary care services currently delivered by 28 GP practices. The aim of the level 2 service is to provide enhanced community based services for all adult patients with diabetes, and also manage those who have more complex needs such as injectable therapies (e.g. GLP-1 and insulin) with the view of improving clinical outcomes.

Level 3 is a consultant led specialist multi-disciplinary service, delivered in secondary care/hospital setting and aimed at patients requiring specialist input. Maidstone and Tunbridge Wells NHS Trust (MTW) are the current providers of Level 3 (intermediate) services and employ a multi-disciplinary team of:

- Consultants in Diabetes and Endocrinology
- Diabetes Specialist Nurses
- Diabetes Inpatient Specialist Nurse (DISN)
- Diabetes Specialist Dieticians
- Diabetes Specialist Podiatrist

Level 4 is a consultant led multi-disciplinary service, delivered in secondary care/hospital settings aimed at patients with complex needs and also includes an inpatient service and emergency admissions**.**

NHS West Kent CCG is working to redesign diabetes services for adults with the intention to enable a larger proportion of care to be delivered outside of an acute setting. At present, a significant level of activity takes place as outpatient consultations within MTW by Consultant Diabetologists and Diabetes Specialist Nurses, although Kent Community Healthcare Foundation Trust (KCHFT) provides some community based services. It is recognised that a significant amount of the care for level 3 patients could and should be delivered by a skilled workforce closer to patient's homes i.e. in a community setting and outside of an acute hospital. This in turn would release capacity inside the acute hospital for the treatment of complex level 4 patients, whose care is dependent on a hospital infrastructure.

Predicted levels of local future need

The resident population of NHS West Kent CCG is 467,500 and 86,000 of those people are aged 65 or over, a higher proportion than across England as a whole. In the CCG, 2.5% of people live in the most deprived fifth of areas in England. In 2013/14 a total of **20,485** patients (17 years and over) were recorded to have diabetes which is significantly lower than any other CCGs. There were an estimated **4,800** people who remain undiagnosed suggesting the total number of adults with diabetes in the CCG was around **25,300**. Between 2013/14 and 2019/20, the crude prevalence rate of diabetes in adults is expected to increase from 5.5% to 6.8% and the undetected prevalence rate is expected to increase from 1.3% to 2.6%.

People with diabetes are at a higher risk of having a heart attack or stroke. In this area, people with diabetes are 88.5% more likely than people without diabetes to have a heart attack. This is lower than the figure for England which is 108.6%. People with diabetes are also 103.2% more likely to have a stroke. This is higher than the figure for England where there is an 81.3% greater risk. NHS West Kent CCG spent £320 on prescribing per person with diabetes which is higher than the England average of £285. The total spend on prescribing for anti-diabetic items between April 2013 and March 2014 was £6,550,000. Prescriptions to treat diabetes accounted for 9.1% of the total CCG prescribing budget.

The National Institute for Health and Care Excellence (NICE) recommends nine care processes for diabetes. There are five risk factors (body mass index, blood pressure, smoking, glucose levels (HbA1c) and cholesterol) and three tests to identify early complications (urine microalbumin, creatinine, and foot nerve and circulation examination). Eye screening is recommended but not included in the data presented. Controlling the risk factors helps a person with diabetes reduce his or her future risk of developing diabetic complications. There are also recommended targets for HbA1c, cholesterol and blood pressure. NHS West Kent CCG data for 2012/13 (most recent data available) is listed below:

Indicator	Local	Comparator CCGs	England
People with diabetes who have had 8 recommended care processes	48.6%	56.7%	59.5%
People with diabetes whose last HbA1c was equal to or less than 58mmol/mol	64.2%	68.6%	62.4%
People with diabetes meeting blood glucose, blood pressure and cholesterol targets	35%	34.8%	36%

For West Kent CCG there have been 1,216 episodes of care for diabetic foot disease between 2011/12 and 2013/14, accounting for 10,847 nights in hospital. The annual rate of episodes of care for diabetic foot conditions per 1,000 adults with diabetes is significantly higher than the national average. There were 41 major amputations performed during the three years, giving an annual rate of 0.7 major amputations per 1,000 adults with diabetes, which is not significantly different from the national average. 549 different patients were admitted for foot disease. 51.2% of these had more than one episode of care in the three years, which is significantly lower than the national average. Of the 549 patients, 13.5% had more than four periods of care, which is significantly lower than the national average.

Using national data from 2011, Type 2 diabetes can be estimated to cost NHS West Kent CCG £13 million for treatment and management, as well as £51 million from diabetic complications. For 2019/20, a cost of nearly £21 million to the local health economy is projected using the crude prevalence of diabetes.

It has been shown in studies that good diabetic management in the first 10 years of diagnosis has the maximum impact on morbidity and mortality, hence timely diagnosis and appropriate initial management of the disease is crucial to a patient's clinical outcomes.

Case for change

The current status of service provision and strategy around diabetes prevention and management within west Kent has much scope for improvement, and is ill placed to meet the future challenges that will come with the predicted rising prevalence:

- There is a lack of a comprehensive obesity strategy to slow the rise in the expected number of diabetics in west Kent
- The current programmes (e.g. NHS health checks) for early detection of diabetes has had variable impact with much room for improvement especially in the deprived and ‘hard to reach’ populations.
- There is a lack of comprehensive local strategy or pathway to deal with patients with ‘impaired glucose regulation’ in terms of identification, registers and clinical management
- Primary care capability is variable leading to variable standards of care delivered to patients
- Primary care capacity has not risen with the rise in prevalence due to resource constraints which has affected patient care and outcomes
- There has not been any ‘workforce planning‘ for diabetes in west Kent, leading to patchy and variable provision of services based on historical commissioning (e.g. dietetics and podiatry)
- Services like specialist nursing, diabetic podiatry and dietetics are predominantly secondary care based, which is both expensive and fails to reach patients who need their services in the community
- Diabetic related preventable non-elective admissions are on the rise and consuming a significant level of resources
- Most secondary care based diabetic services are based on activity rather than outcomes
- The financial risks to NHS West Kent CCG related to the above points are worsening each year in rising planned, unplanned and prescription costs
- It is estimated that nationally only 15% of diabetic patients meet the 3 ‘best practice targets’ (Hba1c: 6.5% or 48mmol/mol, Cholesterol: <4mmol and BP: <135/80)

NHS West Kent CCG aims to address the current issues facing primary, secondary and community care by developing a Prevention and Obesity Strategy to slow down the expected rise in prevalence. A primary care diabetes prevention programme is in place to support earlier diagnosis of diabetes and improvement in control of the main risks associated with diabetes; namely blood pressure, cholesterol and glycaemic control.

Patient and Stakeholder Engagement

During May and June 15, NHS West Kent CCG led a joint patient and stakeholder engagement programme to seek views on improvements in diabetes care, covering both local health care professionals and patients.

Patient Engagement: An engagement plan was developed and agreed to ensure people with diabetes were asked to provide feedback using an online and paper survey, discussion groups and one-to-one discussions. A total of 210 responses were received to the survey and 39 individuals took part in both the groups and individual discussions. The full report is attached as Appendix 1.

Summary of findings

- The majority of respondents were not aware that they were at risk before they were diagnosed
- Whilst most respondents feel well informed and confident in managing their diabetes, there is mixed feedback as to whether information has been provided. Most answering the online survey indicate information was provided whilst the focus groups and individual discussions highlight a lack of recent and up to date information
- The “location of appointments at the GP” and “quality of care at GP”, both receive the highest ratings with a mean score of 3.49 out of 4.
- The “waiting time to get an appointment in community” is rated lowest (a mean score of 2.61 out of 4) as well as “waiting time to get an appointment at hospital” (2.79 out of 4)
- Most respondents had not experienced any problems getting to appointments and the main issue for the remaining respondents included the waiting time for appointments with nurses
- Whilst two thirds of respondents believe that the proposal would improve their experience of diabetic services either a little or a lot, the remainder indicates no improvement, although this is mainly due to respondents indicating they already receive good quality of care, often already delivered in a community setting.

- Respondents highlighted:
    - a need to improve podiatry and dietary services for patients
    - importance of psychological support for new diabetic patients
    - a need for more education on diabetes – possibly in community settings
- The main areas that would help respondents to manage their diabetes more effectively include:
    - More support and help with diet including losing weight, information and education on food groups and support with exercise
    - More regular appointments with diabetic nurses to ensure their levels were stable.

The main fixed risk factors associated with diabetes relate to age, gender and ethnic group. The rate of onset of Type 2 diabetes increases with age, diabetes is more common in men and in certain ethnic groups: it is up to six times more common for people of South Asian ethnicity, and up to three times more common in those of African and African-Caribbean descent. As part of the analysis, it was noted that due to the low response from the BME population, more focussed work is needed to ensure appropriate input and representation. This is due to be completed by the end of August 15 and will further inform the service specification.

GP Membership Stakeholder Engagement: NHS West Kent CCG held two diabetes GP workshops on 25 June 15 at the protected learning time events as follows:

- Tonbridge, Tunbridge Wells and Sevenoaks locality – represented by 90 GPs and 11 community nursing staff
- Invicta, Maidstone & Malling locality – represented by 75 GPs

The workshops were designed to raise awareness, generate discussion about current services, identify gaps and invite feedback on how diabetes services can be improved to inform the service specification. The workshops involved a presentation from the CCG GP chief commissioner and GP diabetes lead outlining the aims for the session, the strategic context for diabetes care as a key priority for NHS West Kent CCG and the outcomes that the CCG hopes to achieve through improving diabetes care. Round table group discussions were held where all GPs were asked to discuss 4 key areas:

- What services should be based in the 'hubs' and what services should be based in the 'spokes?'

- What should be the number of 'hubs' and the number of 'spokes' to meet the service needs of west Kent population (62 practices, 465,000 patients and 21,000 diabetics)? Pease identify the population number that an individual hub and a spoke should service on average respectively?

- What systems of communication (including technological innovations) should be specified for the service to ensure that each practice clinician has a quick and easy, direct and virtual access to Consultant, DSN and Podiatry expertise based at these hubs and spokes?

- Define in your own view what an ideal format for continual education and training for primary care should look like under the redesigned services.

The full summary report detailing outcomes and themes from the discussions is attached as Appendix 2.

The patient and stakeholder engagement plan has provided valuable input relating to current gaps in service provision, together with suggestions of what an improved service may look like to meet future challenges. In summary, NHS West Kent CCG has received no opposition to the principle of redesigning the service and will ensure that suggested areas for improvement are included in the service specification.

The proposal

A diabetes project group has been established to oversee the development of the proposed service with input from both commissioners and clinicians. Work is underway to identify how existing resources can be realigned to support the integrated 'whole system' approach.

The detailed service specification is currently work in progress but is based on the following key principles:

- Improved integration between primary and secondary care
- A single point of access/triage pathway
- Shifting specialist services to the community to reach a larger cohort of complex patients needing multidisciplinary specialist input
- Better skill mix utilisation
- Care closer to home – range of community based clinics 'spokes' across a wider geographical area
- Implementation of new payment structure 'single integrated tariff' that will cover the care of both Type 1 and Type 2 patients as a 'single package of care'. This tariff will be based on activity and outcomes.
- Current level 2 and level 3 services to be commissioned under a singly multisystem community provider (MSCP) contractual model

Based on the outcome of patient and stakeholder engagement, the proposed model of care is outlined in Appendix 3

Next steps:

- An equality impact assessment is being carried out. Given the increased risk factors associated with ethnicity, a targeted patient engagement approach is being undertaken to ensure the needs of BME patients are reflected - final report due end of August 2015
- Finalise service specification / model reflecting outcomes of patient and stakeholder engagement
- The Clinical Strategy Group / Governing Body to meet in November 2015 to consider the business case for the proposed clinical model
- The planned start date for the new service will be 1 July 2016

Recommendation:

Members of the Health and Overview Committee are asked to:

- NOTE the contents of this report

Appendices:

Appendix 1: NHS West Kent CCG Patient Engagement Report – May to June 15
Appendix 2: NHS West Kent CCG GP Membership Engagement Report – June 15
Appendix 3: NHS West Kent CCG Proposed Model of Care

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NHS
West Kent
Clinical Commissioning Group

NHS West Kent Clinical Commissioning Group (WK CCG) Engagement Report – Diabetes Services

Report Produced by:
Participation and Insight Team, South East Commissioning Support Unit (SECSU)
Julie Van Ruyckevelt, Principal Associate;
Ferne Haxby, Senior Associate;
Victoria Dyer, Senior Associate

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Appendix B – Detailed Responses – see attached document 16

2 Introduction

NHS West Kent CCG is working with partners to review Diabetes services in the area and the Participation and Insights team (P&I), South East Commissioning Support Unit (SECSU) were asked to gather insights in order to help inform the business case.

An engagement plan was developed and agreed with WK CCG to ensure people with diabetes were asked to provide feedback using an online and paper survey, discussion groups and 1-2-1 discussions.

A total of 210 responses were received to the survey and 39 individuals took part in both the groups and individual discussions.

3 Background

Diabetes services are being actively re-commissioned by many CCGs in the country. There are various models in place or being planned. Local factors and CCG priorities have resulted in different models being implemented in different areas but each following a common underlying principle of moving the bulk of diabetes services into the community.

NHS West Kent CCG is working intensively with partners and the local Health and Wellbeing Board in the development of an obesity strategy that strategically aligns with the diabetic service; the same alignment is being sought with Public Health in strengthening the vascular check services for early detection.

The commissioning proposal is to decommission the current secondary diabetic services for West Kent CCG and re-commission a service fit for purpose in the community under level 2 & 3 services. Secondary care services could be re-contracted for level 4 only which will be a significantly smaller service than is currently provided. Further it is proposed that the level 2 LES with individual Practices should be decommissioned. Both level 2 & 3 could be procured under a single MSCP (Multisystem community provider) contractual model where federations will need collaborative arrangements with specialist services, preferably from the local Foundation Trust.

4 Methodology

The overarching aim for this engagement activity is to provide the CCG with feedback from patients and carers, primarily, and other members of the public on the current status and proposed re-design of diabetes services in order to ensure any changes reflect patient views. Specific objectives for the engagement and insights work, as agreed with the CCG, are to obtain feedback on the following areas:

- Awareness of condition & symptoms - current and projected epidemiology of Diabetes
- Quality implications of proposed vertical integration of primary and secondary Diabetes services
- Access to diagnosis/treatment
    - Location
    - Accessibility
    - Waiting time etc.
- Perceptions of current level of care – primary and secondary
- Education on condition and signposting

    - Awareness and use of educational courses (DAFNE and DESMOND)
    - Other self-help groups
- Preferences for re-design
    - Location of services
    - Timings/frequency
    - Specialist staff available
- Possible improvements
- Patient experience

A survey was developed in consultation with CCG commissioners to address these objectives. The survey was provided online and as a paper version where required. In addition, a short discussion guide was developed (based on key questions from the survey) in order to undertake a small number of focus groups with existing diabetes support groups. Furthermore, those individuals that agreed to be involved in further work around diabetes were also contacted by telephone and email to provide more in-depth feedback around key issues.

The survey and discussion guide can be found in Appendix A.

The table below describes the channels used to distribute the survey including the groups and individual discussions undertaken:

Target Group/Channel	Methodology	Dates
PPG Chairs Meeting	Discussion and Feedback	13.5.15
West Kent CCG Database	Email and paper	19.5.15
Healthwatch	Email for distribution	19.5.15
WKCCG Website	Website with link to survey	19.5.15
WKCCG Practice Bulletin	Insertion with link	19.5.15
WK Voluntary Action	Distribution to all diabetics on list	19.5.15
Bearsted Diabetes Support Group	Discussion and Feedback	21.5.15
Wateringbury Diabetes Support Group	Discussion and Feedback	25.5.15
KCC Community Liaison Officers in each of the boroughs	Email for distribution	10.6.15
Independent Diabetes & Renal Support Working with South East Strategic Clinical Networks and Senate	Email for distribution	1.05.15
Diabetes UK	Email for groups and distribution	1.05.15
One to One Interviews	Email, Telephone	23.6.15
One to one Interviews	Email, Telephone	24.6.15
One to one interviews	Email, Telephone	26.6.15
One to one interviews	Email, Telephone	28.6.15

A total of 38 respondents wish to be added to the West Kent CCG Health network and 71 respondents are interested in being further involved in the continuing work relating to diabetes.

5 Summary of Findings

- The majority of respondents were not aware that they were at risk before they were diagnosed.
- Whilst most respondents feel well informed and confident in managing their diabetes, there is mixed feedback as to whether information has been provided. Most answering the online survey indicate information was provided whilst the focus groups and individual discussions highlight a lack of recent and up to date information.
- The "location of appointments at the GP" and "quality of care at GP", both receive the highest ratings with a mean score of 3.49 out of 4.
- The "waiting time to get an appointment in community" is rated lowest (a mean score of 2.61 out of 4) as well as "waiting time to get an appointment at hospital" (2.79 out of 4)
- Most respondents had not experienced any problems getting to appointments and the main issue for the remaining respondents included the waiting time for appointments with nurses.
- Whilst two thirds of respondents believe that the proposal would improve their experience of diabetic services either a little or a lot, the remainder indicates no improvement, although this is mainly due to respondents indicating they already receive good quality of care, often already delivered in a community setting.
- Respondents highlighted:
  - a need to improve podiatry and dietary services for patients
  - importance of psychological support for new diabetic patients
  - a need for more education on diabetes – possibly in community settings
- The main areas that would help respondents to manage their diabetes more effectively include:
  - More support and help with diet including losing weight, information and education on food groups and support with exercise
  - More regular appointments with diabetic nurses to ensure their levels were stable.

5.1 Recommended Next Steps

Given that ethnic groups are at higher risk of diabetes and whilst they are represented according to overall population, it is recognised that further more targeted engagement is required with these population groups within west Kent. The existing ethnic minority organisations and groups were contacted by email and paper as appropriate with the survey link and a request to complete and disseminate however given the relatively low response rate, further targeted work will be undertaken as follows:

- Work with Public Health, District Council contacts and Equality & Diversity Manager at the CSU to cross reference and identify relevant contacts.
- Distribute emails and conduct telephone calls to known ethnic minority organisations, voluntary groups and social groups to encourage involvement in engagement around diabetes services.
- Undertake telephone depths and discussion groups where possible.
- Incorporate feedback in final engagement report.

This work will be undertaken during late August and September 2015.

The responses were analysed in a number of ways to check for any significant differences according to demographics as well as responses to other questions within the survey. However no differences were identified and responses were similar across age groups, gender and in relation to time with diabetes.

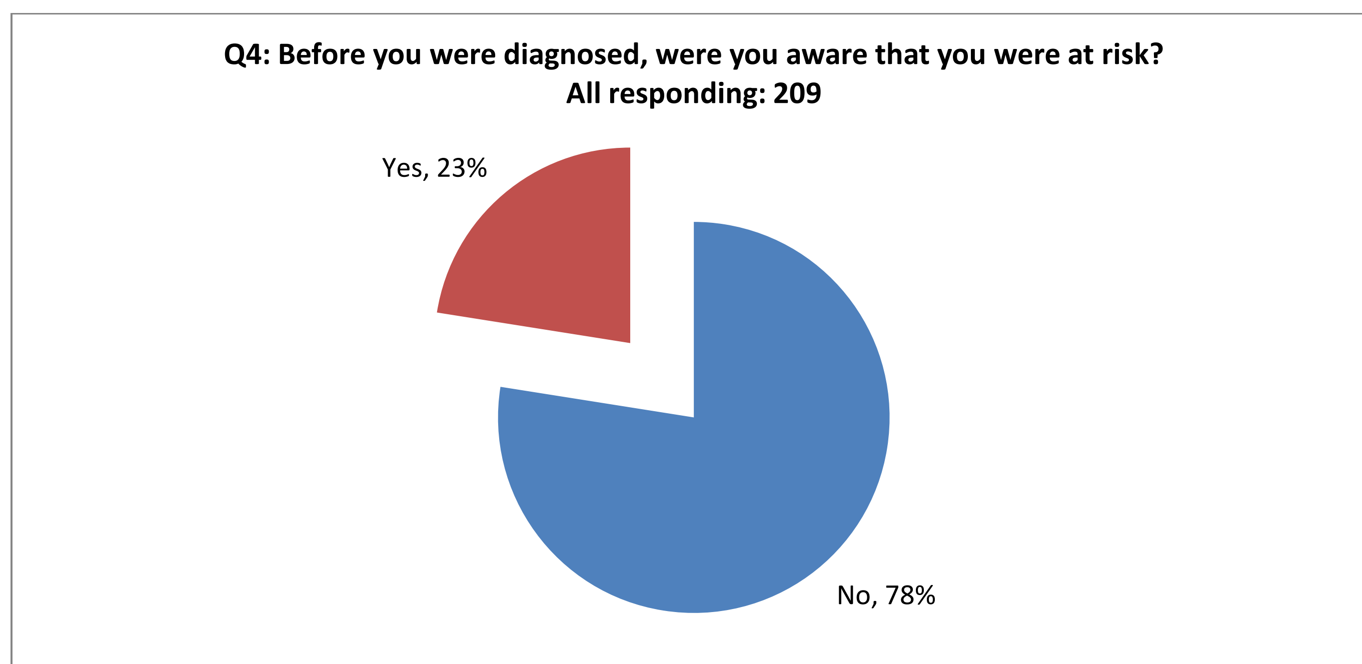
5.2 Respondent Condition

In order to put responses into context, respondents were asked to provide details of the type of diabetes they have and how long they have had diabetes.

	Total	Up to 1 year	2-4 years	5-7 years	8-9 years	10 years or more	Number of Respondents
Type 1	20%	5%	10%	10%	7%	68%	**41**
Type 2 (no medication)	19%	10%	28%	23%	10%	28%	**39**
Type 2 (medication only)	47%	7%	33%	21%	9%	30%	**98**
Type 2 (medication and insulin)	15%	0%	0%	13%	6%	81%	**31**
All responding	**209**	**13**	**47**	**38**	**18**	**93**	**209**

As shown in the table, almost half the respondents overall indicate that they have Type 2 diabetes and are on medication only (47%). Of those with Type 1 diabetes, two thirds have had it for 10 years or more (68%).

Over three-quarters of respondents were not aware that they were at risk before they were diagnosed (78%) as shown below. In fact of those responding 88% indicated that they were not provided with any information to prevent or delay onset. Where information was provided, this mostly related to dietary advice.

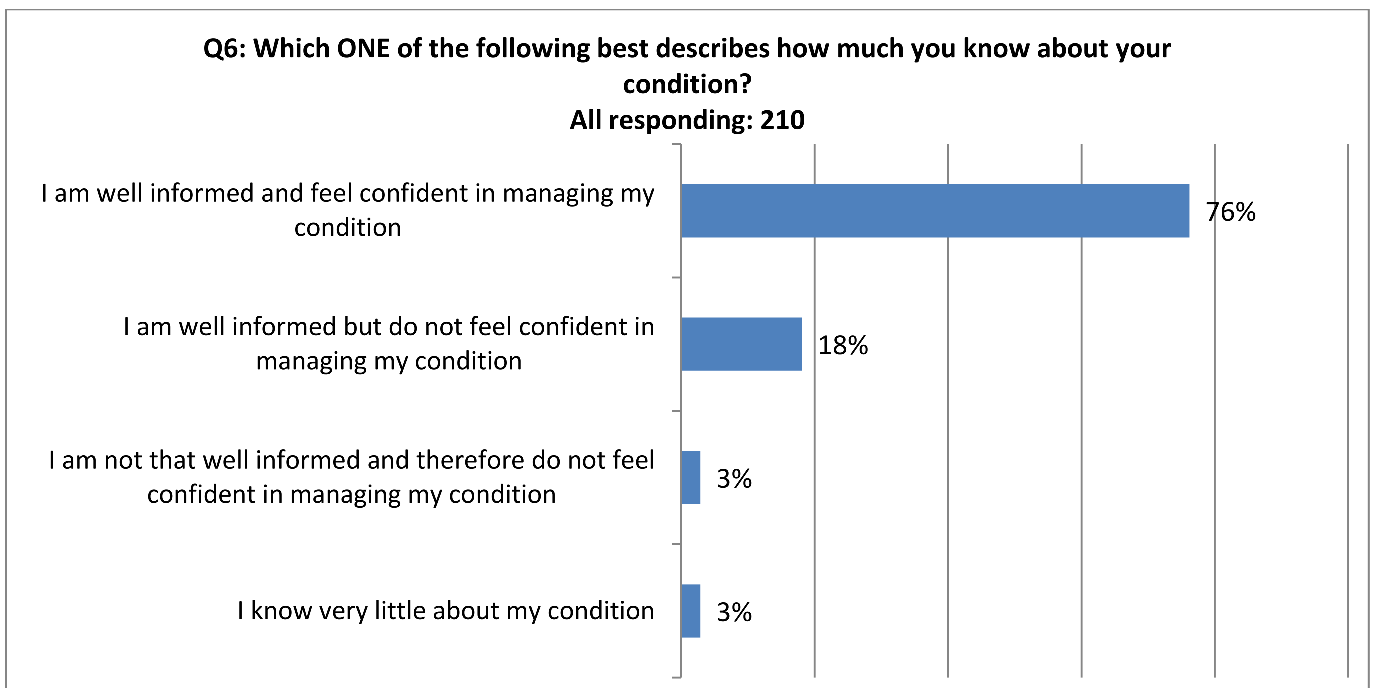


"Lose weight, exercise more. But not explained could result in Diabetes."

"Diet and weight control."

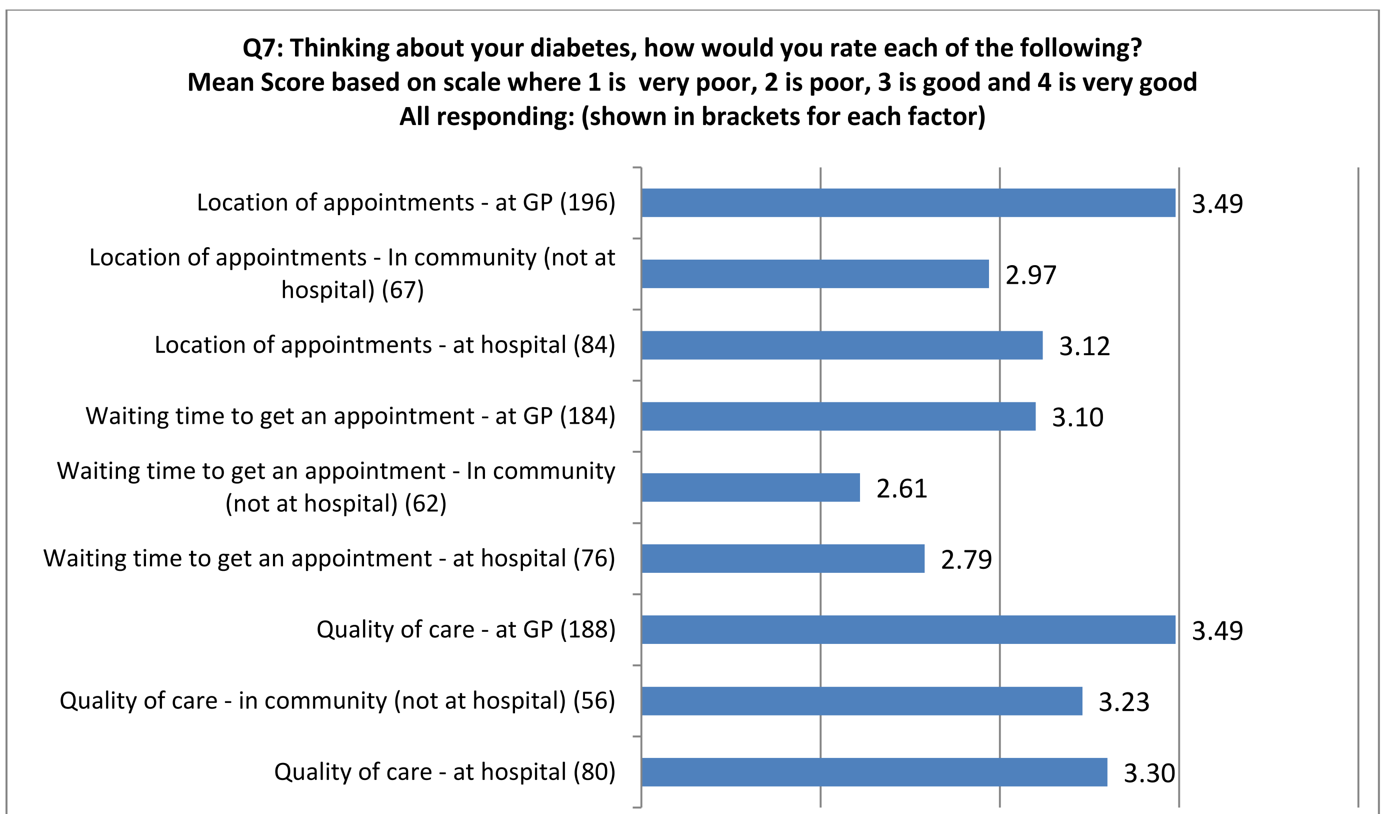
"Weight control and healthy diet."

Three-quarters of respondents indicate that they feel well informed and confident in managing their diabetes (76%). A further fifth (18%) feel well informed but not confident in managing their diabetes.



5.3 Current Experience of Services

Highest rated factors are "location of appointments at the GP" and "quality of care at GP", both with a mean score of 3.49 out of 4.



Lowest rated factors are "waiting to get an appointment (in community)" with a mean score of 2.61 out of 4 and "waiting to get an appointment at hospital" with a score of 2.79 out of 4.

5.3.1 Problems Getting To Appointments

When asked if they had experienced any problems getting to appointments related to their diabetes, 57 responded and the main themes were as follows:

- 18 indicated that they had no problem getting to appointments
- 13 respondents stated that there were delays getting nurses appointments. Most felt that the nurses were very busy and waiting lists could be up to several months and clinics were only held on a couple of days a week, which causes further delay.
- 4 respondents reflected that getting to hospitals with parking problems and public transport issues proved problematic in getting to appointments
- 2 people stated that it was almost impossible to get a podiatry appointment.

"Diabetic nurses are busy - appointments can take several months"

"Delay in getting appointment as "clinics" only held two days a week"

"Surgery under resourced (One Health Care practitioner for diabetes) so difficult to get appointments."

"Appointments at Podiatry Clinic hardly ever happen!"

"Parking at the Diabetes centre in Tunbridge Wells (Abbey Court) is appalling. I had to find a space on the road which made me late for my appointment even though I had allowed myself 20 minutes to find a space."

"Travelling to the hospital for eye outpatients is quite difficult as bus services are quite infrequent."

5.3.2 Information Received about Condition

When asked if they had received any information related to their diabetes (written or online), 62% indicated that they had (38% said no) and the main themes were as follows:

- 41 respondents stated that they had received general information in the form of leaflets and pamphlets. These ranged from guidance leaflets when first diagnosed, information on pregnancy and their condition.
- 33 respondents reflected that they received information from the health care professionals when they went to appointments/reviews, this included test results and diet advice.
- 14 respondents indicated that they found information from the Diabetes UK website or other sources on the internet. One person mentioned that he liked to look up information himself.
- 11 respondents had received copies of information passing between consultants and their GP
- 9 respondents had received education and information by attending educational courses (DAFNE)

"Guidance leaflets when first diagnosed"

"I was given some information at diagnosis"

"Got the NHS booklet"

"With every appointment, what are key areas etc."

"From the diabetic nurse"

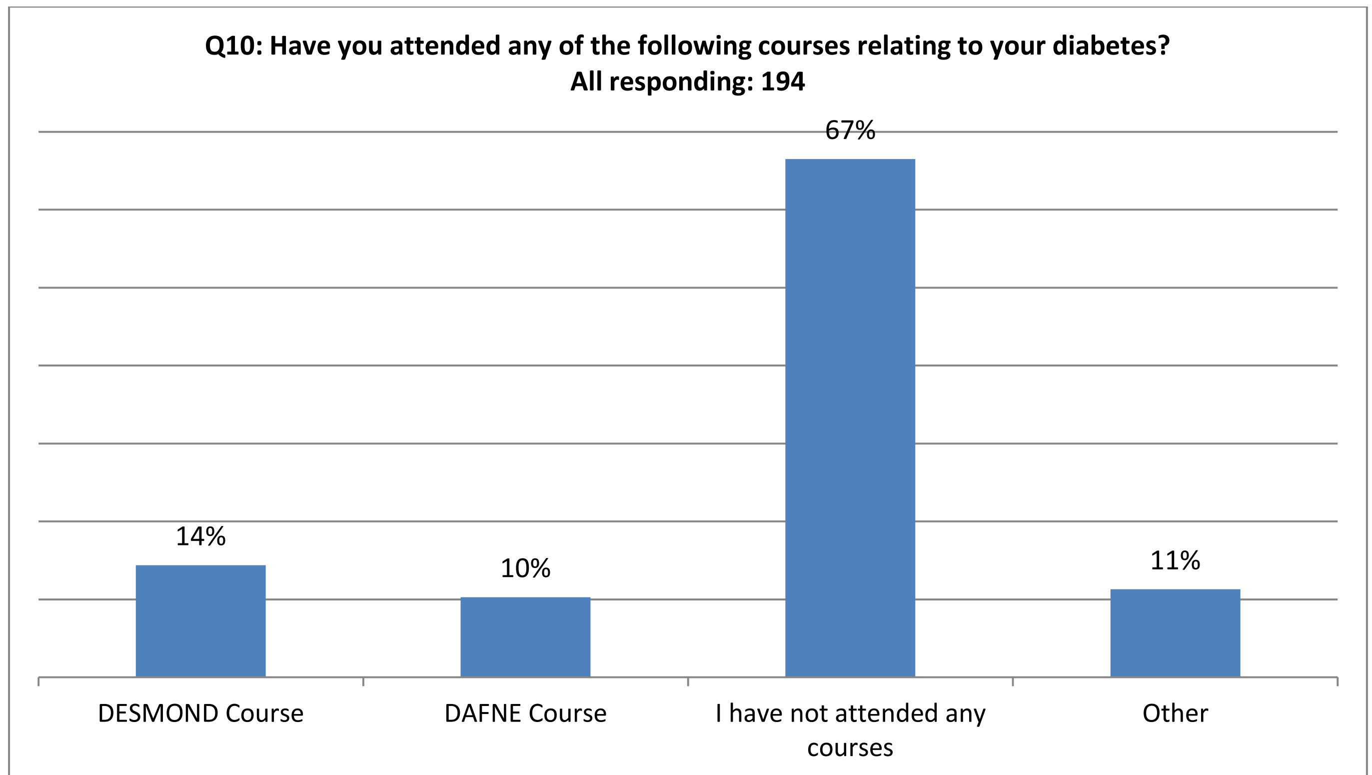
"Regular Handouts by my GP on test results and other information as required"

“What I found myself”

“Annual letter from consultant following appointment”

5.3.3 Courses Attended

Two thirds of the respondents have not attended any courses relating to their diabetes (67%)



Other courses mentioned include:

- 5 respondents said that they had had one to one interviews with their clinicians about diabetes, including dieticians and doctors
- 3 respondents had attended day courses, including the ‘Living with Diabetes Day’
- 2 respondents had attended different courses, Pitstop and Xpert
- 2 respondents had attended meetings put together by their surgeries
- 3 respondents are awaiting attendance to the DAFNE course.

“Living with Diabetes Day -excellent seminar”

“Initial General Course when first diagnosed + Diet course +dietician detailed guidance.”

“Health talk at surgery”

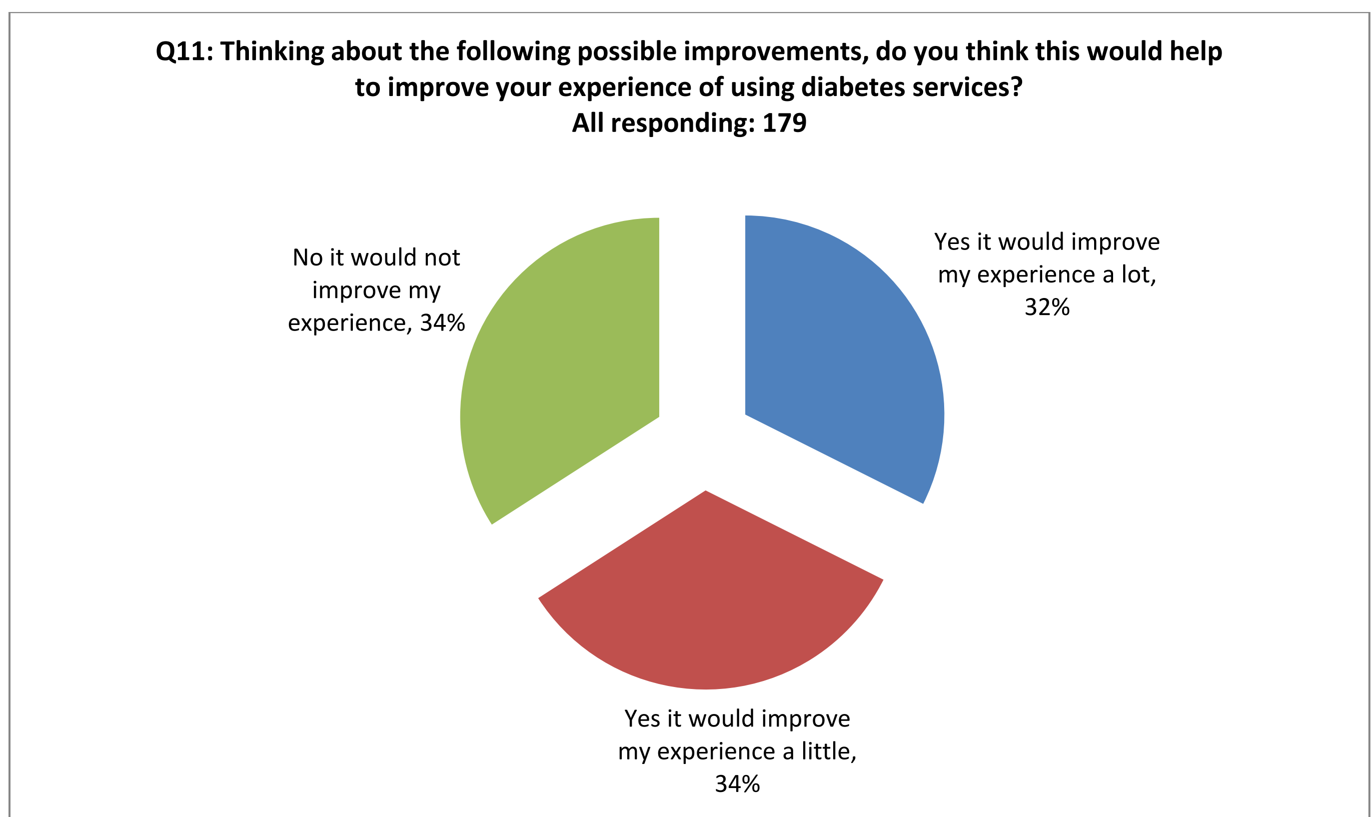
5.4 Feedback on Proposal

The following possible improvements were presented to respondents:

Possible improvements identified by NHS West Kent CCG include:

- **Move services typically provided at hospital to community settings**
- **Provide a more local, specialist led service to include:**
  - Access to community specialist services for housebound diabetics
  - Specialist dietetics including psychological support
  - Specialist podiatry
  - Insulin pump service
  - Education and support for patients
  - Multidisciplinary assessment and case management (specialist, nurse, dietician and podiatry)
  - Education, training and closer communication between this new service and GPs/Practice Nurses
- **Services provided face-to-face as well as via email and telephone as appropriate.**

Respondents were then asked to indicate to what extent, if any, these possible changes would improve their experience of using diabetes services.



Opinions are fairly evenly divided, although two thirds indicate that the possible improvements would improve their experience to some extent (32% a lot and 34% a little).

Of those indicating the proposal would "**<u>improve their experience a lot</u>**" a variety of comments were made (45 respondents) with few common themes emerging.

- 7 respondents felt the need to improve podiatry and/or dietary services for patients. The need to access and have regular podiatry check-ups is not available at present. Also advice and education on diet would be helpful.
- 5 respondents expressed a view that psychological support was very important to new diabetic patients
- 4 respondents indicated that local services would have the benefit of specialist care and help overstretched surgeries.
- 3 respondents would like to see improved communication between health care professional and patient as well as clinician to clinician
- Other comments included:
  - Personal care plans for diabetic patients
  - Not everyone is on a computer
  - More appointments being available
  - Proposals would provide a more holistic service

"Feels more like an holistic service"

"Psychological support is very important as I had a real chock and was in denial. Also I don't have symptoms so I tend to forget that I'm diabetic. Dietician & podiatry help will be good support too."

"I have received specialist psychological support in another area and it was vital to improving my ability to control the diabetes. This must be offered quickly to whoever requests it if better control is to be achieved."

"I do not feel that access to dieticians or podiatry is good at present. Maybe it is because of cost".

"Having a more local specialist led service would be much better than using my overstretched GP surgery facilities"

"I am not fully aware of what services are available. More regular communication. Reminders when I should be having blood tests etc."

"Having no computer I find myself isolated from receiving much relevant information, this must be remembered when planning services. Many of the older patients have this problem."

"I would like the service to be tailored to the individual by means of an agreed (patient & carer) annual care plan"

Of those indicating the proposal would "**improve their experience a little**" a variety of comments were made (44 respondents) with the following themes emerging:

- 7 respondents indicated that an improvement in the podiatry service would be welcome. One person had been waiting since November 2014 for an appointment.
- 6 respondents felt that more education on the condition should be available with 2 saying dietary help would be beneficial
- Services closer to home would be welcome to 3 respondents with education available

- 5 respondents felt that they were getting sufficient care for diabetes but would welcome improvements as they could see that this could only improve patient experience
- Other comments included:
    - More check-ups being made available
    - Having greater flexibility on appointments within primary care
    - Improved face to face appointments

"I live close to my Practice so have no problems with travel. Podiatry care needs urgent improve I am still waiting to attend a Nov 2014 appointment due to lack of slots available"

"Regular podiatry would make a difference"

"I received podiatry service monthly for 1 year and was then told that I should seek private podiatry. I have had a replacement hip and find it extremely difficult to trim my toe nails."

"The more education and support, the better the chances of patients understanding and acting to improve their health."

"Explain personal diet and support face to face"

"There is always room for improvement but I am happy with my standard of care"

"I guess because I'm already pretty confident it would not affect me personally dramatically, but I think it would improve most patients' experience a great deal."

"Services provided face-to-face as well as via email and telephone as appropriate."

"Better location/time of day flexibility"

Of those indicating the proposal would "**not improve their experience**" a variety of comments were made (48 respondents) with the following themes emerging:

- 23 respondents stated that the care they receive from the surgery could not be improved. 6 referred to their GP, 6 specified the Nurse.
- 16 respondents felt that the care they receive already was good and could not be improved. 5 out of the 16 also felt they were in control of their condition that they did not need any further intervention.
- 2 respondents felt that they were very borderline in their condition and could not offer any comment
- 2 other respondents highlighted that they were happy with the care they received from the hospital and felt that their experience could not be improved.

"The person to person care given by my local surgery would be hard to improve"

"I feel very well served by the specialist nurse at my GP surgery."

"I am very aware of my situation and I try to manage my life by a good balanced diet and exercise."

"I have my condition under control and know what I should be doing and what I should be eating."

“I am satisfied with the care I receive.”

“Provision of services related to my condition are excellent.”

“My daughter has type 1 diabetes. She is incredibly well supported by both the consultant and ds nurse at Maidstone hospital. She receives regular 3-monthly check-ups. These cover psychological support if required, podiatry check-ups, discussions about the management of her diabetes via the pump. She feels well supported. However, I do feel that GPs could be more well-informed.”

“I can access the hospital easily for my appointments. The nurse at the GP surgery does the annual checks for their records.”

The full list of responses can be found in Appendix B.

5.5 One Big Thing to help Manage Condition More Effectively

When asked what one big thing would help them to manage their diabetes more effectively, 136 people responded and the following are the most frequently mentioned themes:

- 34 respondents felt they are managing their diabetes at the moment with about half saying they are happy with the care they receive.
- 22 respondents would like more help with their diet. 4 specifically wanted help losing weight and a couple felt exercise would help. Although several people mentioned that they could self-manage themselves better with their diet, most felt they needed help knowing those foods that were high in sugar and could affect their diabetes.
- 13 respondents stated that they would like to be seen more regularly by the diabetic nurses to ensure their levels were stable. Not everyone said how often they attended but a couple stated that 6 monthly and even 1 year appointments were not regular enough.
- 7 respondents reflected that they required more information around their condition and accessing the nurse for this was difficult, one person saying that they had to wait over 24 hrs for the nurse to come back to them on a question.
- Smaller numbers reflected on:
    - Access to podiatry (4)
    - Having better education around diabetes (4)
    - Access to psychological services (CBT) (3)
    - Group support (2)
    - Local services (3)
    - Pharmacies (2) difficulty getting diabetic essentials

“Finding more variety of food that is low in both sugar & fat together with cheaper options for nice and not boring exercise to help the reduction of the weight “

“Having a regular 3/4 month blood check automatically” “Regular compulsory blood testing by GP practices for all diabetics. i have experienced a GP's refusal to do just this.”

“Treatment and discussion about my condition as an intelligent individual; the 'lowest common denominator' approach is condescending and rude. Explanation of the roles of both Consultant and Diabetic Nurse at the onset for a new patient (new diabetic or new patient moving into the area).”

"Help, either on line or at a call centre that is manned extended hours and weekends."

"Improve access to podiatry service"

"Diabetic support groups locally e.g. Doctors surgery"

"Being able to have blood tests at my GP Clinic rather than at the local hospital. It would be far more convenient, time efficient and would mean that I would be more likely to have my blood tests more regularly than I do at present. Pressures of work mean that I do not find it easy to visit the hospital during their opening hours for a blood test."

"We have regular problems with the local chemist and their supply of diabetic necessities. They constantly run out of stock. This would not be an issue if they called us once the repeat prescription has been submitted and they knew there was nothing in stock. We could then instantly go to another chemist"

"My medication is on a 28 day batch system for some of the items. All the items should be on a batch system and the Pharmacy should not demand 3 days advance notice for the next batch - they have all the information that they need to prepare the next batch needed in 28 days time."

6 Discussion Groups and One to Ones- Detailed Analysis of Findings

6.1 Respondent Background

There were two support groups that agreed to run focus groups as follows:

- Bearsted: 21 patients attended – 1 Type 1, 20 Type 2
- Wateringbury: 6 patients attended – 1 Type 1,5 Type 2

A further 12 respondents to the online survey agreed to some follow up questions relating to prevention and education.

It appears from the focus groups that most respondents were **not advised that they were at risk** before developing diabetes (around 6 out of 27 were advised). Two respondents also highlighted the lack of information of genetic risk. It became evident from the individual discussions that no specific advice was provided to patients other than to lose weight and without any clarification of the importance of doing so. The individuals highlighted the fact that they often feel fine at the point of diagnosis and that more should be done to promote the risks and early signs of diabetes.

In terms of **information provided** to respondents this is an area that needs to be improved. There needs to be more information provided at time when advised an individual is at risk as well as at the time of diagnosis. Respondents indicate that this information should be about managing the condition rather than clinical. Other respondents also highlight the need for information to be updated regularly as medical advice and available treatments change.

Few respondents had heard of DAFNE and DESMOND courses although they were all very positive about them and felt they should be offered to all patients with diabetes stating the benefits of education as well as sharing experiences with other patients. When education was discussed, individuals raised the

question of making courses available within primary care or within a community setting rather than at hospital.

6.2 Location and Quality of Care

Virtually all respondents **attend their GP surgery for check-ups** relating to their diabetes (1 attends hospital). The quality of care at the GP practice is considered good and those attending Wateringbury practice specifically highlighted the good communication and continuity of care.

6.3 Feedback on Proposal

Whilst on the whole respondents were positive about the proposal to provide more diabetic care in community settings with specialists, some gaps were identified in general:

- Difficulty obtaining podiatry appointments
- Lack of choice of hospital appointments
- Lack of flexibility of appointments especially for working people and parents

6.4 One Big Thing

When asked what one big thing would help them to manage their diabetes more effectively the following comments were made:

- Easy to understand list of symptoms you get when you get a 6 month check-up. If you want anything you have to ask, this should be made available.
- More information and for all information to be kept simple and clear especially information relating to diet and nutrition as patients can get confused over proteins, fats etc.
- Information on self-management - some patients use sticks, others don't and there is contradictory advice from clinicians.
- Better knowledge and help with support groups.
- Exercise classes for all – not just told to exercise and sent away but advice given on what exercise is good.
- Buddy Schemes and walking groups in surgeries

6.5 Respondent Profile

In order to put the responses into context the following provides a demographic profile of respondents.

Ethnicity	Total
White - English/Welsh/Scottish/Northern Irish/British	89%
White – Irish	1%
White - Gypsy or Irish Traveller	-
Any other White background	4%
Mixed / Multiple ethnic groups - White and Black Caribbean	-
Mixed / Multiple ethnic groups - White and Black African	-
Mixed / Multiple ethnic groups - White and Asian	1%
Any other Mixed / Multiple ethnic background	1%
Asian / Asian British - Indian	-
Asian / Asian British - Pakistani	-
Asian / Asian British - Bangladeshi	-
Asian / Asian British - Chinese	1%
Any other Asian background	1%
Black / African / Caribbean / Black British - African	1%
Black / African / Caribbean / Black British - Caribbean	-
Any other Black / African / Caribbean background	-
Other Ethnic Group - Arab	1%
Prefer not to answer	2%
Number of Respondents	**179**

Age	Total
16-24 years	1%
25-34 years	2%
35-44 years	4%
45-54 years	10%
55-64 years	22%
65-74 years	37%
75 years or more	23%
Prefer not to answer	1%
Number of Respondents	**182**

Gender	Total
Male	59%
Female	40%
Prefer not to answer	1%
Number of Respondents	**177**

Appendix A – Questionnaire – see attached document

Appendix B – Detailed Responses – see attached document

Diabetes Service Review 2015/16
GP Membership Engagement Events held at PLT on 25/06/15

a). what services should be based in the hubs and what services should be based in the spokes?

Tonbridge, Tunbridge Wells, Weald and Sevenoaks

Hubs	*Spokes*
• Education groups etc. • Pump management • Vascular clinics • Antenatal care • Paediatrics • Transition paeds/adult • HCP education • Consultant • Communication • Education • Resource centre • Diabetic consultant • Renal consultant • Antenatal • New Type 1 DM	• Diabetic retinopathy • Dietetics • Podiatry • 'One stop shops' • Nurses • GP • DSN • Dietetics • Psychologist

Other Comments:

- Floating level 2/3 & clinics rotating around practices
- Community nurse to see patients that don't have level 2 access
- Level 1 – All practices
- Level 2 – Federation based services including; injectable (initiation and optimisation), dietician, podiatrist with proper fast access to;
  - Foot specialist
  - Renal specialist
  - Complex case nurses for housebound
  - Specialist diabetic nurse
- Level 3 – Diabetic consultant and ED specialist

Invicta, Maidstone & Malling and Weald

Hubs	*Spokes*
• DSN • Podiatry • Dietetics • Resources and training material and facilities. • Daphne/Desmond • Foot Clinic • Largely level 4, some exceptions from level 3 • Insulin pump services • Podiatry • Dietician • GPwSI Diabetes • Podiatrist • Specialist Nurses • Level 3 (GPwSI and one consultant) • Consultant Endocrinologist and current level 3-4 DSNs. • Visiting vascular opinion	• DSN • Health Education • Obesity • Specialist GP • Podiatry • Dieticians, Podiatry Level 2 and Level 1 • Education • DESMOND • Predominately Level 2 and 1 with liaison between (DSNs, Specialist Practice Nurses, Practice Nurses) • Level 2 trained practitioners (DSN, Practice Nurse, GP for insulin/ GLP-1 initiation and adjustment. • Available for advice to other clinicians. • Patient education (delivery) • Type 2 for insulin • All level 2 in spokes

• Patient education (coordinated) • Transition child – adult • Level 4 and 3 – podiatry, dietetics, DAPHNE, development of Kinesis • Type 1 diabetes • Children and young people diabetes. • All level 3 in hubs	

Other Comments:

- Questioned whether physical hubs and spokes required
- Need 5 year commitment to structure and service provision

b). what should be the numbers of 'hubs' and the number of 'spokes' to meet the service needs of west Kent population. Identify the population number that an individual hub and a spoke should service on average.

Tonbridge, Tunbridge Wells, Weald and Sevenoaks

- Pending geography
- Hubs? – Paula Carr, TH and Pembury, Abbey Court
- In conjunction with regional/area services and at practice level
- Questioning the need for this model – can the services be provided at a practice level
- Minimum of two hubs – could be Cottage Hospitals not necessarily acute settings
- Spokes should not necessarily be fixed, could rotate.
- Depends on available resources. Provided access is good, requirement for very few hubs. Unsure of number of spokes.

Invicta, Maidstone & Malling and Weald

- 4 hubs; MGH (4) linking to Central Maidstone, South Maidstone and West Maidstone (all 3).
- 3 Hubs (Maidstone, Tonbridge, T Wells linking to mobile spokes incorporating rural practices – approach linking to a Diabetes bus.
- 30000 patients per spoke, 15 spokes in total all linking to 3 hubs.
- Proposal for a hub in Cranbrook clinic, highlighting that several hubs needed to ensure coverage of rural areas and community access.
- Hubs formed around clusters of 30000 patients.
- Roving hub where 1 team covers several sites – plus potential for home visits (Paula Carr type system)
- Population not represented by hub, dependent on numbers of complex patients requiring input.
- Moving spokes across fixed premises with moving staff. Set hubs would need geographical access to be considered – are all patients within 20 minutes of a hub. For those which are housebound, DSN will be required from spoke. Propose 4 hubs and 16 spokes (4 spokes around each hub) – 25000 practice population per spoke or 1500 diabetics per spoke.
- Hubs based on 2 hospital hubs (focusing on level 4 provision) and a number of primary care hubs (incorporating podiatry, dietetics and DAPHNE)
- Highlighted that not enough information to form decision, outlined that 6 practices could form 1 spoke

c). what systems of communications should be specified for the service to ensure that each practice clinicians have a quick and easy, direct and virtual access to a consultant, DSN & podiatry expertise based at these hubs and spokes?

Tonbridge, Tunbridge Wells, Weald and Sevenoaks

- Better kinesis (improving communication and collaboration)
- Integrated systems (GP-Specialist (inc. podiatry)) - hospitals for viewing of patient referrals and interactions across services.
- Contracts for IT systems
- Role of Abbey Court

- Role/responsibility of a lead consultant → upskill nurses
- IT training resources
- Kinesis for Doctors and Nurses
- 24hr access to a diabetes nurses
- Use of telehealth for monitoring
- Notes sharing
- Hubs need integrated IT view
- Hubs to have primary care system to allow them to see primary care record
- MDT
- Kinesis

Invicta, Maidstone & Malling and Weald

- Vision & EMIS
- Skype for working
- BOS (?) links training
- System like Kinesis
- Access to notes of patients at other practices and ability to add to these notes (held centrally)
- MDT to have some access
- Kinesis type system to link hub and spoke. DSN inclusion
- Clinical information to be directly entered onto clinical system
- Will patients have access to system? – could patients email DSN directly
- Emails with phone calls and faxes
- Unified information – same system
- Email advice along with robust system
- Teledermatology for some Podiatry
- Email, Kinesis, Telephones
- Telehealth, Remote monitoring
- DESMOND

Other Comments

- CCG will need to provide respective funding for infrastructure.

d). define in your own view what an ideal format for continual education and training for primary care should look like under redesigned services

Tonbridge, Tunbridge Wells, Weald and Sevenoaks

- Specialities in the spokes to share skills and patient information, assist in MDT discussions.
- Pit stop courses have improved availability
- 'On the ground' teaching from CNS' to practice staff
- Learner centred education – tailored to individual

Invicta, Maidstone & Malling and Weald

- Training re Consultant to DNS and Consultant to GP interaction
- Meeting in practices with DNS
- Electronic toolkits in a fashion amenable to all members
- Individual educational needs/methods
- Case discussion
- Diabetes leads in practices
- Access to GPwSI/Consultant when needed (Kinesis style)
- Many GPs will not need to keep up to date as of specialist nurses
- Spokes provide education sessions to practices in their area
- Hubs provide education /mentoring for people in spokes.
- Annual education event for all, within hub.
- Fast and clear – letter, email communications.

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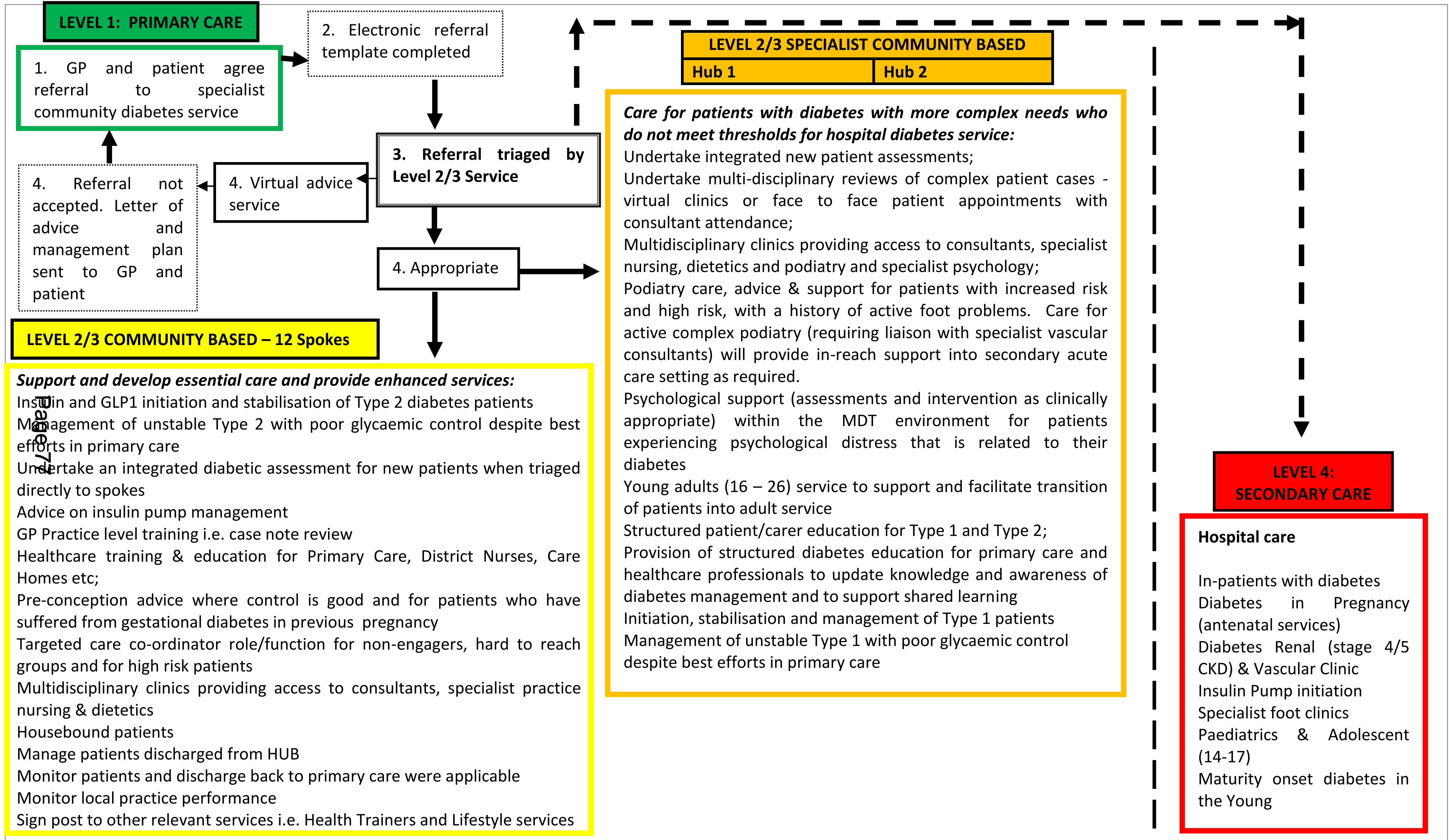

Level 0: Prevention & Self Care themes across all Levels: NHS Health Checks, Weight Management clinics, screening patient advice & signposting, healthy eating, stop smoking and general pre-conception advice.

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Item 7: Healthwatch Kent: Strategic Priorities

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 September 2015

Subject: Healthwatch Kent: Strategic Priorities

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

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

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1. Introduction

(a) Healthwatch Kent has asked for the attached reports to be presented to the Committee:

Healthwatch Kent Strategy 2015	pages 81 - 92
Healthwatch Kent Annual Report 2015	pages 93 - 112

2. Recommendation

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

Background Documents

None

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healthwatch Kent

Healthwatch Kent
Strategy 2015/16

Chief Executive Officer's foreword

This strategy sets out how Healthwatch Kent works and how we intend to continue working in 2015-16.

After a troubled beginning in 2013/14 Healthwatch Kent achieved a huge amount in 2014/15.We recruited, inducted and trained over 60 volunteers and two additional staff. We produced project reports on:

- Mental health inpatients
- Mental health carers
- Eastern European patients in East Kent
- Children & adolescent mental health services (CAMHS)
- Complaints in health and social care

Our project reports can be found here: http://healthwatchkent.co.uk/projects

We also undertook Enter and View visits to:

- an acute inpatient mental health ward
- 5 older person's care homes
- 5 learning disability services
- 3 A&E departments and 1 minor injuries unit
- 3 Outpatient departments

In addition to this a review of discharge arrangements in an acute hospital was completed.

We held events across the county to speak to the public about a variety of topics. We also built links with the voluntary sector, Patient Participation Groups and GP practices.

We have developed ways of working which empower our volunteers to represent Healthwatch at strategic meetings and forums across the county. We are committed to ensuring Healthwatch Kent is a partnership of volunteers and paid staff working in an open, transparent way, agreeing how we work and the issues we work on.

We have built our relationships with organisations and stakeholders via regular liaison and through our work at Kent's eight Health and Wellbeing Boards. We are seen as an objective, credible partner; this allows us to challenge poor quality services and acknowledge good practice. We are now being proactively approached by organisations to help them ensure the public are involved in service redesign.

We have a come a long way in the last year which is a huge credit to the volunteers and paid staff team. This strategy describes the way we work and identifies the areas **we will** develop in 2015/16.

Steve Inett, CEO, Healthwatch Kent

About Healthwatch Kent

What is Healthwatch Kent?
Healthwatch Kent was established in April 2013 as the new independent consumer champion created to gather and represent the views of our community.

Healthwatch plays a role at both national and local level and makes sure that the views of the public and people who use health and social care services are taken into account.

What do we do?
Healthwatch Kent took over the role of Kent Local Involvement Network (LINk) and also represents the views of people who use services, carers and the public to the people who commission plan and provide services. Healthwatch provides a FREE signposting service for people who are unsure where to go for help. Healthwatch Kent can also ask Healthwatch England and the Care Quality Commission to take action on concerns raised about the quality of health and social care.

Our Mission Statement
Our mission is to raise the public's voice to improve the quality of local health and social care services in Kent. We listen to you about your experiences of health and social care services and take your voice to the people who commission these services.

Our FREE Information and Signposting service can help you navigate Kent's complicated health and social care system to ensure you can find and access the services that are available for you. Call us on 0808 801 0102 or email info@healthwatchkent.co.uk

Our Values
- Partnership of volunteers and paid staff (over 60 volunteers, 7 staff)
- Information and intelligence based
- Support and guidance for services
- Two way communications
- Partnerships and relationships – achieving more in partnership than alone
- Honest, accountable and transparent

Equality & Diversity

Healthwatch Kent recognises that many people in our society experience discrimination or lack of opportunity for reasons that are not fair. Healthwatch Kent challenges discrimination and lack of opportunity in its own policy and practice and encourages other organisations and individuals to do the same.

Healthwatch Kent aims to create a culture that respects and values individual differences. Healthwatch Kent sees these differences as an asset to our work as they improve our ability to meet the needs of the people and organisations we serve.

In 2015/16 **we will** continue to build on our understanding of the diverse communities within Kent and proactively engage with them to gather their views about the health and social care services they receive. **We will** continue to ensure all the information and services we provide are fully accessible to all Kent residents. **We will** complete Equalities Impact Assessments for all our projects to ensure we hear the voices of those most affected. We have a programme of gathering public feedback where we focus on a different district council area each month. Before carrying out our engagement with the public in a district, **we will** have undertaken and Equalities Impact Assessment and prioritised the communities we want to ensure we speak to.

Our responsibilities

In 2015/16 we will continue to use our position as a voting member of the Kent Health & Wellbeing Board to amplify the voice of the public. Our volunteers will continue to represent the public's voice at the seven local Health & Wellbeing Boards across the county. **We will** also engage fully in agreeing the Joint Strategic Needs Assessment (JSNA), Health & Wellbeing Strategy and Pharmaceutical Needs Assessment (PNA) to ensure the public are actively engaged in setting strategic priorities and Healthwatch Kent is a credible partner of the Health & Wellbeing boards.

We will scrutinise and contribute to the Quality Accounts of the main health and social care providers.

We will use our statutory power to Enter and View services to understand people's experiences of places like A&E, Outpatients departments and care homes and publish the results.

We will use our attendance at the Kent Health Overview & Scrutiny Committee to give feedback from the public and contribute to investigations they undertake.

Partnership of volunteers and paid staff

Healthwatch Kent is not a membership organisation. It exists to serve the whole population of Kent regardless of whether individuals have signed up as a member.

To be actively involved members of the public can sign up as a volunteer. There are a variety of roles volunteers can undertake, and the organisation could not achieve its aims without them.

We work proactively with the general public in Kent to gather their feedback and Healthwatch Kent holds a database of people who have asked to keep up to date or contribute to what we do. Networking with other voluntary sector groups and membership groups allows us to cascade Healthwatch information to a further group of people who may not wish to register with Healthwatch directly.

Healthwatch Kent ensures that volunteers represent the public and patients of Kent, supported and partnered by a small team of paid staff. Volunteers are fully inducted and trained and understand that their role is to be the conduit for the feedback Healthwatch Kent receives, they do not use it as a platform for their own concerns.

Our volunteers are involved at every level of what Healthwatch Kent does. They:

- help agree priorities
- gather intelligence and information
- plan and carry out Enter & View visits
- represent Healthwatch Kent at meetings and forums
- liaise with stakeholders
- gather feedback from the public
- promote Healthwatch
- work together in their locality to improve services

In 2015/16 **we will** undertake a targeted volunteer recruitment campaign to ensure our volunteers are representative of the localities and diversity within Kent. **We will** develop our induction and training and provide regular updates on agreed topics. **We will** continue to improve our internal information sharing systems to ensure volunteers feel informed and engaged.

How we work with others

We always aim to work in partnership and an open, transparent manner to ensure we are a credible partner to organisations and stakeholders.

We will strive to maintain an open, two way relationship to develop understanding and negotiation. However when we raise a concern with a statutory organisation they are required to respond to us. We avoid duplication of the work of others and aim to understand and enhance that work. We work with Kent organisations and stakeholders in a variety of ways.

Commissioners

We will continue to liaise closely with the organisations that fund services. In Kent there are seven Clinical Commissioning Groups (CCGs) who have GPs as their members and commission many community and hospital services. We meet with the CCGs regularly, sharing intelligence and informing their evaluations of the quality of services. We support them in ensuring the public are fully consulted on planned services. **We will** also work closely with NHS England who hold the contracts with GPs and specialist services.

We are a key partner in Kent County Council's strategy for improving the cost effectiveness of services and how they work more closely with health services to offer seamless service to the public.

Providers

We have strong relationships with the three hospital trusts in Kent as well as the community health trust, the community mental health trust and the ambulance trust. We update them regularly on the feedback we receive from the public about them, alert them to serious quality issues and we are supporting many of them with engaging with the public.

We will continue to visit care homes, day services and talk to the public about services they receive at home. We always raise any concerns and good practice directly with the provider before anyone else. **We will** continue to publish reports on our findings that are balanced and objective to ensure we continue to be seen as credible representatives of the public. **We will** work hard with providers to ensure recommendations are acted upon.

Inspectors

We have monthly liaison with the Care Quality Commission (CQC), who inspect all health and social care services in England. We provide intelligence on services about to be inspected and assist the CQC with listening events prior to large inspections where the public are invited to give feedback. Following inspections we are invited to 'Quality Summits' where all partners hear the outcome of the inspection before it is published and confirm what support can be given with the action plan to improve the service. We have worked with East Kent Hospitals University Foundation Trust and Maidstone & Tunbridge Wells Hospital Trust following their inspections and worked in partnership with Monitor who ensure NHS services are meeting targets and are financially viable. In 2015/16 **we will** continue to work with organisations following their CQC inspection such as the mental health trust Kent & Medway Partnership Trust. Where there are serious concerns raised about a service **we will** inform the CQC who will then decide whether to inspect.

Voluntary Sector

We recognise that voluntary organisations work with the groups most disadvantaged by the way health and social care services are delivered. **We will** continue to work in partnership with those organisations to utilise their relationships with those groups so we can help ensure their views are heard. **We will** increase the number of voluntary and community groups that have a Healthwatch Kent Community Champion and ensure every group is aware of how to link with Healthwatch Kent.

Elected members

Healthwatch Kent is an independent organisation and so does not take part in party political activities or campaigns. We recognise the importance of those who are democratically elected to represent the public and **we will** continue to develop our relationships with MPs, county, district and parish councillors. The feedback they receive from the public is valuable intelligence to understand their experiences of health and social care services.

Patient engagement

We work closely with many patient and public engagement networks and forums and **we will** support them to continue to develop and be essential parts of engagement with the public:

Patient Participation Groups (PPGs) are based in GP practices and are a vital network in listening to the public's views on health and social care services. We have met with many of them but **we will** ensure every PPG understands how to work in partnership with Healthwatch Kent.

The Mental Health Action Groups are regular forums for patients, carers, providers and commissioners to discuss service issues in mental health. We attend the Kent forum and are nominating Healthwatch Kent representatives on the others.

We ensure we keep in touch with carers groups and forums and will ensure we have more representatives attending. **We will** also continue to link with other patient and public engagement activities across the county.

Healthwatch England and neighbouring local Healthwatch

We are part of a network of 152 local Healthwatch organisations. The network is supported by a national organisation;

Healthwatch England. Healthwatch England (HWE) provide support to local Healthwatch and collate the work being done by them to look at the national picture. **We will** continue to work closely with HWE and share the outcomes of the work we do.

Where an issue can only be addressed on a national level **we will** escalate it to HWE who have a direct relationship with the Department of Health, NHS England and Care Quality Commission nationally, and can also lobby parliament behalf of the public.

We have worked closely with neighbouring Healthwatch in East Sussex, Bexley and Medway and in 2015/16 continue to work closely on projects that affect our residents. **We will** also continue to meet regularly with all Healthwatch in the South East to see what we can achieve on a regional level.

How we work with the public

Feedback from people about their experiences of health and social care services is the information we use to do our job, so we make it as easy as possible for the public to talk to us:

- The Information and Signposting freephone line is the easiest way to contact us on **0808 801 0102**, Monday to Friday 10am to 4pm. We work hard to ensure we immediately answer any call received in the opening hours but if you have to leave a message **we will** ring you back within one working day.

- You can email on **info@healthwatchkent.co.uk** and **we will** respond within two working days.

- You can text us on **07525 861639** and **we will** respond within two working days. Use this service if you require a British Sign Language Interpreter.

The phone line cannot deal with complaints but can provide information about how to complain to the relevant organisation. **We will** continue to respond urgently to cases where people are potentially at risk or the quality of a service is extremely poor. **We will** continue to have quarterly liaisons with the patient experience departments in the main providers to share anonymised feedback we have received from the public and ensure we can contact the correct person urgently if necessary.

We also ensure that we meet people face to face:

- Anyone can go into their local Citizens Advice Bureau (CAB) and be helped to contact us.
- We hold four public meetings a year, in venues across the county, to update people on our work and gather feedback.
- We visit a different district council area each month and visit libraries, CABs, community groups and events. During these 'public voice' sessions we raise awareness of Healthwatch Kent and the freephone line, give information about patient rights, gather feedback of people's experiences, and recruit new volunteers.
- We work with other organisations to deliver events to gather public views
- We work with voluntary organisations who feed us the views of their service users

In 2015/16 **we will** ensure we are easily accessible to the most disadvantaged groups in each district to ensure their voice is heard by commissioners and providers. **We will** also increase the activities our volunteers undertake in their local area to engage with the public and understand local issues re health and social care services. **We will** continue to raise awareness of Healthwatch Kent amongst the public; it is now a requirement for health services to display our information and **we will** be monitoring that this happens. We are also touring with our big red bus in June 2015 which will visit every district in Kent to raise awareness of Healthwatch Kent and gather feedback.

How we decide our priorities

From the feedback we receive from the public we look at trends in services to see what issues are affecting people the most.

We also look at the issues being discussed with commissioners and providers around the county. Healthwatch Kent have a network of volunteer representatives who attend meetings and forums throughout Kent and report back the main issues that are being discussed. We also respond to urgent issues such as the outcome of Care Quality Commission inspections and closures of services. All these issues are brought to our Intelligence Gathering Group (IGG) each month which is made up of volunteer readers.

Once we have gathered the issues volunteers read and research to understand what work might already being done in those areas to avoid duplication. This involves looking at commissioning plans and speaking with commissioners and providers to understand the current situation. If we feel the issue needs further investigation, and that the views of patients and the public have not been heard, the decision of whether it becomes a priority for further work is made by our Deliberations & Directions (DaDs) group. The DaDs group is made up of volunteers and paid staff who consider the evidence provided by IGG. If something is agreed as a priority, Healthwatch Kent will undertake further work as described in the section **how we improve services.**

In 2015/16 we anticipate the amount of feedback we receive will increase as it has in 14/15. **We will** implement systems to manage the increased amount of feedback effectively and be clear about the main themes and areas of concern.

We will continue to listen to our external representatives and the issues they discuss at meetings and forums giving them feedback on how the information has been used.

How we improve services

We can influence and improve services in a number of ways. These include:

- Under Events & Workshops section
- Change sentence to read

We will continue to host events and workshops for the public to share their experiences and to discuss ways to improve services. The people that commission and provide services will always be part of these discussions.

- **Discuss with the provider or commissioner concerned.**
  This might be done by the Healthwatch Kent Chief Executive Officer or the local Area Team of volunteers. In 2015/16 **we will** continue to work in a transparent way with stakeholders to understand the issues, agree the value of the public feedback and gain assurance that the issue is being addressed.

- **Undertake an Enter & View visit to speak to patients face to face and make recommendations.**
  In 2015/16 **we will** continue with our programme of Enter & View visits to social care services such as care homes and day services to speak to service users, carers, family and staff about their experiences and feed this back to the organisations involved. These reports will have recommendations which the organisations are required to respond to and are published on our website.

- **Agree to undertake a project.**
  In 2015/16 **we will** continue to use some of our funding to commission community organisations and specialists in exploring issues and making recommendations. Project reports are published for the public to review what we have done.

- **Events and workshops.**
  We will continue to host events to allow the public to agree actions for our projects.

- **Action plans and follow up.**
  We have worked hard to ensure we follow up on our projects and monitor how actions are completed.

- **Ongoing liaison.**
  We developed regular liaisons with organisations to monitor our action plans and have already seen organisations using that liaison to proactively involve us in upcoming service changes.

Where we are not able to effect improvements alone, we escalate to Healthwatch England or the Care Quality Commission.

Strategic priorities 2015/16

Below is a list of the priorities agreed by our DaDs group as described in the section **How we decide our priorities.** This list is not exhaustive and **we will** continue to respond to issues brought to our attention as described in the same section.

Improvement of Mental Health Services

We will undertake an evaluation to establish whether actions taken in response to reports published by Healthwatch Kent in 2014 have led to improvements in services for service users and carers.

Improvement in Children and Adolescent Mental Health Services (CAMHS)

We will work in partnership with commissioners to ensure the voice of young people is heard in the redesign of CAMHS, now known as Children and Young People's Services (ChYPS).

Health & Social Care Complaints

We will follow up our evaluation of complaints processes in health and social care with an evaluation of the improvements that have been made from complaints and how those improvements are maintained.

End of Life Care

We will also continue to link with other patient and public engagement activities across the county.

Dentists

We will speak with patients of dental practices in Tunbridge Wells to understand their experiences, and work with those practices on evaluating their services.

Focus on Social Care Services

We will ensure we have equal focus on social care services and health services.

We will continue to work in partnership with commissioners in ensuring public participation in planning and procurement.

Children & Young Peoples Services

We will work closely with existing networks that gather feedback from young people and families. **We will** work closely with Children's Health & Wellbeing Boards to ensure that the voice of children, young people and their families are heard in setting strategic priorities and developing new services. **We will** gather feedback on the challenges faced by children and their families in accessing health and social care services, in particular the experiences of schools referring children into services.

Integration of Health & Social Care Services

Healthwatch Kent has already been heavily involved in the strategies for integrating services.

We will monitor the impact of the Better Care Fund but recognise that new services put in place for this fund may need to be reviewed in 2016 for evaluation to be meaningful. In the meantime Healthwatch Kent will gather the experiences of people, in particular older people, who are moving between services e.g.

- From hospital to a care home
- From hospital to the community
- From the community to hospital

We will undertake this work where short term improvements in services can be made, without needing to wait for integrated services to become effective.

We will employ our statutory power to 'Enter & View' services to speak to service users, carers, family and staff about their experiences and feed this back to the organisations involved. These reports will have recommendations which the organisations are required to respond to.

Consultations

We will work in partnership with organisations to ensure they actively engage communities when consulting on service changes. **We will** act as a critical friend, setting out our expectations of good practice.

Governance

The funding for Healthwatch is provided by the Department of Health and passed to local authorities to administer. Kent County Council (KCC) manage the funding and Engaging Kent CiC were awarded the contract to deliver Healthwatch Kent. KCC and Engaging Kent have agreed an outcomes framework to measure the performance of Healthwatch Kent.

There are two types of governance in relation to Healthwatch Kent:

Corporate Governance:
A framework of rules and practices by which the Engaging Kent Board ensures accountability, fairness and transparency in its relationships and stakeholders with regard to Healthwatch.

Organisational Governance:
The process of overseeing of the direction, running and effectiveness of an organisation, in this case Healthwatch. This is undertaken by the Chief Executive Officer (CEO), the Deliberations & Directions Group and the Intelligence Gathering Group.

Engaging Kent CIC role and function
Directors of the Engaging Kent CIC are not directors of Healthwatch. Their responsibility is to oversee the delivery the contract and ensure the highest standards of quality and adherence to best practice. It is the employer of staff working within Healthwatch.

Engaging Kent CIC has a duty to ensure that the governance structure and processes in place to deliver Healthwatch are robust and that the service meets its contractual and statutory obligations. This is done via the line management of the Healthwatch CEO and delegated areas of responsibility. It provides assurance that Healthwatch Kent's priorities and activity cohere with the Outcomes Framework and local stakeholder and national bodies' expectations of best practice. It assesses and manages risks to Healthwatch Kent.

Deliberations and Directions Group (DaDs) Role and Function
The Deliberations and Directions Group (DaDs) is the body which determines the direction, content, format and schedule of work that reflects Healthwatch Kent's priorities and goals. Its remit is to define, shape and implement what Healthwatch Kent wants to achieve. The DaDs group is a core part of the governance arrangements through which Healthwatch Kent can deliver its operational and strategic objectives.

The DaDs members make decisions based on their knowledge and expertise; and from the evidence based information they receive from the Intelligence Gathering Group (IGG). IGG captures information and data from multiple sources – large and small organisations, public, community and professional bodies, official and lay individuals – and sorts, refines and presents it to the DaDs group.

DaDs reviews the intelligence received and determines what to act on, how to act and to whom it should award grant pot money. It is helped in this choice by testing each issue against the priority setting tool. This is a simple weighting and multiplier system that selects and assesses the potential impact of each proposed project. Transparency, rigour and objectivity are the basis for DaDs effective and successful working.

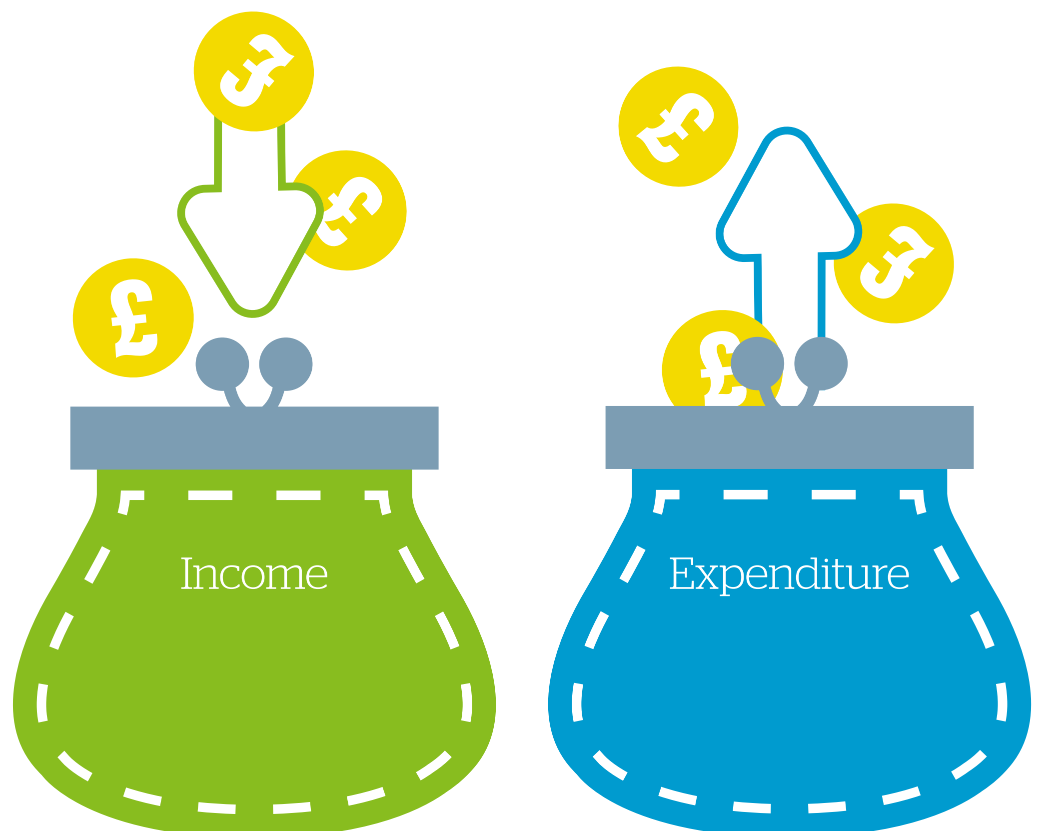
The DaDs group also receives project reports, analyses and data from the 'Enter and View' projects.

The group operates by discussion and consensus and is chaired by the CEO, who has the ability to veto any activities they consider to be contrary to the Outcomes Framework, the contract or best practice. It is empowered to take agreed actions forward within the allocated budget lines and available resources and determine delivery timeframes.

Ensuring value for money

In 2015/16 Healthwatch Kent will continue to be open and transparent about the funding it receives and how it is spent by undertaking the following actions:

- **We will** publish our accounts each year in our annual report.
- **We will** ensure funds are used effectively in the day to day operation of Healthwatch Kent.
- **We will** ensure we offer opportunities for funding for project work as widely as possible and select organisations based on the quality of the proposals as well as value for money.
- **We will** undertake value for money evaluations of project work to demonstrate robust monitoring of the use of funds.
- **We will** ensure volunteers are not left out of pocket by working with us and pay expenses according to our agreed policy.



healthwatch
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Healthwatch Kent

Annual Report 2014/15

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Our vision, mission and values

Our mission

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

Our vision

You, the public, are listened to, and involved in, improving our 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
- Truly represent residents of Kent

Foreward from our Chief Executive

This time last year, I was reflecting on the end of our first year and the progress we had made in setting up a new organisation, recruiting and training new volunteers. Now another year on, and Healthwatch feels very grown up.

We have nearly 70 volunteers all of whom are actively involved in supporting us in different aspects of our work. Together with our volunteers, we have embarked on a number of detailed projects and reviews of Kent's services. This work is already delivering changes for people who are receiving services right now or improving services for the future.

We passionately believe that by working in partnership with other organisations we can achieve more together. Although we have nearly 70 volunteers, we remain a small organisation covering a huge geographical area with vast differences and priorities from district to district. We continue to invest time in our relationships with the organisations who provide and commission health & social care services in Kent. These relationships mean that we are regularly approached for our input and advice on how best to engage with, and listen to the public. For example, we have recently completed some work in West Kent which saw us involving 215 people and organisations in the plans to improve stroke services. We are currently working in East Kent to ensure the public are involved in plans to change and improve hospital services. These relationships also mean that when we regularly request in-depth information from providers and commissioners about aspects of their work all of them have responded, and willingly work with us in our bid to improve services.

As we move into our third year we are conscious that we are not yet hearing enough from young people. We are planning a new project that looks to build our relationships with youth groups and engage better with young people. We are also looking to invest in new ways to build more meaningful relationships with the voluntary sector and people who are traditionally harder to reach.

This report details just some of the highlights from this year. We hope you find it useful. Do please get in touch if you would like to be involved in any way or would simply like more information.

You can reach us anytime on 0808 801 802 or via email on info@healthwatchkent.co.uk

Steve Inett
Chief Executive, Healthwatch Kent

Our volunteers

Our volunteers are essential to us. They are the life blood of Healthwatch Kent. They are involved in every single aspect of Healthwatch from making decisions about our priorities, through to helping us stuff envelopes. We simply could not function without them.

We asked one of our volunteers, Helen Stewart what it's like to be a volunteer with Healthwatch Kent.

Why did you become a volunteer?
I recently retired from social services but I still wanted to play an active role in improving services for people.

What do you do for Healthwatch?
All sorts! The time I have available varies so some weeks I do more than others but that is the great thing as Healthwatch is flexible and fits round my life.

I represent Healthwatch at meetings which means I update the meeting about the work that Healthwatch does. I also relay information back to Healthwatch about the work of the meeting group which in this case is the Swale Health & Well Being Board. My meeting report is used along with similar reports from lots of other volunteers as a source of information by our Information Gathering Group (IGG). I also sit on the IGG group which is one of Healthwatch's key Governance groups.

We are a mixture of volunteers and staff and we review and analyse all the information that comes to Healthwatch either from the public, from voluntary groups, meetings reports from people like me and intelligence from surveys and reports. We then make recommendations up to the Healthwatch Deliberations & Directions Group (DaDs) about what we think Healthwatch should be focusing on. The DaDs group is again made up of volunteers and they look at all the recommendations alongside the resources that we have and determine what our priorities and projects should be going forward.

I have been trained to do Enter & View visits. I am due to visit a mental health ward in Canterbury very soon and I have already completed a number of visits to hospitals and care homes. I've also been trained to be a facilitator which means when we meet with the public I know how best to gather their experiences and thoughts on services.

What does it mean to be a volunteer with Healthwatch?
I very much value the work I do with Healthwatch. It is so varied but we have already achieved so much. I am proud to be making a difference to the community I live in.

We have a huge variety of volunteer roles to suit all interests and availability. Give us a ring and find out more. Call our Volunteer Co-ordinator, Theresa on 0808 801 0102 or email theresa@healthwatchkent.co.uk

How do we work for you?

Feedback from people about their experiences of health and social care services is the information we use to do our job. We can't work to improve a service, if we don't know the issues, so we make it as easy as possible for people to talk to us:

- The Information and Signposting freephone line is the easiest way to contact us on **0808 801 0102**, Monday to Friday 10am to 4pm. We work hard to ensure we immediately answer any call received in the opening hours but if you have to leave a message we will ring you back within one working day.
- You can email us on **info@healthwatchkent.co.uk** and we will respond within two working days.
- You can text us on **07525 861639** and we will respond within two working days. You can request a British Sign Language Interpreter via our text service and they will arrange to meet with you.

The phone line cannot deal with complaints but can provide information about how to complain to the relevant organisation. We will continue to respond urgently to cases where people are potentially at risk or the quality of a service is extremely poor. We will continue to have quarterly liaisons with the main providers of health and social care services to share the anonymised feedback we have received from the public.

We also ensure that we meet people face to face:

- Anyone can go into their local Citizens Advice Bureau (CAB) and be helped to contact us.
- We hold four public meetings a year, in venues across the county, to update people on our work and gather feedback.
- We visit a different district council area each month and visit libraries, CABs, community groups and events. During these 'public voice' sessions we raise awareness of Healthwatch Kent and the freephone line, give information about patient rights and gather feedback of people's experiences of local services.
- We work with other organisations to deliver events to gather public views
- We work with voluntary organisations who feed us the views of their service users.
- We capture people's feedback via our website and social media. We also have a range of printed materials including a Speak Out form which people can complete and send back to us for free. Our leaflet is available in six languages.

We have proactively taken Healthwatch to many different communities this year. For example, we have visited the deaf community along with our British Sign Language Interpreter to gather experiences of people with hearing loss. We have also worked with our colleagues at Healthwatch Medway and Healthwatch East Sussex on joint projects as we recognise that Kent residents use services outside of the county borders. Equally, many East Sussex residents use Kent services.

In 2015/16 we will improve our accessibility to the most disadvantaged groups to ensure their voice is heard by commissioners and providers. We will continue to raise awareness of Healthwatch Kent amongst the public. You've told us that you want to see Healthwatch raising our profile so we are touring the Healthwatch Big Red Bus in June 2015 which will visit every district in Kent to raise awareness of Healthwatch Kent and gather feedback. We hope to see you there!

Every Comment Counts

What do we do with the information you share with us?

1 Healthwatch Kent receives comments from the public (anonymously if you want).

An example of a comment we have received: "My elderly aunt is in a care home and has a fortnightly chiropody appointment. The patient transport often turns up late. It's making her very worried about missing her appointments and not getting the treatment she needs"

We may signpost you to other organisations where appropriate (e.g. complaints department)

We will take immediate action over comments causing serious concern (e.g. safeguarding)

2 The comments are put onto our database and reports of all comments are sent to health and care service managers.

We check the comments on the database and look for areas with common themes, and of people who are experiencing a good or poor service.

For some big issues, we publish reports with findings and recommendations. This helps health and care service managers to understand what works best from the public's point of view.

3 Using our legal powers we can ensure that health and care managers respond, saying what action they will take.

4 You can read our reports on our website and find out more about current projects.

5 You can sign up for our regular newsletters, with news from around Kent

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 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!

1,225 people contacted our Information & Signposting service this year.

Of these contacts, here is a snapshot of what people wanted to talk to us about

4% Health visitors

5% Handling of prescriptions

8% Staff attitude

20% Issues with making a complaint

6% Waiting times

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

How we decide our priorities?

We are always analysing the feedback we receive from the public to identify trends and issues. We combine this information with feedback from our volunteers who attend a variety of meetings on our behalf. All these issues are brought to our Intelligence Gathering Group (IGG) each month which is made up of volunteer readers.

Mental Health

We undertook a project to talk in-depth to patients, carers and their families from across Kent about their experiences of mental health services. As part of our project we conducted an Enter & View visit to Little Brook Hospital in Dartford. The results of this visit, plus the findings of our project culminated in a series of actions and recommendations. We have been working alongside carers, patients and the mental health trust to make a number of improvements including the completion of a Carers Charter, free wifi for patients at Little Brook, a free bus service for families visiting from Medway to Dartford. Mental health remains an important priority for us in the year ahead.

Quality of Care in Nursing & Residential Homes

We have escalated three concerns for patient safety to the Care Quality Commission and Kent County Council following information we have received from the public. We would urge anyone with worries to contact us for free anytime. In addition we have visited a number of Care Homes across Kent as part of our Enter & View programme. We will continue to plan visits to Care Homes for the coming year.

Complaints systems

People ring us with questions and issues about making a complaint more than anything other issue. This has triggered us to undertake a project to look in-depth at the systems and process that our hospital trusts use to handle and manage complaints. We are also scrutinising the system for people wishing to complain about social care services. We are actively working alongside Healthwatch England, who are campaigning for a total reform of the complaints system at a national level.

Our volunteers further research around these issues to determine what is already being done to avoid duplication. If we feel the issue needs further investigation, and that the views of patients and the public have not been heard, the decision of whether it becomes a priority for further work is made by our Deliberations & Directions (DaDs) group. This year, our DaDs group have agreed on a number of priorities and projects for Healthwatch.

All our reports can be found on our website

Nursing Care at Home

Working in partnership with Kent Community Health Foundation Trust we have invited patients from Thanet & Canterbury to take part in a pilot project to gather the experiences of people who are receiving nursing care at home. We gathered experiences through home visits, telephone interviews and written feedback.

Children and Adolescent Mental Health service

We heard from a number of families about their experiences of this service. This prompted us to undertake a detailed project talking to families who use this service and identifying the key issues that they face. Our report has made a number of recommendations which we are keen to see implemented. We will be working with the organisations that commission and provide this service in the year ahead and revisiting the families to understand if their experience has improved.

Access to services by the Eastern European community

Healthwatch has 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 has been working on a project to investigate. We have held a number of focus groups and worked closely with existing support groups and voluntary organisations. Coupled with a detailed literature analysis we have identified a number of issues and will be making a number of recommendations.

Enter & View

Part of Healthwatch Kent's remit is to carry out Enter and View visits. Trained volunteers carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement.

The Health and Social Care Act allows Healthwatch Kent authorised representatives to observe services and talk to service users, patients, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

This year we have completed 17 Enter & View visits. Copies of all our Enter & View reports are on our website. If you require printed copies just let us know by ringing 0808 801 0102.

Darent Valley A&E, Dartford
Purpose of the visit: Concerns had been raised with us about services at A&E by the Health Overview & Scrutiny Committee.
Outcome: Patients on the day were broadly positive. We will revisit once the new A&E building is finished.

Faversham Minor Injuries Unit, Faversham
Purpose of the visit: We had heard strongly from local residents about the importance of the Unit following news that it may be closed.
Outcome: patients were receiving a good service. Signage and promotion of the Unit should be improved to ensure local people knew where to go should they need it.

Tunbridge Wells Hospital, Pembury
Purpose of the visit: As part of a nationwide inquiry into Hospital Discharge we wanted to talk to patients who were being discharged that day. This visit was in conjunction with Healthwatch East Sussex.
Outcome: the new pilot system was making progress at Pembury and the relevant teams were working well together to ensure quick and seamless discharge of patients. Some concerns raised about discharge of mental health patients and challenges about where they could be discharged too.

William Harvey A&E, Ashford and Queen Elizabeth the Queen Mother Hospital, Margate
Purpose of the visit: As part of our work to support East Kent University Hospital Foundation Trust (EKUHFT), following their Inadequate rating by the Care Quality Commission we undertook a number of visits to East Kent services. The purpose was to establish a baseline of patient experience during this initial visit. Return visits are planned for May/June 2015 to hopefully see improvements.
Outcome: Patients on the day broadly had a positive experience.

Outpatient Clinic at:
- **Kent & Canterbury Hospital, Canterbury**
- **Royal Victoria Hospital, Folkestone**
- **Buckland Hospital, Dover**

Purpose of the visit: As part of our work to support East Kent University Hospital Foundation Trust (EKUHFT), following their Inadequate rating by the Care Quality Commission we undertook a number of visits to East Kent services. The purpose was to establish a baseline of patient experience during this initial visit. Return visits are planned for May/June 2015 to hopefully see improvements.
Outcome at Kent & Canterbury Hospital, Canterbury: The signage has been improved to help patients navigate their way but also to highlight services such as the water dispenser. Whiteboards have been instated to help communicate with patients about any delays and the reasons why. The appointment system is being reviewed.
Outcome at Royal Victoria Hospital, Folkestone: They will explore interim options to help patients find their way in advance of a full scale Way Finding project which is currently being planned. Also planning a new centralised reception to better support patients. Our return visit will examine both of these elements.
Outcome Buckland Hospital, Dover: The new Dover Hospital should address some of the issues around accessibility and signage that we found. In the meantime, they are exploring interim solutions to the signage issues to help patients find their way.

Care Homes:

- **Barnetts Residential Home, Tunbridge Wells**
- **Broad Oak Manor Nursing Home, Dartford**
- **Sonia Lodge Care Home, Deal**

Purpose of the visit: this was part of a number of visits to Care Homes. Homes were selected on the basis of previous CQC reports which had raised concerns about the quality of care that residents were receiving.

Outcome at Barnetts Residential Home, Tunbridge Wells: Continue to make improvements to the physical elements of the home.

Outcome at Broad Oak Manor Nursing Home, Dartford: Residents told us that they felt their calls bells were not answered as quickly as they liked. We recommended that the Manager investigates this further and involves residents and families in the solutions.

Outcome at Sonia Lodge Care Home, Deal: Positive changes have clearly been implemented over the past two years.

Learning disabilities day centres and residential services:

- **Folkestone Independent Living Service, Hythe**
- **Future Home Care & The Birches Respite Facility, Tonbridge**
- **Martha Trust Centre, Deal**
- **Rosecroft Care Residential Home, New Romney**
- **Whiterose Care, Canterbury**
- **Little Brook Hospital, Dartford**

Purpose of the visit: Healthwatch Kent undertook a series of visits to learning disabilities day centres and residential services, as part of a Kent wide observation of provision within the county. Care homes were selected on recommendation from Kent County Council.

Outcome at Folkestone Independent Living Service, Hythe: The transformation of the service from a traditional day centre to a Community Hub has clearly been welcome and well used by clients.

Outcome at Future Home Care & The Birches Respite Facility, Tonbridge: The clients and staff we spoke to on our visit clearly had a good rapport and clients seemed relaxed and comfortable.

Outcome at Martha Trust Centre, Deal: Staff have created a Family Forum. They work with the Forum to look at ways to continually improve the service. The management try to resolve any issues by regular contact with parents individually and through the Family Forum and are constantly looking at ways to improve the service they offer. The CEO has developed a Parent's Representative.

Outcome at Rosecroft Care Residential Home, New Romney: The Trust demonstrated a good relationship with parents and families.

Outcome at Whiterose Care, Canterbury: The residents we met had a positive experience of the service provided by Whiterose.

Outcome at Little Brook Hospital, Dartford: Free wifi for residents was installed almost immediately after our visit, allowing patients to communicate more freely with their families. A free bus service has been established for relatives wishing to visit from Medway. Improvements have been made to the outside area and the number of activities for patients has been improved.

What difference have we made?

1,225 people have directly contacted us this year either by phone, email, through our website or by talking to us face to face at events and community meetings. We have helped each of them with information and signposting to the right service or support.

Hundreds of people have shared their experiences of services with us and we have taken those experiences directly to the people who commission and provide them in order to improve them for the future.

Other ways we have made a difference is through our projects and Enter & View visits. Our visits give people a voice. By talking to us and voicing their experiences we can help to make a difference to services. So for example, **mental health patients** and their families told us about how difficult it was to stay in touch and visit loved ones when the mental health hospital was so far from home. As a result free Wi-Fi has been installed at Little Brook Hospital in Dartford and a free bus service is now provided for families from Medway wishing to visit patients in Dartford.

We have attended meetings to help plan the move of another ward from Medway, this time to Maidstone. In response to our work visiting Sapphire Ward in Dartford this year, we were asked to contribute to the plan for the move of Emerald Ward to Maidstone to ensure issues such as travel for relatives and activities on the ward were planned effectively.

Our visits to **care homes** led to changes being instigated re menu choice and staff training, as well as improving the decoration.

We facilitated a meeting between a **Fibromyalgia** support group and a GP practice where there were concerns from the group about the approach of the practice to fibromyalgia. The meeting was very successful and the practice have agreed to display information about the condition and the support group.

Following every Enter & View visit we make a number of recommendations. On visiting **Outpatients** in East Kent we made a number of suggestions for improvement to their appointment systems and waiting rooms. Most of our recommendations have now been implemented and we are planning a follow up visit to ensure patients are enjoying a better experience.

Similarly by working with mental health **carers** and other voluntary organisations we have helped to raise the voice of mental health carers. We've worked collectively together to ensure a Carer's Charter is now in place and a regular communication with carers across Kent has recently started. Carers have been trying for many years to make these relatively simple changes.

Working with the **Deaf community** we have heard about the extreme difficulties that have in making appointments and securing British Sign Language Interpreters to support them. We've been working jointly with Kent Community Health Foundation Trust, Kent County Council and East Kent University Hospital Trust to create a free credit card which they can present to any health or social care professional to indicate that they require a translator. These cards will be available shortly. Linked to this, we have created a new text service for people with hearing loss who want to contact us. The text service allows people to share their experiences or ask for information. It is also a route for people wishing to set up an appointment with our BSL interpreter to have a more in-depth conversation.

Other examples of our impact are related to **safeguarding** issues. We regularly share our intelligence with the Care Quality Commission and we have escalated three issues this year which we deemed to be serious safeguarding concerns. These issues have been dealt with swiftly by either Kent County Council or the relevant Clinical Commissioning Group.
Through our feedback to organisations about the quality of their previous consultations we have worked closely with hospital trusts to ensure a robust engagement takes place with the public going forward. This work has been on stroke services with Maidstone & Tunbridge Wells NHS Trust which spoke to over 200 people. We are also in the process of working with East Kent University Hospital Trust to ensure the public are fully involved in their clinical strategy.

We have also been an integral part of the **integration** of health and social care services. We took over as chair of the communication and engagement working group of the Kent Integration Pioneer and worked with partners to develop a shared language to be used by organisations across the county when talking about integration.

We are one of the first Healthwatch in England to speak to **people in their own homes** about the services that come to them. Although it is not part of our powers such as Enter & View, many people receive care at home. We found many people received a good service but we fed back to the community trust the areas patients felt they could improve.

The year ahead?

Together with our volunteers, we have identified the following strategic priorities for 2015/16

Improvement of Mental Health Services
We will work with patients and carers to establish if they feel services have changed following our work to improve services

Improvement in Children and Adolescent Mental Health Services (CAMHS)
We will work in partnership with commissioners to ensure the voice of young people is heard in the redesign of CAMHS, now known as Children and Young People's Services (ChYPS)

Health & Social Care Complaints
We will follow up our evaluation of complaints processes in health and social care with an evaluation of the improvements that have been made from complaints, and how those improvements are maintained.

End of Life Care
We will get feedback from patients on the effectiveness of new end of life care pathways in the hospital and community trusts in Kent.

Dentists
We will speak with patients of dental practices in Tunbridge Wells to understand their experiences, and work with those practices on evaluating their services.

Focus on Social Care Services
We will ensure we have equal focus on social care services and health services.

Children & Young Peoples Services
Working with existing networks we will ensure that the voice of children, young people and their families are heard in setting strategic priorities and developing new services.

Integration of health & Social Care services
Healthwatch Kent has already been heavily involved in the strategies for integrating services and we will continue to monitor the impact of the Better Care Fund. We will actively gather experiences of people who are moving between services such as from a hospital to a care home.

Public Consultations
We will work in partnership with organisations to ensure they actively engage communities when consulting on service changes. We will act as a critical friend, setting out our expectations of good practice.

We will also be continuing to raise our profile amongst the general public. If you can help by placing posters and leaflets within your local community do please let us know.

You can follow the progress of these projects through our website or sign up for our monthly newsletter. If you are particularly interested in any of our priority areas or would like more information, do please get in touch.

Finances

Table heading showing statement of activities for the year ending 31 March 2015

Income	Total
KCC Contract	£411,555
KCC Business case projects	£122,213
Project income	£13,940
Total income	**£547,708**

Expenditure	Total
Engaging Kent	£15,601
Staff employment costs	£170,587
Staff recruitment / training	£2,395
Staff and volunteer expenses	£17,978
Projects and research	£287,277
Professional fees	£5,667
Office related costs inc Insurance	£25,345
Total expenditure	**£524,850**

Surplus on activities before taxation	£22,859
Surplus on activities after taxation	£18,287

Balance sheet as at 31st March 2015

Fixed assets	
Tangible assets	£3,981

Current assets	
Debtors	£104,337
Cash at bank	£154,341
Total current assets	**£258,678**
Creditors (amounts falling due within one year)	(£243,576)
Net current assets /(liabilities)	£15,102
Total assets less current liabilities	£19,083
Provisions for liabilities Deferred tax	(£796)
Net assets	£18,287
Capital and reserves	£18,287

Notes

Tangible assets, based on ICT equipment purchases minus a depreciation charge.
Cash at Bank - funds allocated to current projects
Creditors - trade creditors, taxation and social security, deferred income and accruals.

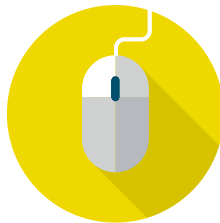
Talk to us | **Tel** 0808 801 0102 | **Email** info@healthwatchkent.co.uk | www.healthwatchkent.co.uk

Your voice counts
We want to hear from you

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

By Telephone:
Healthwatch Kent
Freephone 0808 801 01 02

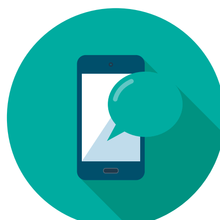
By Email:
Info@healthwatchkent.co.uk



Online:
www.healthwatchkent.co.uk

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

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



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

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Item 8: Chemotherapy Services in East Kent (Written Briefing)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 4 September 2015

Subject: Chemotherapy Services in East Kent (Written Briefing)

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

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

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

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1. Introduction

(a) Following a discussion at the HOSC Pre-Meeting in July, the information for this item has been requested from East Kent Hospitals University NHS Foundation Trust (EKHUFT). The EKHUFT report is attached for Members' information.

2. Recommendation

RECOMMENDED that the report be noted and the Trust be requested to provide a verbal update on chemotherapy services when it returns to the Committee on 10 October with an update on its Clinical Strategy.

Background Documents

None

Contact Details

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East Kent Hospitals University NHS
NHS Foundation Trust

Briefing on the Chemotherapy Services in East Kent
Kent Health Overview and Scrutiny Committee

September 2015

East Kent Hospitals University Foundation Trust delivers Chemotherapy services from its three acute sites (Celia Blakey Day Unit at Ashford, Cathedral Day Unit, Canterbury and Viking Day Unit, Margate); we also have a Chemotherapy Mobile Unit which delivers services at Herne Bay, Dover and Hythe.

In the early part of June this year the Celia Blakey unit at Ashford reported an emerging staffing risk which would see the unit down to 50% of its permanent workforce, by the end of June, due to a mixture of Vacancy, Maternity leave and long term sickness. This presented a patient safety issue and required the service to consider how it would safely continue to deliver care to patients. A number of options were considered and discussed with the Divisional Leadership Team and Executives. There were two clear options one involved agency staff and the other to extend the hours at Canterbury Cathedral day Unit and use the Chemotherapy Mobile unit on the Ashford site for appropriate chemotherapy regimens for a temporary period.

The agency option was very expensive and required us to use off framework agency staff, due to the specialism of this service. The estimated cost for twelve months was in the region of £660k. Furthermore, it is not recommended to run services on such high agency staffing and therefore, the alternative option to provide care from the mobile unit at Ashford 3 days a week and to move those who needed more complex care to Canterbury, was considered the better option. All other non-chemotherapy appointments remain at the William Harvey Hospital if more convenient for patients.

The patient appointments were moved to Canterbury on the 6th July. The Cathedral Day Unit has extended its hours of opening to 9pm Monday to Friday and is opening on a Saturday. Alongside this the Chemotherapy Mobile Unit is available at Ashford three days per week. These arrangements are expected to remain in place for between nine and twelve months. All new chemotherapy appointments remain within the unit on the William Harvey Hospital site.

It is very unusual for our chemotherapy units to recruit chemotherapy competent staff, as there is a national shortage. Normally we recruit band 5 registered nurses and train them, the training takes twelve months. A programme of recruitment has started and we are planning to be back in the Celia Blakey unit within the year. In

addition to recruiting new staff we are in the process of contacting staff who have left our chemotherapy services in the last twelve months. The aim is to find out why they left and could we have done anything differently to have encouraged them to stay. We are also benchmarking ourselves against other Trusts in Kent, Medway and London to establish what grades chemotherapy trained staff are recruited in order to make us a competitive employer.

We have tried to communicate with all concerned and involved in the service. We wrote to and rang patients before we introduced the move and have used media, our CCG and MP's to share the message widely. To support patients we have shared the telephone contact details for the Cancer Care Line to allow them access to our staff, who can support or signpost their concerns.

There had been discussion taking place within the organisation around moving some services to support emergency care at William Harvey and the Celia Blakey Unit, incorporating, chemotherapy, ambulatory and outpatient care were part of the discussion. The Trusts financial position has meant that such plans are currently not being considered and Chemotherapy services will return to the Celia Blakey Unit once our staffing levels are appropriate.